

HORIZONTAL VIOLENCE IN THE NURSING PROFESSION

by

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## Abstract

Workplace violence, which exists in many professions, is not excluded from the nursing profession. The term *horizontal violence* is commonly used to define violence amongst colleagues in the work force. Despite an increase in the literature during the last three decades, horizontal violence continues to remain a serious issue for the nursing profession. This phenomenon must be taken seriously because studies indicate that nurses encountering co-worker violence often intent to leave the profession. Clearly, this will cause a greater strain on the current nursing shortage, which is currently projected to increase. The strain of nurses encountering incivility amongst one another, will not only impact the nursing profession but also health agencies/organizations. The ongoing recruitment and termination of nurses' will adversely impact organizations. Finally, as health care is already associated with many stressors, the additional strain of horizontal violence will ultimately impact patient care.

The intent of this study was to explore nurses' experience of horizontal violence; this to draw attention of the possible consequences and the seriousness of horizontal violence to the nursing profession and health care organizations. The intent was also to identify strategies to mitigate horizontal violence in the workplace. A qualitative approach was employed using phenomenology as the research methodology. Phenomenology is the study of the phenomena through the lived experience, which is exactly the essence that I intended to capture in the work place violence study. Data collection was completed via individual in-depth interviews. Themes and patterns were identified during the interview process. The results of this study revealed that nurses were enduring horizontal violence and the current methods of dealing with co-worker incivility

were not effective. Although policies were in place to deter co-worker violence, these were not enforced, and the reporting methods were a deterrent to report horizontal violence.

## Preface

This study required approval from the UBC Behavioral Research Ethics Board (H12-00676-A001).

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## Dedication

First and foremost, I dedicate this work to my daughter. I extend great gratitude for her continuous support throughout this journey. The endless nights that she assisted me were countless. I could not have undertaken this project without her encouragement. I would also like to dedicate this project to my parents. To my mother, for her strength and wisdom, and finally to my late father who I hope is proud of my achievements.

## CHAPTER 1

### Introduction

In this chapter I introduce the issue of horizontal violence amongst nurses. I also provide the background and the research question as well as the significance of violence to the nursing profession.

There are many challenges facing the nursing profession. Today nurses are confronted with ongoing staff shortages, increased workload, increased patient acuity, decreased job satisfaction and high turnover rates (King-Jones, 2011). In addition to these challenges is the issue of workplace violence within the nursing profession. Horizontal violence is a term that has been associated with much of nursing workplace violence; it is defined as “overt and covert non physical hostility” (King-Jones, p.80), in this case, directed by one nurse or a group of nurses towards another nurse or nurses. This can include “antagonistic” behaviors including gossiping, verbal abuse, sarcastic comments, disinterest and controlling behaviors (King-Jones). There are other terms nursing authors have associated with workplace violence such as “bullying” “aggression” “incivility,” “mobbing,” “workplace violence” “sabotaging,” “eating the young,” “vertical” “lateral violence” “horizontal hostility” and “horizontal violence” (Center, 2011; Billings & Kowalski, 2011; Farrell, 1997).

Lateral violence is described as “dissatisfaction inward toward each other, toward themselves, and toward those less powerful than themselves” (Woelfle & McCaffrey, 2007, p.128). Vertical violence is similar to lateral violence; it is defined as act of violence, which occurs amongst two or more individuals on different levels of the

hierarchical system (Chantey, 2013). This research project will focus on *horizontal violence* within the nursing profession.

It is evident horizontal violence is widespread in all areas of nursing and affects all nurses from nursing students to the most experienced nurse (Thomas & Burk, 2009). Other authors have commented that violence within nursing is more distressing than physical assault from patients (Farrell, 1997). From my experience horizontal violence in the nursing profession can create a hostile work environment and cause additional stress. Ultimately horizontal violence compromises a nurses' ability to provide safe care for patients. Therefore, this is a serious issue that needs to be acknowledged, and addressed by the nursing profession and health care authorities. As Johnston, Phanhtharath and Jackson (2010) state "workplace violence is detrimental to the dynamics of healthcare, and has become an issue that can no longer be ignored...it is becoming increasing prevalent among nurses...and is creating outcomes that are dangerous to healthcare organizations, the nursing profession and to patient care" (p.37). The prevalence of negative outcomes in health care due to horizontal violence is a concern. This topic is insufficiently investigated (King-Jones, 2011). Although there is the existence of literature on this topic for the last thirty years, the phenomenon of horizontal violence continues to exist (King-Jones). This fact and my own experience in the workforce have led me to choose to do my thesis on this topic.

### Research Question

The purpose of my study was to explore the phenomenon of horizontal violence and gain an enhanced understanding of the lived experience of Registered Nurses who have experienced this phenomenon. By exploring the issue of horizontal violence I

intend to bring to the attention of health care agencies the importance of this issue, and its consequences to nurses and patients as well as possible solutions. The question guiding this research is what is the lived experience of registered nurses who have encountered workplace violence enacted by other nurses?

### Background

The origin of horizontal violence can be linked to the generational and hierarchical structure in nursing. According to Bartholomew (2006) the fact that the nursing profession has been positioned as subordinate within the health care system is a contributing factor to the culture of horizontal violence. Furthermore, the management of hospitals within a rigid hierarchical system has bred a culture of authoritarian style and attitude (Cleary, Hunt & Horsfall, 2010) that has supported this approach. This hierarchical and authoritarian style has not promoted a culture of professional collegiality. Therefore this authoritarian structure in the health care organization is a possible contributor to co-worker violence amongst nurses.

Horizontal violence can be generated through the formation of subgroups in the nursing profession. For example, formation of “cliques” can be a major factor in fomenting interpersonal difficulties. Dellasega (2009) describes a nurse who have an elitist attitude, or a nurse who form “cliques,” as a contributing to horizontal violence. A clique can be a two or more nurse who ban together to, in this case, in a negative way in relation to another nurse or nurses. According to Farrell (2001) clique formation is a major activity that leads to horizontal violence. Farrell provides evidence indicating that the formation of cliques’ is frequently encountered in the work settings of nurses. According to some scholars, the formation of the subgroups can be due to workplace

conditions for example, increased stress, organizational change and unrealistic goals (Barton et al., 2011). It is also evident in the literature that the behaviors of this kind of subgroups can destroy morale and can lead to higher nurse turnover (Barton et. al.).

Farrell (2001), states that one of the reasons for interpersonal conflict may be the disempowerment of nurses through the removal of many nurses from decision making processes and a lack of control and autonomy over their working conditions. The idea that this kind of activity is oppressive and can lead to oppressive behaviors within the group who has been affected is referred to as the much-discussed ‘oppression theory.’ Woelfle and McCaffrey (2007) notes that according to the oppression theory “oppression exists when a powerful and a dominant group controls and exploits a less influential group” (p.124). According to Woelfle and McCaffrey, oppression may be one of the explanations for the existence of horizontal violence within nursing.

The position of a nurse can also influence workplace violence. The term “lateral violence” is defined as violence that is inflicted by nurses in positions of power on nurses with less power (Jackson, Clare & Mannix, 2002). Thus unequal power relations and control will often occur between nurse manager or nurse in charge and bedside nurse staff. Jackson et al. note that managers inflict the majority of the “bullying” on subordinate staff, a form of lateral violence. In a British study done on bullying in nursing, it was found that 61% of nurse respondents in the study indicated managers were a continual source of violence and bullying (McMillan, 1995). In another study conducted by Johnson and Rea (2009) on nurse experience with workplace bullying, they reported that 50% of the participants indicated their managers had bullied them, and 25% identified their charge nurse. According to Cleary et al. (2010), managers and charge

nurses engage in behaviors such as withholding information, assigning work below the ability of the nurse, ignoring uncivil behavior and/or use bullying as a management style. These studies suggest that management is part of the problem in the area of workplace violence within the nursing profession. Furthermore, scholars overwhelmingly suggest that nurses generally feel unsupported by management (Fisher et al., 1995).

In addition to the issues noted above culture plays an important role in horizontal violence. Nursing culture can be partially influenced by the approaches of nursing management. If horizontal violence is allowed to continue within the work environment, there is a risk that it will become the norm within the nursing culture (Clare, 1991). As several authors note, organizational cultures can foster an environment that supports violent behavior and actually protects perpetrators (Clare, 1991; McMillan, 1995; Thomas, 1995). The research of Erickson and Williams-Evans (2000) suggest that most that most nurses believe that violence and assault are part of the job. Unfortunately, it appears that *horizontal and lateral violence* is becoming an accepted part of the workplace culture in the nursing profession (Erickson and Williams-Evans).

Nursing students and new graduates are the future of the nursing profession. In most cases students and new graduates are vulnerable to bullying due to their lack of experience in nursing. In a study done by Vessey, Demarco, Gaffney and Budin (2009) with a sample size of 303 nurses, the researchers reported that of the nurses who had worked five or fewer years 58% (N=122) experienced the horizontal violence; and of the nurses who worked 6-15 years 26% (N=55) experienced horizontal violence; and nurses with five years or less years were faced with negative behaviors from co-workers. In another descriptive study with a sample of 511 nurses in Massachusetts Simons (2008)

found no difference in relation to the incidence of horizontal violence between new graduates and experienced nurses. My experience in nursing echoes these findings. It can be devastating for new nursing graduates and experienced nurses to enter into an environment where co-worker incivility is the norm.

Workplace violence impacts individual nurses on a personal level. The aftermath of an aggressive incident is an emotional time, with consequent emotions such as anger, hurt, fear and a loss of self-esteem and self-confidence (Jackson et al., 2002). In addition, nurses who have been bullied often have to continue to work and deal with ongoing poor working relationships. O'Connell, Young, Brooks, Hutchings and Lofthouse (2000) suggest an association between aggression in the workplace and sick leave, burn out, staff turnover and drug and alcohol usage amongst nurses. Other researchers also draw a link between horizontal violence and staff attrition (Dalphond, Gessner, Giblin, Hijazzi & Love, 2000; Farrell, 1999). There have also been feelings of vulnerability and negative attitudes expressed towards work (Farrell).

Scholars have noted the incidence of impaired work performance due to incivility amongst nursing co-workers (Robbins, Bender & Finnis, 1997). One other possible consequence of horizontal violence is the poor quality care and standards of practice. Weinand (2012) states, “nurses who are either perpetuating, participating in, or dealing with the effects of negativity are less likely to respond fully and attentively to their patients needs” (p.24). Clearly this type of response could result in risks to patient safety.

Horizontal violence is a problem for nurses in North America and also internationally (Jackson et al., 2002). Although there is an overwhelming increase in horizontal violence literature over the past decade, there appears to be minimal research

or literature related to the perceptions of nurses encountering workplace violence. There is also a paucity of literature related to the possible consequences of horizontal violence. Given these consequences I therefore believe it is important that we get a better understanding of nurses' perceptions that have experienced the phenomenon of horizontal violence.

Furthermore, many studies have pointed to various strategies to combat horizontal violence such as the zero tolerance policies. There is minimal literature that describes implementation of these strategies and/ or outcomes of the strategies. Given the scope of this thesis project, I explore the phenomenon of horizontal violence from the perspective of nurses who have experienced violence in the work environment. It is my hope that the findings of this study will draw attention to the seriousness of this topic and provide a foundation for more strategizing.

In this chapter, I have outlined the main rationale for the study, its purpose, the research question and my approach. In Chapter Two I will provide a literature review on horizontal violence. Chapter Three includes an overview of the methodology chosen and research methods, and Chapter Four provides the findings of the study. Finally in Chapter Five I provide a discussion of the findings, the implications and recommendations for further research.



## CHAPTER 2

### Literature Review

In this chapter I provide an overview of the literature related to horizontal violence in the nursing profession to complement the references I have cited in Chapter One. This chapter includes an overview of the 'theory of oppression', which is cited in much of the literature as one of the causes of horizontal violence (Farrell, 1997, 1999, 2001; Hutchinson et al., 2006; Randle 2003). Next, I discuss the impact of organizational culture on workplace violence. I also provide an overview of the literature related to generational violence. Finally in this chapter I discuss the consequences of horizontal violence for the nursing profession and the health care organization more broadly.

### Research Studies

Health care professionals are enduring workplace violence more than any other profession (Johnson & Rea, 2009; Sweet, 2005). It is ironic to see violence within health care environments given the commitment of the healthcare professions to promote health and well-being. As I have indicated in Chapter One the victims of horizontal violence include any practicing registered nurse (Randle, 2011).

There have been several studies conducted to examine the presence of co-worker nurse violence. Farrell (1997; 1999) conducted two studies in Australia. In the first study, Farrell's (1997) reported aggression from co-workers was more problematic than aggression from patients. A follow up study by Farrell (1999), which measured the level of distress caused by co-worker aggression and review of the actions were being taken after the reporting of violence. The results confirmed the presence of violence and

defined that the most frequent source of violence was amongst colleagues and between colleagues. Of the total number of respondents in this study, 30% stated they dealt with violence daily, and 25% stated co-worker aggression caused increase stress (Farrell, 1999).

Many studies have indicated the serious damage created by horizontal violence to the nursing professions and organizations According to Brunt (2011), on an international level, one out of three nurses will leave the profession due to co-worker incivility. There are many other scholars who attribute staff attrition to horizontal violence (Dalphond et al., 2000; Farrell, 1999). Nurses leave their jobs for a variety of reasons, but dissatisfaction with the job is regarded as the primary reason for an increase turnover within the nursing profession (Simons, 2008).

In their study, Johnson and Rea (2009) describe nurses' experiences with horizontal violence and the association with 'intent to leave' their job. The findings of this study revealed that 50% of the 249 participants indicated that their managers were the source of bullying, and 25% of the participants stated it was the charge nurses. This study also revealed that nurses who were bullied had intentions to leave their current position or the profession (Johnson & Rea, 2009). Based on previous studies, Wilson, Diedrich, Phelps and Choi (2011) note that the term 'intent to leave' is a strong indicator that nurses will actually leave. In a quantitative study in the U.S done by Wilson et al. (2011) reported that 85% had seen or experienced co-worker violence, 90% have difficulty confronting the perpetrator, 20% called in sick and 40% were considering leaving their current position as a consequence of workplace violence.

In a recent study on turnover intentions and bullying done by Houshmand, O'Reily, Robinson and Wolff (2012) it was revealed individuals who are bullied were impacted as well as those in the environment who are not bullied. The study also confirmed an association between 'bullying' and high employee turnover intentions.

It is clear that if horizontal violence remains largely unaddressed the number leaving the profession will only increase and place a further strain on the nursing profession and health care organizations. To further complicate this serious issue horizontal violence is reported to be on the increase (Randle, 2011). According to Gallant-Roman (2008), the demand for nurses will increase 40% by 2020.

### Theory of Oppression

Oppression has been documented in the literature as one of the causes of horizontal violence (Hutchinson et al., 2006). Brunt (2011) states "oppression exists when a powerful, prestigious group controls and exploits a less powerful group" (p.7). Nurses who experience having limited control and power, such as in decision-making processes within the work environment (Hutchinson et al.), may exhibit symptoms of oppression such as bullying or other forms of horizontal violence. This is confirmed in a study conducted by Simons (2008) who examined 'bullying' experienced by nurses and the 'intention to leave' the organization. This was a descriptive study (N=51; age 22-64 years), which revealed that when nurses experience a loss of power and control over their practice, there is a risk of horizontal violence. This finding supports the idea that oppression can lead to bullying behavior as a strategy to deal with oppression [oppression theory]. Furthermore, the findings of Simons study also revealed 79% of participants were bullied, and as workplace bullying increased so did the nurses' 'intent to leave.'

However, scholars such as Johnson and Rea (2009) note that horizontal violence is a far more complex phenomenon, i.e., that oppression theory is limited; they state “this theory does not take into account the fact that workplace aggression also occurs in other professions and is most like the result of a complex interplay of individual, social and organizational characteristics” (p.84).

### Culture of Horizontal Violence

Although there has been a large body of literature on horizontal violence over the past several decades, it is unclear how long nurses have been enduring this kind of violence in the workplace. According to Hutchinson et al. (2006), horizontal violence is an accepted phenomenon within the nursing profession, a ‘norm’ if you will, and therefore it continues with minimal reporting.

In the literature, underreporting is a common theme within the topic of workplace violence (Erickson & Williams-Evans, 2000; Hutchinson et al., 2006). The fact that many nurses remain silent could suggest that bullying is embedded as part of the culture of nursing. There are nurses who witness their colleagues get bullied and choose to ignore it, whilst the person who is being bullied is reluctant to report the event (McMillan, 1995). Randle (2011) states, “it is evident that there is a general reluctance to voice concerns...bullying is not a subject that is readily discussed” (p.393) and notes that not reporting could be related to an unwillingness to get involved and to the fact that reporting can be difficult, e.g., there is not enough time to do the paper work and there is little or no gain in terms of positive consequences. Generally, nurses who choose to report horizontal violence encounter frustration because the reporting is ignored or there are delays in dealing with the complaints (Randle, 2011).

## Generational Bullying

Generational and hierarchical bullying occurs when a senior nurse abuses a new graduate nurse. The most vulnerable group of nurses to generational abuse are newly hired nurses, float nurses, newly licensed nurses and male nurses (Griffin, 2004). Center (2011) notes the term “eating the young” as associated with the bullying of a student or a newly hired graduate nurse.

McKenna, Smith, Poole and Coverdale (2003) conducted a study on horizontal violence amongst nurses in their first year post graduation in New Zealand. The goal was to describe the most negative incidents experienced by the new graduates (N=551; 94% females) and the presence of consequences, including the psychological impact. The participants completed anonymous questionnaires. The nurses who responded worked in a variety of clinical areas: 21% on medical units, 26% on surgical units, 30% in other inpatient services, 13% in mental health, 6% in community and 4% worked in other roles such as educator roles. Over half of the participants from the study reported being undervalued by their colleagues and over one third reported that learning opportunities were dismissed, that they felt isolated and that increased responsibility was given with minimal support. In addition, 34% indicated that they planned to leave the profession. The identified perpetrators were the charge nurse, supervisor, unit manager, acting charge nurse and senior nurse (McKenna et al., 2003).

Randle (2003) conducted a qualitative three year longitudinal study in United Kingdom (UK) exploring the self-esteem of nursing students with a convenience sample of 39 participants (31 females; 8 males), ages 20 to 50 years. The results revealed that the self worth of nursing students was associated with how they were treated in the

clinical environment. Further, the study revealed that in addition to students being bullied, patients also were bullied. These student nurses observed patients being humiliated and belittled

Based on findings from the late 1990s, Daiski (2004) explored the perceptions of nursing staff with their colleagues and other health care professionals. The study was descriptive and explorative. The sample was purposeful and consisted of 20 nurses' (17 females; 3 males). The study revealed that nurses valued the collaboration and acceptance of other health care members who were non-nursing. It also revealed a presence of lack of support from co-workers with infighting amongst nurses. The participants for this study informed that most nurses do 'eat the young' and the 'newly hired' nurse (Daiski).

#### Organizational/Structural Factors

Organizational factors also can be related to the presence of co-worker violence. Hutchinson, Wilkes, Jackson and Vickers (2010) identified organizational factors when workplace violence becomes embedded within its institutions. They argue that the socialization of horizontal violence begins in the clinical setting during undergraduate education. It appears horizontal violence exists in areas where there are no effective sanctions and as stated previously, becomes part of the organizational culture and the staff/profession. According to Johnston et al. (2010) "bullying arises from organizational cultures that tolerate violence...and subconsciously supports the behavior" (p.38). These findings suggest possible reasons that nurses tend to remain silent on this topic, and do not report their experience. The misuse of power within an organization can lead to the internal bullying within the nursing profession.

The creation of a competitive 'efficiency-oriented' environment within healthcare

also is seen to contribute to horizontal violence. As Hutchinson et al. (2006) note “output measurement, performance management, industry bench marking...can be seen as forms of disciplinary technique, reinforcing power within organizations” (p.121) This type of environment may reinforce bullying behavior in senior nurses towards new nurses or the new graduates since newer staff initially may be less productive as the more experienced nurse. Furthermore, demands and increased workload may be a factor contributing to the increased stress in the nursing profession.

According to Hutchinson et al. (2006) “the goals of healthcare services are often described in terms of efficiency and quality...nursing activities are constantly under surveillance and increasingly monitored, measured, reported and scrutinized” (p.121). Therefore, patients can be seen as tasks and meeting time deadlines can contribute to increase stress for each nurse, which in turn can lead to horizontal violence.

Experienced nurses are susceptible to workplace violence. From an organization perspective if he or she is more qualified or seeks to make changes a manager may refuse to participate in any innovations from someone who may be more qualified. According to Hutchinson et al. (2006) this type of experienced nurse “may be denigrated or humiliated by bullies in an attempt to maintain the status quo...through this process accepted organizational values are confirmed and reinforced and those bullied learn their place in the order of things” (p.122).

Much of the literature cites managers as being one of the main perpetrators of lateral or vertical violence. As I indicated in Chapter One, the terms lateral and vertical violence have been associated with leaders bullying front line nurses (Cantey, 2013) who appear to sustain the patriarchal structure within the nursing (Daiski, 2004). According to

Johnson and Rea (2009) when leaders are the source of bullying it is difficult for nurses to seek support and end horizontal violence.

### Impact on Health Care

Horizontal violence impacts individual nurses on a personal level. The aftermath of an aggressive incident is an emotional time, with emotions such as anger, hurt, fear, pain, loss of self-esteem and self-confidence often being reported (Barber, 2012; Jackson et al., 2002). In addition nurses who have been bullied still have to work and deal with poor working relationships. The study findings of O'Connell et al. (2000) suggest an association between aggression in the workplace and sick leave, burn out, staff turnover and drug and alcohol use amongst nurses. Horizontal violence also can create feelings of vulnerability, dissatisfaction and low staff morale (Barber, 2012; O'Connell et al., 2000)

Impaired work performance was also noted to be a consequence of work place violence (Robbins et al., 1997). In Farrell, Bobrowski and Bobrowski (2006) study, two-thirds of nurses made errors when they were upset due to horizontal violence. Wilson's (2013) study describes nurses who were bullied and the impact on their nursing decisions such as: performing procedures that were unclear, lifting heavy or debilitated patients with no assistance, administering medications that a nurse was unsure, interpreting unclear physician orders and following an order which may have not been the best interest of a patient. It is clear from Wilson's study, workplace violence in the nursing profession can have potential serious adverse outcomes on patients. Barber also (2012) notes, not only is there deterioration in the quality of patient care when health care workers are dealing with the issue of bullying; but poor quality nursing care can result in



family complaints, a lengthy process of investigation and significant financial costs to the organization.

As discussed earlier in this Chapter, the intention of nurses to leave the organization can have serious consequences. At a time when there is a general shortage of nursing staff this kind of loss can be devastating to the nursing profession and the organization. The costs of nurse turnover can be high. For example, in an acute care hospital in the USA in 2002 the cost of replacing a nurse ranged from \$62,000-\$67,000; in 2007 the nurse turnover rate increased to \$82,000 (Wilson et al., 2011).

### Summary

The existence of workplace violence amongst nurses is apparent globally. The fact is that horizontal violence phenomenon has been cited in literature for the last thirty years, yet it continues to exist and there are signs that it is on the increase. At a time when the nursing profession is faced with staffing shortages the research literature indicates that many nurses intend to leave their position due to workplace violence. It is not only the young or new graduates who are enduring horizontal violence but also more experienced nurses.

This literature review revealed that there exists 'no tolerance policies' related to workplace violence in most organizations. However, there is little research examining the impact of such policies on horizontal violence and on nurses. Furthermore, minimal studies exist on the process of reporting, which could be a hindrance to improving reporting and addressing horizontal violence.

In the next Chapter I provide an overview of the research methods employed in a qualitative study in which I explored the lived experience of nurses with horizontal

violence in the workplace. My goal is to further our understanding of the impact of horizontal violence on nurses and health care more broadly and to fuel ideas for ways to move forward.

## CHAPTER 3

### Methodology and Methods

In this Chapter I provide an overview of the methodology and methods used in this study. The methods of recruitment, data collection and data analysis are discussed. The chapter concludes with ethical consideration for the research study. As I articulated in Chapter One and Chapter Two, my overall purpose in this study is to describe nurses lived experience of horizontal violence. The research question for the study is “what is the lived experience of nurses with horizontal violence enacted by other nurses?”

#### Research Methods

This study employs a qualitative approach using a phenomenological method. Phenomenology has its roots in philosophy and psychology (Polit & Beck, 2004). Its purpose is to describe a phenomena or the appearance of lived experience (Speziale & Carpenter, 2003).

Polit and Beck (2007) explain that phenomenology as a way of viewing ourselves, others and everything else whom or with which we come in contact in life. There are two views on phenomenology; there is the descriptive and the interpretive (hermeneutics) view (Polit & Beck, 2004). *Descriptive* phenomenology was developed by the philosopher Husserl who was primarily interested in the meaning of human experience (Polit & Beck, 2004). *Interpretive* phenomenology was developed by Heidegger (Husserl’s student) (Polit & Beck, 2004). Heidegger stressed the importance of interpreting and understanding human experience (Polit & Beck, 2004). In this research study I used both interpretive and descriptive phenomenology because descriptive

allowed finding the meaning of human experience and the interpretative allowed interpretation and understanding of the meaning of the findings.

### Recruitment and Sample

The setting for the study was a community hospital in an urban setting. The study involved participants from the following areas: intensive care unit (ICU) and a post anesthetic care unit (PACU), as well as medical, surgical, neonatal, palliative and gerontology units. There were acute care nurses and community nurses working in the same facility. Recruitment of participants was made possible through the distribution of pamphlets (Appendix 1), which were made available to all nurses via educators and bulletin boards. I also used resources offered by the health authority in which the study took place; for example, I used broadcast via email services (Appendix 2). The other form of recruitment was via word of mouth, for example, the participants who had volunteered told others to volunteer if they had experienced horizontal violence. The inclusion criterion for this study was any nurse currently employed as a registered nurse in this particular facility; students were excluded from the study. I intermittently work as a clinical instructor in another urban acute care setting. Therefore any nurse who I may have taught in the clinical realm and was currently working at the study site was excluded from the study.

Participants were recruited for this study from April to July 2012. The sample size was based on the needs of the study, i.e., the ability of the sample to provide the needed information. The sample was purposeful one, meaning that the sample was defined based on the ability of the participants to provide in-depth information of their experience of horizontal violence in nursing.

All participants initially made contact with myself via email. Clarification of the study was provided at that time. During the initial contact I assessed the ability of the interested participants to provide information about their experience of horizontal violence. I then made appointments to meet the participants at locations of their choice.

All of the nurse participants were female and were currently working in the study site. Their ages ranged from 28 to 55 years. Education ranged from the RN diploma to the Master of Nursing degree. The length of time working at the study site included a range of 3 to 20 years. The areas of work included: education (n=1), medical surgical (n=1), critical care (n=1), neonatal nursing (n=1), community health (n=1), community-palliative (n=1) and community-gerontology (n=2). At the time of the interviewing the palliative nurse participant had chosen to terminate her employment due to *horizontal violence*. The sample consisted of nurses working in a variety of areas. The total number of participants for this study (N) was 8.

### Data Collection

In depth interviewing was the source of obtaining information from participants. Prior to all interviews I reviewed the purpose and the focus of the study. Prior to data collection, consent to participate was obtained and participants were informed of their right to leave the study at any time (Appendix 3). An outline of interview questions was used as a guide (Appendix 4) to the interview process. Interviews consisted of open-ended questions to promote ongoing dialogue with the participant, and to provide an opportunity for the participant to fully share their experience with co-worker violence. During data collection more questions were added as appropriate to the dialogue. For example, I asked an additional question of one participant (5) regarding her preparedness

in school, which was not part of the interview guide. She elaborated the fact there was minimal education on horizontal violence and that education on this topic was lacking in nursing schools. I required clarification with participant (8) about the impact on patient care so I rephrased and repeated the question to capture data “going back to the events you described how did that impact your nursing care?” “So your nursing care was not comprised” (P8). Detailed notes were taken and audio recording was used during the interview.

Audio recording and field notes were dated and labeled with numbers and all identifying information was removed from the transcripts. Each interview recording was transcribed rather than relying on interview notes. Since interviews were the main source of data collection a limit was set on the number of interviews conducted per day. The maximum number of interviews conducted was two per day. I transcribed all interviews in full. The duration of the interviews ranged from thirty minutes to ninety minutes.

I (the researcher) conducted all interviews done in this study. I am a registered nurse with eighteen years of nursing experience. I have worked in several areas of nursing in various hospitals located in the city that this study was conducted, and in England. For the last thirteen years I have worked in a critical care environment in a major urban hospital. As stated previously I am also a clinical instructor working for an institution in the city of this study.

I have observed, witnessed and experienced horizontal and lateral violence within the nursing profession as a student, experienced nurse and clinical instructor. I had worked in other jobs prior to my nursing career, and became aware from my early days the presence and prevalence of horizontal violence in the nursing profession. I therefore

decided to contribute to health care organizations and nursing profession by conducting this research.

### Data Analysis

Data was analyzed using the phenomenological approach of descriptive and interpretive analysis. In this study I followed four steps common to phenomenological studies. These steps are: *bracketing*, *intuiting*, *analyzing* and *describing* (Polit and Beck, 2007). Lopez and Willis (2004) state that *bracketing* involves the researcher holding their own ideas, preconceptions and personal knowledge when listening to participants. Geanellos (2000) states that personal knowledge is both useful and necessary to phenomenological research. Furthermore, Heidegger (1962) emphasized that it is impossible to ignore the background of understanding that leads the researcher to consider the topic worthy of research. Since I have chosen to use descriptive and interpretive phenomenology I allowed my background knowledge in horizontal violence to inform the analysis of the study and therefore I do not apply the aspect of bracketing. However during the interviews I was aware that I needed to reflect on any prior assumptions or biases that I might have had that would influence the data collection. This approach was maintained during the interview to capture the participant's experience.

*Intuiting* involved knowing the phenomenon as experienced by the participants and remaining open to the idea of horizontal violence described by the participants (Polit & Beck, 2007). This was done by listening, recording and capturing the stories as experienced by the participants. Participants were allowed to voice their experience of

horizontal violence. As stated above I did not divulge to the participants my research findings from the literature or my own experience with horizontal violence.

Hermeneutical analysis was used during the *analysis* phase, which involves inductive examination of field notes and interviews to understand the meanings (Massey, 1995). I reviewed all field notes and read the transcriptions to get an overall sense of the ideas presented from the interviews. I then extracted words and sentences and clusters were formed. It was during this process that common themes began to emerge.

During the *descriptive phase*, the goal was to communicate the data. In this phase understanding and defining the phenomena of horizontal violence took place (Polit & Beck, 2007).

### Rigor and Credibility

Rigor in this study was maintained using Lincoln and Guba's framework as described by Polit and Beck (2007). Lincoln and Guba recommend five criteria for evaluating trustworthiness of a qualitative study, these are: *credibility*, *dependability*, *confirmability*, *transferability* and *authenticity* (Polit & Beck, 2007).

*Credibility* is confidence in the truth of the data (Polit & Beck, 2004). To attain credibility my interviews involved engagement with participants listening and clarifying their story on workplace violence. There was prolonged engagement until there was a clear understanding of the information. The length of engagement also provided a sense of connection and trust between the participants. For example allowing sufficient time for the participants to share their stories, attain clarification, listen and observe allowed a sense connection and trust between participants and myself.



As part of the credible data collection persistent observation was also employed. Persistent observation involves focus during the interviews on the conversation, which is relevant to the phenomenon being studied (Polit & Beck, 2004). For example, as participants revealed their experiences on horizontal violence I asked additional questions regarding their feelings in the moment while the events were occurring or how horizontal violence impacted their personal lives.

*Dependability* in a qualitative study refers to stability of data over time (Polit & Beck, 2004). A technique used in dependability is inquiry audit. For this study I used recordings, notes and transcriptions. The supervisor for this study reviewed all transcriptions and assisted with the common themes. The supervisor also assisted with the ethics application. The supervisor and committee members reviewed the drafts for this study. This review also assisted with the *confirmability* of the data.

*Transferability* means that the study findings would be expected in similar situations; it can also be labeled “fittingness” (Speziale & Carpenter, 2003). In my study I provided descriptive data from a variety of nurses in unique roles and positions that would allow greater likelihood of transferability.

*Authenticity* is defined as requesting negative descriptions of the phenomenon under investigation assist in establishing authenticity (Speziale & Carpenter, 2003). In this study descriptions of enduring *horizontal violence* and the consequences such as medication errors were revealed, which displayed the authenticity of the research interviews and collection of data.

Data *triangulation* was used for the study. *Triangulation* refers to the use of many methods to collect and interpret data about a phenomenon; it is defined as use of data

sources for the purpose of validating the information (Polit & Beck, 2004). There are three types of *data triangulation*: time, space and person. *Time triangulation* involves collecting data on the same subject at different points in time to verify the congruence of the subject (Polit & Beck, 2004). This study involved nurses with variety years of experience. *Space triangulation* involves collecting information about the phenomenon from different areas and to validate data by testing cross-site consistency (Polit & Beck, 2004). For my study nurses were interviewed from a variety of nursing departments such as gerontology, neonatal, acute care and community. *Person triangulation* was achieved via interviewing a variety of nurses with different years of experience, education and leadership roles.

The *investigator triangulation* refers to “two or more researchers to analyze and interpret data” (Polit & Beck, p.431, 2004). As this research was part of a graduate degree, as mentioned previously I had a supervisor and committee members who have been reviewing my research study from the initial stages. The supervisor has expertise in violence and the committee has expertise in nursing issues and workplace challenges. The faculty members all have expertise in qualitative research. The committee’s reviews allowed *investigator triangulation*.

### Reflexivity

*Reflexivity* is defined as self-assessment of ones own biases; it is a process of self-awareness in an attempt to demonstrate the trustworthiness of the research findings (Speziale & Carpenter, 2003). Although, I choose this topic for my thesis because I am passionate about the topic. During the interviews I remained non judgmental and was constantly examining my assumptions to allow the participants share their in-depth

stories. In my interview questions, I was cautious not use phrases such as ‘eating the young’ which could impact my data collection. My supervisor also reviewed my interview questions prior to the interviews.

### Ethical Considerations

One of the major ethical considerations for this research project, as mentioned earlier, is that I work in a major acute care setting and I also teach clinically in the same hospital. Therefore, recruitment of participants took place in a different facility in an urban community hospital.

Several ethical considerations were addressed prior to commencing the research study. An application was made to University of British Columbia (UBC) Research Ethics Board (REB). Application was also made to the selected organization to conduct research study and, permission was also required from the director of the hospital.

Steps were taken to assure the participants understood the research study. The purpose and benefits of this study were explained, and the potential risks. Participants were told the length and process of the interview. All questions about the study were answered by: email, phone and prior to commencing the interviews. Participants were informed about the importance of privacy and confidentiality for this study. Information on being a volunteer, anonymity and confidentiality were assured. Furthermore, it was also stressed that participants could withdraw from the study anytime without prejudice (Appendix 3). Interview tapes and notes were identified though the use of codes to protect the identity of all participants and agencies. The interview tapes and notes have been kept locked at my residence, and are only accessible to myself.

Consent from participants was done prior to each interview. The participant and I reviewed consents prior to any commitment to participate in the study. All questions and clarification of the consent were provided (a copy of the consent form is available in Appendix 2). A copy of the signed consent was provided to each participant in this study. Polit and Beck (2007) state “informed consent means that participants have adequate information regarding the research, are capable of comprehending the information and have the power of free choice, enabling them to consent to or decline participation” (p.176). To protect confidentiality the consents were locked and stored at my residence.

As in depth interviewing for this study raised sensitive issues on horizontal violence in nursing. Recall of events was emotional for two of the participants in this study. At that time I attempted to stop the interviewing, however the two participants wished to continue with the interviewing while they were emotional. They voiced at the end of the interview their surprise about how the events of horizontal violence could still stir emotions. All participants were provided with information on counseling services. A confidential Employee Family Assistance Program (EFAP) is available to all employees of the organization and so participants were aware of this service prior to the interviews.

### Summary

In this chapter I have articulated the methodology and methods used in this study. I described the process of recruitment of 8 nurses data collection and data analysis. In Chapter 4, I present the findings from the study interviews.

## CHAPTER FOUR

### Data Collection from Interviews

This study was guided by the research question, “What is the lived experience of nurses who have experienced horizontal violence?” In this chapter I present the findings of the interviews. Through the process of analysis described in Chapter Two, I identified five themes as follows: Eating the young, silent violence, violence as normative and unspoken, leaders and lateral violence and the liabilities of horizontal violence in nursing. I discuss each of these themes in the subsequent sections.

Table below displays the demographic description of participants in this study.

Demographic descriptions of participants:

<b>Participant</b>	<b>Age</b>	<b>Education</b>	<b>Years of Practice</b>	<b>Clinical Area</b>
1	48	Diploma	27 Years	Gerontology
2	55	Diploma	27 Years	Critical Care
3	58	Diploma	37 Years	Gerontology
4	31	BSN	8 Years	Medical/Surgical
5	28	BSN	3 Years	Palliative
6	48	Diploma	26 Years	Neonatal
7	50	BSN	28 Years	Educator
8	40	MSN	17 Years	Community

BSN= Bachelor of Science in Nursing

MSN= Masters of Science in Nursing

All participants in this study had observed or had encountered workplace violence enacted by other nurses. The participants were able to reflect and disclose encounters

they had endured. During the interviews more than one participant was emotional during recalling of the events. The experience of horizontal violence had a significant impact. All participants voiced that the reason for participating in the study was to raise a greater awareness of horizontal violence amongst nurses; an issue, they agreed that has been ignored. During the interview there were many common themes as noted above.

### The Initial Exposure to Violence

During the interviews participants expressed that their initial exposure to workplace violence occurred in their clinical learning experiences as a student, their first nursing job or when they changed jobs. They described the experiences as intimidating and isolating. Participant (1) described her experience in the following,

*My very first nursing job I was bullied by my head nurse, and she was still a nurse even though she was in the senior leadership role. There were times when she walked by me and looked me up and down...I didn't know what she didn't like about me.*

For several of the participants in the study, there was a sense of incredulousness that a person in a senior position of authority would bully them or be uncivil. This invoked feelings of vulnerability, fear and pain. For other nurses there was a sense that they would have to prove themselves as noted in the following interview excerpt with Participant (4),

*A lot of time you just have to prove yourself. Instead of them helping you its like people are sitting back to see what you can show. I read the article they eat their young. I find a lot of that stuff is going on.*

Unfortunately for this participant, 'eating the young' was a lived reality. The idea that new nurses need to prove themselves was commonly practiced, and several participants

in the study noted their difficulty in gaining credibility within the ranks of more senior nurses. Similarly, Participant (5) described her experience as a new graduate in the following,

*My experience with workplace violence goes back to when I first started in palliative. I was a new graduate nurse I had done my preceptorship there and got hired. I knew from my preceptorship days it was a difficult area to break into [palliative unit]. The staff was used to working with another, and for the lack of a better term it was very 'clique.' I had a challenge getting the staff to like me and accept me. Not only because I was a new grad but also because I was a new face and not part of the group. There was a few staff that was receptive to me. However, there was few of the staff that regardless what I did or say didn't like me and they make it quite known.*

There was a liability associated with being a new graduate; many of the participants spoke about not being accepted into the experienced working group. In addition to new graduates, nurses who changed their jobs also encountered unfriendly staff in a new location and experienced feeling alienated and set apart from many nurses in the unit. Participant (6) described her experience in the following,

*In my experience when I changed departments or when I was a 'new kid on the block' I always felt excluded. I wasn't part of that stable group of nurses. There was always this feeling you had to prove yourself before you were accepted. So not being heard, yes for sure I've experienced that. Challenged on decision-making, which I thought, was 'nit picky.' It was around nurses not knowing what I was capable of, so sure I've experienced that as a new staff... It's unfriendly.*

For this nurse changing her job and breaking into a new group of nurses proved to be quite a challenge. As noted above, it was not uncommon for a new nurse to have their abilities scrutinized and their confidence undermined by the dominant group of nurses. Another participant shares a similar experience in the following interview excerpt,

*It was definitely when I was new into a position and by senior staff. I was young I was right out of high school I started my nursing education so I think age became to play a big factor, and everyone was quite shocked the fact how young I was and how I could be a nurse. That has kind of always come up. Age and experience was always a factor...it was definitely demoralizing and discriminatory,*

(Participant 8).

This participant was not alone in her experience of being picked on by senior staff, and was aware that her age put her at disadvantage. She associated the need to prove herself with being a new nurse and being young.

Participant (2) also discusses her experience with the researcher in the following, *I saw a nurse who just finished the ICU (course) and she came down to PACU, then she was mentoring a new nurse and I saw her quizzing the new nurse in front of patients and us. I felt it was uncomfortable, it seemed like she was belittling that person. The one she was quizzing was in a teaching role at [name of institution]. They are both young. I thought where would you learn this...why would you be like that with that young nurse?*

Although the notion of ‘eating their young’ was a common theme during the interviews, participants also encountered nurses picking on one another within the ranks of less experienced nurses, as the above Participant (2) noted ‘they were both young.’



Power dynamics were played out in multiple ways across nurses with a variety of roles and responsibilities.

### Silent Violence

Many of the participants experienced violence as a normative in their workplace. As participant (1) stated “I’ve dealt with silent violence...like lack of communication, withholding information, looks and snide rolling eyes.” This kind of treatment was accepted by nurses and became part of the work culture. Participants also shared examples of unfair assignments or favoritism by the charge nurses. Isolating or ignoring a worker was also a common example. As Participant (6), “I’ve seen nurses ignore each other, not acknowledge each other, treat the other like they are invisible”. Similarly, Participant (5) discusses her experience as a new graduate,

*It was really clear to me they didn’t like me because I would come to work, and I’m the type of person say hello how are you, and start small talk to get the day on to a good start and I was not acknowledged when I would walk into the room. But when I would walk in to the room with another person whom they liked these staff members acknowledged other staff members and pretended I wasn’t even there. I would be given tasks that should have been done during the days like changing dressing of PICC lines. They would say we didn’t get around to do it. They would leave me extra work. If someone else was coming on the shift they would have found the time to do it because it’s me, they will leave it for me... There were other staff members I was comfortable talking to I did make them aware of what I was experiencing, but a lot of them were saying we don’t notice that...I knew that they knew but they did not want to get involved because there*

*was a sense of 'cliqueness' on the ward. They did not want to be part of the drama.*

The experiences of these nurses suggest that in many health environments, workplace violence has become a norm. In many units, although there were colleagues who were not part actively involved, they unwittingly were part of the problem because they were not willing to get involved in addressing this type of violence. In the following example Participant (8) comments further on this issue,

*Do you feel safe? Do you feel protected? It's all of those basic needs I suppose...because if that person is being bullied and the management are allowing it to go on; how can anybody support you? Where as if it was different someone witnessed it [bullying] and said wait a minute that's not right...and that it was not going to be allowed there may be more people willing to take a zero tolerance [approach].*

In addition to this type of ignoring or accepting the phenomenon there were other issues such as documentation that created a barrier to dealing with workplace violence. As participant (8) states,

*The problem is I'm the one who is doing all the documentation. I'm the one who has to model good behavior that is a lot of burden on the victim, the person who is experiencing the bullying or the violence, and often it is easier to walk away.*

The current process of reporting and documentation was expressed as emotionally exhausting, often falling on the shoulders of only a few people. Participant (8)'s experience points to the need for other means or methods of addressing horizontal violence and supporting those nurses who are willing to support its irradiation. Another

participant notes “Maybe [there needs to be] development of a simple documentation tool so that if there is an incident of bullying and what bullying looks like, because I still feel that a lot of managers feel bullying is striking out.” (Participant 7). Safe and efficient processes for addressing *horizontal violence* as well as defining violence was deemed by this participant as an important step in addressing the issue.

### Leaders and Lateral Violence

It was apparent through this study that not only did nurses experience workplace violence between frontline staff nurses; they also encountered issues with team leaders, managers and clinical instructors, i.e., those people in positions of authority. Some participants recalled events that occurred over twenty years ago that still were bothersome to date. In the following exemplar, Participant (3) comments on an encounter with the head nurse and clinical instructor while she was a student,

*I was reprimanded in front of the patient for not having done “peri-care properly” and in retrospect totally disrespectful...you know with demonstration of what I had missed in peri care! It’s almost the patient was subjected to the same ridicule...my Operating Room instructor put the fear of god into me, while teaching me. I found myself hyperventilating, making mistakes that I wouldn’t have normally made. The operating room is a bit of a microcosmic anyway, so if you make any mistakes in the break of technique...you put your patient to risk so it needs to be spoken...The rigor moral with what went on which instrument was next, or I wasn’t enough prepared to do that assist or a particular task that was set for me. I still to this day am terrified of that woman.*

This narrative clearly displays the tremendous power that nurses in authority hold, and the lasting effects of misuse of power. To compound this issue many of the participants in this study found that nurses in positions of authority ignored or were ineffective in dealing with this kind of behavior; these individuals in authority did not necessary enact *lateral violence*, but contributed to it by not addressing it. Participant (5) describes her experience with leader in the following, “She was a smart person and worked there along time, but she knew she couldn’t do a whole lot about it. She would say things like “don’t let it bother you, you come here to do your job, don’t worry about it.” In the following exemplar Participant (8) shares a similar experience,

*For me, I just wanted it to end the hostility and the anger that was projected towards me. The program leader stated, “this person isn’t going to change so you have to pick your battles” ... To me that is unacceptable. Where is the consequence for this person? Where is the accountability for this person? Why are we tolerating this? There needs to be zero tolerance... Our leadership and management need to take a stronger stance with zero tolerance.*

For this participant, and others, ignoring *horizontal violence* had lasting negative effects, and the leadership in nursing often was experienced as ineffective in this realm.

However, participants also recognized the challenges management faced in dealing with workplace violence. Participant (6) shares her insights into the problem in the following:

*The managers that I’ve worked with over the years have been so busy and overwhelmed with the jobs they have a huge portfolio. This [issue] is one more thing; it’s too big to take on. I don’t think that they [manager] don’t care its one more thing for them.*

This participant recognized the impact of workplace processes and structures and the demands placed on nursing leadership that make dealing with issues such as horizontal violence difficult. The expanding portfolios and the challenges and demands of health care make the idea of confronting co-worker violence problematic. This perspective is reiterated by participant (1) in the following,

*I have worked closely with a lot of managers they are unbelievably overworked so they don't have the time to deal with "problems" so they don't. They don't have the time, they don't have the resources. They end up going to meeting, and then rushing to the next meeting, then there is another initiative, and then it's 'god I have to deal with this problem' ...they are spread so thin that when there is a problem they can't deal with it. It's time consuming.*

Another perspective related to the lack of resources and empowerment was shared by Participant (7), who spoke of her sense of the difficulties managers face: “[the] manager that we currently have could have done a lot more had she been empowered, and able to by the union and administration. She made sure there was extra staff on, she really tried to find as much support for the staff as she could.” In addition to workload issues, this participant’s narrative points to the reality of many health care environments where middle management is often unsupported by the larger administrative structures such as the nurse unions and the institutional structures.

Most participants acknowledged the union was not helpful addressing horizontal violence. As Participant (1), stated, “as far as the support for people who filled [filed reports] out reports...there was no support from the union...so you step out of your fearful box...and then you're left there and you have actually no idea of what is

happening.” Similarly Participant (8) also expressed concerns about the union being unsupportive.

Throughout the interviews all participants mentioned the presence of a policy related to workplace violence within the health authority. However, participants also voiced that although the policy was in place, it was not necessarily being utilized. As Participant (1) states in the following,

*We have a policy it is ignored. Nobody uses it, because I believe there isn't the education and support to utilize it. It's great if we have policy, it's wonderful but if you're not using it, it's useless! It's not even worth the paper it's written on in my opinion...If you behave badly there are no consequences or you might be spoken to, but then what?*

Similarly participant (5) notes, “people know about it but it is not being enforced.” In relation to the leadership roles, participants felt strongly that although those in nursing leader positions were challenged in multiple ways, they also agreed that it was “not OK” to accept co-worker incivility and that they expected more. As Participant 5 goes on to say,

*Positive role modeling needs to be in place. If you see a manager who does not tolerate bullying the staff will too. In this unit the staff knew the manager was tolerating bullying. The staff knew there were no repercussions for their actions... There needs to be more repercussions against staff members. As a unionized worker you don't get fired it's not that I want these people terminated, but I did want something done. You get in trouble if you call in sick too many times, you*

*could even be terminated if it continues. There needs to be penalties... there should be an anonymous reporting system*

The union was regarded as almost complicit in horizontal violence because of the lack of action due to poor reporting structures, and union mandates that often were found to be in conflict with addressing this issue.

Many of the participants in this study looked to local solutions initiated by the leadership within their units to deal with bullying. All participants agreed that the current system of reporting or enforcing policy was not working. The participants made several recommendations. For example, one of the recommendations was to form an independent “Nurse peer councilors” (P1), which would comprise of staff trained on how to deal with horizontal violence.

Another recommendation by Participant (4) was that although union members and management involvement was required, staff networking and cohesion could be strengthened through several approaches. For example, surveys could be developed and distributed to staff containing questions such as, “Are you being supported at work...How the team is being treated?” As she noted, she had never had an opportunity to comment on this or to see if others were on the “same page.” She noted that she would like to know, how others would answer: What is the purpose on this unit? What are our priorities? and How can we support each other?

### Nursing Liabilities of Horizontal Violence

Participants described the impact of workplace violence to their professional and personal lives. Professionally, Participant (5) described her experience with working with staff who were bullying in the following,

*It was really difficult because sometimes the manager would come to me and have these talks and it was really hard to concentrate because I was accused of things... That sort of thing would happen at work and it would be hard to continue on the shift with a positive attitude and continue with the type of work I was doing. As an example, I was making mistakes on medications because my mind is else where... my mind is thinking like back to the instance of questions and thinking did that really happen? Why don't I remember it the way they are saying? Why is my integrity questioned when I didn't do anything wrong? I would have to pay attention to work more than usual. I felt comfortable pouring medications but on those particular occasions I really had to focus, actively focus... When they would leave there would be a sense of relief. As much as I would protect myself it affected me. I would be watching the clock to go home. I looked forward to work, but on the shifts when these individuals were working I found myself not wanting to go to work, I have called in sick in a few instances because I had to take a mental health day. If my first night encounter with them was quite nasty I pretty much knew my next shift was going to be bad, and I didn't want to suffer through it so I would take a mental health break. I wasn't sick like I didn't have the flu I just couldn't get myself physically to work.*

After enduring violence for three years, Participant (5) decided to leave her position and work for another agency. Other participants also paid a similar price as the recipients of bullying behavior such as noted in the following, "I found myself hyperventilating, making mistakes that I wouldn't have normally made." (Participant 3) and, "I not did not want to return to the ward. I did not want to return to the facility. I did not want to work



for an organization that treats someone like that and allow it to happen” (Participant 1), and

*For the most part I was able to dissociate and was able to give competent care. It was more of my personal you know, and so a lot of it came home with me and that was challenging. So it affected my personal life or myself as an individual in the sense it was a huge burden to carry that stress. (Participant 8).*

Participants (1) and (8) terminated their employment at the facilities where they worked. In other words horizontal violence behavior dramatically impacted both participants.

Other participants in the study drew attention to the contextual features of bullying that they experienced as influencing/shaping nurses and patients. For example, Participant (7) describes her experience in the following,

*We lost a lot of nurses; we could not fill our positions. We were actually at that point when I first started here. She [perpetrator] already had the reputation of bullying. It was well documented, and management knew about it. They were at the point of hiring nursing from the agencies to fill shifts here because they could not get anybody to work here...My experience with her is it affected patient care because with me [an educator] she wouldn't come to learn anything. She refused to partake in education. She was confused about one medication, and when I called her into the office because she had given the wrong drug...I got an absolute screaming match.*

Here the bullying behavior was experienced as influencing recidivism in addition to safety of patient care. This example displays a bullying issue that is not dealt with the

organization it appears to be accepted and the result is the negative impact on staffing and, more importantly, patient care.

### Summary of Findings

The purpose of this study was to investigate nurses' experience of *horizontal violence* and the impact on their lives and practice. It was clear there were consequences for nurses, who had experienced horizontal violence, it is also clear that this type of violence has direct effect on patients safety for example, medication errors related to stress experienced from co-workers. Throughout the interviews it was evident that co-worker violence was not being addressed. It was an issue that was being ignored by nurses, leaders and health authorities. Minimal support was available from the unions and management, and although some leaders attempted to address horizontal violence, limited resources hindered their ability to make a difference. Although policies on respectful workplace are in place at the study site (and were recently [revised]) according to the participants for this study the policies was not being utilized or enforced.

## CHAPTER 5

### Discussion and Recommendations

In this qualitative research I used a phenomenological approach to provide insight into eight nurses' lived experiences of horizontal violence. The nurses in this study recognized that the presence of co-worker violence results in negative consequences for individual nurses, organizations and patients. In this Chapter I focus on a discussion of the findings. This chapter also includes recommendations.

#### Eating The Young

Many participants during the interview talked about their initial exposure to horizontal violence as a student. In a qualitative study done by Randle (2003), nursing students were monitored for three years. At the beginning of the study most students were eager and enthusiastic, however, as the students progressed in the nursing program they became increasingly distressed. Exposure to bullying by clinical mentors was cited as the most significant cause of the distress.

Another study done by Curtis, Bowen and Reid (2007) revealed that 50% of nursing students experienced workplace violence from staff nurses. Curtis et al. also found that new graduate nurses reported a higher level of absenteeism than the experienced nurse and expressed ideas about leaving the profession. Furthermore the Curtis et al. study revealed that many participants indicated the presence of a culture of horizontal violence, a culture that tolerated incivility towards students. In this study Participants (1), (3), (4), (5) and (8) had expressed they had experienced workplace violence from co-workers because of their age.

The culture of bullying is supported by the behavior of negative role models within the health care environment. Eggertson (2011), states, “nurses who have been bullied themselves tend to view bullying as a kind of initiation that others particularly new graduates or new members of a unit must endure” (p.18). Barton et al. (2011) describes that when incivility is witnessed by student or novice nurses those uncivil behaviors may be internalized and perpetuated as a norm; to “gain a sense of belonging to the profession, the new nurses continue to bully others” (Barton et al., p.34). In this study Participant (5) expressed the nurses who were part of the clique behavior were young nurses, who had not worked in the unit for a long period of time. Perhaps to gain the sense of belonging they chose to be uncivil to Participant (5).

### Cliques in Nursing

The presence of cliques appears to be a contributing factor in workplace violence in the nursing profession. According to Barton et al. (2011) a clique is defined as a:

Group of persons...held together by common interests, views or purposes. Clique membership is usually exclusive and based on social qualifications. Factors supporting cliques include social standing, similar interests and goals, job title and friendships. To maintain the clique power structure, bullying harassment or exclusion takes place. (p.32).

Farrell (2001) notes that the formation of cliques is common in the nursing profession, and states “these subgroups can serve a useful purpose in providing a safe haven for individuals when they are threatened, but can also become a power base for individuals to gain control” (p.28).

Participants for this study were not part of subgroup called cliques and instead they described their positions as being on the exterior of the subgroups. Participants described feelings of isolation, being continuously observed/scrutinized, feeling insecure and minimally supported by colleagues. Barton et al. (2011) state cliques destroy the environment morale, and have an impact on nurse turn over. For example, in this study Participant (5) was bullied by a ‘group of nurses’ and as a consequence terminated her position. Barton et al. notes that it is the responsibility of management to recognize whether their unit is functioning as a clique or as a team. Managers need to ensure that all staff are included as valued team members.

### Managers/Leaders

In this study managers were identified as playing a key role in relation to *lateral violence*, a commonly used term. Leaders dealt with bullying by ignoring the issue, or alternatively were part of the bullying. According to Leiper (2005) the most common bullies are nurse managers. Taylor (2001) states bullying “tends to filter from the top down and is often seen as an acceptable way of managing and getting promoted” (p.407). Furthermore, Farrell (2001) states that nurse managers are “blamed more for acts of omission than acts of commission” due to failure to provide “supportive structures when incidents arose or to take appropriate action to prevent their occurrence (p.30).

This study demonstrated that one of the manager (as described by Participant 5), in response to reports of horizontal violence, was inclined to minimize incidents by encouraging staff to learn to ‘pick their battles,’ perhaps unwittingly normalizing violence in the workplace. Participants felt that managers had a responsibility to

intervene in the event of this kind of report; this perspective is clearly articulated by Participant (7) in the following,

*I would think that if someone reports to the manager that they are being bullied then action should be taken to remove the bully from the workplace and that isn't done, and even when there are witnesses to the bullying...it's not being done.*

Therefore if lateral or horizontal violence is enacted and/or viewed as acceptable behavior by nursing leaders, their behavior can be seen as a contributing factor to the bullying culture of nursing.

The complicit behavior of managers in this study was seen by nurses as a consequence of the contextual features of the work of managers; generally, they were seen as being overworked and lacking resources and support from workplace institutions/agencies. The focus for managers is implementing budgets, or rapid patient flow through or focus on innovations that promote efficiency in a time of scarcity (Rodney & Varcoe, 2012). This focus distracts them from promoting a healthy work environment. Managers do not have time for dealing with co-worker incivility, perhaps due to the lack recognition of the seriousness of the problem.

### Silent Voices

Silence attached to the issue of workplace violence has been well documented. For example, as Becher and Visovsky (2012) state, “over half the events of horizontal violence are never reported” (p.211). However, investigations of nurses who were surveyed related to horizontal violence assert its existence amongst colleagues as being widespread as much as 65-80% (Becher & Visovsky). As Barber (2012) states “bullying

is always present somewhere, but many people including those who have the power and authority to prevent it, recognize or acknowledge it, are choosing not to see it” (p.301).

According to some scholars choosing not to report is contributing to the co-worker incivility. Roy (2011) claims that reporting is the determining factor in eliminating horizontal violence amongst nurses, and individual nurses need to be the catalyst factor on this issue. Roche, Diers, Duffield and Catling-Paull (2010) suggest that nurses sense reporting is an empty gesture with a general lack of support. However, we also know that silence on this topic will perpetuate horizontal violence. In keeping with the findings of Roche et al. this study revealed that participants experienced reporting as not only an onerous process but also one with little support or consequence for the perpetrator. It is likely that this kind of experience is generating and will continue to generate, under reporting by nurses.

### Organization Policies

Employers have a duty to foster employees’ from physical and mental health, hence the need for policies (Health and Safety Report, 2008). Vancouver Coastal Health (VCH) (2010) has a ‘Respectful Workplace and Human Rights Policy’ (Appendix 5). This policy defines disrespectful conduct. The policy also provides a systematic plan for resolving disrespectful conduct in the workplace. In this research study Participant (7) followed the policy and describes the process in the following,

*So we had to go to conflict resolution with HR and the union and the managers. Again I felt it was unfair. I wasn't in conflict I wasn't doing anything wrong. I went to the meeting. The only reason this ever got looked at was because the HR advisor was changed, we had an amazing HR person; it had nothing to do with*

*management. The old HR person would say, 'Oh she cried, she said she will be good' ...When we had this conflict resolution meeting they had drawn up a contract that we both had to sign. It was how I practice everyday, any in-service I did I had to provide them to her [HR]...Long story short she [the bully] did not end up signing the contract and she was let go. But that was after 5 years of me being here, 3 years of me being bullied, and 12 years after documentation of bullying in the unit*

As Participant (7) went on to say, “It’s exhausting when an event happens documenting pages of notes of what occurred, of what was said, and the actions...bullying is not handled appropriately.” Following the policy appears to be challenging; documentation and follow-up processes consume tremendous time and effort. Furthermore, participants found minimal or no action taken on the documented incidents. While most participants described horizontal violence as emotionally draining, the process of reporting created an additional exhaustion. Again, this provides at least one explanation for why nurses are choosing to remain silent on this topic.

Policies related to a *respectful work environment* may require an evaluation and further investigation. It appears policies are present due to mounting research on this topic, yet policy effectiveness in this realm has not been documented in the literature. For example, although the policy on workplace violence in one health authority was recently reviewed, many other policies [on respectful work environment] are in place but not reviewed. As Barton et al. (2011) state, “many facilities have policies related to bullying behavior, however the policies are written...forgotten and never evaluated” (p.36).



## Impact of Horizontal Violence

Horizontal violence amongst nurses has an impact on the individual nurse, patient care, the profession and the organization. This was reflected in a study conducted with 29 participants, where it was revealed horizontal violence was more distressing for nurses than physical assaults from patients (Farrell, 1997).

In another study on bullying within nurses conducted by the International Center for Human Resources in Nursing (ICHRN) (2007) it was reported that workplace violence not only affects individual nurses, but also patient care. ICHRN included a number of descriptions of those affects such as: deterioration in the quality of patient care; deterioration in quality of staff relations; low staff morale; increased stress levels; feelings of shock, disbelief, shame, guilt, anger, fear, and/or powerlessness; depression and self blame; sleeplessness; low levels of job satisfaction; and high staff attrition rates

Similarly this study revealed that participants were impacted by the events of violence from their colleagues in multiple ways. For example, participant (5) relayed descriptions of the emotional by her inability to sleep, *“I took medication for my ability to sleep and relax. I couldn’t be at ease.”* Participant (3) described how her clinical instructor made her emotionally fearful while she was a student. Jackson et al. (2002) notes the existence of psychological effects of violence such as: sleeplessness, anxiety, stress, decrease confidence and diminished work performance. In this study, Participant (5) felt that the experience of horizontal violence resulted in her making medication errors. *“As an example I was making mistakes on medications because my mind is else where.”* Clearly, this is a serious issue and one that requires immediate attention. If

nurses are making errors on medications due to horizontal violence this issue requires immediate attention.

Another impact of horizontal violence on patients is that of nurses withhold information, often from new nurses or new graduates; this could be information that could also have a significant impact on a patient's life. Becher and Visovsky (2012) state that when important information is withheld as part of horizontal violence "the victimized nurse is in a poor position to care for the patient and patient safety is compromised. The subsequent cost to patient, family and institution from compromised care as well as potential legal action can be staggering" (p.211). In addition, if nurses encountering horizontal violence are unable or reluctant to seek clinical assistance from colleagues they may be less likely to seek assistance during a procedure, which may also have consequences for patients; again, patient care will be compromised. Not only are patients suffering, but also the organization suffers when staffs are not able to perform to a high standard of patient care. Health care agencies need to be aware of the consequences of ignoring the issue of horizontal violence because there is potential of a serious impact on patient care and the organization.

There is also an increase in absenteeism due to the emotional impact of violence. Brunt (2011) states, "currently bullied people take an average seven days more off per year than those who were neither bullied nor witnessed bullying" (p.7). Eggertson (2011) states that "according to the 2005 National Survey on the work and health of nurses, more than 22 percent of nurses who reported experiencing low respect from their coworkers had been absent for at least 20 days in the year" (p.19). As I indicated in Chapter Four, in this study Participant (5) talked about how there were instances where she had to take a

mental health day because of the encounters she experienced with the individual nurses who bullied her. Also when Participant (8) was asked if she was impacted with workplace violence her response was *“It did in a sense, it never did when I was working directly with the patient, but it did impact for absenteeism. If you were going to be scheduled with that person that you’re having that ongoing conflict with definitely”*

At this time of nursing shortages nursing (King-Jones, 2011) nurses who have experienced *horizontal violence* are terminating their employment with agencies. This causes a financial impact on health organizations/institutions. The cost of hiring and orienting new nurses only to have them terminate their position in six months or a year is an issue that requires awareness. As Barber (2012) states, “recruiting for new staff can be expensive and time-consuming...clinical areas where bullying is prevalent may develop a negative reputation among staff who may not wish to work in such an environment” (p.300). Seeking nurses to work in a particular area with a ‘known reputation of bullying’ will cause health care agencies challenges in addition to adding to the current shortage of the nursing workforce.

### Recommendations

#### Education

Many methods were recommended by the participants to combat workplace violence amongst nurses. One strategy is to educate nurses to raise awareness of problems and resources related poor co-worker relations. In this study participants believed that health institutions/organizations had a responsibility in this regard and yet this obligation was not being fulfilled.

Brunt (2011) states that “the number one strategy to deal with horizontal violence is to increase awareness of the problem. This would include education of staff, development and communication of policies” (p.7). Thobaben (2011) recommends that education sessions on bullying and agency policies be offered in health care agencies during *staff orientation*. This would assist new staff, including new nursing graduates to become aware of the agency policies, resources and clarify the agency norms in relation to workplace violence amongst co-workers. Thobaben further states there also needs to be yearly education session for the regular employees to continue to raise awareness of horizontal violence and associated polices to support a culture of respect.

### Research

In this study there were participants who terminated their employment as a consequence of the experience of horizontal violence; as noted above, this can be costly for health institutions/agencies. An increase turnover of nurses should be an indicator for organizations to further investigation. Health agencies/institutions should consider tracking possible indicators of horizontal violence. According to Bartholomew (2006), managers need to be able to identify the indicators of horizontal violence, such as increased absenteeism, the presence of cliques and levels of nurse satisfaction.

As one of the participants (3) in this study recommended it may be useful for agencies to track the incidence of co-worker violence, and to consider having staff complete surveys to ascertain how they are feeling about the department they are working, to see if there is any issues that need to be addressed and what support or resources staff may be required to maintain a high standard of patient care.

## Leaders and Organizations

To combat workplace violence within the nursing profession, it is evident that management must play an active role. Managers need to be positive role models to their staff. Belittling staff in the presence of patients or other staff members needs to be extinguished from leadership roles. Managers should create an environment where they are approachable, and are able to communicate without staff fear of being intimidated. This would enable those nurses encountering workplace violence with their colleagues to communicate to leaders. Management needs to create working relationships with their staff, which would benefit the organization.

The lack of attention to workplace violence by managers may be due to a lack of knowledge and education. Therefore, organizations need not only to provide education and resources to nurses on horizontal violence but also to leaders. Brunt (2011) recommends providing conflict management training, and education on how to dealing with co-worker violence. There should also be clear policy guidelines on how to prevent distressful behavior in the workplace, and how to deal with it efficiently.

Dealing with the issue is as important as timing. Prolonging documentation, as the participants voiced in the study will not assist with eliminating or decreasing horizontal violence; it may deter nurses from reporting. Brunt (2011) states, “not dealing with cases speedily will give rise to worsening of the situation, and may increase the psychological damage involved” (p.7).

Most participants for the study voiced the union were not helpful. The British Columbia Nurses Union (BCNU) (2013) partakes on an annual pink T-Shirts anti-bullying campaign, which is one step towards raising awareness of the issue. However,

unions also need to take on a greater role in the prevention of and engagement with methods to deal with horizontal violence. In addition, the unions need to provide better support to individuals who have made complaints

Finally, organizations need to remember their responsibility to the College of Registered Nurses of British Columbia (CRNBC). The CRNBC state that employers are responsible to provide essential support systems including “human and material resources, which allow nurses to meet their professional standards” (CRNBC, 2012, p.6).

### Individual Responsibility

Nurses need to take individual responsibility. As I have explained above, nurses have standards put in place by CRNBC’s governing board that state, “Individual nurses are responsible for acting professionally and being accountable for their own practice. All nurses are responsible for understanding the professional standards and applying them to their practice, regardless of their setting, role or area of practice” (p.6). There are four standards: Professional responsibility, knowledge-based practice, client focused and ethical practice (CRNBC). Under the ethical practice standard it states nurses will promote and maintain respectful communication in all professional interactions. It also directs that colleagues, students and other health care professionals are to be treated in a respectful manner (CRNBC). Therefore, as nurses we all need to be aware of our ethical obligation to the nursing profession and patients. As Eggertson (2011) states, nurses “have legal responsibility and professional accountability based on their licenses, to ensure that the standards of practice are in place. Those standards and the professional’s code of ethics require nurses to support one another to create a positive work environment” (p.20).

Students are valuable to the nursing profession. They require ongoing support to gain self-esteem while they learn the challenging roles of being a nurse. The Canadian Nurse Association *Code of Ethics for Registered Nurses* (2008) state, “nurses share their knowledge and provide feedback, mentorship and guidance for the professional development of nursing students, novice nurses and other health care team members” (p.49). Therefore tactics such as withholding of information or isolating or belittling from students (or any other nurses) is defying our code of ethics and governing body.

### Study Limitations

This qualitative study had a couple of limitations. Time was a factor for three of the participants and as such their stories were limited. Although their stories were rich, participants were unable to answer all of the trigger questions in depth. Another limitation was there were no male participants in this study.

### Study Strengths

This study provides valuable insights in the area of horizontal violence in nursing. The sample was a representation of the population of nursing within an acute care setting. The variety in work experiences of the participants, and the variety of work areas they represented were strengths of this study.

## Conclusion

*Horizontal violence* is a serious issue that is detrimental to patient safety. This study demonstrated the continuing existence of horizontal violence despite the overwhelming literature addressing the topic for the last thirty years. This study also depicted the consequences of horizontal violence, which can incur potential serious results such as medication errors and poor patient care standards. In addition, this study confirmed the reluctance of nurses to report horizontal violence due to the complicated and prolonged processes associated with reporting and the lack of attention to the issue when it is reported.

The study also confirmed that management was involved inadvertently in the phenomenon of horizontal violence. There were leaders who chose to ignore the issue of co-worker violence. There often is a lack of support, including people and financial resources to deal effectively with co-worker incivility. Further, this study demonstrated that policies of respect are valuable, but if the policy they are not being enforced, or if the policy is complicated by its reporting with tedious and ineffective reporting processes then the policy is problematic.

Health care organizations need to be more aware of the serious consequences of horizontal violence. It is evident there are serious implications for patients safety, quality of care, and nurse retention. Strategies such as greater awareness through increased education and associated resources need to be in place to assist in preventing and addressing co-worker violence.

Further studies are recommended on policy implementation related to respectful environments and the current reporting systems of horizontal violence.



## Bibliography

- Barber, C., (2012). Use of bullying as a management tool in healthcare environments. *British Journal of Nursing, 21*(5), 299-302.
- Batholomew, K. (2006). *Nurse to nurse hostility: Why nurses eat their young and each other*. Marblehead, MA: HCpro
- Barton, S., Alamri, M., Cella, D., Cherry, K., Curll, K., Hallman, B., Mckeon, R., Meyers, D., Williams, A. & Zuraikat, N. (2011). Dissolving clique behavior. *Nursing Management, August* 32-37.
- Becher, J. & Visovsky, C., (2012). Horizontal violence in nursing. *Professional Practice, July-August, 21*(4), 210-213.
- Billings, D. M., & Kowalski, K (2011). Mandates for patient safety: Are they enough to create a culture of civility in health care? *Journal of Continuing Education Nursing, 42*(1), 16-17. doi: 10.3928/00220124-201.10105-04
- British Columbia Nurses Union (BCNU), 2013. Promoting a bully free workplace. Retrieved from [https://www.bcnu.org/pdfs/pulletins/2012/pdfs/Bull\\_009.pdf](https://www.bcnu.org/pdfs/pulletins/2012/pdfs/Bull_009.pdf)
- Brunt, B., (2011). Breaking the cycle of horizontal violence. *Indiana State Nurses' Association Bulletin, 37*(2), 6-11.
- Cantey, S. W., (2013). Recognizing and stopping the destruction of vertical violence. *American Nurse Today, 8*(2), 1-4. Retrieved from <http://www.americannursetoday.com/article.aspx?id=9966&fid=9912#>

- Center, D. (2011). Mandates for patient safety: are they enough to create a culture of civility in health care? *Continuing Education in Nursing, 42*(1), 16-17.  
doi:10.3928/00220124-201.10105-04
- Clare, J. (1991). Professional disunity: the effects on preparation for practice. *Nursing Praxis in New Zealand, 6*(8), 5.
- Cleary, M. C., Hunt, G. E., & Horsfall, J. (2010). Identifying and addressing bullying in nursing. *Issues in Mental Health Nursing, 31*, 331-335.  
doi:10.3109/01612840903308531
- Code of Ethics for Registered Nurses (2008). Retrieved from [http://2.cna-aiic.ca/CAN/documentation/pdf/publication/code\\_of\\_Ethics\\_2008\\_e.pdf](http://2.cna-aiic.ca/CAN/documentation/pdf/publication/code_of_Ethics_2008_e.pdf)
- College of Registered Nurses of British Columbia (CRNBC) (2012). Professional standards. Retrieved from <http://www.crnbc.ca>
- Curtis, J., Bowen, I., & Reid, A. (2007). You have no credibility: Nursing students' experience of horizontal violence. *Nurse Education in Practice, 7*(3), 156-163.
- Daiski, I., (2004). Changing nurses dis-empowering relationship patterns. *Journal of Advanced Nursing, 48*(1), 43-50.
- Dalphond, D., Gessner, M., Giblin, E., Hijazzi, K., & Love, C. (2000). Violence against emergency nurses. *Journal of Emergency Nursing, 26*(2), 105.

- Dellasega, C. A. (2009). Bullying among nurses. *American Journal of Nursing, Jan 109*(1), 52-58.
- Eggertson, L. (2011). Targeted the impact of bullying and what needs to be done to eliminate it. *Canadian Nurse, 107*(6), 16-20.
- Erickson, J. & Williams-Evans, S (2000). Attitudes of emergency nurses regarding patient assaults. *Journal of Emergency Nursing, 26*(3), 210-215.
- Farrell, G. A., Bobrowski, C. & Bobrowski, P. (2006). Scoping workplace aggression in nursing: findings from an Australian study. *Journal of Advanced Nursing, 55*(6), 778-787. doi:10.1111/j.1365-2648.2006.03956.x
- Farrell, G.A., (2001). From tall poppies to squashed weeds; why don't nurses pull together more? *Journal of Advanced Nursing, 35* (1), 26-33.
- Farrell, G. A., (1999). Aggression in clinical settings: nurses' views-a follow up study. *Journal of Advanced Nursing, 29*(3), 532-541.
- Farrell, G., (1997). Aggression in clinical settings: Nurses views. *Journal of Advanced Nursing, 25*(3), 501-508.
- Fisher, J., Bradshaw, J., Currie, B., Klotz, J., Robbins, P., Searl, K., & Smith, J. (1995). Context of Silence: Violence and the Remote Area Nurse. Central Queensland University.
- Gallant-Roman, M. (2008). Strategies and tools to reduce workplace violence. *American Association of Occupational Health Nursing, 56*(11), 449-454.

- Geanellos, R. (2000). Exploring Ricoeur's hermeneutic theory of interpretation as a method of analyzing research texts. *Nursing Inquiry*, 7(2), 112-119.
- Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *Journal of Continuing Education Nursing*, 35(6), 257-262.
- Health & Safety Report. (2008). Putting an end to workplace bullying. Retrieved from <http://www.ccohs.ca/newletters/hsreport/issues/2008/04/ezine.html#inthenews>
- Heidegger, M. (1962). *Being and Time*. New York: Harper and Row.
- Houshmand, M., O'Reily, J., Robinson, S., & Wolf, A. (2012). Escaping bullying: the simultaneous impact of individual and unit-level bullying on turnover intentions. *Human Relations*, 65(7), 901-918. doi:10.1177/0018726712445100
- Hutchinson, M., Wilkes, L., Jackson, D., & Vickers, M. (2010). Integrating individual, work group and organizational factors: testing a multidimensional model of bullying in the workplace. *Journal of Nursing Management*, 18, 173-181. doi:10.1111/j.1365-2834.2009.01035.x
- Hutchinson, M., Vickers, M., Jackson, D. & Wilkes, L. (2006). Workplace bullying in nursing towards a more critical organizational perspective. *Nursing Inquiry*, 13(2), 118-126.
- International Center for Human Resources in Nursing (2007). Workplace bullying in the health care sector. Retrieved from [http://www.icn.ch/images/stories/documents/publications/fact\\_shetts\\_FS-Bullying\\_Health\\_Sector.pdf](http://www.icn.ch/images/stories/documents/publications/fact_shetts_FS-Bullying_Health_Sector.pdf)

- Jackson, D., Clare, J., & Mannix, L. (2002). Who would want to be a nurse? Violence in the workplace—a factor in recruitment and retention. *Journal of Nurse Management*, 10, 13-20.
- Johnston, M., Phanhtharath, P., & Jackson, B., (2010). The bullying aspect of workplace violence in nursing. *Journal of Nursing Administration*, 12(2), 36-42.
- Johnson, S. L & Rea, R.E., (2009). Workplace bullying concerns for nurse leaders. *Journal of Nursing Administration* 39(2), 84-90
- King-Jones, M. (2011). Horizontal violence and the socialization of new nurses. *Creative Nursing*, 17(2), 80-86.
- Leiper, J. (2005). Nurse against nurse: How to stop horizontal violence. *Nursing*, 35(3), 44-45
- Lopez, K., & Willis, D. (2004). Descriptive versus interpretive phenomenology: their contributions to nursing knowledge. *Qualitative Health Research*, 14(5), 726-735.  
doi:10.1177/1049732304263638
- McKenna, B. G., Smith, N. A., Poole, S. J., & Coverdale, J. H. (2003). Horizontal violence: Experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing*, 42(1), 90-96.
- Massey, V.H. (1995). *A Study and Learning Tool Nursing Research* (2<sup>nd</sup> edition). Pennsylvania: Springhouse Corporation.
- McMillan, I., (1995). Losing control. *Nursing Times*, 91 (15), 40.

- O'Connell, B., Young, J., Brooks, J., Hutchings, J., & Lofthouse, J. (2000). Nurses' perceptions of the nature and frequency of aggression in general ward settings and high dependency areas. *Journal of Clinical Nursing*, 9(4), 602-610.
- Polit, D. F., Beck, C.T. (2004). *Nursing Research: Generating and Assessing Evidence for Nursing Practice* (7<sup>th</sup> edition). Philadelphia: Lippincott, Williams, and Wilkins
- Polit, D. F., Beck, C.T. (2007). *Nursing Research: Generating and Assessing Evidence for Nursing Practice* (8<sup>th</sup> edition). Philadelphia: Lippincott, Williams, and Wilkins.
- Randle (2011). Workplace bullying in the NHS. *Clinical Feature*, 21(11), 391-393. ISSN 1467-1026
- Randle, J., (2003). Bullying in the nursing profession. *Journal of Advanced Nursing*, 43(4), 395-401.
- Robbins, I., Bender, M & Finnis, S (1997). Sexual harassment in nursing. *Journal of Advanced Nursing*, 25(1), 163-169.
- Roche, M., Diers, D., Duffield, C., & Catling-Paull (2010). Violence toward nurses, the work environment and patient outcome. *Journal of Nursing Scholarship*, 42(1), 13-22.
- Rodney, P., & Varcoe, C. (2012). Constrained agency: The social structure of nurses' work. In F. Baylis, B. Hoffmaster, S. Sherwin, & K. Borgerson (Eds.) *Health care ethics in Canada* (3<sup>rd</sup> ed.; pp. 97-114). Toronto ONT: Nelson. (rev. of Varcoe C, Rodney P. (2009) Constrained agency: the social structure of nurses' work. In:

- Bolaria BS, Dickinson HD, eds. *Health, Illness, and Health Care in Canada*. (4th ed; pp. 122-151). Toronto, ONT: Canada: Nelson Education).
- Roy, J., (2011). Horizontal violence staff awareness and education are needed to rid the nursing environment of this disastrous infection. Retrieved from <http://nursing.advanceweb.com/Editorial/Content/printFriendly.aspx?CC=102740>
- Simons, S., (2008). Workplace bullying experienced by Massachusetts registered nurses and the relationship to intention to leave the organization. *Advances in Nursing Science*, 31(2), E48-E59.
- Simpson, K. R. (2008). Horizontal hostility. *Maternal Child Nursing*, 33(5), 328. doi: 10.1097/01.Nmc.0000334910.31625.8e
- Speziale, H., & Carpenter, D. (2003). *Qualitative research in Nursing, Advancing the Humanistic Imperative*. Philadelphia: Lippincott Williams & Wilkins.
- Sweet, M. (2005). Beating bullying. *Australian Nursing Journal*, 12(9), 16-19.
- Taylor, B. (2001). Identifying and transforming dysfunctional nurse-nurse relationships through practice and action research. *International Journal of Nursing Practice*, 7(6), 406-413.
- Thobaben, M., (2011). Bullying in the nursing profession. *Home Health Care Management and Practice*, 23(6), 477-479. doi:10.1177/1084822311413556.

- Thomas, S. P., & Burk. (2009). Junior nursing students experience of vertical violence during clinical rotations. *Nursing Outlook*, 57(4), 226-231.
- Thomas, B. (1995). Risky business. *Nursing Times*, 91(7), 52-54.
- Vancouver Coastal Health (VCH) (2010). Respectful workplace and human rights policy. Retrieved from <http://www.vcha.ca/page610.htm>
- Vessey, J. A., Demarco, R. F., Gaffney, D. A., & Budin, W. C. (2009). Bullying of staff registered nurses in the workplace: A preliminary study for developing personal and organizational strategies for the transformation of hostile to healthy workplace environments. *Journal of Professional Nursing*, 25(5), 299-306.  
doi:10.1016/j.profnurs.2009.01.022
- Weinand, R. (2010). Horizontal violence in nursing: history, impact and solution. *Journal of Chi Eta Phi Sorority*, 54(1), 22-26.
- Wilson, B.L, (2013). Horizontal hostility: A threat to patient safety. *Journal of Nursing Administration*, 15(1), 51-57. doi:10.1097/NHL.0b013e3182861503
- Wilson, B. L., Diedrich, A., Phelps, C. L., & Choi, M. (2011). Bullies at work the impact of horizontal hostility in hospital setting and intent to leave. *Journal of Nursing Administration*, 41(11), 453-458. doi:10.1097/NNA.06013e3182346e90
- Woelfle, C. Y., & McCaffrey, R. (2007). Nurse on nurse. *Nursing Forum*, 42(3), 123-131.



## APPENDICES

APPENDIX 1

Pamphlet

**WHO IS  
DOING  
THE  
RESEARCH?**

**THE  
RESEARCH  
TEAM:**

Jas Mahli, UBC  
Grad student

Dr. Vicki Smye,  
UBC Nursing-  
Supervisor

Dr. Geertje  
Boshma, UBC  
Nursing-  
Committee

Dr. Paddy  
Rodney, UBC  
Nursing-  
Committee

**ANY  
QUESTIONS**

**ABOUT THE PROJECT:**

**CONTACT  
Jas Mahli**

**ABOUT THE RIGHTS OF A  
RESEARCH PARTICIPANT:**

**Director of Research  
Services**

**University of British  
Columbia**

**Phone: (604) 822-7503**

Health Professionals and Support  
Staff

**INVITATION**  
**Introducing**  
**Research Project for MSN**



**WORKPLACE  
VIOLENCE  
IN NURSING!!**



***What is this Project about and the benefit of this research?***

- *The goal is to learn more about workplace violence within nursing.*
- *To do this, volunteers are required who have experienced workplace violence with other nurses.*

The benefit of this research study:  
-Alert health care agencies of the existence of the violence within the nursing culture.  
- Explore individual nurse experience with violence in the workplace

**IF YOU AGREE TO PARTICIPATE, THE RESEARCHER WOULD:**

- Interview you for about 30- 60 minutes about your experiences with violence within the nursing profession (violence with nurses only, this study does not include violence with patients, family or physicians).
- Provide you with the results of this study.

***Voluntary Participation:***

- There is **no** obligation to participate in this study and you can withdraw at any time.
- Your participation **will not** interfere with your practice.
- Your participation will in **no way** affect your employment or performance evaluations.
- This **is not** an evaluation project.

**PROTECTING CONFIDENTIALITY**

- Names or identifying information **will not** be used in the study or in any reports or publications.
- Employers or managers **will not** have access to any of the information you provide.
- All information will be securely locked to protect all participants privacy and confidentiality

## APPENDIX 2

### Email Broadcast

## RESEARCH STUDY EMAIL BROADCAST

<b>Name of Study:</b>	<a href="#">Workplace Violence within Nursing</a>
<b>Purpose of this study:</b>	<b>Explore the issue of violence within nursing. Bring attention to health care authorities the importance of this matter. Also the potential impact it may on patient care, as well as possible solutions</b>
<b>Who can participate? Hospital</b>	<b>All Registered Nurses working in Richmond General Hospital</b>
<b>What is involved?</b>	<b>Interviews with the research investigator for 30-60 mins about experience of violence with nurses</b>
<b>When does this study take place?</b>	<b>Recruitment commences in March - May</b>
<b>Where does this study take place/location?</b>	<b>Meetings for interviews will be decided with participants</b>
<b>Principal Investigator:</b>	<a href="#">Dr.Vicki Smye PHD</a> <a href="#">School of Nursing Professor</a> <a href="#">University of British Columbia</a>
<b>Contact Information:</b>	Jas Mahli

## APPENDIX 3

### Consent



**School of Nursing**  
T201- 2211  
Westbrook Mall  
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Canada

For the Research Project Workplace Violence Within Nursing

**Consent Form for Participants  
(For Interviews)**

Research Primary Investigator:

Dr. Vicki Smye, University of British Columbia, School of Nursing, phone

Research Co-investigator:

Jas Mahli, University of British Columbia, School of Nursing, Graduate Student

Committee Member:

Dr. Geertje Boschma and Dr. Paddy Rodney

**What is this Project about?**

As part of a thesis for MSN on Workplace Violence at Vancouver Coastal Health (Richmond General Hospital). I'm interested in exploring the issue of workplace violence amongst nurses. The purpose is to explore nurses' experience of workplace violence.

**What does the Study involve?**

You may be interviewed any location of your choice. The length of the interview will be approx 30-60mins. I will be taking notes as we talk and use a digital recorder. At any point in the interview, you can ask for the recorder to be turned off or have the tape erased.

**Risks and Benefits**

There is a minimal risk of psychological distress due to recall of events with violence during the interview. Therefore, resource contact numbers where support can be sought if required will be provided. The benefit of this research study is assist in illuminating the existence workplace violence in the nursing profession in Canada. This is to inform strategies to mitigate violence in the workplace and to assist with the provision of adequate support for nurses (and other health care professionals).



### **Protecting Privacy and Confidentiality**

The information you provide (identifiable data) is strictly confidential. Your confidentiality will be protected in several ways.

1. Your name will not be used in the study or in any reports or articles written about the study. Instead, a number code will be given to each person in the study.
2. You will not be identified in any of our discussions with other members on this project.
3. Information that could identify you or any other you will be deleted from all interview tapes, notes, and documents.
4. The research team members listed above will have access to the research information without your name on it.
5. All information will be locked securely.

The results of this study will be for MSN thesis, and also will be published in a nursing Journal. The research information will be kept for at least five years after the research is published and presented. Thereafter all data will be destroyed.

### **Consent**

Your decision to be in the study is completely voluntary. If you decide to be in the study, and then change your mind, you are free to drop out of the study at any time.

If you have any questions about your rights as a research participant, you can contact Director of the University of BC Research Services and Administration, in Vancouver.

If you have questions or comments about this study, you can contact Jas Mahli.

By signing this consent form you agree to participate in the study described above. You have received a copy of this consent form, which you can keep.

Signature of Participant

Date

Please print your name

## APPENDIX 4

### Interview Guide

## Appendix 4

### Interview Guide

1. How long have you worked as a nurse?
2. Tell me about your experience with workplace violence.
3. How did the experience impact you as a nurse?
4. How did the experience impact your nursing care?
5. Were there any resources/supports available?
6. Did you access any of the resources available to you?
7. Given your experience, what resources do you think are essential to support nurses (or other health care providers) when they experience violence in the workplace?
8. How do you think we can prevent and/ or address workplace violence in nursing?

APPENDIX 5

Copy of VCH Respectful Workplace Policy

**Examples:**

<i>Respectful Conduct</i>	<i>Disrespectful Conduct</i>
<ul style="list-style-type: none"> <li>• Courteous communication</li> <li>• Expressing disagreement in a professional manner</li> <li>• Providing feedback in a respectful manner regarding job performance</li> </ul>	<ul style="list-style-type: none"> <li>• Profanity, name calling, yelling, abusive language</li> <li>• Verbal or physical threats</li> <li>• Malicious gossip or rumor mongering</li> <li>• Purposely ignoring questions or requests of colleagues, or withholding information</li> </ul>

**4.0 Procedures for Resolving Disrespectful Conduct and Discrimination in the Workplace**

The Human Resources Advisor (HR Advisor) is available to assist at any time in the resolution process. A person has the right to seek the involvement of a Union Steward or HR Advisor or Physician Advisor at any point.

If the alleged disrespectful conduct or discrimination is between the person (i.e., complainant) and his / her Manager or Physician Leader, and the person is unable to have the conversation (per Step 1) then the complainant has the option to contact the Manager’s Supervisor, Medical Division Head or HR Advisor. Where the HR Advisor is contacted, the Advisor will inform the Manager’s supervisor of the complaint. The complainant will be dealt with at step 2 of the process.

**Step # 1 – Resolution (Informal Conversation):**

Persons who experience disrespectful conduct or discrimination are strongly encouraged to engage in a conversation with the other person(s) to clarify and resolve the concerns.

Where the person is unable to have the conversation directly with the other person(s), he/she should contact his / her Manager/designate or Physician Leader as soon as possible. If needed, the Manager /designate (typically the Supervisor) will offer assistance such as: scheduling the conversation between both persons or attending the meeting as an observer.

**Suggestions to Support a Successful Conversation between Persons:**

- ✓ *Relax:* This is an opportunity for conversation, not confrontation. Choose a quiet setting and work together to seek clarity on conduct. Sit in a welcoming manner (i.e., try not to cross your arms) and make eye contact (i.e., connect in a respectful manner). A person’s body language, tone of voice, and attitude can influence the outcome of any conversation.
- ✓ *Speak slowly and clearly:* Identify the specific behaviour with examples. Thank the other for agreeing to discuss the conduct, speak calmly in a non-blaming tone and take turns speaking.

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	Review Date: September 4, 2010
Issued By: Vice President – Employee Engagement	

- ✓ *Listen carefully:* Take time to check your understanding of what has been said, ask questions to clarify what the other person means, confirm what has been relayed (i.e., sometimes what we hear can be different from what is being said).
- ✓ *Stay focused on how the issue is impacting you and your work.* State your commitment to being part of the resolution. Confirm what was said and agreed upon and thank the other for their willingness to bring clarity to the issue. Try to agree on ways to improve the relationship.

### Step # 2 – Resolution (Manager / Designate Involvement):

If there is no resolution under Step 1, and the complainant continues to seek resolution, then he/she should approach his / her manager/designate or physician leader with the concern(s). If one or both of the persons involved are physicians, the matter should also be referred to the Medical Department Head for resolution. The goal is to understand and mutually resolve the issue so that persons conduct themselves in a civil, respectful and cooperative manner.

Steps taken by the Manager/Designate (typically Supervisor) or Medical Department Head to facilitate resolution could include:

- ✓ meeting separately with each person involved in the complaint to review concern;
- ✓ meeting together with all persons to facilitate a conversation aimed at understanding and resolving the issue;
- ✓ reviewing policies with persons reinforcing expectations of respectful conduct;
- ✓ seeking commitments from persons that they will conduct themselves in a respectful manner;
- ✓ following-up where appropriate with persons after the resolution process to ask whether commitments to respect are being adhered to; and/or,
- ✓ recording steps taken in the resolution process.

### Other Resolution Processes

This Policy does not preclude persons from advancing complaints through the applicable collective agreement, relevant professional bodies, or the BC Human Rights Tribunal. In the event persons file complaints outside of this policy, VCH reserves the right to not proceed with Steps 1-3.

### 5.0 Violation of this Policy

Any person found in violation of this Policy may be subject to remedial and/or disciplinary action up to and including termination of employment, cancellation of contract and/or revocation of privileges pursuant to applicable Health Authority processes.

For patients / clients (including family members and visitors) found in violation of this Policy, VCH may impose restrictions up to and including discharge from the VCH program or service if determined appropriate in the circumstance. ([Reference Policy: PCG C-585: Conduct Acceptable Behaviour of Patient and Visitors](#))

Persons who file complaints in bad faith may be subject to disciplinary action.

### 6.0 Retaliation

No person will be subject to retaliation for reporting in good faith disrespectful conduct or discrimination.

### 7.0 Confidentiality

No information will be disclosed by any person during the investigation or resolution of a complaint under this policy except as necessary to enable due process under Policy or to protect the persons, public, and/or assets of VCH.

#### In original only:

Issued by:

Name: Anne Harvey Title: VP, Employee Engagement Date: December 4, 2007