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# Registered Nurses Experience with and Perceived Effects of Horizontal Violence

Reba B. Williams
*Gardner-Webb University*

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Registered Nurses Experience with and Perceived
Effects of Horizontal Violence

by

Reba B. Williams

A thesis submitted to the faculty of
Gardner-Webb University School of Nursing
in partial fulfillment of the requirements for the
Master of Science in Nursing Degree

Boiling Springs

2013

Submitted by:

___________________________
Reba B. Williams

___________________________
Date

Approved by:

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Janie Carlton, EdD, RN

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Date

Abstract

The prevalence of horizontal violence in nursing has been well documented in the past 20 years. Recently the focus of the literature has been on developing strategies to prevent horizontal violence from occurring. The purpose of this exploratory descriptive study was to ascertain how Registered Nurses at one rural North Carolina hospital experienced and perceived horizontal violence. A "zero" tolerance policy was in place at the time of the study. The Nursing 2011 horizontal violence survey was used to examine a convenience sample of 40 nurses in this facility. The subjects were employed in seven different units throughout the hospital. While there were nurses personally affected by the violence, the majority reported never or only a few times in answer to the questions about this subject. Overall, approximately 67% of the nurses surveyed witnessed or experienced horizontal violence while on the job. This substantial finding reinforces research literature that identifies horizontal violence persistence in nursing as being related to existing workplace cultures.

*Keywords:* Horizontal violence, lateral violence, incivility, bullying, nurse violence

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# CHAPTER I

# Introduction

## Background

Horizontal violence (HV), lateral violence, vertical violence, and bullying are all terms for inappropriate intrapersonal behaviors ranging from eye rolling to physical violence among nurses and others in the workforce. One of the newest terms for this type of behavior is labeled incivility. Regardless of what it's called, the behavior is inappropriate. Horizontal violence has been defined as "…overt and covert actions by nurses toward each other and especially towards those viewed as less powerful" (Walrafen, Brewer, & Mulvenon, 2012, p.6). "Horizontal and lateral are terms that are used interchangeably to identify hostility within homogenous groups or between individuals with similar roles or status, i.e., peers and coworkers" (Miller & Hartung, 2011, p. 11). Miller and Hartung (2011) go on to describe vertical violence as that which exists between groups of higher and lesser power (p.11). The hierarchy that occurs between those with more power toward those of lesser power in the workplace has also been labeled as bullying. This phenomenon of psychological and physical violence has been recognized in nursing literature for over 20 years; from the first definition of "nursing eating their young" the literature suggests that little progress has been made in actually preventing horizontal violence among nurses. Unfortunately, nursing leadership has inflicted their own forms of horizontal violence on their staff in practices such as deliberate understaffing, ignoring physical or mental health of nurses, disregard for safety, and belittlement of nurses concerns (Blanton, Lyebecker, & Spring, 1998). On the other hand, nursing leadership also

has been recognized as a key factor in the prevention of a problem that is all too common among nurses.

## Theoretical Framework

To examine the bureaucratic structures, processes and cultural/environmental variables that nurse leaders must negotiate in curbing horizontal violence among nursing staff, Marilyn Anne Ray's Theory of Bureaucratic Caring, was used as the framework for this study. The Theory of Bureaucratic Caring (TBC) defines the work nurses do in clinical practice and the factors that affect performance outcomes.

The major concepts of bureaucratic caring are divided into two domains, humanistic and bureaucratic. The humanistic concepts are caring, spiritual-ethical caring, educational, and social-cultural. The bureaucratic concepts are political, legal, technological, economic, and physical. All seven concepts happen within a holographic context, meaning that "…everything is whole in one context and a part in another—each part being in the whole and the whole being in the part (Talbot, 1991)." (Alligood & Tomey 2006, p.121).

The application of the Theory of Bureaucratic Caring to horizontal violence can be conceptualized by applying the concepts of the TBC.  Caring to do the right thing, being fair and just in terms of what could and should be done in horizontal situations, combined with spiritual-ethical caring that facilitates the making of choices for the good of others, and refusing to participate in horizontal violence or to tolerate it. Turkel (2007) provided an outline of Ray's conceptualization of the TBC summarized as follows: (1) educational—programs aimed at defining and preventing HV,  promoting awareness of policy and procedure pertaining to HV, using appropriate media to convey, and sharing of

information; (2) physical— relates to the physical state of being, mentally and physically, victims of HV often show physical symptoms such as nervousness, anger, depression, etc; (3) social-cultural—encompasses ethnicity, family structure, intimacy friends and family, communication, social interaction and support, understanding interrelationships, involvement, and intimacy; and structures of cultural groups, community, and society, standards of moral behavior; (4) legal— involves responsibility and accountability for interactions with coworkers, rules and principles to guide behaviors such as policies and procedures, informed consent, privacy rights, malpractice and liability issues, and practice of defensive medicine in nursing; (5) using technology— to maintain patients wellbeing, (monitors, ventilators, blood pressure cuffs etc.), sharing knowledge of functioning of equipment with others, and electronic documentation; (6) economically—HV costs in terms of turnover  rates, medical problems related to HV, limitations related to HV, allocation of human and material resources to keep the organization solvent; and (7) political— relates to role and gender stratification among nurses, physicians, and of care influences i.e., use of power, prestige, and privilege to promote self and others and competition for scarce human and material resources. The depiction of these concepts can be viewed in Figure 1, followed by Figure 2; showing an adaptation of the Theory of Bureaucratic Caring to include variables used in this study.

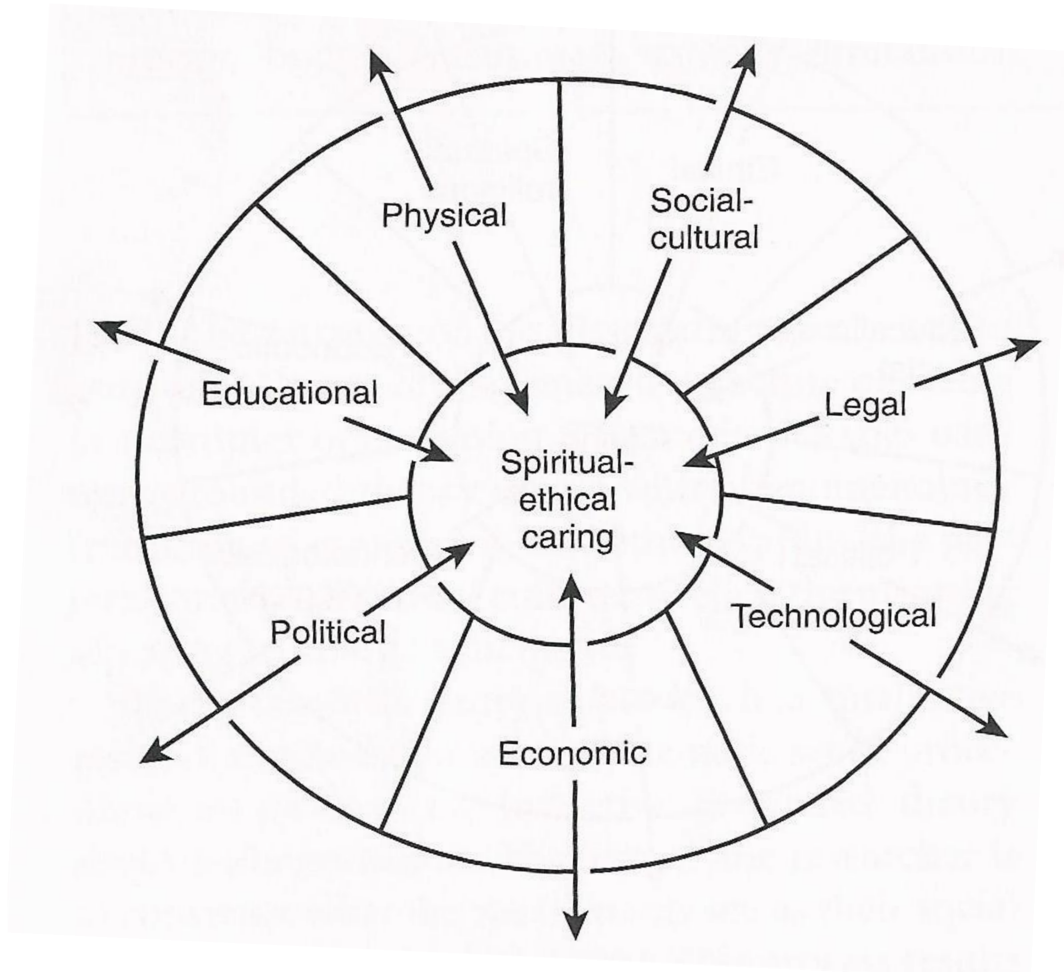


*Figure 1.* Marilyn Anne Ray's holographic Theory of Bureaucratic Caring. The different aspects of care are depicted by the outer circle sections containing the equally spaced concepts of Bureaucratic caring converging on the central focus, and showing how the central focus is affecting each concept; and the concept extending beyond the model (Alligood & Tomey, 2006, p.124).

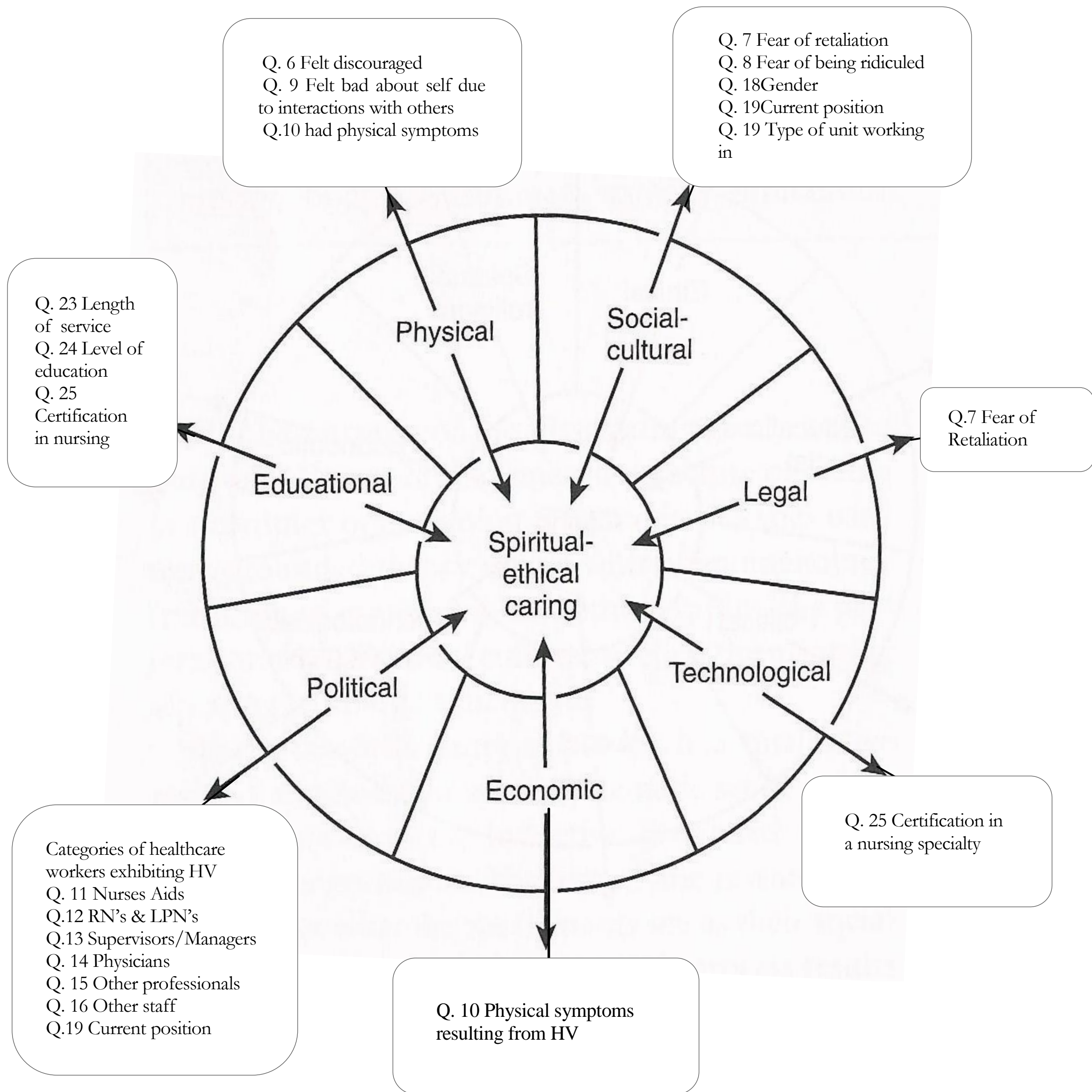


*Figure 2.* A Modified Theory of Bureaucratic Caring showing an adaptation to include horizontal violence variables.

## Research Problem

Horizontal violence among nurses is a daily occurrence. It assumes many forms including but not limited to: eye rolling, gossiping, sarcasm, yelling, throwing things, inappropriate touching, mocking, intimidation, and physical violence. Involvement of registered nurses in this behavior undermines the establishment of a culture of safety, affects retention, and ultimately increases costs.

## Purpose and Rationale

Although much has been written in the research literature about horizontal violence and the many forms it takes, closer examination reveals that little progress has been made in actually preventing horizontal violence. Even with several years worth of literature and discussion of the horizontal violence phenomena "victims or perpetrators of horizontal violence may not be aware of the situation, and the behavior continues" (Sellers, Millenbach, Kovach, & Yingling, 2009-2010, p. 21). The aim of this study was to explore and describe the registered nurses' experience and perception of personal effects of horizontal violence within the past 12 months, within a small rural hospital where policy and procedures currently exist to curb horizontal violence.

## Research Questions

What is registered nurses' experience with horizontal violence?

What is registered nurses' perception of personal effects of Horizontal Violence?

# CHAPTER II

## Review of Literature

Database searches used in the review of literature included Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, Medscape, and Google Scholar using the following key words: horizontal violence, bullying, incivility, lateral violence, nurse violence.

The review of the literature revealed an abundance of instances of horizontal violence (HV) among nurses with few studies reporting improvement after instituting measures to prevent HV. In fact, one pilot study exploring the prevalence of horizontal violence among New York State registered nurses reported "…theoretical literature suggests that HV is so ingrained in nursing's organizational culture that it is not recognized; until a phenomenon is recognized and named little can be done to alter it" (Sellers et al., 2009-2010, p. 23). The purpose of the above study was to explore the knowledge of nursing administrators among the New York Organization of Nurse Executive members concerning the prevalence of horizontal violence among them and to ascertain if they used evidenced based leadership in their roles (Sellers et al., 2009-2010).

Sellers et al. (2009-2010) pilot study examined knowledge and prevalence of horizontal violence among registered nurses in New York State. This descriptive study utilized part one of the Briles' Sabotage Savvy Questionnaire, a tool to measure nurses knowledge and involvement in HV. Of the 108 participants, 103 were women, white, and between 50-60 years of age (Sellers et al., 2009-2010). Forty-six percent were nurse administrators, 90% worked in acute care, and most had been employed by their facilities approximately eight years. There was a nearly even split between those facilities having

policies to prevent HV (55%) and those who did not (43%). Enforcement of the policies in the facilities having them was 42% (Sellers et al., 2009-2010). The results found that horizontal violence is present among New York State nurses. These authors found that the prevalence of HV may even be underreported in this population, most likely due to the acceptance that the behaviors are "…historically and culturally acceptable in nursing" (Sellers et al., 2009-2010, p. 23). In order for a culture of acceptance to change, the nurse manager must change the attitudes of a unit from acceptance of HV behavior to one of intolerance. Sellers et al. (2009-2010) believe that the use of evidenced based practice by nurse leaders and the use of rewards for "good" behavior is the way to change inappropriate behavior among the nursing staff. The authors cited Griffin's (2004) study of nursing students that were taught techniques of cognitive rehearsal, as a way to prepare in advance a response to incidents of horizontal violence, and to begin to change a culture of a unit. The trained nurses were able to positively confront and diffuse horizontal violence situations, ultimately resulting in better retention rates.

The American Nurses Association (2012) website *NursingWorld* reported one of the most notable attempts to improve the incidence of horizontal violence among nurses has been the 2009 Joint Commission standard (LD.03.01.01) in the "Leadership" chapter. The standard became effective January 1, 2009 and addresses disruptive and inappropriate behaviors in two of its elements of performance:

> EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.
>
> EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors (para.7).

The Joint Commission standard has resulted in policy changes in many institutions incorporating policies known as “zero tolerance” of horizontal violence actions. In addition, a number of nursing organizations have issued statements regarding the detrimental effect of disruptive behavior on both patients and nurses, and have called for solutions to address the problem (American Association of Critical-Care Nurses, 2004; AORN, 2003, 2007; International Council of Nurses, 2006; National Student Nurses Association, 2006) (Lateral Violence, 2008, para. 6). In addition, both the “…Center for American Nurses and the National Student Nurses Association have adopted policies in support of a professional workforce culture and have called for the elimination of horizontal violence among nurses” (Tittle & Morrison, 2012, p. 5). The Joint Commission has developed new standards published in the spring of 2012 dropping the term *disruptive behavior* because of the negative connotation the term carries. McNamara (2012) reports the Joint Commission “…standards will identify behavior or behaviors that undermine a culture of safety and call attention to the fact that behavior that intimidates others can create an environment of hostility and disrespect that affects morale, and increases staff turnover, and can lead to distractions and errors, all of which are detrimental to patient care” (McNamara, 2012, p. 535). Nurse leaders are therefore mandated to fight the culture of horizontal violence that exists in so many nursing units.

Members of the Virginia Nurses association in their article *Taming the Beast of Lateral Violence* describe nurses work environment as an organizational culture,“…defined as commonly held values, beliefs, and attitudes by members of the organization” (Brothers, Condon, Cross, Ganske, & Lewis, 2010, p. 8). Cultures that share values, beliefs, and attitudes that are “…strongly held, widely shared, and deeply embedded, and are not easily

changed" (Brothers et al., 2010, p. 8). Nursing cultures that propagate horizontal violence become "toxic" according to the authors until nurse to nurse relationships change to reflect the customs of that unit. Conversely, the opposite can be true, if a nursing unit does not tolerate horizontal violence, the culture changes to reflect a unit intolerant of HV. Cultures, in this case nursing units, that support power struggles via horizontal violence often have members who have the support of their nursing leaders, further propagating a climate conducive to horizontal violence. "A white wall of silence" (Murray, 2009) may surround incidents of lateral violence and provide strong incentives for ignoring or perpetrating violence" (Brothers et al., 2010, p. 7). These authors also find nursing leadership as a potential solution for bullying behaviors in nursing units.

Ditmer (2010) feels that "…workplace violence has become a public health problem epidemic" (p. 9). Seventy-five percent of nurses have experienced horizontal violence during their careers, and 80% have experienced bullying (Ditmer, 2010). Bullying is defined as violence from a superior a vertical violence. The traditional hierarchical power structure leads to the cliché of "nurses eating their young" whereby the horizontal violence becomes a rite of passage into the nursing profession (Ditmer, 2010, p.10). Another feature of hierarchical power comes into play when nurses gain specialties which can lead to special treatment of those nurses, and often result in feelings of inequality and hostility. "Critical care nurses, emergency department nurses, and surgical nurses are often perceived as more valuable than their peers who work in medical units" (Ditmer, 2010, p.10).

The effects of horizontal violence compromise teamwork, create an uncivil work environment, lead to burnout, and impede professional development. In these hostile environments, patient safety is jeopardized, and quality of care is lacking. "[The Joint

Commission] TJC attributes lack of teamwork and ineffective communication to 24% of sentinel events resulting in death, injury, or permanent loss of function" (Ditmer, 2010, p. 10). Patient falls and medication errors have also been linked to horizontal violence.

Physical symptoms such as obesity, headaches, insomnia, fatigue, and gastric problems, have all been related to working under constant stress such as that seen in horizontal violence, including long term effects such as post traumatic stress disorder. It has been estimated that healthcare expenses for those affected by horizontal violence can be as much as 50% more than for others not exposed to the stressful environment [NIOSH,1999] (Ditmer, 2010). Horizontal violence also can cause problems with recruitment and retention of nurses; as many as 14% of nurses reported horizontal violence as a major factor in their decision to leave nursing (Ditmer, 2010).

Implementation of a zero tolerance policy, living up to the nurse's code of ethics, educating nurses about horizontal violence, supporting legislative initiatives, and promoting standards that create a culture of safety for patients is the solution to breaking the cycle of horizontal violence according to Ditmer, 2010.

Longo and Sherman (2007) defined horizontal violence as "…an act of aggression that's perpetrated by one colleague toward another colleague" in their article *Leveling Horizontal Violence* (p.35). The authors report reasons for this behavior in nursing environments as an "…expression of oppressed group behavior evolving from feelings of low self esteem and lack of respect from others" (Longo & Sherman, 2007, p. 35). This leads to a feeling of powerlessness about the work environment and rather than hazard retaliation from leaders frustrations lead the nurses to take it out on each other in the form of horizontal violence.

Longo and Sherman (2007) suggested steps that could be used by managers in halting horizontal violence: observing staff interactions, increasing staff awareness through education, allowing staff to voice concerns, provide a process to address horizontal violence issues as they occur, and the provision of conflict management training (p.50). Research has shown that nursing leadership can be a key solution to horizontal violence in the workplace. The focus of this article is on creating work cultures that encourage empowerment of nurses, thereby stopping horizontal violence. The authors realized that in order to make a change, nursing leadership has to make a commitment to the nursing culture to implement measures to prevent horizontal violence.

Khalil's (2009) dissertation employed an ethno-phenomenology approach to explore levels of violence in nursing at eight Cape Town, South Africa hospitals. Khalil (2009, p. 208-209) identified six levels of violence among nurses:

- Psychological – includes behaviors such as bullying, verbal, gossiping, marginalization, public humiliation, and all forms of non-physical behaviors that result in emotional discomfort for another person or colleague. Victims often find it hard to convince others that the violence is occurring.
- Vertical – the abuse of power relationships among staff members.
- Horizontal – can be either physical or psychological against coworkers of the same rank within the organization. Behaviors such as failure to respect others privacy, lack of support, sabotage of other nurse's work, hiding needed equipment can be seen with this type of workplace violence.
- Covert – the victim is threatened, coerced, or forced to keep silent about the level of violence directed at him/her. This form is often related to

professional jealousy. Acts of backstabbing, scapegoating, negative criticisms of another's work are examples of this nurse to nurse violence.

- Overt – involves public humiliation of the victim.
- Physical – reflects physical violence against another person.

The most frequent form of horizontal violence identified is psychological (45%), followed by vertical (33%), horizontal (29%), covert (30%), and overt (26%); the level that is seen the least is the physical (20%), (Khalil, 2009). The conclusions of this study identified three main factors contributing to violence among nurses: (1) lack of effective communication, (2) lack of respect, and (3) inadequate anger management training for nurses (Khalil, 2009, p. 215). The author concluded that these behaviors can be controlled through "…professional development and in-service programs," counseling, and anger management strategies added to curriculums at various points of entry into nursing (Khalil, 2009, p. 216).

Tame (2012) explored "The relationship between continuing professional education and horizontal violence in perioperative practice" (p.220). Tame's research found that the work environment affects decisions about pursuing continuing education. She discovered that resentment and negative attitudes from managers and peers was a common factor affecting those trying to attain higher education. The nurses seeking more education are often viewed as "…argumentative or as troublemakers" by their peers and managers (Tame, 2012, p. 220).

Tame's study used a descriptive qualitative method to sample perioperative nurses currently engaged in continuing education. Twenty-three nurses were interviewed and some reported the incidence of horizontal violence as a direct result of their continuing

education activities. In the perioperative environment, "manager's attitudes seemed to be pivotal in determining the cultural milieu, and whilst some were perceived as supportive, a lack of interest and support was a source of discontent for many" (Tame, 2012, p. 221). The study revealed an element of elitism in the perpetuation of horizontal violence in the perioperative area. Some of the study subjects reported they were denied access to continuing education to insure that only certain individuals would be in possession of unique skill sets (Tame, 2012). The study also found that the nurses interviewed had, in some cases, adopted techniques to prevent being subjected to incidents of horizontal violence; they downplayed their accomplishments. In some cases, the nurses went as far as to study in secrecy. This paper linked the perioperative culture and horizontal violence toward its members pursuing higher education.

An exploration of the prevalence of horizontal violence in a "…multi-institutional hospital system" was conducted by Walrafen et al. (2012). A mixed method descriptive design was used. This study's review of literature identified three areas into which horizontal violence can be categorized: (1) "…prevalence and consequences, (2) root causes, and (3) and how to best address the phenonomen in the workplace" (Walrafen et al., 2012, p. 1).

Horizontal violence has been identified in varying degrees throughout the world. In Scandinavian countries, the UK, and the US the range is from 5% to 38%, up to 58% in Australia, and 86.5% in Turkey (Walrafen et al., 2012). Causes are as variable as the prevalence rates of the various countries. These authors report Duffy's 1995, and Roberts, Demarco, and Griffin, 2009 studies that cited oppressed group behavior as the root cause of

horizontal violence but acknowledges the differing viewpoints of various research articles recently reported (Walrafen et al., 2012).

It was determined that prevention hinged on education. Nurses must be taught how to identify horizontal violence and have increased professional accountability for participation in these negative behaviors.

## Summary

There is a notable lack of research about the results of preventative programs directed against horizontal violence. The working nurse's experience of horizontal violence and its perceived effects after implementation of strategies to prevent its occurrence is an area that needs further exploration. Bally (2007) believes that leadership and mentoring is the key to reducing horizontal violence and creating an organizational structure that values its nurses. Others believe education is the key, but the fact that studies identifying further instances of horizontal violence since the release of the 2009 Joint Commission culture of safety standard supports the need for further research into the persistence of the phenomenon (Brothers et al., 2010; Dumont, Mesisinger, Whitacre, & Corbin, 2012; Tittle & Morrison, 2012; Walrafen et al., 2012).

# CHAPTER III

## Methodology

### Design, Setting, and Sample

An exploratory descriptive survey design was used to investigate registered nurses experience with and perceived effects of horizontal violence in the workplace. According to Burns and Grove (2009), an exploratory descriptive study is intended to add to the body of knowledge about a specific area of study; the design is not used to compare groups (p.359). This study researched members of nursing units in situ examining the incidence of horizontal violence experienced by registered nurses and its perceived effects. There was no treatment or intervention, data was obtained from a single rural hospital in North Carolina. The sampling method was one of convenience; 75 nurses were given the 25 question survey to complete, with 40 completing the survey.

### Data Collection and Method of Analysis

The instrument used in this study was the Nursing 2011 survey for horizontal violence developed by Dumont, Riggleman, Meisinger, and Lein (2011) (Appendix A). Permission to use the instrument was obtained from Wolters Kluwer Health (Appendix B). A letter of permission to conduct the research at the hospital was obtained through its Institutional Review Board (IRB), both forms and a thesis proposal were submitted to Gardner-Webb's IRB and resulted in approval to conduct the study.

The questionnaire uses a six point Likert scale to ascertain the perceived effects and experience with horizontal violence of registered nurses at the study facility. The survey is in three parts, one for demographic collection, those witnessing who engages in horizontal violence, and the personal effects of that violence on the subject. The survey was made

available to 75 nurses in seven different units of a small rural hospital. Forty nurses elected to participate yielding a 53.33% response rate. The data gathered was analyzed using Statistical Package for the Social Sciences (SPSS) version 19 (2010) for descriptive statistics.

## Protection of Human Subjects

The study did involve human subjects, therefore required the development and procurement of informed consent. A cover letter (Appendix C) was attached to the survey explaining that by completing and returning the survey, *implied* consent was given to be a research subject. The participants were assured of confidentiality as the surveys collected no identifying information. No promises of benefits were expressed. The subjects were not exposed to any risks by participation in the survey other than the possibility of emotional discomfort generated by some of the questions. The format of the survey was explained with the statement that it would take approximately 20 minutes to complete. The researchers name and contact information was provided to the subjects in case any questions might arise about the survey.

# CHAPTER IV

## Results

The subjects involved in this study consisted of 40 nurses working in a small critical access hospital in rural North Carolina. A total of approximately 75 nurses are employed at this facility. “Unlike facilities such as Medicare Dependent Hospitals and Sole Community Hospitals, CAHs [Critical Access Hospital] represent a separate provider type with their own Medicare Conditions of Participation (CoP), as well as a separate payment method” ("Critical Access Hospital," 2012, p. 1). Acute care beds are limited to 25 beds, with an additional 10 beds available for the geriatric psychiatric unit, and 10 available for the emergency department. Data gathered from this sample using the Nursing 2011 Horizontal Violence Survey instrument are exploratory in nature and were analyzed using descriptive statistics.

The study subjects are comprised of staff nurses, supervisors, nurse managers, and administrative nurses employed throughout the hospital. All participants were 21years of age or older, with 35% in the 51-60 year old range. Females comprised 80% of the survey subjects. Of the 40 nurses voluntarily participating in the study, descriptive statistics yielded the mean time subjects worked a specific unit at 8.71 years (n=40, SD 5.533), and the question “how long have you been a nurse” resulted in a mean of 20.51 years (n=40, SD =12.224). Staff nurses comprised 67.5% of the sample population, 35% of them worked the medical-surgical unit and had been in nursing greater than 15 years. Table 1 data show demographic characteristics of the study sample in terms of frequency and greatest percentage resulted.

Table 1

*Sample Demographic Characteristics*

| | Frequency | Percent |
|---|---|---|
| What is your current position<br>Staff nurse | 27 | 67.5% |
| Years in current position<br>>15 years | 14 | 35% |
| Type of unit worked<br>Med-Surg | 13 | 32.5% |

The first five questions of the survey explored the personal experience of Registered Nurses with or witnessing of specific incidences of horizontal violence. Questions one through five used a six point Linkert scale to elicit responses of never, once, a few times, monthly, weekly, or daily to gather data about the nurse's experience. The results indicated a nearly even split between those nurses who never experienced or witnessed the behaviors for questions one, two, and five, while questions three and four resulted 45% of the population (n=40) having experienced these negative behaviors. Table 2 graphically displays the descriptive statistics obtained in terms of highest frequency and highest percentage.

Table 2

*Personal experience with or witnessing of Horizontal Violence within the past 12 months*

| | Frequency | Percent |
|---|---|---|
| Harshly criticizing someone without hearing both sides | 14 never<br>13 a few times | 35%<br>32.5% |
| Belittling/making hurtful remarks about a coworker | 14 never<br>12 a few times | 35%<br>30% |
| Complaining about a coworker instead of discussing perpetrator's behavior with them | 18 a few times | 45% |
| Raising eyebrows/rolling eyes | 18 a few times | 45% |
| Pretending not to notice a coworker struggling with their workload | 15 never<br>13 a few times | 37.5%<br>32.5% |

The second research question used the same six point Linkert scale to study how the registered nurses were personally affected by horizontal violence in the workplace over the past 12 months. Table 3 details the information gathered about this component of the survey. The data showed that nurses stand up for themselves as evidenced by 67.5% reporting they never let fear of being ridiculed keep them from speaking up, while 52.5% never let fear of retaliation keep them from speaking up when they thought something was wrong. Surprisingly, 60% did not suffer any physical symptoms related to horizontal violence. However, all questions had some nurses that did suffer personal effects of horizontal violence as demonstrated in Table 3.

Table 3

*Personal effects of Horizontal Violence on Registered Nurses*

| | Frequency | Percent |
|---|---|---|
| Discouraged because of lack of positive feedback | 19 a few times | 47.5% |
| Didn't speak up for fear of retaliation | 21 never<br>13 a few times | 52.5%<br>32.5% |
| Hesitated to speak up for fear of ridiculed | 27 never | 67.5% |
| Left work feeling bad about self due to coworker interactions | 17 never<br>15 a few times | 42.5%<br>37.5% |
| Physical symptoms due to poor interactions with coworkers | 24 never | 60% |

Table 4 shows categories of healthcare workers displaying the negative behaviors common to horizontal violence. Again the same six point Likhert scale accessed the Registered Nurses observation of horizontal violence behavior among hospital workers. Physicians were observed by 52.5% of the respondents engaging in negative behaviors as compared to 42.5% of nurses. All categories of workers were observed engaging in negative behaviors by the nursing staff with percentages near or at 50%.

Table 4

*Registered Nurses observation of healthcare workers exhibiting negative behaviors*

| | Frequency | Percent |
|---|---|---|
| Unlicensed assistive personnel (nurses' aides) | 6 never<br>20 a few times | 15%<br>50% |
| Nurse peer (RN and LPN) | 5 never<br>17 a few times | 12.5%<br>42.5% |
| Supervisors, directors, managers, educators, charge nurses | 8 never<br>17 a few times | 20%<br>42.5% |
| Physicians | 5 never<br>21 a few times | 12.5%<br>52.5% |
| Other professionals (respiratory, pharmacy, PT, radiology, etc. | 18 never<br>15 a few times | 45%<br>37.5% |
| Other staff (housekeeping, security, secretarial, maintenance) | 18 never<br>18 a few times | 45%<br>45% |

# CHAPTER V

## Discussion

The purpose of this study was to explore the Registered Nurses' experience with and the perceived effects of horizontal violence at one small rural hospital. This was accomplished using the Nursing 2011 Horizontal Violence Survey tool. This study documents the continuing incidence of these behaviors in a facility with a "zero tolerance" policy in place. There are numerous studies of horizontal violence reported in the literature over the last decade identifying the various forms of the phenomenon. Though many studies offer solutions to remedy the problem of HV, it continues as evidenced by the results of this study.

Realistically, horizontal violence cannot be entirely eliminated from nursing, but certain overt sources could be decreased or eliminated by teaching nurses to recognize HV and respond appropriately. Nurse Managers are especially taxed with observing staff behavior and intervening with education to raise staff awareness, providing a safe environment in which to voice concerns, providing a process for reporting, and make conflict management training available (Longo & Sherman, 2007, p.32).

Research question number one asked the question, what is the Registered Nurses experience with horizontal violence? The survey's first five questions addressed specific ways in which the Registered Nurses personally experienced or witnessed incidences of horizontal violence. The first survey question revealed that 35% of Registered Nurses stated that they never harshly criticized someone without hearing both sides of the story, or witnessed anyone else displaying that behavior. However, 43.6% said they had seen or

participated in that behavior. This finding possibly reflects perpetrator and victim perspectives in the same facility.

Question number two asked about making hurtful or belittling remarks about a coworker in front of others; again the results were nearly evenly split between "never (35%) and (30%) reported "a few times". Overall approximately 65% of the nurses surveyed had witnessed or experienced this type of conduct among hospital staff members.

Registered nurses reported the perceived effects of horizontal violence as less frequent than the percentages of experiencing or witnessing. One question did not follow this pattern, however. Question number six asked if a nurse had ever left work feeling discouraged from lack of positive feedback, 47.5% of respondents said they did. It is possible that this result is due to lack of recognition of horizontal violence behavior as reported by Sellers et al. (2009-2010, p. 21).

## Limitations

There are several limitations to this study. Hypothesis testing was not undertaken. The methodology restricts analysis and implication of study findings. The study described the phenomenon of horizontal violence in one small hospital and did not define any relationship between the variables. The study results indicate that nurses in the survey perceive that they experience horizontal violence while on the job. Although procedures were in place to assure confidentiality, anonymity, and the ability to refuse to participate without harm were in place and communicated to the subjects, there is the possibility that the nurses may have felt intimidated or may have feared retaliation as indicated by notes written on the margins of some of the surveys. The small sample size and the single

facility surveyed limit generalizability of study results and may not be representative of all hospitals.

## Implications for Nursing

The results of the study indicate a need for further understanding of the culture of organizations that continue to display horizontal violence behaviors in their staff even with policies in place to prevent it. Dimter (2010) found that "…both victims and perpetrators of horizontal violence frequently do not recognize it (p.9)." This statement reinforces the idea that education can be a key to eradicating horizontal violence. Nurses must learn to recognize and respond appropriately to this destructive behavior. Nursing cultures must learn not to tolerate the behaviors. However, if interventions are to truly work, the entire organization must respond by providing an environment that supports change; thereby, lending support for the Theory of Bureaucratic Caring to provide a framework on which to base changing a nursing culture.

## Conclusions

This study explored the Registered Nurses' experience with and perceived effects of horizontal violence among nurses working in a rural North Carolina hospital. The study revealed that horizontal violence behaviors such as belittling, criticizing, complaining about coworkers, eye rolling, and allowing a coworker to struggle with their workload while pretending not to notice continue in this setting in the presence of existing policies forbidding it. All departments in the hospital had personnel that were observed by registered nurses to have perpetrators of horizontal violence. The continued prevalence of horizontal violence oblige this hospitals' organizational frame to develop educational programs, make available support services, and enforce existing policies to prevent

horizontal violence, and to promote a culture of safety for patient's as well as staff through standards that discourage all forms of horizontal violence.

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# Appendix A

## Nursing 2011 Horizontal Violence Survey

***Instrument***

| Please read each item and mark the answer that best represents your experience. | |
|---|---|
| Within the last 12 months, how often have you personally experienced or witnessed the following: | Answer these questions from the perspective of how you personally have been affected within the last 12 months at your current workplace. |
| 1. Harshly criticizing someone without having heard both sides of the story.<br>☐ never ☐ monthly<br>☐ once ☐ weekly<br>☐ a few times ☐ daily | 6. I've felt discouraged because of lack of positive feedback<br>☐ never ☐ monthly<br>☐ once ☐ weekly<br>☐ a few times ☐ daily |
| 2. Belittling or making hurtful remarks to or about coworkers in front of others.<br>☐ never ☐ monthly<br>☐ once ☐ weekly<br>☐ a few times ☐ daily | 7. I haven't spoken up about something I thought was I thought was wrong because of fear of retaliation.<br>☐ never ☐ monthly<br>☐ once ☐ weekly<br>☐ a few times ☐ daily |
| 3. Complaining about a coworker to others instead of attempting to resolve a conflict directly by discussing it with that person.<br>☐ never ☐ monthly<br>☐ once ☐ weekly<br>☐ a few times ☐ daily | 8. I've hesitated to ask questions for fear I'd be ridiculed.<br>☐ never ☐ monthly<br>☐ once ☐ weekly<br>☐ a few times ☐ daily |
| 4. Raising eyebrows or rolling eyes at another coworker.<br>☐ never ☐ monthly<br>☐ once ☐ weekly<br>☐ a few times ☐ daily | 9. I've left work feeling bad about myself because of interactions with coworkers.<br>☐ never ☐ monthly<br>☐ once ☐ weekly<br>☐ a few times ☐ daily |
| 5. Pretending not to notice a coworker struggling with his or her workload.<br>☐ never ☐ monthly<br>☐ once ☐ weekly<br>☐ a few times ☐ daily | 10. I've had physical symptoms such as inability to sleep, headaches, and abdominal pain because of poor interactions with certain coworkers.<br>☐ never ☐ monthly<br>☐ once ☐ weekly<br>☐ a few times ☐ daily |

Nursing 2011 horizontal violence survey (Dumont, Riggleman, Meisinger, & Lein, 2011)

How often have you observed the following categories of healthcare workers exhibiting the negative behaviors described in this survey?

11. Unlicensed assistive personnel (nurses' aides)

- ☐ never ☐ monthly
- ☐ once ☐ weekly
- ☐ a few times ☐ daily

12. Nurse peer (RNs and LPNs)

- ☐ never ☐ monthly
- ☐ once ☐ weekly
- ☐ a few times ☐ daily

13. Supervisors (directors, managers, educators, charge nurses)

- ☐ never ☐ monthly
- ☐ once ☐ weekly
- ☐ a few times ☐ daily

14. Physicians

- ☐ never ☐ monthly
- ☐ once ☐ weekly
- ☐ a few times ☐ daily

15.Other professionals (such as respiratory therapists, lab technicians, physical therapists, radiology technologists, pharmacists)

- ☐ never ☐ monthly
- ☐ once ☐ weekly
- ☐ a few times ☐ daily

16.Other staff (such as housekeeping, security, secretarial, maintenance)

- ☐ never ☐ monthly
- ☐ once ☐ weekly
- ☐ a few times ☐ daily

17. What is your age

20. How many years have you been in your current position?

- ☐ 2 or less ☐ 11 to 15
- ☐ 3 to 5 ☐ over 15
- ☐ 6 to 10

21. In what type of unit do you primarily work?

- ☐ medical-surgical
- ☐ ICU/CCU
- ☐ emergency
- ☐ perianesthesia/OR
- ☐ oncology
- ☐ obstetrics/gynecology/nursery
- ☐ geriatric
- ☐ pediatric
- ☐ geriatric
- ☐ psychiatric
- ☐ outpatient
- ☐ other (please specify)

_______________________

22. How many years have you worked in this unit? _________

23. How long have you been a nurse? ____________ years

24. What is your highest level of education?

- ☐ LPN/LVN diploma
- ☐ RN diploma
- ☐ AD
- ☐ BSN
- ☐ MSN
- ☐ PhD or other doctoral degree
- ☐ other (please specify)

______________________

25. Are you certified in a nursing specialty?

☐ yes (please specify)

<table>
<tr><td>□ under 21 □ 41 to 50<br>□ 21 to 30 □ 51 to 60<br>□ 31 to 40 □ over 60<br>18. What is your gender?<br>□ female □ male</td><td>________________________________<br>□ no<br>Please add any comments or observations about this issue (on separate sheet if necessary.</td></tr>
<tr><td>19. What is your current position?<br>□ staff nurse<br>□ charge nurse/assistant nurse manager<br>□ manager/supervisor<br>□ staff educator/case manager<br>□ director/administrator<br>□ advanced practice nurse<br>□ faculty, school of nursing<br>□ other (please specify)</td><td></td></tr>
</table>

Nursing 2011 horizontal violence survey (part 2) (Dumont, Riggleman, Meisinger, & Lein, 2011)

Appendix B

Permission to use Measurement Instrument

WOLTERS KLUWER HEALTH LICENSE TERMS AND CONDITIONS
Mar 20, 2013

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This is a License Agreement between Reba Williams ("You") and Wolters Kluwer Health ("Wolters Kluwer Health") provided by Copyright Clearance Center ("CCC"). The license consists of your order details, the terms and conditions provided by Wolters Kluwer Health, and the payment terms and conditions.

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Appendix C

Participant Cover Letter

**Consent to be a Research Subject**

**Introduction**

This research study is being conducted by Reba Williams at Gardner-Webb University to determine if a relationship exists between nursing leadership and the incidence of horizontal violence among nurses.

**Procedures**

You will be asked to complete a written questionnaire consisting of 25 questions and will take approximately 20 minutes to complete. The questionnaire includes questions about your observations of incidences of horizontal violence you have witnessed or experienced and how these incidences have affected you. The survey also asks if you have observed other healthcare workers exhibiting the negative behaviors described in this survey. Certain demographic data will also be covered.

**Risks/Discomforts**

Other than the possibility of feeling emotional discomfort when answering the questions there are no risks involved with your participation in this study.

**Benefits**

There are no direct benefits to research subjects involved in this study. However, it is hoped that your participation will help nurse researchers learn more about the influence nurse leaders have on the occurrence of horizontal violence.

**Confidentiality**

All information provided will remain confidential and will only be reported as group data with no identifying information. All data, including questionnaires will be kept in a secure location and only those directly involved with the research will have access to them. After the research is completed, the questionnaires will be destroyed.

**Compensation**

You will not be compensated for participation in this study.

**Participation**

Participation in this research study is voluntary. While your full participation is desired you can refuse to answer any or all questions. Completion and return of the survey implies that you have read the information in this form and consent to take part in the research. Please keep this form for your records or future reference.

**Questions about the Research**

If you have questions regarding this study, you may contact Reba Williams at 828-894-8770 or williams.reba1@gmail.com.