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Nurse leaders as problem-solvers:

Addressing lateral and horizontal violence

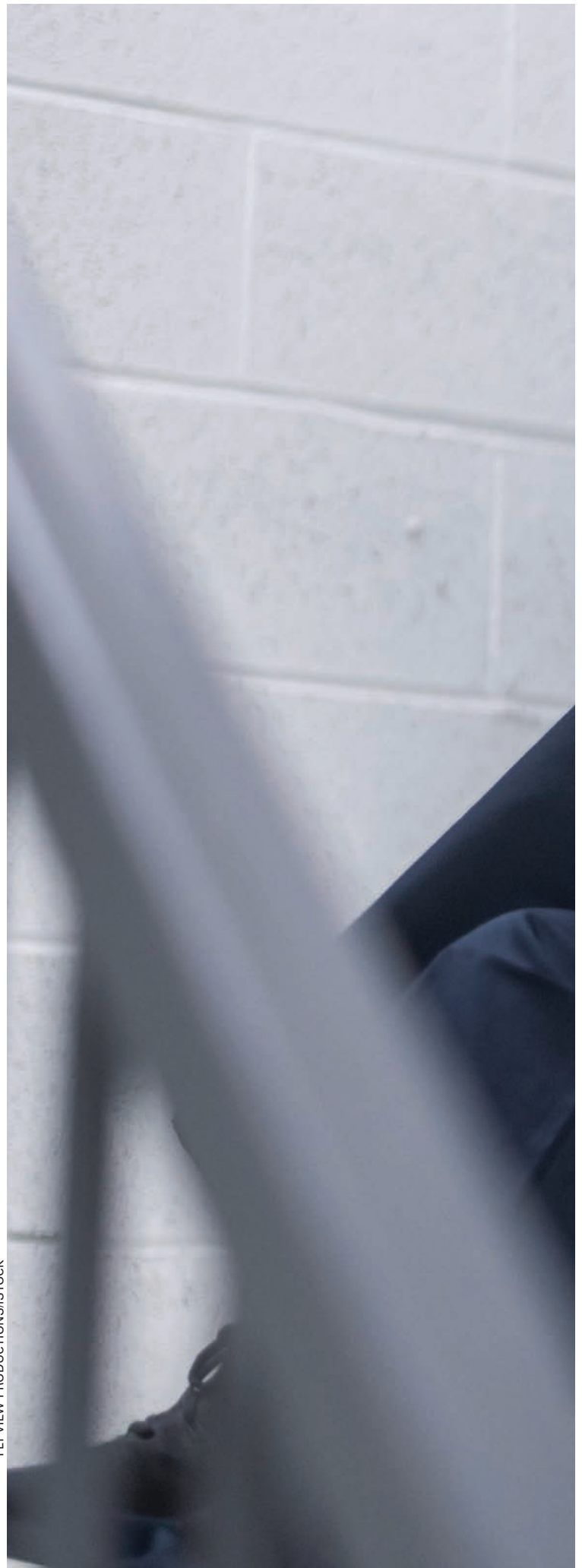
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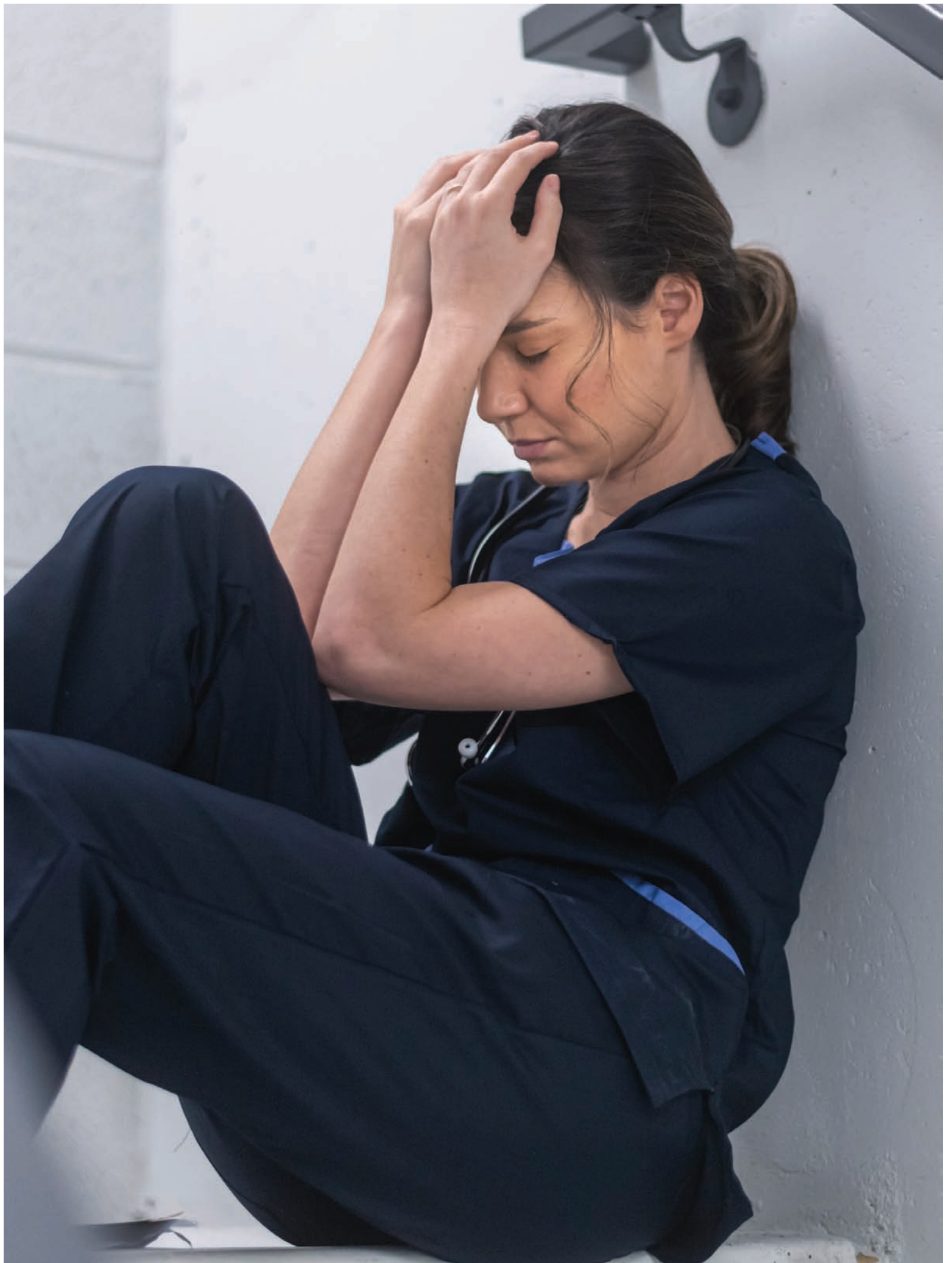
The issue of lateral and horizontal violence (LHV) has plagued the nursing profession for more than 3 decades, yet solutions remain elusive. The significance of LHV isn't lost on nurse leaders because it creates an unhealthy work environment. Research literature worldwide has continued to report the prevalence of disruptive behaviors experienced by nursing students, novice nurses, and seasoned nurses in the workforce. The World Health Organization, International Council of Nurses, and Public Services International have recognized this issue as a major global public health priority.¹

LHV, also called nurse-on-nurse aggression, disruptive behavior, or incivility, undermines a culture of safety and negatively impacts patient care.^{2,3} This experience, known to nurses as “eating their young,” isn't only intimidating and disruptive, it's also costly and demoralizing to the nursing profession and healthcare organizations.^{4,5} Although the impact of LHV can be dreadful for both the institution and its staff, little is known about the reasons for these behaviors among nursing professionals.²

LHV encompasses all acts of meanness, hostility, disruption, discourtesy, backbiting, divisiveness, criticism, lack of unison, verbal or mental abuse, and scapegoating.⁶ The sole intent of

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bullying behaviors is to purposefully humiliate and demean victims. Bullying behaviors also taint healthcare organizations; cause irreparable harm to workplace culture; breakdown team communication; and severely impact the quality of the care provided, thereby jeopardizing patient safety.^{7,8} Researchers have reported that acts of LHV are used to demonstrate power, domination, or aggression; for retribution; to control others; and to enhance self-image.⁹⁻¹²

Previous studies have shown that the frequency of LHV in healthcare organizations is quite severe, with about

a substantive theory from the results.

Literature review

A paucity of evidence exists in the literature regarding how nurse leaders perceive their role in addressing LHV.¹⁴ Studies have shown that this phenomenon is attributed to heavy workloads, a stressful work environment, and lack of work-group cohesiveness, as well as organizational factors such as misuse of authority and the lack of organizational policies and procedures for addressing LHV behaviors.¹⁵

In one study, one-third of the nurses reported that

ciation, 27% of respondents experienced acts of bullying in the past 6 months.¹⁹ Another study reported that 27% to 85% of nurse respondents had experienced some form of uncivil behavior.²⁰ Other data have shown that those more vulnerable to violent, disruptive, and intimidating behaviors are newly licensed nurses beginning their careers.²¹

Although nurse leaders can be perpetrators of LHV, they play an essential role in addressing LHV behaviors and creating a safe work environment.²² The literature suggests that, in many cases, a lack of awareness and response



Accepting the status quo is unacceptable and can cause irreparable harm to organizational well-being if LHV isn't addressed.

90% of new nurses surveyed reporting acts of incivility by their coworkers.¹³ Sixty-five percent of nurses in one survey reported witnessing incidents of despicable acts, whereas another 46% of coworkers in the same survey reported the issue as "very serious" and "somewhat serious."¹³

LHV poses a significant challenge for nurse leaders who are legally and morally responsible for providing a safe working environment.²⁶ The purpose of this qualitative, grounded theory study was to gain a deeper understanding of nurse leaders' perceptions of their role in addressing LHV and develop

they had observed emotional abuse during several of their work shifts.¹⁶ Another study indicated that 30% of survey respondents (n = 2,100) stated LHV occurs weekly.¹⁷ A third study revealed that 25% of participants noted LHV happened monthly, and a fourth study of ED nurses reported that about 27.3% of the nurses had experienced LHV perpetrated by nursing leadership (managers, supervisors, charge nurses, and directors), physicians, or peers in the last 6 months.¹⁸

In a survey completed by members of the Washington State Emergency Nurses Asso-

by nurse leaders adds to the prevalence of LHV.²³ This may be due, in part, to nurse leaders being aligned with the perpetrators who are creating the toxic work environment.⁶ The literature suggests that an environment where staff members feel safe to practice results in a culture that decreases burnout and promotes nurse retention and quality outcomes.^{24,25}

Method

This qualitative, grounded theory study focused on nurse leaders' perception of their role in breaking the cycle of LHV for staff members whom

they supervise. Two research questions guided the study:

1. How do nurse leaders perceive their role in addressing LHV among nursing staff members under their supervision?
2. What substantive theory may emerge from the data collected during interviews with nurse leaders?

A grounded theory methodology was used to explore the nurse leader's role in addressing LHV with the intent of developing a substantive theory through the meaningful organization of data themes to provide a framework to address the phenomenon of LHV. Purposeful sampling was used to recruit a total of 14 participants for this study from a large healthcare system in the Southeastern US. The participants were chosen because of their experience with LHV and their ability to discuss and reflect on those experiences. Informed consent was obtained before the start of the study, which included explaining the reason for the study and what to expect. In addition, permission was obtained from the Institutional Review Board.

Data collection and analysis

Demographic data collected to describe the sample included gender, age range, number of years holding a management position, supervisory responsibility, and highest degree obtained. (See Table 1.)

Semistructured, in-depth interviews were the primary mode of data collection. The recorded interviews were conducted face-to-face and lasted about 60 minutes. Data collec-

tion continued until saturation was achieved. Data saturation occurred when no new descriptive codes, categories, or themes were emerging from the analyzed data. The interviews were transcribed verbatim and verified through a member check process.

During the data analysis process, themes and patterns were identified. Data from each participant's interview were examined to determine if the responses were aligned with the identified themes. Analysis of the data included coding at increasingly abstract levels and constant comparison. Qualitative software assisted in coding the information and uncovering subtle trends.

Results

Four themes emerged from core categories developed during the qualitative data coding process.

Theme 1: Understanding/ addressing LHV. In question one, participants were asked to describe their understanding of LHV. Five subthemes emerged from the data collected with this question. (See Table 2.)

Theme 2: Experience addressing LHV. In the second question, participants were asked about their experience with addressing incidents of LHV. Six subthemes were identified. (See Table 3.)

Theme 3: Role perception in addressing LHV. In the third question, participants were asked what they perceive their role to be in addressing LHV. Six subthemes resulted from this question. (See Table 4.)

Table 1: Participant demographic characteristics

Characteristic	Number of participants
Gender	
Male	4
Female	10
Age	
36–40	1
41–45	2
46–50	3
51–55	5
56–60	3
Years in current position	
0–5 years	5
5 years or more	9
Nurse leader in charge of	
All shifts	3
Multiple units/depts	7
Specific shifts	1
1–2 units/all shifts	1
All units/specific shifts	2
Highest education level	
Bachelor's degree	5
Master's degree	9
Doctoral degree	0

Theme 4: Organizational impediment to addressing LHV. In question four, participants were asked to describe the factors within the organization that influence or impede their role in addressing LHV. This question yielded nine subthemes. (See Table 5.)

Substantive theory

As a result of the themes that emerged from the data, a substantive theory was developed. This is especially important

Table 2: Question one core category and identified codes

	Number of participants describing their experience	Percent of participants sharing their experience
Understanding/addressing LHV (core category)	14	100%
Bullying	3	21%
Bullying incivility	1	7%
Inappropriate behavior	1	7%
Undesirable behavior	1	7%
Inappropriate interactions		14%

Table 3: Question two core category and identified codes

	Number of participants describing their experience	Percent of participants sharing their experience
Experience addressing LHV (core category)	14	100%
Fact finding/gather evidence	3	21%
Meet with individual/call out behavior	3	21%
Address educationally	3	21%
Communicate	1	7%
Support/supportive	1	7%
Healthy work environment/culture	1	7%

Table 4: Question three core category and identified codes

	Number of participants describing their experience	Percent of participants sharing their experience
Role perception in addressing LHV (core category)	14	100%
Problem-solver/investigator	8	57%
Resolve/solve/address		
Role model	5	35%
Collaborative	1	7%
Expectation/guiding expectations	1	7%
Setting the expectation/tone	2	14%
Mediator	1	7%

for the nursing profession to develop as a scientifically based practice. Theories help guide research and provide the expansion, generation, and validation of the science of nursing knowledge.²⁶ The substantive theory will help nurse leaders become more cognizant of the role that effective leadership plays in preventing or intervening in incidents of LHV in the workplace. The analysis revealed that nurse leaders are aware that the quality of patient care and staff well-being can be adversely affected by the impact of LHV.

Data themes were used to formulate the following theory: Nurse leaders address LHV affecting their staff members by solving problems, creating a safe work environment, and reducing institutional barriers that impede addressing LHV in a timely fashion. Nurse leaders perceive their role as a problem-solver, which is a necessary step in advocacy.²⁷ Problem-solving is a process that contains the elements of decision-making and critical thinking.²⁸

The theory that emerged from the core categories explicitly focused on the central phenomenon of LHV in the nursing work environment. *Figure 1* shows the interrelatedness of the themes to the resultant substantive theory.

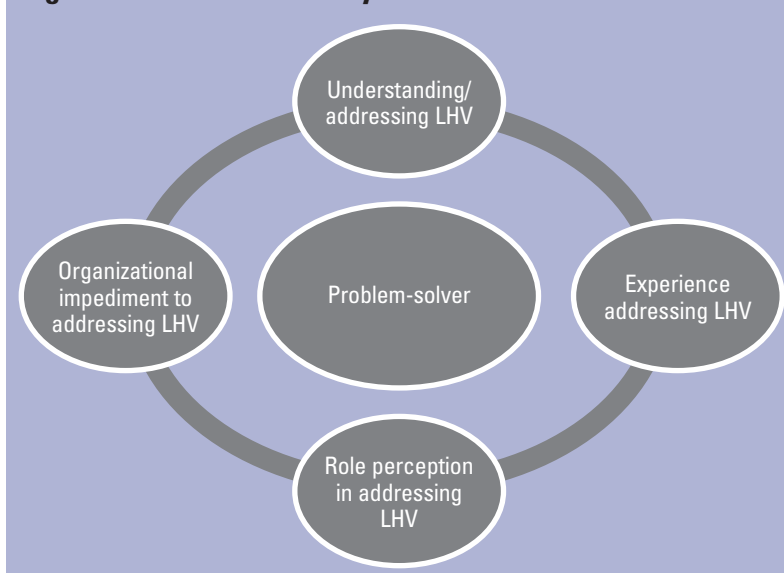
Discussion and implications

The study results have several implications for both the nursing profession and nurse leaders. The nursing profession requires decisive and robust leadership, and the role of the nurse leader is to be a combination of nurturer, investigator, and judge to

Table 5: Question four core category and identified codes

	Number of participants describing their experience	Percent of participants sharing their experience
Organizational impediment to addressing LHV (core category)	14	100%
Human resources/timelines	3	21%
Union/union procedures	4	28%
Professionalism/unprofessionalism	2	14%
Unsupported/lack of accountability	2	14%
Staff protection	1	7%
Targeted/blacklisted/intimidated	1	7%
Acknowledge behavior	1	7%
Troublemaker	1	7%
Fear of retaliation/losing job	2	14%

Figure 1: Substantive theory



examine incidents of LHV.^{26,29-32} Nurse leaders are responsible for setting the tone and expectations for a safe work environment.

This includes modeling the expected ethical behaviors; for example, doing the right things for the right reasons, being col-

legial toward each other, and being respectful of other's differences. One participant remarked, "This is a different world based on how I was raised. I was raised to be respectful to people."

In addition, nurse leaders are responsible for enforcing policies created to address disruptive behaviors and working with the administration as soon as an incident occurs. Past research indicates that a healthy and collaborative work environment fosters nurse engagement and patient safety.^{25,30} Staff members and patients need a leader to protect them when necessary; thus, the nurse leader needs to "walk the walk" in providing a safe environment for all. Nurse leaders engaged in these kinds of behaviors are providing strong leadership and practicing strong decision-making, thus ensuring the continued robustness of their organizations.

Recommendations and limitations

Future research could replicate this study in a different geographic region to explore the causes of LHV by soliciting the views of nursing students, new graduate nurses, and nurse educators from unionized and non-unionized hospital systems and comparing the results to further understand this phenomenon. Additionally, developing a tool to test the substantive theory could substantiate the nurse leader's role as a problem-solver to address incidence of LHV in the workplace.

The decision to conduct this study in one type of healthcare

organization limits the ability to compare the interviewed nurse leaders' experiences with nurse leaders in other healthcare organizations. The experiences of nurses in other healthcare organizations may be different; thus, overall generalizability of the study may be limited.

Say "no" to the status quo

The results of this study support the findings of previous researchers.^{23,31,33,34} Accepting the status quo is unacceptable and can cause irreparable harm to organizational well-being if LHV isn't addressed. Collaboration between nurse leaders and administrators is essential to successfully reduce institutional obstacles that prevent the timely handling of LHV incidents. The role of the nurse leader as a problem-solver should be clear, defined, and well supported to seek resolutions to toxic behaviors that are hurting the work environment. But we must remember that creating a policy doesn't equal change. Every employee from the lowest level in the organization to the highest ranks of administration must model civil behaviors. **NM**

REFERENCES

- Hinchberger PA. Violence against female student nurses in the workplace. *Nurs Forum*. 2009;44(1):37-46.
- Ditmer D. A safe environment for nurses and patients: halting horizontal violence. *J Nurs Regul*. 2010;1(3):9-14.
- Bloom EM. Horizontal violence among nurses: experiences, responses, and job performance. *Nurs Forum*. 2019;54(1):77-83.
- Center for American Nurses. Lateral violence and bullying in the workplace. *Ala Nurse*. 2008;35(2):23-24.
- Taylor RA, Taylor SS. Reframing and addressing horizontal violence as a workplace quality improvement concern. *Nurs Forum*. 2018;53(4):459-465.
- Green CA. Workplace incivility: nurse leaders as change agents. *Nurs Manage*. 2019;50(1):51-53.
- The Joint Commission. Patient safety. Joint Commission Online. 2015. www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/joint-commission-online/jconline_april_29_15pdf.
- Rainford WC, Wood S, McMullen PC, Philipsen ND. The disruptive force of lateral violence in the health care setting. *J Nurs Pract*. 2015;11(2):157-164.
- Ballard M, Argus T, Remley TP. Bullying and school violence: a proposed prevention program. *NASSP Bull*. 1999;83(607):38-47.
- Felson RB. A social psychological approach to interpersonal aggression. In: Van Hasselt VB, Hersen M, eds. *Aggression and Violence: An Introductory Text*. London, UK: Allyn and Bacon; 2000:9-22.
- Olweus D. Bullying at school: basic facts and effects of a school based intervention program. *J Child Psychol Psychiatry*. 1994;35(7):1171-1190.
- Yamada DC. The phenomenon of "workplace bullying" and the need for status-blind hostile work environment protection. *Georgetown Law J*. 2000;88(3):475-536.
- Major E, Alvarz Abderrahman E, Sweeney JI. "Crucial conversations" in the workplace: offering nurses a framework for discussing and resolving incidents of lateral and horizontal violence. *Am J Nurs*. 2013;113(4):66-70.
- Sellers KF, Millenbach L, Ward K, Scribani M. The degree of horizontal violence in RNs practicing in New York State. *J Nurs Adm*. 2012;42(10):483-487.
- Hutchinson M, Vickers M, Jackson D, Wilkes L. Workplace bullying in nursing: towards a more critical organisational perspective. *Nurs Inq*. 2006;13(2):118-126.
- Roche M, Diers D, Duffield C, Catling-Paull C. Violence toward nurses, the work environment, and patient outcomes. *J Nurs Scholarsh*. 2010;42(1):13-22.
- The Advisory Board Company. *Transitioning New Graduates to Hospital Practice: Profiles of Nurse Residency Program Exemplars*. Washington, DC: The Advisory Board Company; 2009.
- Johnson SL, Rea RE. Workplace bullying: concerns for nurse leaders. *J Nurs Adm*. 2009;39(2):84-90.
- Johnson SL. International perspectives on workplace bullying among nurses: a review. *Int Nurs Rev*. 2009;56(1):34-40.
- Warrner J, Sommers K, Zappa M, Thornlow DK. Decreasing workplace incivility. *Nurs Manage*. 2016;47(1):22-30.
- Mammen B, Hills D, Lam L. Newly qualified graduate nurses' experiences of workplace incivility in Australian hospital settings. *Collegian*. 2018;25(6):591-599.
- Brewer KC, Kyeung MO, Panagiota K, Xiaoquan Z. Workplace bullying among nurses and organizational response: an online cross-sectional study. *J Nurs Manag*. 2020;28(1):148-156.
- Sauer PA, McCoy TP. Nurse bullying and intent to leave. *Nurs Econ*. 2018;36(5):219-245.
- The Joint Commission. Sentinel event alert 40: behaviors that undermine a culture of safety. 2016. www.jointcommission.org/en/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-issue-40-behaviors-that-undermine-a-culture-of-safety.
- Germann S, Moore S. Lateral violence, a nursing epidemic? Reflections on Nursing Leadership. 2019. www.reflectionsonnursingleadership.org/features/more-features/Vol43_1_lateral-violence-a-nursing-epidemic.
- Alligood MR, Marriner-Tomey A. *Nursing Theorists and Their Work*. 7th ed. Maryland Heights, MO: Mosby Elsevier; 2010.

27. Walsh M. Teaching qualitative analysis using QSR NVivo. *Qual Rep.* 2003;8(2):251-256.
28. Yoder-Wise P. *Leading and Managing in Nursing*. 5th ed. St. Louis, MO: Mosby; 2011.
29. Shibata H. Problem solving: definition, terminology, and patterns. *Media Frontier*. 1998. www.mediafrontier.com/Article/PS/PS.htm.
30. Douglas TJ, Fredendall LD. Evaluating the Deming management model of total quality in services. *Decis Sci.* 2004;35(3):393.
31. Latham J, Vinyard J. *Baldrige User's Guide: Organization Diagnosis,*

Design, and Transformation. New York, NY: Wiley; 2004.

32. Gandossy R, Sonnenfeld J. *Leadership and Governance from the Inside Out*. Hoboken, NJ: John Wiley & Sons; 2004.
33. Bartholomew K. *Ending Nurse-to Nurse Hostility: Why Nurses Eat Their Young and Each Other*. Marblehead, MA: HCPRO, Inc.; 2006.
34. Griffin M. Teaching cognitive rehearsal as a shield for lateral violence: an intervention for newly licensed nurses. *J Contin Educ Nurs.* 2004;35(6):257-263.

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