COURSE OBJECTIVES

- Identify and define the problem.
- Research alternative behaviors.
- Project a positive solution.
- Evaluate possible outcomes.

Hello. My name is Kate Woehl, and today, I want to talk to you about lateral, horizontal-type violence. This program is titled “Are You Full Yet: How to Stop Eating Our Next Generation.” You’ll hear this all the time, how nurses eat their young. It brings to the image of cannibalism, but that’s not exactly where we’re going with this today. The gap statement for this presentation is: “This presentation was created to address a growing problem with the emotional, verbal, and sometimes physical abuse. In a qualitative study identified by Judith McIntosh, strategies were presented to intervene in the workplace violence. Almost all of these studies are related to nursing as a whole.”

The purpose or the goal of this little presentation (this program) is: To present logical information regarding violence in the workplace, especially geared towards nursing. It’s a goal for our current faculty and our current nurses in the field because it is a problem in academia as well as in the actual workplace. We’re going to talk about each of those. It’s our goal to alert nurses to this behavior, to question it in participants that you’re around, and to also question your own behavior. Are you part of the problem? We need to rectify and model good behavior. We need to redirect and mentor new graduates or new people that are coming to a new area of the hospital. It doesn’t have to just be a brand new nurse. It can be a nurse that’s worked five years in trauma center, and all of sudden, they’re working in the operating room. They’re new to that area even though they’re not a new nurse. We also want to reassure the public that nursing is a trusted profession that can guide its own outcomes in a positive way, which is why we’re going to do this presentation.
Some of the objectives – what the learner will gain from this program: You’re going to be able to identify and define the problem; you’re going to know some of the latest research with alternative behaviors; you’re going to be able to project a positive solution and evaluate and have positive probable outcomes.

Although it is an old saying, “eating our young,” unfortunately it is still alive and well. Some of the definitions – bullying, horizontal violence, lateral violence. Bullying is a pervasive feature at most if not all workplaces. Although single acts of aggression or harassment occur in the workplace, bullying is differentiated as a form of repeated behavior that occurs over time.

Horizontal or lateral violence – it can be defined as aggressive and destructive -- certainly destructive behavior or one nurse towards another. I have my research on here if you want to look up some of this.

Look at this picture. Eating should be something that is a pleasant experience. You should enjoy it and benefit from it. The kind of eating we speak of and the purpose of this presentation do not have any... any at all, positive outcomes. In fact, it is total destruction. Those destroyed are not only the victim of the bullying or the violent act but also the one doing the behavior. It disrupts the team. It makes errors possible, and it makes patients unsafe. It’s time to say, “I’m full up to here.” It’s time for nurses to take back the nurturing behavior that everybody knows us for and stop destroying our own people.

Where does this term come from – “eating our young”? The term originated from acts of bullying and has been recently changed from the “eating our young” to the new terms of “horizontal or lateral violence.” In the past, it has been acts of hostility from experienced nurses to novice nurses or the new nurse. Some of these changes of this have been noted in Bartholomew.

For those of you who are educators, whether in academia or a clinical preceptor or a mentor, you know the finished product, which is the student, comes out of school as a generalist. They are not supposed to know everything when they graduate. They know a little bit about everything at best. It’s a broadened term. Even NCLEX-RN is a generalized survey. It’s a general assessment. It relies on the guidance of mentors and preceptors to teach our young. For those of you that are sitting out there saying, “If they got out of school, they should know everything about everything. When they come out, I shouldn’t have to teach them anything.” That is not how schools work. There are so many things that have to be taught in nursing school, there is not time to teach them everything. Even your NCLEX exam is just about generalists.
What happens when these student nurses or a new nurse coming to a new floor asks questions? What happens? They need to be paired with someone that’s receptive to teaching at the next step, at the next level because education never stops. The skills and the simulation labs that occur in nursing schools are just the basic settings where students are given an opportunity to maybe place a catheter. They may go their entire nursing career and never place a real live catheter in a human being. They’ve only done it in the sim lab. Chances are, when they get to the floor and their patient is assigned, maybe has a physician order stating that they need to have a catheter placed, they need to be able to “buddy up” with someone else in the preceptor role, mentor role, or even a friend that can help them walk through the process because they know the steps; they just don’t have the experience behind them. It’s important that our students aren’t eaten in the environment they’re in. We need to be mentoring them, caring for them versus violence.

Historically, nurses are usually a culprit that affects their own kind. Nurses subject their new hires, recruits, replacements with physical abuse, emotional abuse, and verbal abuse. You’re looking at that, and you’re saying, “Seriously? Really? Physical abuse?” Physical abuse is any act where you touch another person. If someone walks by someone and shrugs their shoulder and kind of brushes them as they go by. This is a form of physical abuse when you’re intimidating and using body language as an intimidation factor. That’s physical abuse.

The treatment has changed some. Despite the change in treatment toward nurses, there continues to be a movement of violence and lack of mentoring. It started out with physicians. Physicians were one of the first ones to be abusive towards nursing. Instead of treating the nurse as a qualified, educated part of a team, they were asked to go get coffee. The physician maybe said, “Excuse me. I believe that’s my chair.” There were different kinds of abuse in the beginning. Now, we have protections in place, and one of those protections is when we put RB, or read back, that is supposed to be a form of protection for the nurses that they have written the orders correctly from the way the physician has dictated them. Physicians (more recently) are more accountable with their EMRs (electronic medical records) instead of doing the dictating by phone, so that’s helped some of that problem.

The change in behavior for years of abuse from above nurses has changed for the role as the aggressor. The acts of violence have moved somewhat away from physicians to nurse-to-nurse. The experienced nurse has become the aggressor; the nurse colleague against colleague. Not always is it the novice nurse who’s verbally or physically attacked, and I’ll give you an example. If you are a nurse that is experienced or even I’ve seen this happen in practice – a nurse has been out of patient care at the bedside. Maybe they went to academia, or they were
in management. Their hospital closed, so now they’re back to working at bedside. Maybe they worked in management for five years, eight years and decided that they really missed being with patients, so they’re coming back to the bedside. They come back to the bedside to do bedside nursing, and they have this 25-year-old young nurse that is queen of the show and decides that she’s going to teach this old person a few tricks. You can have violence go in all kinds of different directions. The bullying can occur from any avenue and any venue.

Perhaps the least popular form of aggression towards nurses is that of physical abuse. Perhaps it’s due to legalities and the evidence that’s there or proof of aggression. It’s seen as a form of pushing; accidentally bumping into someone; bumping into the new nurse; dropping or pushing their paperwork; their personal property; or other items to the floor. These are all meant to be acts of physical abuse.

You also have your verbal and your emotional abuse. This is what you’re going to see most often. It can be delivered in the tone and the message that’s delivered — a threatening manner, challenging, belittling, or being hostile. “Oh, is that too hard for you, you that has been in nursing for 25 years? Are you not able to get that done?” Who wants to come to work in an environment of that nature when your fellow cohort is acting in that kind of way? Some of the emotional things you might see are creating an environment that hosts feelings of inferiority. It ends up where the nurses are second guessing themselves. They’re so stressed, and they’re so anxious. They begin to fear going to work each day. As we’re going to talk about in the future slides after this, this becomes a problem that becomes physical to the nurse that’s being bullied. They physically have ulcers and stress-related injuries and evidence of practices that are not up to standard because they can’t think straight, and they can’t clear their medications to make sure it’s the right medications to give because they’re so stressed in the environment that they work.

Cleary, Hunt, and Horsfall wrote an article about the act of bullying, how it can be overt, and act as a form of intimidation for others. It may be invisible or unrecognizable by others. There’s total, noted job dissatisfaction. People don’t want to return to an environment of that nature. Physiologic or psychological conditions may arise, and it’s a huge expense for the organization that has bullying going on. You have an increased amount of people that are leaving. Your attrition rate is sky high. Everybody’s leaving your area. Or people are calling in sick. Or you have an increased amount of time that they’re gone. They’re asking for leave over and over again. All of this means that you don’t have continuity. You don’t have productivity. You don’t have satisfaction among the people that are still there, and your morale is in the toilet. Nobody wants to work there anymore. All of these acts of violence come around to hurt everyone that’s there.
Some of the ramifications of abuse in the workplace: Besides the dissatisfaction with the job, there are other consequences. Rowe and Sherlock wrote an article talking about that. The absenteeism is phenomenal, and the statistics are there to prove it. There’s no loyalty to the employer because you see yourself as a victim, and the employer is not helping you at all. They’re not making the situation better or making it worse. There’s no management there at all. There are lots of errors in patient treatment. Can’t think straight, you can’t do your meds right, can’t get the treatments right. There is real illness that originated with stressful environment that’s now manifesting as genuine physical concerns.

The abuse and violence with no action: Sometimes, the abuse is by no action whatsoever. Doing something that probably should have been done. For example, you’re in report, and the person that is giving you report is the shift that’s leaving. They’ve been acting violent towards you since you started on this unit, so they deliberately withhold information from you. Maybe you’re new to the unit, and they deliberately don’t orient you. You have no idea where the crash cart is. All of a sudden, something happens to one of your patients, and you’re supposed to run and get the defibrillator. There is such a thing as bullying but not doing a single thing, by withholding. Reporting is one of the big things that I saw, in the research that I read, that came up over and over again – withholding things in the report, not giving a conclusive, well-rounded report, leaving out bits and pieces that were very crucial.

The effects of abuse can be devastating and last a long time, sometimes throughout a career. There are people that have actually been involved in these studies that have decided that nursing just wasn’t for them because of the treatment that they had had at the hospitals where they worked. The physiological and the psychological consequences can be detrimental to the success or the lack of success in a nurse. In Rowe and Sherlock’s study, the most frequent abuser of a new nurse is not the physician, but rather the staff nurse that is meant to mentor and nurture that new nurse.

In a Portuguese nurse study, there were 107 nurses in Portugal; 13% reported acts of bullying over the past six months. Three of the most common types of identified bullying in this study, the nurses were told to do tasks that were below their competence level or their skill set. They were told to do menial jobs. They were having responsibilities removed or replaced by trivial or unpleasant tasks, or they were being exposed to a workload that is difficult to manage.

Where does the abuse originate? Are experienced nurses just bad? Are all the nurses who have been out there forever just bad influences and bad individuals? Here’s where some of it comes from, I believe. The origination of the violence: Often the origination of abuse starts
with burnout. This is the number one thing that study after study after study said – burnout is the major cause of bullying and violence towards each other. Nurses who are exhausted mentally and physically have little time to mentor or nurture anyone. They don’t even have time for themselves. Longstanding abuse towards them, like domestic abuse, leads to abuse in the next generation. That was also identified. The nurse that was abused in their home life will abuse at work. Years of verbal abuse from physicians and colleagues leads to a continuation of that abuse. Maybe you have a nurse that is very experienced, and they were used to the physicians talking down to them and being rude to them. They’ve decided that they’ll just carry on the tradition to the next generation of nursing people.

The forms of abuse that are reported today -- the most common being experienced nurses to novice nurses. You also have nurse colleagues, nurse managers, families of the patients, physicians, and patients.

In a conclusion on the Rowe and Sherlock study, they stated that nurses who experienced verbal abuse may be stressed more than others. They will be less happy at their jobs, have frequent call-ins, absenteeism, and provide substandard care to patients. That’s the critical one, people – substandard care to patients.

One of the biggest stressors out there is nursing shortage. Here we come to the nursing shortage. Think about all the stress we’ve talked about thus far – how nurses that are experienced are bullying and being verbally and aggressive towards the newer generation. The newer generation is being aggressive towards the older generation, and it just kind of goes back and forth. We’ve got nurses involved. We’ve got physicians involved. Now, to make everything worse, we’re going to have a nursing shortage where we don’t have enough of everybody. The nursing shortage has an impact on all clinical settings. Patients are now coming to the hospital, and they’re more ill than ever before. They have huge, high acuities. Nurses are working with less staff. The first person to get cut is usually the CAN (certified nursing assistant), so there’s nobody to help.

Nursing shortage extends to the field of academia as well. The lack of qualified faculty is going to decrease the opportunity for nursing students to come into a program because you don’t have the faculty to teach them, to take them to clinical. At the hospital itself, there’s a lack of preceptors. They can’t help when we do bring nursing students to the facility.

Increase in retirees: People are getting older, believe it or not, and they do want to retire. They want to get out of nursing, especially when some of this stuff comes to light. We’re having fewer coming out of nursing school. We’re having fewer that are staying in the
workforce, and the ones that are in the workforce are working with less than ever before. We have an increase in shift and floor nursing. There’s a shift from people that were bedside nursing, have moved into nurse practitioners. We’ve lost some people for higher education.

Some of the roadblocks to getting staff in are the declines in enrollment which we just talked about. There are not as many students coming in anymore. We have an aging workforce. There’s a change in profession; they’re moving from one discipline to another. The wages and the entrance testing that’s occurring -- entrance isn’t just in the hospitals, but it’s in academia as well. There’s entrance testing that must be done, and that’s one of the roadblocks for getting students into school. They decide they don’t want to take that test to get into school. They have no problem taking tests in school, but they don’t want to take an entrance test and it’s the same thing with facilities that require PBDS (Performance Based Development System) or other testing to show that you’re competent before you come and work for them. That’s kind of a roadblock for getting more staff in.

There’s a stress with increased workload; stress with student preceptorship; and stress with the new equipment and lack of training and experience. Oftentimes, when nurses are floated, they’re not given the whole training as another nurse that’s normally on that floor, and that’s another roadblock for gaining new staff to want to come to that floor.

The electronic charting and the age of computers and familiarity play a huge role in the receptiveness to change. We have some of our nurses that are not computer savvy, that do not feel that this is something that they can ever master. That adds more stress to a job that they were already feeling familiar with, and now all of a sudden, they’re out in left field because they don’t know how to manage the new charting. Usually seasoned nurses plus technology is not a very good mix. You add some nursing students to that stress that are seeking wisdom from this experienced nurse, and you’ve got a volatile situation sometimes.

Enter the nursing student. Colleges and universities are teaching the latest, evidence-based practice information. The floor nurse may be still practicing with a “this-is-how-it’s-always-been-done” mentality, which you’ve got heads butting right there. Your faculty holds nursing students to highest standard and preceptors are held accountable as well. You have multiple nursing programs and a short supply of preceptors. Often, hospitals are hiring new staff, and they pull their experienced and their best nurses to work with new staff coming in. You don’t have anybody that’s going to precept the new nursing students. We’re wondering why our hostility and our frustration is climbing.
The nursing shortage: With the well-known shortage of nurses, one would think nurses would receive their new recruits with open arms, but that’s just not the case. Nurses who are exhausted with regular duties, mentoring and precepting students, and additional duties of orienting new recruits all added to the facts of the census growing, acuity climbing, more extensive nurse-to-patient ratios, and I said the sicker clients – all adds to their stress level.

When you have a graduate nurse, somebody that’s brand new, how do you prepare the graduate nurse to the possibility that the environment they’re going to go into will be hostile? We have to prepare them because this is reality. Until we can fix the problem – and quite frankly, I don’t see a solution around the corner – we need to prepare our students that are getting out of schools that this is probably reality. They need to have a culture shock to realize that you’re going to be walking into an environment that may not be friendly. What we’re going to do is we need to educate them, give them adequate knowledge to enter the setting, giving the conflict resolution tactics, unveil the possibilities of what their environments and the culture might be, teach the students what to ask in an interview for a position. Ask your employer: “Are there any violence, hostile behaviors in this environment? Are there any unfriendly...” You probably don’t want to ask if there are any unfriendly people, but you can ask what kind of environment you’re going to be walking into. “Is there someone that’s going to mentor you?” “Will they be attached to you the whole six weeks you’re in training?” “How many years have they had experience?” Ask those kinds of questions so you know what you’re walking into. See if you can meet the person that’s going to be mentoring you if you get hired.

How to avoid cliques and being the outsider: You don’t want to get involved in any kind of bullying behavior towards an individual. You don’t want to become a part of that clique that’s bullying another person, but you don’t want to be an outsider either. You need to teach students how to be that middle man that can try and make peace in the unit.

In an Australian study “The educators need to acknowledge probable stressors and oppressive practices so students and new hires can be proactive.” In the Kelly/Ahern study, they concluded that the educators hold some responsibility in the outcome of the students merging into the professional life and coping with aggression. Nursing courses should deal with socialization after school ends. Again, it needs to be built into academia so that the students that come out of nursing schools are aware of what they could be facing when they get into the real world. It brings new meaning to the real world. Workplace violence and cultural consideration at various facilities and coping with stressors: They all need to be a part of the curriculum. A means to be proactive in dealing with silence and aggression: They need to be given tools so that they can cope and know how to deal with silence that they may get when they come into a new environment.
New graduates found nurse managers had not prepared them for cultural norms and limited assistance with unfamiliar tasks or responsibilities they received from their registered nurse mentors. In this study, they talked about how the nurse manager was kind of the middle man from administration and the nurses, and they didn’t assist the new employee and, subsequently, quite often lost that employee.

Often, nursing facilities have nurse managers that decide which nurses are qualified or able to assist in the mentoring process. Often, the decision is not left to the individual nurse. Often, the nurse is inundated with new people, students, preceptors, and new hires, and often, they have no voice in the decisions.

New orientation systems may have the program that states GN (graduate nurse) is not ready or is ready for the preceptor doesn’t have to concur. Basically, what this is saying is there are new hire orientation processes where you have the student go through their learning methods, maybe as a six-week program. The one that’s precepting the student feels confident that that student or that new hire is going to be good at the job, that they’re safe, and they’re ready to go on the floor, but because of the different system that your hospital employs as a test, the student may not perform up to where they think they should be. They subsequently let them go which makes the preceptors that are given this responsibility of mentoring these students very upset because their word has not been listened to. Their voice is not heard.

Nursing management must address these acts of hostility and aggression. Nursing management must acknowledge attrition rates. If you have a department – let’s say an OB (obstetrical) department – and you have five, six, seven, eight people leaving, and a month later, you have three more people leaving. Someone in administration somewhere needs to see that there is a problem here. You don’t get that kind of attrition on your unit for just no reason whatsoever. There’s got to be something underneath the surface that’s going on. You’ve got someone on the floor that’s being a bully or some kind of behavior that needs to be investigated, and interventions need to be put in place.

Retention and recruitment: If applications for job openings are not seen, is there a reason why? Has word spread in the community that yours is not a hospital or a department that others want to come to whether they’re experienced or a novice. Sometimes, word precedes job openings. There might be seven job openings in the telemetry department at ABC Hospital, and nobody is applying. There’s usually a reason behind that.

When do you know that you have had enough? It’s time to move away from the aggression and become the one that’s actually the nurturer. Kathleen Bartholomew – In
Bartholomew’s writings, she points out that the etiology of horizontal hostility is a characteristic of all groups considered oppressed. This author points out that we cannot afford to lose from the profession. She is quoted and goes on to note that 60% of the newly-registered nurses are leaving their first positions within six months because of horizontal hostility. This is staggering, staggering data. Bartholomew brings attention to nurse managers who, she says, are often caught in a no-win situation between demands of upper management and the complaints of subordinates. All of the politics that middle management faces make their hands often tied which gives the new nurses no support and no choice other than to quit.

In Daiski’s article, he calls for radical changes within the profession. Develop effective strategies bringing bedside nurses to the decision-making process. This is seen when facilities round and include nursing. You’ve heard of “rounding.” This is what this article talks about. When they go from patient’s room to patient’s room, the nurse is part of that integral part of the team. This helps get the nurse’s views and the nurse’s expertise out there for the team to consider for taking better care of our patients. It gives the nurse more power. The nurse — and I said ‘she,’ but it could be he or she — voices a need for mutual respect and awareness through education, the development of caring nursing communities through mentorship and non-hierarchal leadership. By giving nurses positive feedback and positive pats, it helps their attitude, so that they have a better outlook on life. They aren’t so down and depressed and able to go towards violence.

We need to destroy the silos. The destruction of silos is very important. We no longer are nursing, medicine, pharmacology. We all are working together in an interdisciplinary way, so we need to destroy the silos. There should be no “I.” It’s all about team. We need to respect and understand we need to destroy the silos. The nursing is part of the team. Interdisciplinary thinking is key to success and change. Respect from top down and amongst the same discipline. The interdisciplinary teamwork is crucial for the success and continued care of our patients.

To multiply to this problem, not only is there evidence of hostility with new nurses and nurse colleagues of displaying acts of aggression against themselves, but now there are also statistics of abuse toward older nurses — and I put me — and floating. I can tell you an experience of my own when I went back to work because I like to keep my fingers in the pie. I went back to work, and I worked on a unit. I would hear comments that would say, “She’s a teacher, so obviously she knows everything.” Do any of us know everything? I challenge you to say that you know everything out there because I most certainly do not, nor would I ever come across as knowing everything. There are ways to be abusive towards — and I’m not going to say I’m older because I’m not — but there are ways to be abusive towards people that are not familiar with your unit.
The other thing I wanted to point out is “floating.” Oftentimes, if you are employed in a unit that is one of those that has feast or famine – it’s either busy or it’s not – oftentimes, you are called upon to float. Our whole topic today is talking about violence and bullying and hostility. You throw floating in there, and you’ve got a whole can of worms right there in that one word – floating. When you leave your department which you are familiar with and you go to work in a unit that you’re unfamiliar with, it’s going to be very stressful for you as well as for the people that are counting on you to take care of the other seven patients that they didn’t have a nurse for. Where this situation becomes troublesome and unsafe towards patients is oftentimes the nurse that is coming from another floor has not been given the same training as the ones that are there all the time. If you’re on a medical surgical unit, you are someone that’s familiar with NG (nasogastric) tubes. You are someone that is familiar with TURPs (transurethral resection of the prostate). You are someone familiar that is with Pleur-evacs. You are someone that’s familiar with DVTs (deep venous thrombosis) and CVAs (cerebrovascular accidents) and all these other things; whereas, if you’re someone that’s coming from the NICU (neonatal intensive care unit) or the nursery, this is a downright stressful, scary, horrific time to be placed there. Then to have someone else that is part of your team say, “You’re in education, so you should be the one that floats there because you know everything.” You can imagine how stressful. That isn’t someone punching me. That’s not someone physically abusing me, but it is a form of abuse to be saying comments and belittling other people. There’s a lot of stress involved if you’re someone that’s being told that you must float.

Acts of physical violence are a very big concern for nursing especially in the emergency room. The governor of Texas signed into effect House Bill 705 which made violence against emergency room nurses a third-degree felony. Other states are following up with the state of Texas governor and are having more, similar bills put into effect.

In a study by Child and Mentes, it proves that further study needs to be done to understand the identity and reasons and solutions for workplace violence. Emergency and psychiatric nurses are the most vulnerable for abuse from patients. The nursing shortage is expected to increase. The age of the workforce is expected to increase. Recruitment and retention of qualified nurses may be influenced by workplace violence. People don’t understand why this all occurs, although stress it the one thing – and overwork and burnout – was the major factor identified.

In Lux, Hutcheson, and Peden’s study – this is a descriptive study, and all the participants agreed that when interacting with an individual who was confrontational or abusive, it is important to talk things out in private. Get them away from others and especially
away from the patient. Usually, when you’re in a pack – what do you think of when you say “pack”? Everybody’s got one person’s back, and somebody’s the one that you’re going to all feed on is what I think of when I hear “pack.” It’s important to get that individual away with just you and that other individual to talk things through, especially away from patients. Delay confrontation until all the parties are calmer. Acknowledge that all parties have a perspective, have an input. At the conclusion to this study, the nurses stated outcomes were positive and gave them a feeling of an improved practice environment.

Learning to get along: As you can see in this slide, these are not individuals that normally would get along, but they’ve found a way to be cohabitating. It has to be the same way in the hospital environment where we are able to all work together whether it’s nurse to nurse, physician to nurse, or whichever discipline you are. We have to be able to work together for safety’s sake.

All relationships need to be nourishing and positive. Respect is the key. Everyone has something to offer. Often, the newest nurse on the floor has the most current, evidence-based practice knowledge that will aid the patients. The experienced nurse has developed the gut instinct that is invaluable, so between the two of them, you have a phenomenal team if they will just work together and talk with each other. You have the experience; the newest, latest research; and you have the one that just in her gut knows what’s right and what’s wrong and what will work best. That’s just a phenomenal team if they get together.

Some solutions: Bring education into the school environment. Bring awareness to nurse management teams. Gain involvement from nursing administration. Nursing administration needs to be aware that this problem exists. They can’t close their eyes anymore. They have to be able to look at the numbers. They have to see their attrition rate -- all these people that are leaving. The absenteeism is phenomenal. They can’t wear blinders anymore. They need to gain involvement. We need to poll and inventory your nursing culture. Is it one in which new blood would be welcome?

Benefits need to be weighed for new hires to rotate through the hospital to find a suitable slot. I really liked this idea. I read this in I can’t remember which article, but I read this in one of the articles that I have. You can see in the references later. They talked about before someone was hired – they were hired, but they weren’t hired for a specific area. They were hired, and they spent time in each and every department. The person in this study identified five areas within the hospital that they wanted to try. They went to each area of the hospital to see which the best fit was. This is a wonderful way to see what the culture is; to see if you would be a good fit to that area; and it really alerts the new nurse to “This is an area of hostility.
I don’t fit in there at all.” This way you didn’t lose all your new hires. You were able to get the best person in the right job that was going to be comfortable there, and bottom line was going to stay and take good care of patients. That was just phenomenal.

In the Griffin article, the newly licensed nurses are a group most vulnerable to lateral violence during their socialization to nursing practice. Griffin points out that by alerting new graduates to the prospect of lateral violence – this is what we talked about. Bring this information back to the schools to let the schools know that they need to tell new grads, “Hey, when you get out here, the culture may not be receptive to you going to work there.” He says make sure you tell them about lateral violence so it can be depersonalized. It’s not all about “they’re out against me.” It’s just that they’re just not happy in their environment themselves or unhappy with themselves in total. They can’t very well be happy with you coming in when they’re already unhappy where they are. Depersonalize it. It’s not about you. This allows them to ask questions and continue their learning without thinking, “Hey, this person’s jumping all over me. I don’t want to work here anymore.” It depersonalizes it.

Knowledge is power. The learned cognitive responses help new hires or GNs (graduate nurses) confront the lateral violence offender. This early alert provided an ability to process behavior prior to actual offense which in turn affected retention rates. This brought the problem to the forefront. It brought everybody’s awareness to this unit has a problem. These people in particular have a problem. They’re all – each and every one of them is a very good nurse, but sometimes when they get together, it’s not good for the other people on the floor. The problem was brought to the limelight. Everybody was aware of what was happening. That helped retention.

“Bullying in the nursing profession,” an article by Jacqueline Randle. She talks about how bullying was found to be commonplace in the transition to becoming a nurse. Students were bullied and also witnessed patients being bullied by qualified nurses. The internalization of nursing norms meant that students then bullied others. Students’ self-esteem was very low. This kind of shows again another process. The experienced nurses that were supposed to know what they were doing and were supposed to be the ones that were in charge of the situation were actually bullying patients. Student nurses saw this occurring and started acting the same way the other nurses did. They kind of followed in line, and it became a vicious cycle which made all the students not really like their jobs from the very beginning of the employment.

Bully and its effects on self-esteem are perpetuated by practices within nursing. This situation will often be changed if nurses and educators transform their practice in the context in which bullying occurs. Otherwise, each new generation of nurses will continue to be
socialized in negative practices which undermine both their own feelings of self-worth and standards of nursing care. It’s going to be a cycle that keeps repeating itself unless we bring these concerns to everyone’s attention; hence, this presentation. Everybody needs to be aware that this is alive and well out there in our communities, in our hospitals, in our nursing homes. It is patients being mistreated; it is nurses being mistreated. There’s just a vicious, vicious cycle.

As one of the most respected professions in the world nursing needs to implement methods to make change occur: Nurses are trusted to lead. Nurses need to lead by example. What kind of example are you giving if you’re an experienced nurse on the floor; you’re bullying patients; you’re making your brand new hires run away in tears? The reason you even got this way is because when you came to work today, you were in a pretty good mood. You got there, and three people called in sick. You were supposed to only take 20 patients on your floor, but they had to give you overload. You have 25. Your day has just gone to heck, so you’re upset. You turn around, and you yell at everybody around you. You belittle the new people. Before you know it, everybody’s unhappy in their job including you. We need to lead by example; try to make the best of every situation.

Some implications to nursing practice: The hostility and the violence – the implications that it has for practice today. Nursing is built on compassion, trust, and knowledge. Nursing is about mutual trust between team members, nurse to patient, nurse to family member, etc.

Significant advantages to team work: You have safe care for patients. If you work as a team – like in the scenario I just gave you. You’re short-staffed. You have more patients than you know what to do with, and you don’t know what you’re going to do. You’re bottom line remains the same no matter if you have full staff or not enough staff. The patients are your number one concern, and they have to stay safe. You need to start with your game plan in the very beginning. What am I going to do to keep these patients safe? I’m down three people. Can I call up and get – maybe there are some spare CNAs on another floor? Or maybe the nurse manager can come out of her office and help for a while – whatever the situation may be. Some of the significant advantages to working as a team, getting everybody to work with you is, bottom line, patients stay safe.

Nurses stay safe. You don’t have to worry about calling Safe Harbor. You don’t have to worry about giving the wrong medications. You’re going to work as a team. You’re going to get extra people to help you, and everybody’s going to be happy in their job.

The financial benefit is great for you, for the hospital, for everyone. You’re going to keep your job. You’re going to keep your benefits. You’re going to stay at this job, and everything is
going to accrue to where you have a wonderful retirement. The benefits are all good for you. The staff is happy. The patients are happy. You have a decreased turnover rate, and your productivity – the hospital is in “hog heaven” because your productivity in your hospital is skyrocketing because everybody is working together as a team, and everybody is happy in their jobs.

Some hospitals institute what’s called “shared governance.” There is a Baylor study about shared governance. They have shared responses, and they talked about accountability -- keeping every person on your team accountable. They also talked strongly about managerial support. The management staff of Baylor has taken on the responsibility of making sure that their employees are happy and they have the resources they need to give good patient care. They also have a peer involvement where they do different, various meetings where they talk and they visit about what could have been done better; what should we do next time for different situations that occur. They deal with lateral violence openly in their shared governance meetings. This is one of the tools that they have. Open and truthful communication occurs.

The Baylor study begins with open dialogue. This leads to mutual trust because it’s transparent. It allows for measurable goals and commitment to a positive outcome that will create a unified, effective organization, all of which will create an investment from the organization. They communicate freely with each other. They have known – everybody knows the goals. Everybody trusts each other because they have transparency. Everybody knows what everybody’s doing. The organization has said, “You have my support. I will make sure we need to do what we need to do to make sure this violence doesn’t occur, to make sure we all have a good team, and to make sure that our patients are safe.” Everybody is committed to this mutual goal.

TeamSTEPPS®: You’ve probably heard of TeamSTEPPS® also. TeamSTEPPS is all about good rapport, good report, and good communication. This is where a lot of hostility and lateral violence occurs because there’s mismanagement of information. Like I said when we first started the presentation, some information is withheld. Some information is not given accurately. What TeamSTEPPS® talks about is all disciplines getting together and working as a team for the ultimate goal of patient safety and good plan of care. Effective communication allows relationships to become strong and effective in the workplace.

What do you see here? I see chaos. We need to get rid of the chaos. We need to work toward a common goal. Don’t let fatigue, chaos, frustrations turn to disrespect and hostility. We want to get rid of the clutter; get down to the nitty-gritty; what needs to be done to care
for our patients. Promote an atmosphere of respect and caring for nurses as well as the patients. Hold every single person on your team accountable. Point out unacceptable behavior, and do it right away. Don’t let it breed to where you have five people that now have the same mentality that a week ago only one person had. Hold everyone accountable. Point out that unacceptable behavior right away. Remember when we talked about don’t do it in front of patients? Pull them aside and talk about unacceptable behavior.

Work outside your discipline. Create an environment without silos. Use team-driven expectations. Work towards a greater workplace because that’s what we all want. We want to go to work and be happy in our jobs, take good care of patients, and we want to make a difference. I don’t know about you, but the reason I went into nursing was I wanted to make a difference in my patients’ lives. I wanted to be someone that could be trusted to do a very good job with the knowledge that I had been given in nursing school and that had come about through my experience.

In case study number one: Conflicting personal, professional, and organizational obligations. You are an RN (registered nurse). You have been working the oncology unit since graduation one year ago. Your supervisor often compliments your work and lets you relief charge from the 3 to 11 shift. You work occasionally on the med/surg unit when oncology has low census. Now, you are asked to work the delivery room. “Just go and do the best you can.” What do you think about that? Do you feel that as an oncology nurse, only one year of nursing experience, and all that time it’s been oncology with a little bit of floating to the med/surg area, how capable, competent, and confident are you to work labor and delivery? Is this even legal? What problems do you see? Is this a form of lateral violence? Is this nurse qualified to do floating on this floor? What competency levels would be necessary to work in the delivery room? Does this nurse have them? Do you believe because a nurse has a license that they can work in any area of the hospital? “You have a license, don’t you?” Have you ever heard that before? “You have a license, don’t you? You’re a nurse aren’t you? Why can’t you go up there?” What are the possible actions that this nurse should take? If you were her, what would your choice be? Are you allowed to just come in and say, “I’m going home; I’m not going to work there”? What happens when you just refuse to work at your job and you just go home? You have to be very careful about patient abandonment. If they’ve already put your name down as taking report on those patients, are you abandoning those patients? You have to be very careful.

Some possible solutions: All nurses are expected to be competent, yes. Nurses have orientation to their place of employment, so they’ve been oriented to the oncology floor. They haven’t been oriented to labor and delivery. The obvious solution is that the nurse will go to the
delivery area but only as a “warm body.” What does that mean – warm body? It means you’re there, but you don’t do any technical, skillful thing that is labor and delivery-oriented. This nurse is not confident or competent to deliver a baby. Who would want to have a pregnant person delivered by someone that had never worked in labor and delivery before? It would be like on the street, somebody helping you. They might do something that a warm body would do such as taking vital signs from everyone, assist with prep, or provide a second set of hands for whatever needs to be done, but they would not take a patient load. They would not be competent to do so.

Case study number two: You are an RN graduate from a BSN program. Since graduation six months ago, you have worked outpatient emergency clinic – outpatient. An older diploma nurse, working with you constantly belittles BSN nursing education. “Didn’t they teach you anything in nursing school?” The clinic supervisor has consistently given you high evaluations at three months and at six months. You are becoming increasingly defensive regarding the comments from the other nurse.

Solutions: Take a step back. Is there any worth to the comments made by the diploma nurse? Are there gaps in the BSN training that you have? Is there a need for more experience in certain areas? Confront the nurse in a private environment to discuss the comments between the two of you. What part of BSN curriculum bothers that nurse? If you wish to go back to school, point out that your hospital offers tuition reimbursement. Maybe this nurse would like to go back to school herself. Ask another nurse to step in and be a middle party, a mediator. Seek managerial assistance if it cannot be handled between the two of you.

Case study number three: Physician versus nurse. You are an RN on a surgical unit. MJ is an orthopedic surgery patient two days postop. The physician orders PCA (patient controlled analgesia) with morphine as well as IM PRN Demerol every three to four hours. The patient continues to have pain. Today, the doctor orders additional 100 mg of Demerol now, even though the patient received 100 of Demerol less than an hour ago as well as the PCA pump. You approach the physician. The dose described by the physician is harmful to the patient. Solutions must come from the charge nurse or administrative nurse. Contact must be made to pharmacy as well as the medical director. Do not give the medication as ordered. Monitor the patient closely from the prescribed dose already given. This is a med/surg floor without proper monitoring equipment. What’s going to happen if this patient has all of this Demerol on board? It’s not a situation for the patient to be in, is it? What you express verbally and non-verbally makes your day and other people’s day. Attitude is everything. Don’t brag about what you can do. Show the world what and that you can.
I am Kate Woehl, and I hope you learned just a little bit today about lateral violence. It is a huge, pressing problem in our world, and I hope that you take some of this information back and see if you can make your environment a better place to practice for our patients’ sakes as well as all of ours. Thank you.

Presenter: Kate Woehl, RN, MSN

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