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# Lateral Violence of Nurses in the Hospital Environment: The Need for Caring

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**Abstract**

Nurses today are plagued with doing more with less and are forced to work in high-stress situations. These conditions lead to a stressful situation and contribute to lateral violence. While lateral violence has the potential to be present in any setting, it is more prevalent in healthcare. The adage of "nurses eat their young" is still in effect today. With a change in focus from a to-do list with a focus on genuine caring, not only the nurse but the patient as well will benefit. The purpose of this analytical review of research literature was to evaluate the prevalence of lateral violence experienced by nurses, determine ways to identify and eradicate it and educate the medical community on the incidence and eradication of lateral violence. Jean Watson's Theory of Human Caring was determined to be the most comprehensive approach for guiding this review. For nurses to provide optimal care to patients, nurses must be able to work in a positive team-like atmosphere. Future strategies for improving lateral violence in the hospital environment include more educational workshops and nursing residency programs. Scholars suggested educating nursing students early in their nursing curriculum on lateral/horizontal violence to reduce the effects of lateral/horizontal violence for the future.



**Key Words:** Lateral violence; nurses; hospital; caring; Jean Watson; residency program; education; culture

## Introduction

Lateral violence is defined as a deliberate and harmful behavior demonstrated in the workplace by one employee to another especially a problem in the nursing profession (Christi & Jones, 2013). Also, it is known as horizontal violence or workplace bullying. Besides, lateral violence has a negative effect on the work environment and the nurse's ability to perform quality patient care.

Lateral violence in the workplace has taken many different forms and a variety of labels over the years including aggression, incivility, bullying, and horizontal hostility (Major, 2013). While it is a problem in any workplace, it has been historically an issue in the nursing profession with a famous statement of "nurses eat their young" that was coined over 25 years ago by Meisner (Sauer, 2012). Unfortunately for the nursing profession, that phrase is still appropriate today.

Negative workplace culture has multiple negative consequences including the institution allowing the behavior, the nurse experiencing the behavior, and the patient's outcome due to things that could be avoided in a different work environment (Lachman, 2014). With the Joint Commission stating that lateral violence can contribute to medical errors, adverse outcomes, and high staff turnover an institution must be not only aware of the situation but also implement strategies to improve cases of lateral violence (Lachman, 2014).

The culture of a workplace is important for job satisfaction, but no other location is more important than in health care (Dimarino, 2011; Kennedy, 2020;

Kennedy & Wider, 2020.) If a nurse is experiencing lateral violence, this behavior can affect their psychologically but physically status (Craft, Schivinski & Wright, 2020; Kennedy, 2020; Lee, Bernstein, Lee, & Nokes, 2014). Common mental health problems include anxiety, depression, lower self-esteem, and medical conditions include headaches and gastrointestinal problems.

When a nurse is exposed to lateral violence, there is potential for there to be unnecessary burnout which can affect the cognitive ability of the nurse (Lee et al., 2014). With a decline in the nurse's cognitive ability, there is an increase in the opportunity for nursing mistakes to be made with a potential adverse outcome for the patient (Lee et al., 2014).

Lateral violence can be described as occurring in three different categories that are verbal, physical, and psychological (Blair, 2013; Kennedy, 2020). Verbal lateral violence can take the form of rude comments, condescending comments, or direct verbal attacks (Blair, 2013;Kennedy, 2020). Psychological violence is one that is subtle and can include activities such as a lack of collaboration, blaming others in front of a patient, or withholding information (Blair, 2013; Kennedy, 2020). Physical violence is more apparent and can include sexual misconduct (Blair, 2013).

Multiple entities are affected by lateral violence including the victim, the patient, and the facility (Sansones & Sansones, 2015). Workers experiencing lateral violence can experience an array of effects such as stress, depression, insomnia, and possibly even posttraumatic stress disorder (Blair, 2013;

Kennedy, 2020). The effects of lateral violence can potentially escalate into substance abuse and possibly suicidal behavior (Blair, 2013; Kennedy, 2020). Lateral violence costs the facility as well and has been estimated in 2006 to be as much as $4.2 billion being spent on replacing nurses that leave the profession (Blair, 2006).

Lateral violence can also hurt patients and ultimately cause serious injury and possibly death as a result (Blair, 2013; Christi & Jones, 2014). The Joint Commission discovered that 70% of sentinel events were due to a lack of communication (Blair, 2013). Communication breakdown can occur with lateral violence in the form of the victim displaying avoidance of the culprit (Blair, 2013). With bullying or intimidation taking place on a nursing unit, communication can be affected, and as a result, patient care can suffer (Blair, 2013). Lateral violence can affect patient care in the form of increased absenteeism which leads to decreased patient satisfaction and substandard patient care (Bambi et al., 2014; Blair, 2013). This paper is an analytical review of the literature on lateral violence among nurses in hospital settings. The next sections of this paper include : (a) an overview of literature violence; (b) Theoretical Framework of Jean Watson's Theory of Human Caring ;(c) literature review; (d) results of findings; (e) strategies for improvement; and (f ) implications for Future Research.

## Overview of Lateral Violence

With nurses being one of the major players in the health care area, being able to work in an environment that provides for not only a team atmosphere but also fosters an environment for optimal patient outcomes (Rainford, Wood,

McMullen, & Phillipsen, 2015). Lateral Violence can take many forms and have varying definitions. In the broadest sense, it can be defined as an action that causes harm, humiliation, offense, or distress in the victim (Sauer, 2012). It can be called lateral violence, horizontal violence, bullying, incivility and can be defined in different ways but is generally accepted as any activity that is considered offensive, intimidating, malicious, insulting, and any abuse of power that is intended to undermine, humiliate or injure the victim (Fisher, 2015).

The healthcare sector appears to be a place for increased episodes of lateral violence with a reported 46% of radiologists experiencing this phenomenon (Trad & Johnson, 2014). On an international level, the prevalence is present with estimates in different countries ranging from as little as a reported 14.7% in Australia and as prevalent as 86.5% in Turkey (Saucer, 2014).

Rates of workplace bullying in the general workforce have a reported rate of 11% (Sansone & Sansone, 2015).

Problems with lateral violence can include increased mental distress, sleep disturbances, fatigue, depression, anxiety, and even work-related suicide (Sansone & Sansone, 2015). The prevalence of workplace violence did not change with a change in position with nurses reporting the prevalence at 51.7% for nurses and a reported prevalence of 53.1% for midwives (Sheehan & McCabe, 2015). Nurses and patients alike can experience post-traumatic stress disorder (PTSD) because of lateral violence with a general population lifetime estimate of 8.7% (Bowsfield & Samra, 2015).

The Joint Commission and the American Nurses Association have also attempted to address the problem with lateral violence (Lachman, 2014). A survey conducted by the Institute for Safe Medication reported that 40% of clinicians either did not speak up or elected to remain passive during patient care events due to an intimidating person (Lachman, 2014). With some lateral violence being reported as high as 85%, the problem is still quite prevalent today (Lachman, 2014). The American Nurses Association also issued a statement that disruptive behavior is considered a violation of the Code of Ethics for Nurses and addresses specifically disruptive behaviors (Lachman, 2014).

The lateral violence comes at a price with an estimated cost of more than $4 billion every year related to lost time, decreased productivity, and training new staff due to turnover (Rainford, Wood, McMullen, & Phillpsen, 2015). Turnover leads to not only increased cost to the facility but also leaves the remaining employees with an increase in workload which can exacerbate a decrease in morale to the remaining employees (Rainford et al., 2015). This decline in confidence and increased workload enhances the risk of medical errors (Rainford et al., 2015).

Lateral violence is experienced by many different types of professions and in countries throughout the world (Rainford et al., 2015). Lateral violence affects the nurses' the ability to provide care for their patients. Also, lateral violence interferes with the nurse's ability to handle both personal and professional stress, the climate of the workplace, and the supervisor's ability to handle episodes of lateral violence appropriately (Rainford et al., 2015).

Lateral violence in the health care setting is so prevalent that the International Labour Office (ILO), The International Council of Nurses (ICN), the World Health Organization (WHO), and Public Services International (PSI) developed policies and strategies to combat this issue (Martino, 2003). Despite the efforts on an international level, the problem persists.

## Theoretical Framework

For appropriate changes to be made, there needs to be an evaluation of the present situation, a determination of a method of development, and a process to follow. In researching different theories to utilize as a framework for improvement, Jean Watson's Theory of Human Caring was determined to be the most comprehensive approach. This method includes both the nurse- to- nurse relationship as well as the nurse-to-patient relationship, and it also involves the relationship between nursing and administration (Wagner, 2010). The application of Orem's theory in decreasing lateral violence in the workplace would be useful for improving the nurse-nurse relationship thereby improving patient outcomes.

*Jean Watson's Theory of Human Caring* has been in use for some time with positive results on both nurse satisfaction and patient outcomes (Watson, 2009). The core concepts of this theory include a relational caring for self and others, transpersonal caring relationship, caring occasion/moments, multiple ways of knowing, reflective/meditative approach, caring as an encompassing process, and caring changes all involved in the caring process (Wagner, 2010).

Relational caring for self and others includes moral and ethical philosophies that are based on love and values (Wagner, 2010; Watson, 2009). The transpersonal caring relationship includes a commitment to enhancing human dignity, respect, or love for the person, and providing a sense of honor for the individual's needs, wishes, routines, and rituals (Wagner, 2010; Watson, 2009). It is a heart-centered approach to care that realizes that the caring relationship encompasses more than just the physical body but includes mind, body, and spirit. Therefore, it calls for "Authentic Presence" requiring a humanto-human connection (Wagner, 2010; Watson, 2009). Caring occasion/caring moments call for the encounter to be a heart-felt human to human interaction that is meaningful, authentic, and genuine (Wagner, 2010; Watson, 2009).

Multiple ways of knowing encourages a multidisciplinary approach to include science, art, ethical, personal, cultural, and spiritual knowledge base (Wagner, 2010). The reflective/meditative approach allows for the individual to evaluate the situation to make changes or improvements to the interactions (Wagner, 2010). Caring as being inclusive, circular, and expansive requires that the individual cares for themselves, for others, and the environment (Wagner, 2010).

Watson's theory has identified ten caring factors that have been defined as Caritas Processes which can be utilized to put the theory into practice (Wagner, 2010; Watson, 2009). These ten factors include guidelines such as: practicing loving-kindness and equanimity, being authentically present, cultivating one's

own spiritual practices and transpersonal self, going beyond self, developing a helping-trusting and authentic caring relationship, being supportive of both negative and positive feelings, engaging in the artistry of caring-healing practices, engaging in genuine teaching-learning experiences, creating a healing environment in all levels, attending to basic needs of the individual, allowing yourself to be open to miracles (Wagner, 2010; Watson, 2009).

With a review of Watson's theory, one can see that at the heart of the theory is genuine concern for the human that is in front of you. This theory has many potential applications. It can be utilized by the nurse at the bedside when she is caring for a patient, in the breakroom and working with a co-worker on the unit, and in meetings with supervisors.

This theory encourages the realization that the nurse is more than a technical assistant that focuses on treatments but encompasses the nurse as a healing professional (Watson, 2006). Hospitals have implemented this model around the United States and have gained positive results (Watson, 2006). Many of the hospitals utilizing *Watson's Theory of Caring* have either already obtained a Magnet status or were in the process of getting the status (Watson, 2006). With Watson's theory applied in a nursing unit, there can be a change in the culture of the unit (Watson, 2006). Utilization of this theory will allow for a relationshipcentered approach to patient care (Watson, 2006). In a unit where lateral violence has resulted in a negative, high turnover, low patient satisfaction unit, an implementation of Watson's Theory of Caring can improve the workplace (Carter et al., 2008).

## Literature Review

A literature review was conducted investigating the topic of lateral violence. A total of 14 searches were completed with a total of 3,629 items returned. Databases used were *CINAHL Plus with full text, ProQuest, Ovid, APA Psych, and American Nurses Association website*. A limit of within the last five years was applied. Keywords and abstracts were utilized to determine the content of articles for inclusion or exclusion of items.

The keywords used in the database search were *lateral violence, workplace bullying, lateral violence and nursing, workplace bullying and mental health, nursing turnover, lateral violence United States, PTSD lateral violence, magnet hospital quality of work-life, nurse retention patient outcomes, ending lateral violence.*

### Results of Findings.

**Medical Community.** When studies included other professions, physicians reported 74% and nurses reported 82% of experiencing bullying within the last year (Ekici & Beder, 2014). The victims were younger nurses and less experienced physicians (Ekici & Beder, 2014). Educational background or position did not affect the level of bullying that was experienced (Ekici & Beder, 2014).

The most common behaviors reported were aggression toward professional status and personality which were most delivered by being addressed in a degrading and humiliating way in front of others (Ekici & Beder, 2014). The largest contributing factor was reported as the workload (Ekici & Beder, 2014).

The most common result of bullying was depression which was experienced in 26% of physicians and 40% of nurses (Ekici & Beder, 2014).

**Nursing.** Nursing only studies reported an incidence of 29% (Ganz, et al., 2015), and as high as 44% (Berry, Gillespie, Fisher, Gormley, & Haynes, 2016). Workplace bullying was linked to stress, anxiety, and posttraumatic symptoms (Berry, et al., 2016). The workload in the unit was significantly related to the amount of interpersonal aggression (Drach-Zahavy & Trogan, 2013). Lateral violence experienced by nurses included personal attacks such as criticism, isolation, intimidation, belittling, sneering, eye-rolling, and escalation to physical abuse ( Lees, Bernstein, lee, & Nokes, 2014). Other reports of lateral violence included unfair and punitive actions such as withholding information, posting documentation errors on bulletin boards, and writing abusive letters or notes to co-workers (Lee et al., 2014).

While both vertical and horizontal levels of bullying exist, the most common elements involved violence between superiors (Lee et al., 2014). There is an inherent power imbalance between the bully and the victim (Lee et al., 2014). Supervisor actions include threats of disciplinary measures and indirect economic punishments such as demotions or refusal of promotions (Lee et al., 2014). Other difficulties cited were being given an unmanageable workload (Lee et al., 2014). Bullying was not necessarily experienced daily, but the environment of the unit appeared to have the largest impact on the presence or prevention of bullying (Ganz et al., 2015).

While workplace bullying was not necessarily experienced daily the frequency had a direct relationship with the level of stress experienced (Berry, Gillespie, Fisher, Gormley, & Haynes, 2016). The level of stress experienced was not related to gender, race, educational attainment, prior history of being bullied, or work history before licensure (Berry et al., 2016). Posttraumatic stress symptoms were found to be higher in those 30 years old and older (Berry et al., 2016). Reporting bullying to supervisors could prove to be futile, and some were encouraged to use verbal abuse to stop the perpetrator (Berry et al., 2016). As many as 60% of nurses reported feeling targeted and unable to defend themselves (Berry et al., 2016).

**Different Settings.** Magnet hospital units revealed a 21% lower incidence of hospital-acquired pressure ulcers whereas units, where the environment was negative, had an increase in hospital-acquired pressure ulcers (Ma & Park, 2015). Higher patient acuity was associated with greater medication errors, and heavy perceived nurse workloads and frequent interruptions were reliable predictors for medication errors, falls, and urinary tract infections (Ma & Park, 2015).

Also, emotional exhaustion of nurses is presence in a negative work environment (Kennedy, 2005; MacPhee, Dahinten, & Havaei, 2017). Nurses experiencing heavy workloads daily were 3 and a half times more likely to report high emotional exhaustion (MacPhee, Dahinten, & Havaei, 2017). The strongest predictor of emotional exhaustion was related to workload (Kennedy, 2005; MacPhee, Dahinten, & Havaei, 2017). Heavy workload, frequent

interruptions, inadequate staffing levels, and high patient acuity were associated with lower levels of job satisfaction ((Kennedy, 2005; MacPhee, Dahinten, & Havaei, 2017).

**Student Nurses and New Nurses.** Student nurses were not sheltered from experiencing lateral violence or witnessed lateral violence during their clinical experience (Curtis, & Brown, & Reid, 2007; Rittenmeyer, Huffman, Hopp, & Block, 2013; Sanner-Stiehr & Ward-Smith, 2017). Also, students reported their firsthand experience of understating the term "nurses eat their young" when experiencing lateral violence which was typically accomplished when the clinical instructor was not present (Rittenmeyer et al., 2013). These students identified humiliation, lack of respect, powerless, and becoming invisible (Curtis, & Brown, & Reid, 2007). Students experience appeared to continue when transitioning into the nursing role as new graduates from other nurses (Rittenmeyer, et al., 2013; Sanner-Stiehr & Ward-Smith, 2017). New nurses reported stress from having a task beyond what a nurse could complete in the required time- frame (Rittenmeyer et al., 2013).

Situations reported as contributing to lateral violence included a feeling of powerlessness, constant change, cases of unequal power, a sense of "us and them," and dealing with constant change (Rittenmeyer et al., 2013). Bullying that was reported was minimalized, trivialized, denied, and allowed to continue when the senior staff was involved (Rittenmeyer et al., 2013; Sanner-Stiehr & Ward-Smith, 2017). Experiences of students and new nurses included insulting behavior by a supervisor and an organizational reinforcement where the victim

was framed as weak and unable to be a good nurse (Rittenmeyer et al., 2013). Perpetrators were viewed as excellent clinicians with many years of experience. Bullies seemed to work together in an alliance of sorts to exert some control over the nursing teams.

Emotions experienced were described as fear, confinement, disbelief, selfdoubt, and worthlessness (Rittenmeyer et al., 2013). Effects experienced by the victim included crying, disrupted sleep, and clinical depression (Rittenmeyer, et al., 2013). The poor working conditions, workplace conflict, and lack of support contributed to a high level of emotional and physical distress that contributed to a decrease in work performance and unhappiness in their personal life which contributed to a decision to leave the place of employment (Rittenmeyer et al., 2013).

**Cost of Lateral Violence.** The cost of violence and conflict in healthcare manifested through increase absenteeism, high rate of staff turnover, feeling of hopelessness, poor work performance, and increase healthcare cost (AbuAlRub, 2004; Dijkstra, Van Dierendonck, & Evers, 2005; Dionne & Dostie, 2007; Jones & Gates, 2007). Also, workplace violence has both direct and indirect financial costs to healthcare workers in the organization and society (McKenna, Smith, Poole, & Coverdale, 2003). This cost has a negative impact on patient safety, patient outcomes, recruitment, and retention (Kennedy, 2020 & Wider, 2020).

Attrition rates for units with frequent workplace bullying were as high as 40% (Berry, Gillespie, Fisher, Gormley, & Haynes, 2016). With an attrition rate high consideration must be given to the cost of replacing the nurses lost. The

cost of replacing a nurse was reported as low as $22,000 (Berry et al., 2016) and as high as $100,000 (Lees et al., 2014). Should the nurse file a claim of unlawful discrimination, the cost to the facility would be $96,000 (Lee et al., 2014). Should that claim move forward to a class action defense, the estimated cost would be $460,000 (Lee et al., 2014).

**Nurses Leaving the Profession.** Reasons for leaving the job included limited career opportunities, poor support, lack of involvement in decision making, lack of recognition, and constant change (Dawson, Stasa, Roche, Homer, & Duffield, 2014). Negative staff attitudes, nurse-to-patient ratios, and increased patient expectations were also reported (Dawson et al., 2014).

Approximately, 60 % of new nurses who leave their job after only 6 months are due to some form of horizontal hostility (Griffin, 2004). Also, 20 % of these new graduate nurses leave the profession involving as much as $30.000 to $50.000 loss when resigning (Thobaben, 2007). However, in some cases, nurses may leave the job because of this lateral violence and feeling helpless with no support from the organization (Rittenmeyer et al., 2013).

In a research study, the reasons nurses reported for leaving the profession included increased in workload, changing work demands, work demands exceeding the clinical time available to complete the task assigned, and a lack of time to show real care to patients (Bogossian, Winters-Change, & Tuckett, 2014). Other reasons for leaving the profession include shift work fatigue, an inflexible attitude of managers to nurses that have children, bullying, harassment being

considered the cultural norm and thereby being accepted (Bogossian et al., 2014).

**Positive Environments.** An environment with a positive working environment was found to have a noted level of trust between the leadership and other members of the workplace along with communication being direct, respectful, and transparent (Clark, Sattler, & Barbosa-Leiker, 2016). Positive work environments were also found to have employees that would recommend the organization as a place to work for family and friends and included a high level of engagement, morale, and employee satisfaction (Clark et al., 2016). Surprisingly, competitive salaries, benefits, and other compensation had the lowest rating of importance according to the nurses surveyed (Clark et al., 2016).

## Strategies for Improvement

*Jean Watson's Theory of Human Caring* is a heart- centered approach that realizes that the caring relationship encompasses more than just the physical body but includes mind, body, and spirit. Nursing is a caring profession and has a career out of caring for others. However, in another aspect, they have, they become so volatile to their profession with the use of lateral violence behavior in their practice. *Jean Watson's Theory of Human Caring* has been in use for some time with positive results on both nurse satisfaction and patient outcomes (Watson, 2009). In a unit where lateral violence has resulted in a negative, high turnover, low patient satisfaction unit, an implementation of *Jean Watson's Theory of Caring* can improve relationships in addition to the quality of care in the workplace (Carter et al., 2008). Therefore, strategies are needed to

prevent lateral violence. In the next section, strategies will be discussed to prevent lateral violence in the workplace.

**Educational Interventions**

Educational interventions in the form of a seminar increased the participant's ability to handle hostile situations and opened the topic for discussion (Lasater, Mood, Buchwach, & Dieckmann, 2015). After attending workshops that educated staff on workplace bullying, there was a perceived decrease in bullying (Lasater et al., 2015). While job satisfaction did not see an improvement after the educational workshops, there was a reported increased ability for the individual to handle a situation of bullying (Lasater et al., 2015). Workshops that included practicing simulated situations resulted in the development of a skill that made it easier to confront others when the team goal was clear and shared (Zealand, Larkin, & Shron, 2m016). Improving the ability to handle stressful situations including strategies of relaxation techniques and mindful exercises during the workshop (Zealand et al., 2016). Little effect was observed with multiple training strategies versus a single strategy, and little difference was found with varying degrees of physical fidelity (Zealand et al., 2016). Team training was efficient and led to improved patient outcomes (Zealand et al., 2016). Education in as short of time as one-and-a-half-hour educational session, participants were better able to identify the cause of lateral violence and showed positive trends in decreasing frequency of lateral violence behaviors (Dahlby & Herrick, 2014).

Correction of and ending lateral violence needs to take center stage in the health care arena. One potential solution would be to focus on team building within the unit (Blair, 2013). Another suggestion would be to implement the option of "code bully" in which the victim can call the code, and everyone else stands behind the victim to show support that this behavior will not be allowed (Blair, 2013). The message sent to the perpetrator is then that the behavior will not be tolerated and is well known to the unit, thereby potentially ending the behavior (Blair, 2013). For lateral violence to be eradicated, the management must not only be on board to stop the behavior but hold the perpetrator accountable for the negative behavior (Blair, 2013).

With lateral violence so prevalent and so costly, a method of decreasing the incidence of it should be developed and implemented. Education about the topic is a good place to start. In a meta-analysis of 129 studies, it was determined that the best method to initiate is team training (Hughes et al., 2016).
No difference was demonstrated with the use of different training strategies vs. a single approach (Hughes et al., 2016). The physical element of the training was also not found to be a factor. Team training was shown to be effective, and it was also shown to improve patient outcomes (Hughes et al., 2016).

**Nurse Residency Programs**

Nurse residency programs and mentoring would be useful for preventing lateral violence in the workplace by improving retention and turnover(Cochran, 2017; Crimlish et al., 2017) .Cochran et al. (2017) reported a decrease in the turnover rate from 36.8% to 6.4% after the program was initiated. The result of

the decline in the turnover rate caused a decrease in the contract labor cost from $19,099 down to $5,490 (Cochran, 2017). Before the nurse residency program, retention rates ranged from 31% to 61%. After the residency program, the retention rate increased to 94-97% (Cochran, 2017). The savings realized after the implementation of the nurse residency program was more than was needed to fund the program (Cochran, 2017). However, Crimlish et al. (2017) reported a retention rate of 91% after the implementation of a nurse residency program. This program was designed for new graduates' orientation for one month lasting for 5 days a week followed by a clinical orientation.

Benefits reported from nurses that participated in nurse residency programs included improved critical thinking, improved confidence, and improved communication (Cochran, 2017). The nurses completing the nurse residency program also had an increase of 12% in their primary knowledge assessment test scores and a 41% increase in critical-thinking test scores.

**Nursing Curriculum**

Scholars suggested including lateral violence in the nursing curriculum (Curtis, & Brown, & Reid, 2007; Sanner-Stiehr & Ward-Smith ,2017). Curtis, Brown, and Reid, 2007 suggested that strategies need to be implemented in the Bachelor program to reduce the effects of horizontal violence. They suggested that students need to be taught assertiveness and conflict resolution skills. Also, Sanner-Stiehr and Ward-Smith (2017) suggested incorporating lateral violence in the curriculum of nursing students. This strategy will educate nursing students early on preparing them to manage this phenomenon and reduce the

incidents of lateral violence. This content can be addressed in the simulations, facilitating this knowledge in clinical experience, and increasing faculty awareness of their behavior.

## Implications for Future Research

The prevalence of lateral violence within the nursing profession is without question. The challenge that is presented within the nursing profession is how to decrease the incidence of it and how to eradicate it. Several suggestions have been evaluated within this paper for methods of improvement. Implications can be as simple as initiating a short educational seminar up to implementing a Nurse Residency Program. For lateral violence to be diminished, the program implemented must include not only the nurses on the units but the managers and leaders of the facility as well.

For nurses to provide optimal care to patients, nurses must be able to work in a positive team-like atmosphere (Sanner-Steihr & Ward-Smith, 2014). When a nurse is the victim of lateral violence, the victim could, in turn, lash out and become the perpetrator themselves thereby increasing the hostile environment (Sanner-Steihr & Ward-Smith, 2014). Lateral violence should always be taken seriously, and a culture of respect should be fostered and encouraged (Sanner-Steihr & Ward-Smith, 2014). Positive, respectful, and teamcentered units will yield not only improved nurse health but improved patient outcomes as well (Sanner-Steihr & Ward-Smith, 2014).

## Conclusion

The evidence on the existence of lateral violence in nursing is abundant. The documentation related to the adverse mental, emotional, and physical effects are also abundant. Adverse patient outcomes in areas of lateral violence have also been adequately supported. Communication appeared to be one of the major factors along with a lack of education on lateral violence is needed. However, education of staff and nursing residency or mentoring programs are useful in addressing recruitment and retention. In this analytical review of the literature, another theme emerged was the culture of the individual unit allowing lateral violence behavior to occur and the lack of management not eradicating this behavior. Future investigations should include the determination of a particular process to follow to eradicate lateral violence in the nursing profession.

**References:**

AbuAlRub, R. F. (2004). Job stress, job performance, and social support among hospital nurses. *Journal of Nursing Scholarship,* 36(1), 73-78.

Bambi, S., Becattini, G., Giusti, G. D., Mezzetti, A., Gazzini, A., & Lumini, E. (2014). Lateral hostilities among nurses employed in intensive care units, emergency departments, operating rooms, and emergency medical services. A national survey in Italy. *Dimensions of Critical Care Nursing*, 33 (6), 347-354,doi: 10.1097/DCC.0000000000000077

Berry, P. A., Gillespie, G. L., Fisher, B. S., Gormley, D., & Haynes, J. T. (2016). Psychological distress and workplace bullying among Registered Nurses. *The Online Journal of Issues in Nursing, 21*(3), 1-10.

Blair, P. L. (2013). Lateral violence in nursing. *Journal of Emergency Nursing, 39*(5), e75-e78. doi: 10.1016/j.jen.2011.12.006

Bogossian, F., Winters-Change, P., & Tuckett, A. (2014). "The pure hard slog that nursing is…": A qualitative analysis of nursing work. *Journal of Nursing Scholarship, 46*(5), 377-388, doi: 10.1111/jnu.12090

Bowsfield, M. L, & Samra, J. (2015). Post-traumatic stress disorder in a nursing context. *Ontario Occupational Health Nurse Association,* 26-32.

Carter, L. C., Nelson, J. L., Sivers, B. A., Dukek, S. L., Pipe, T. B., & Holland,

D. E., (2008). Exploring a culture of caring. *Nursing Administration Quarterly,32*(1), 57-63.

Christie, W., Jones, S., ( 2013) . Lateral violence in nursing and the Theory of the Nurse as Wounded Healer. *OJIN: The Online Journal of Issues in Nursing,* 19 ( 1), DOI: 10.3912/OJIN.Vol19No01PPT01

Clark, C. M., Sattler, V. P. & Barbosa-Leiker, C. (2016). Development and testing of the healthy work environment inventory: A reliable tool for assessing work environment health and satisfaction. *Journal of Nursing Education ,55*(10), 555-562, doi: 10.3928/01484834-20160914-03

Cochran, C. (2017). Effectiveness and best practice of nurse residency programs: A literature review. *Medsurge Nursing, 26*(1), 53-63.

Craft, J., Schivinski, E. L., Wright, A. (2020). Transition to practice: The grim reality of nursing incivility. *Journal for Nurses in Professional Development 36*(1), 41-43. doi:10.1097/NND.0000000000000599

Crimlish, J.T., Grande, M.M., Krisciunas, G.P., Costello, K.V., Fermandes, E. G. & Griffin, M. (2017). New residency program designed for a large cohort of new graduate nurse: Implementation and outcome. *Medsurg Nursing*, 26 (2), 83-87.

Curtis, J. , Brown, I., & Reid, A. (2007). You have no credibility: Nursing students' experiences of horizontal violence. Nurse Education in Practice Journal , 7 (3), 156-163, DOI: 10.1016/j.nepr.2006.06.002

Dahlby, M. A., & Herrick, L.M. (2014). Evaluating an educational intervention on lateral violence. *The Journal of Continuing Education in Nursing, 45*(8), 344-350. doi: 10.3928/00220124-20140724-15

Dawson, A. J., Stasa, H., Roche, M. A., Homer, C. S., & Duffield, C. (2014). Nursing churn and turnover in Australian hospitals: nurses' perceptions and suggestions for supportive strategies. *BioMed Central Nursing, 13*(11). doi: 10.1186/1472-6955-13-11

Dijkstra, M. T. M., Van Dierendonck, D., & Evers, A. (2005). Responding to conflict at work and individual well-being: The mediating role of flight behavior and feelings of helplessness. *European Journal of Work and Organizational Psychology, 14*, 119-135.

Dimarino, T. J. (2011). Eliminating lateral violence in the ambulatory setting: One center's strategies. *Association of perioperative Registered Nurses, 93*(5), 583-588. doi: 10.1016/j.aorn.2010.10.019

Dionne, G., & Dostie, B. (2007). New evidence on the determinants of absenteeism using linked employer-employee data. *Industrial and Labor Relations Review*, 61, 108–120.

Drach-Zahavy, A., & Trogan, R. (2013). Opposites attract or attack? The moderating role of diversity climate in the team diversity-interpersonal aggression relationship. *Journal of Occupational Health Psychology, 18*(4), 449-457, doi: 10.1037/a0033989

Ekici, D., & Beder, A. (2014). The effects of workplace bullying on physicians and nurses. *Australian Journal of Advanced Nursing, 31*(4), 24-33.

Fisher, M. G. (2015). What is your workplace culture? Zero tolerance of bullying and harassment? *American Academy of Family Physicians, 25*(11), 210.

Ganz, F. D., Levy, H., Khalaila, R., Arad, D., Bennaroch, K. Kolpac, O., Drori, Y. Benbinshty, J., & Raanan, O. (2015). Bullying and its prevention among intensive care nurses. *Journal of Nursing Scholarship, 47*(6), 505511. doi: 10.1111/jnu.12167

Hughes, A. M., Gregory, M. E., Joseph, D. L, Sonesh, S. C., Marlow, S. L., Lacerenza, C. N., . . . Salas, E. (2016). Saving lives: A meta-analysis of team training in healthcare. *Journal of Applied Psychology, 101*(9), 1266-1304. doi: 10.1037/apl10000120

Jones, C., Gates, M., (2007.) The costs and benefits of nurse turnover: A business case for nurse retention" *OJIN: The Online Journal of Issues in Nursing*. 12( 3) Manuscript 4. DOI: 10.3912/OJIN.Vol12No03Man04

Kennedy, B.R. (2005). Stress and burnout of nursing staff working with geriatric clients in long -term-care. *Journal of Nursing Scholarship*, 3 (37), 281-282

Kennedy, B. K. (2020). *Workplace violence among employees in Health Services: Promoting Organization Development to improve quality of work-life and patient outcomes (3rd edition),BRK healthcare Publications*, ISBN13:978-0-9897244-1-8.

Kennedy, B.R. & Wider, B.S (2020). Workplace bullying and Incivility: Using Organizational Development for improving health work-life for employees. *BRK Global Healthcare Journal* 3 (2), https://brkhealthcare.com/brkhealthcare-journal/

Lachman, V. D. (2014). Ethical issues in the disruptive behaviors of incivility, bullying, and horizontal/lateral violence. *MedSurge Nursing 23*(1), 56-60.

Lasater, K., Mood, L., Buchwach, D., & Dieckmann, N. F. (2015). Reducing incivility in the workplace: Results of a three-part educational intervention. *The Journal of Continuing Education in Nursing, 46*(1), 1524.

Lee, Y. J., Bernstein, K., Lee, M., & Nokes, K. M. (2014). Bullying in the nursing workplace: Applying evidence using a conceptual framework. *Nursing Economic, 32*(5), 255-267.

Ma, C., & Park, S. H. (2015). Hospital magnet status, unit work environment, and pressure ulcers. *Journal of Nursing Scholarship, 47*(6), 567-573, doi: 10.111/jnu.12173

MacPhee, M., Dahinten, V. S., & Havaei F. (2017). The impact of heavy perceived nurse workloads on patient and nurse outcomes. *Administrative Sciences, 7*(7), 1-17, doi:10.3390/admsci7010007

Major, K. (2013). Crucial conversations' in the workplace. *American Journal of Nursing, 113*(4), 66-70.

Martino, V. (2003). Workplace violence in the health sector: Relationship between work stress and workplace violence in the health sector. Geneve. https://www.who.int/violence_injury_prevention/violence/interpersonal/WVstresspaper.pdf

Rainford, W. C., Wood, S., McMullen, P. C., & Philipsen, N. D. (2015). The disruptive force of lateral violence in the health care setting. *The Journal for Nurse Practitioners, 11*(2), 157-164.

Rittenmeyer, L., Huffman, D., Hopp, L., & Block, M. (2013). A comprehensive systematic review on the experience of lateral/horizontal violence in the profession of nursing. *Joanna Briggs Institute Database of Systematic Reviews & Implementation Reports 11*(11), 362-468.

Sanner-Stiehr, E. & Ward-Smith, P. (2014). Lateral violence and the exit strategy. *Nursing Management, 45*(3), 11-15.

Sanner-Stiehr E. & Ward-Smith, P. (2017). Lateral violence in nursing: Implications and strategies for nurse educators. *Journal of Professional Nursing*, 32 (2), 113-118.

Sansone, R. A., & Sansone, A. (2015). Workplace bullying: A tale of adverse consequences. *Innovations in Clinical Neuroscience, 12*(1-2), 32-36.

Sauer, P. (2012). Do nurses eat their young? Truth and consequences. *Journal of Emergency Nursing, 38*(1), 43-45. doi: 10.1016/j.jen.2011.08.012

Sheehan, M., & McCabe, T. J. (2015). Workplace bullying. *World of Irish Nursing, 23*(3), 30-31.

Trad, M., Johnson, J. (2014). Bullying among radiation therapist: Effects on job performance and work environment. *Radiologic Technology, 86*(2), 122131.

Wagner, A. L. (2010). Core concepts of Jean Watson's Theory of Human Caring/Caring Science. *Watson Caring Science Institute.* Obtained from: www.watsonscaringscience.org.

Watson, J. (2006). Caring theory as an ethical guide to administrative and clinical practice. *Nursing Administration Quarterly, 30*(1), 48-55.

Watson, J. (2009). Caring science and human caring theory: transforming personal and personal professional practices of nursing and health care. *Journal of Health and Human Services Administration, 31*(4), 466-482.

Zealand, R., Larkin, D., & Shron, M. (2016). Building relationship-based care among nurses: A holistic, exploratory project. *Creative Nursing, 22*(3), 185-195. doi: 10.1891/1078-4535.22.3.185

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