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Nicole M. Lewis

St. John Fisher College, nikjdlew@hotmail.com

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Abstract

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Applying a Multidimensional Strategy to Mitigate Lateral Violence in a Small Rural Community

Hospital in Western New York

Nicole M. Lewis, BS, RN

DNP Student

St. John Fisher College

Abstract

Providing registered nurses with education and strategies to mitigate lateral violence is an evidenced-based method for creating a culture of civility. A descriptive pilot study with registered nurses was conducted on two medical/surgical units at a small rural community hospital. Strategies included a review of organizational policies, a one-day educational retreat for unit managers and registered nurse champions, and an online educational toolkit on lateral violence for the staff nurses on the pilot units.

Introduction

Using a multidimensional approach when developing and implementing a program to mitigate lateral violence (LV) supports a culture of civility to promote a healthy work environment and improve patient outcomes. Mitigation of LV is a complex process that involves every employee level within an organization and requires a variety of strategies. To change disruptive behaviors in an organization, multidimensional strategies are needed that include organizational policies on workplace violence, leadership support, staff and leadership education, and communication skills. Small rural hospitals have limited access to resources to develop and implement programs for mitigation of LV. The following is a description of a pilot study conducted in a small rural hospital with registered nurses (RNs) on two medical/surgical units. The pilot study identified baseline RN satisfaction and sabotage behaviors on the two units, implemented three strategies to mitigate LV, and measured knowledge and intent to change behavior before and after an online educational toolkit on LV. The goals of this project were:

- Review organizational policies and procedures related to disruptive behavior.
- Conduct a one-day retreat for managers and selected RN champions from the pilot medical-surgical units.

- Provide evidence-based resources in an online toolkit format for the staff nurses on the pilot units.

Shared are the lessons learned from the program implementation.

Literature Review

In today's nursing profession, it is important to understand that teamwork, collaboration, and professionalism are the foundation for providing safe, quality patient care that supports a culture of safety in health care organizations (Agency for Healthcare Research and Quality, 2013). To encourage these types of behaviors in the nursing profession, it is important to eliminate disruptive behaviors, such as lateral violence (LV) that undermine a culture of safety. Lateral violence is defined by Lachman as "unkind, discourteous, aggressive interactions between nurses who work at comparable organizational levels and commonly characterized as disruptive, backstabbing and bickering" (2014, p. 57). Examples of LV behavior may include "complaints shared with others without first discussing with the individual, sarcastic comments, withholding support, ignoring or discounting individual's input, and insulting, condescending, patronizing behaviors" (Lachman, 2014, p. 57).

The Joint Commission (TJC) in 2013 defined disruptive behaviors as "overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities" (p.1). Disruptive behaviors, such as LV, are a national focus in health care. For example, in 2008, TJC issued a *Sentinel Event Alert* on disruptive behaviors stating that it "undermines a culture of safety", and urged leadership in all hospitals to have a code of conduct and process for managing disruptive behaviors (Wyatt, 2013, para. 2).

Specific to nursing, the American Nurses Association (ANA, 2015) issued a position statement on disruptive behaviors in the workplace encompassing incivility, bullying, and workplace violence. The ANA urged nurses to take a stand against these types of disruptive behaviors and to create a workplace culture of respect. The American Association of Critical-Care Nurses (AACN) called for “the creation and continual fostering of a healthy work environment as an imperative for ensuring patients’ safety and optimal outcomes, enhancing staff recruitment and retention, and maintaining health care organizations’ financial viability” (AACN, 2016, p. 1). National organizations published recommendations on disruptive behaviors; after reviewing LV literature, this behavior is still present in the nursing profession.

Research has shown that LV is caused by environmental stressors such as poor staffing, increased workload, and individual stress (Blair, 2013; Christie & Jones, 2014; Dahlby & Herrick, 2014; Embree, Burner, & White, 2013; Roberts, 2015). Consequently, the lack of employee and leadership knowledge, organizational policies, and leadership support adds to an organization’s culture of incivility resulting in LV (Parker, Harrington, Smith, Sellers & Millenbach, 2016). The lack of support from the organization’s policies and leadership regarding this type of behavior leads to underreporting, increased staffing turnover, absenteeism, hostile work environments, and compromised patient care (Blair, 2013; Christie & Jones, 2014; Dahlby & Herrick, 2014; Embree et al., 2013; Roberts, 2015).

Lateral violence occurs frequently in the nursing profession because of nurses’ lack of power and control in the workplace (Roberts, 2015). The novice nurse is commonly the victim; and the experienced nurse is likely the perpetrator. A literature review on lateral violence, completed by Roberts (2015) over the last three decades, found that 46 to 100 percent of lateral violence against nurses occurs within the workplace. Christie and Jones (2014) conducted a

literature review on this type of behavior, which found that 44 to 85 % of nurses experienced LV and that 93 percent witnessed acts of LV. Embree et al. (2013) reported in their literature review that nearly 60 percent of newly licensed RNs will leave their initial employment within 6 months, most likely because of LV. Annually, 4.3 billion dollars are lost in nursing because of LV, which is nearly 250,000 dollars per incident (Embree et al., 2013). Subsequently, smaller organizations are at a higher risk for LV because of limited resources and limited access to new personnel (Embree et al., 2013).

The 2015 *National Healthcare Retention and RN Staffing Report* released by Nursing Solutions, Inc. (NSI), revealed alarmingly high RN attrition rates. According to this report, the turnover rate of bedside RNs increased from 11.2 % in 2011 to 16.4 % in 2015. The survey indicated that the average cost of turnover for a bedside RN is between \$36,900 and \$57,300, which can cost the hospital between \$4.9 million and \$7.6 million, depending on its size and number of nurses. With the increasing attrition rates of RNs, there is a need to address the factors that are responsible for this loss in the RN workforce. Decreasing attrition rates will improve the quality of care, thus nurses need to understand disruptive behaviors and educate others to create a culture of civility. As reimbursement in the US healthcare system is tied to quality of care and patient outcomes, it is incumbent on leadership teams in healthcare agencies to review and enforce policies on disruptive behaviors, provide leadership and staff education on managing disruptive behaviors, sustain efforts to establish a culture of civility, and stem the attrition of nurses in the organization.

In 2010, Congress passed the Patient Protection and Affordable Care Act (PPACA). This act established that hospitals were no longer reimbursed on the quantity but on the quality of care provided to patients. In improving the quality of patient care, the frontline nursing staff are

major contributor to quality care and patient outcomes. The factors that prevent mitigation of LV behavior are the lack of effective policies, awareness or knowledge of the behavior, and training (ANA, 2015; Embree et al., 2013; Mitchell, Ahmed & Azabo, 2014). As a result of their investigations, many experts have concluded that lateral violence is a learned behavior which can be decreased by education and behavioral modification (ANA, 2015; Roberts, 2015). But despite all the research and recommendations, lateral violence still impacts the nursing profession (ANA, 2015; Mitchell et al., 2014; Roberts, 2015). To increase the retention of nurses to meet workforce demands and improve the quality of patient care, the healthcare team must be prepared to reduce this disruptive behavior in the workplace setting.

Research on disruptive behaviors has suggested that zero-tolerance policies on disruptive behaviors are not sustainable, the recommendations from organizations are not followed, and that staff training and education are not always provided (ANA, 2015; TJC, 2013; Mitchell et al., 2014; Roberts, 2015). Typically, policies in health care systems provide the minimum recommendations for prevention of disruptive behaviors to qualify for accreditation and certifications from accrediting organizations. Leadership in organizations mandates disruptive behavior policies with the understanding that the quality of care and resulting patient outcomes are a reflection of the services provided by the frontline health care staff. Promoting quality of care, reliance on teamwork, effective communication, and a healthy work environment are critical in health care. Developing and implementing policies and procedures to address disruptive behavior promotes good quality of care by articulating the behaviors that support a healthy work environment (ANA, 2015).

The National Institute for Occupational Safety and Health (NIOSH) classifies workplace violence into four types. LV is classified as Type III, which involves “worker-on worker”

violence (ANA, 2015; NIOSH, 2013). There are no federal standards that mandate the enforcement of policies in health care agencies for this type of behavior, and requirements can vary between states. Only nine states have enacted laws against workplace violence; however, the individual state laws differ in their definition of workplace violence, what requirements are needed to protect the health-care worker, and the type of facilities that are covered (Occupational Safety and Health Administration [OSHA], 2016). In April 2016, the U.S. Government Accountability Office (GAO) released a final report with recommendations that:

OSHA provide additional information to assist inspectors in developing citations, develop a policy for following up on hazard alert letters concerning workplace violence hazards in health care facilities, and assess the results of its efforts to determine whether additional action, such as development of a standard, may be needed. (OSHA, 2016)

The Joint Commission (TJC), after releasing the 2008 *Sentinel Event Alert*, developed a leadership standard requiring all hospitals to have a code of conduct as well as a process for managing disruptive and inappropriate behaviors. The Medical Director of TJC, Ronald M. Wyatt, M.D., M.H.A., reinforced the recommendations set forth by the College of Physicians and Surgeons of Ontario and the Vanderbilt group after the Institute of Safe Medication Practices (ISMP) released their survey results on workplace intimidation in 2013 (TJC, 2013). The 2013 ISMP survey concluded that disruptive behaviors and intimidation still occur, even after the TJC standard was released in 2008 (TJC, 2013). Although healthcare agencies must establish a standard for accreditation and have mandated policies, that has not reduced the prevalence of disruptive behavior (ANA, 2015; JTC, 2013; Mitchell et al., 2014; Roberts, 2015). It is unclear why these recommendations are failing and why disruptive behaviors remain part of the medical

culture. In order to change this, a multidimensional approach has been recommended as a strategy to mitigate LV and support a culture of civility (ANA, 2015).

Theoretical Framework

A change theory, Kotter's 8-Step Change Model, was used as a framework to embark on an organizational change and to create a sustainable culture of civility (Kotter, 1996). Kotter's 8-Step Change Model starts with creating a climate for change, with the first three steps involving key stakeholders from the organization in creating and engaging a climate of change. To establish a sense of urgency in the organization, evidence from the literature was shared to help the leadership team understand LV and the impact LV behaviors have on the workforce, fiscal outcomes, quality of care, and patient outcomes.

The key stakeholders in the organization included all the nurse managers within the organization, the VP of Nursing, the hospital's NPD practitioner, and selected unit RN champions. Involving the hospital's NPD practitioner provides sustainability of the long-term goal of the program with ongoing education of all RN staff in the organization. The vision for the multidimensional approach to mitigate LV in the organization was to create a culture of civility and impact knowledge, behaviors, and long-term RN attrition and fiscal outcomes for the organization. The next three steps of the model support creating a culture that mitigates LV. Effective communication regarding the program creates buy-in and empowers action in the organization. Developing short-term goals, such as a pilot study used as a test of change, will help to make improvements to the program. Barriers and obstacles that develop during the pilot can be addressed before the program is implemented throughout the organization. Finally, the last two steps in the model are focused on creating an environment of sustainability and implementation within the organization. This is where the program is finalized and implemented

throughout the organization. The NPD practitioner's role in this phase is to facilitate the integration of the program into RN annual education and orientation for all new RNs.

Applying a Multidimensional Approach

Preventing LV in the hospital setting is a complex process that requires knowledge and understanding of this phenomenon. Many studies have researched the prevalence of lateral violence; but very few studies are conducted that apply recommended interventions to reduce it (Embree et al., 2013; Lachman, 2014; Mitchell et al, 2014; Roberts, 2015). Applying a multidimensional strategy for the mitigation of lateral violence will empower leadership, nurses, and staff in the organization to support a culture of civility that is free of LV. Multidimensional strategies include the following: policy change with implementation at the organization level; leadership setting the culture, with administrators' and managers' involvement; and providing resources and education for the bedside registered nurse to change behavior (Embree et al., 2013; Lachman, 2014; Mitchell et al., 2014; Parker et al., 2016; Roberts, 2015). In order for nurses to manage LV, they need to understand what LV is, what causes this phenomenon, and how to identify and prevent LV within their workplace. Because LV is not fully understood by nurses, they need education about LV and a method to develop strategies against LV, such as scripted cognitive rehearsal. Scripted cognitive rehearsal is an evidence-based tool used by nurses to improve communication skills when confronted with LV (Griffin & Clark, 2014; Roberts, 2015). A multidimensional approach supports the complex process of mitigating LV; using a pre/post group comparison and descriptive quantitative design provides statistical outcomes for this pilot study.

Methods

The pilot study was a pre/post, within group comparison, with a descriptive pilot program evaluation design. A pre-survey, which measured knowledge of LV and intent to change behaviors, was sent to all participants one week prior to receiving the education. The results were compared to responses on a post-survey deployed after participants completed the educational intervention. In addition, the pre-survey collected data on participant demographics and individual perceptions of job satisfaction, along with personal experiences with LV. This study used two different educational approaches: a 6-hour educational retreat for key project stakeholders and a self-learning online educational toolkit for the RNs on two medical/surgical units in the hospital. The content for the education program was based on current evidenced-based information from the literature (Refer to Table 1). In addition, the project included a review of the organizations’ policies on disruptive behaviors; and a Code of Conduct was created for the nursing staff during the key stakeholder retreat. The evidence-based communication technique used was developed by a nurse scholar, Martha Griffin, PhD. Permission was granted by Dr. Griffin to use her communication technique for this study. Scripted cognitive rehearsal identifies different types of disruptive behaviors and scripts communication techniques for the RNs to use to mitigate LV in their work environment.

Interventions

Table 1	Multidimensional Strategies
Review of the Organization’s Workplace Violence Policy	<ul style="list-style-type: none"> ● Reviewed and revised in July 2016 ● Defined LV within the policy ● Stressed that LV is not an acceptable behavior ● Outlined the reporting process for LV within the policy ● Safety Committee tracked trends, patterns, and increased risk areas where workplace violence occurred

<p>1-Day Retreat for Key Stakeholders (VP of Nursing, NPD Practitioner, Unit managers and Unit RN champions)</p>	<ul style="list-style-type: none"> • Pre-survey sent 1 week prior to the retreat • Introductory speeches by VP of Nursing, NPD Practitioner, and researcher • Education (3 hours) including: <ul style="list-style-type: none"> • Content (2 hours), using video and presentations: definitions, prevalence of LV, review of TJC and nursing professional organizations’ positions on LV, causes of LV. • Activity (1 hour), using scripted cognitive rehearsal: how to use and apply evidence-based communication techniques • Review of workplace violence policy and development of a “Code of Conduct” for nurses (1 hour) • Post-survey sent 1 day post intervention.
<p>Online Educational Toolkit</p>	<ul style="list-style-type: none"> • Pre-survey sent 1 week prior to consenting study participants • Educational toolkit and revised policy sent to all RNs on the units • Education (2 hours): <ul style="list-style-type: none"> • Introductory presentations (30 minutes): VP of Nursing, NPD Practitioner, and researcher. • Content (1 hour), using video and presentations: definitions, prevalence of LV, review of professional organizations’ positions on LV, and causes of LV • Scripted cognitive rehearsal (1 hour): how to use and apply evidence-based communication techniques • Post-survey sent to consenting participants 2 weeks after receiving the education

Participants and Setting

Participants were RNs practicing on two medical/surgical units in a small rural community hospital in Western NY. All the RNs on the two pilot units had access to the online educational toolkit, but only RNs that voluntarily consented to be included in the study were sent the pre-and post-survey. Inclusion criteria included participants employed full-time, part-time, and per-diem RNs and managers working in the two-acute medical-surgical units for a minimum of 30 days.

Measurement

The participants were given a pre-survey that included five parts: demographics, job satisfaction, prevalence of lateral violence within their work environment, knowledge of lateral

violence, and intent to make a change in behavior (see Table 2). The post survey included knowledge of lateral violence and intent to make a change in behavior.

Table 2		Measurements	
Measurement Tool	Description	Administration	Measures
Demographics	researcher created	Pre-survey	Demographic data
McCloskey/Mueller Satisfaction Scale (MMSS)	Reliability and validity is well established, using criterion-related validity ranging from 0.53 to 0.75 (CHSRF/CIHR Chair Program in Advance Practice Nursing,2017)	Pre-survey	<ul style="list-style-type: none"> • 31-item 5-point Likert scale, ranging from very satisfied to very dissatisfied • Eight domains: satisfaction with extrinsic rewards, scheduling, family/work balance, co-workers, interaction, professional opportunities, praise/recognition, and control/responsibility
Sabotage Savvy Questionnaire (Briles, 1994)	<ul style="list-style-type: none"> • No data found on the initial reliability and validity (CHSRF/CIHR Chair Program in Advance Practice Nursing,2017) • A study conducted by Dunn (2013) reported a Cronbach’s score of 0.86 and 0.72. • A study conducted by Armmer and Ball (2015) reported a Cronbach’s score of 0.86. 	Pre-survey	<ul style="list-style-type: none"> • 39 items, Yes, No, or Not Sure • Questions asked are based on actions that contribute to sabotage in the work environment.
Knowledge Gain	Created by the researcher	Pre-and Post-survey	<ul style="list-style-type: none"> • 17 questions • Multiple choice • Knowledge of LV before and after intervention • Questions were based on: definitions of different types of disruptive behaviors, behaviors displayed by these types of behaviors, resources

			available, current data on LV, and ways to implement a change
Behavioral Change	Created by the researcher	Pre-and Post-survey	<ul style="list-style-type: none"> • 6 questions <ul style="list-style-type: none"> ○ 4- Yes or No ○ 2 open-ended • The questions evaluate the participant’s willingness to change behaviors before and after intervention

Procedures

Institutional Review Boards (IRB) approval was obtained prior to recruitment of participants. A briefing was done with the VP of Nursing and the nurse managers in the organization during a nurse managers’ meeting, which allowed the managers to understand the importance of this study. The unit managers within the pilot medical/surgical units briefed all RN champions and staff RNs on the study. RN champions were selected by the manager because of their leadership skills within the units. For staff that could not attend the briefings, an introduction letter and a consent form were given to the managers and champions to share with the RNs on the unit. Informed consent for the study was obtained before participants voluntarily participated-in the study. A pre-survey was sent out to the study participants 1 week prior to receiving the educational intervention. Managers and RN champions that participated in the 1-day retreat received the post-survey via e-mail after the course. The RNs that received the online educational toolkit were given 2 weeks to review the education program, then were emailed the post-survey.

Data Analysis

Survey data was collected confidentially through Qualtrics, an online survey software product. All survey data were cleaned, coded, and downloaded to SPSS version 24.0 for analysis. The sample size was too small to perform parametric testing.

Results

A total of 20 RNs volunteered to participate in the study. Eleven of the participants completed the pre-survey and 11 participants completed the post-survey. Of these participants only six completed both surveys. Participants were all female, 73% were staff nurses, 18% were team leaders, and 9 % were administrators/managers. The participants included 73% with an associate’s degree and 27% with a bachelor’s degree. According to the MMSS survey results, participants were generally very satisfied to moderately satisfied with the workplace, particularly in the following area: their immediate supervisor, nursing peers, physicians they work with, and the delivery-of-care method used in their unit. Areas that needed further evaluation were nursing research, control over working conditions, and career advancement. The overview of the Sabotage Savvy (Briles, 1994) questionnaire indicated that the participants experienced a low occurrence of LV. Table 3 identifies those questions that scored a high percentage of “yes” responses. Table 4 gives an overview of the knowledge gained. A comparison of the means for knowledge gained resulted in pre-survey score of 39 % and a post-survey score of 48%. Table 5 gives an overview of the behavioral change survey.

Table 3		Sabotage Savvy Questionnaire		
Question:		Yes %	No %	Unsure %
Have you ever felt that information that would make your job easier or clarified has bypassed you or been withheld?		45.5	27.3	27.3
Has anyone ever passed on or exchanged information about you that was untrue?		45.5	36.4	18.2
Has anyone ever not acknowledged you or given you credit for work you have participated in or completed?		54.5	27.3	18.2

Have you ever been reprimanded or confronted by someone in front of others?	54.5	36.4	9.1
Have you ever been stuck with doing a co-worker’s job because she is often late or spends work time doing personal things?	63.6	27.3	9.1
Has anyone consistently criticized areas or items of your work without acknowledging or applauding the positive areas?	45.5	45.5	9.1
Has anyone ever lodged a complaint against you to your supervisor or others whom you work with, without first discussing it with you?	45.5	36.4	18.2

Table 4		Knowledge Gained	
Participants	Pre-survey questionnaire	Post-survey questionnaire	
1	17%	41%	
2	41%	58%	
3	35%	29%	
4	41%	70%	
5	41%	47%	
6	58%	41%	
Means	38%	48%	

TABLE 5		Behavioral Change	
Question	Pre-survey	Post-survey	
Do you feel that lateral violence is a changeable behavior?	54.5 %	90.9%	
Do you think education and resources will help you to make a change in your behavior to prevent lateral violence?	90.9%	81.8%	
Do you feel you can make changes within your practice that will have an impact on workplace culture and patient outcomes?	72.7%	90.9%	
Do you feel that the organization’s policies support the mitigation of lateral violence?	54.5%	72.7%	
<i>NOTE:</i> Only 10 participants answered each question in the pre-survey. The percentages in this table indicate a “yes” response.			

Discussion

This pilot study collected baseline data on job satisfaction and prevalence of LV within the RN’s work environment. This data indicated that the participants were mostly very satisfied to moderately satisfied with their jobs and that there was a low prevalence of lateral violence within their work environment. The MMSS data suggested a need for RN career advancement,

social contact with colleagues after work, writing and publishing, and control over their working conditions. Developing career ladders, healthy work environments, leadership and communication skills, and ongoing professional development for RNs are strategies the NPD practitioner can focus on to improve staff satisfaction. The Sabotage Savvy questionnaire results imply that developing effective communication skills using tools, such as scripted cognitive rehearsal or assertive communication techniques, could provide direct, open, honest communication between co-workers to prevent LV. The American Nurses Association position statement recommends that nurses “create an ethical environment and culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect”; thus, the NPD practitioner can focus on these areas to help improve a culture of civility (ANA, 2015, p. 1). Although the sample size was small, the knowledge gained from the pre/post-test results indicates overall improvement, even with a decrease in some participants’ post-test knowledge scores.

The findings in this pilot study suggest that face-to-face the delivery of the education may be more beneficial than using an online toolkit. A face-to-face method of delivery allows the participants to discuss and ask questions on the sensitive topic of LV and engage in active learning through role play, discussions, and application of cognitive rehearsal and other communication techniques. When asked, “*Do you think education and resources will help you to make a change in your behavior to prevent lateral violence*”, participant responses showed a decrease from the pre-to the post survey. This may indicate that the education program for nurses should be delivered by a face-to-face presentation instead of an online toolkit. A face-to-face format will give nurses the opportunity to role play with cognitive rehearsal scripts and to develop their communication skills.

Strengths and Limitations

This pilot study explored strategies to help mitigate LV and develop a healthy work environment. The long-term goal is to decrease the RN attrition rate in a small rural community hospital. This program is the first within the organization to promote sustainability of a culture of civility. The program addressed LV through awareness, policies, education, and evidence-based tools to improve communication skills. The program is easily replicated, economical, and can be used at small rural community hospitals that typically lack the resources to implement such a program. Additional strengths of the study include the support of all stakeholders and administrators. The involvement of the VP of Nursing and the NPD practitioner in for this program reinforced leadership support.

There are several limitations to consider when implementing these strategies in a small rural community hospital. Small rural community hospitals have limited resources, such as staff availability to participate in the program. During this study leadership did not have access to personnel to easily replace RN turnover. The pilot units used for this study were small in size and both units had a vacancy rate of 46% or higher. Based on the descriptive analysis it is difficult to determine whether the multidimensional approach will have a long-term impact on creating a healthier work environment within these two pilot units.

Policy change was restricted because no regulations or laws are established at the federal or state, levels for workplace violence. Another limitation was the technical issues that emerged when deploying the online toolkit and pre/post-surveys. Since the program and emails to participants were developed outside the organization, the communication was blocked. This required assistance from the information technology department and nurse managers, which results in a delay of the initial emails. In addition, further assessment is needed to determine if

knowledge gain and behavior change would be more effective in a face-to-face classroom setting versus a self-learning educational toolkit.

The findings of the pilot program did align with research on the need for education regarding LV, leadership support, and evidence-based interventions to mitigate LV and create a culture of civility (ANA, 2015; Clark, 2014; Griffin & Clark, 2014; Parker, Harrington, Smith, Sellers & Millenbach, 2016; Roberts, 2015). Further analysis and testing on the effectiveness of multidimensional interventions on mitigation of LV is necessary; however, the results, though limited, did suggest similar findings in the literature.

Recommendations

When developing a program to create a culture of civility, a multidimensional approach allows for policy review, support from key stakeholders within the organization, and the use of evidence-based education and interventions. When initially implementing a program in a small rural community hospital, first conducting a pilot can help identify barriers and give valuable program evaluation feedback. To promote sustainability of the program it is important to involve the NPD practitioner in the project team and in the development, execution, and evaluation of the program for sustainability. NPD practitioners are experts in the assessment, planning, development, implementation, and evaluation of the programs to create an environment of change and promote quality (Harper & Maloney, 2016). NPD practitioners can play an essential role in the initial and continuing education for the long-term sustainability of the program in the organization. NPD practitioners are key stakeholders, leaders, and facilitators in supporting a healthy work environment and offering ongoing professional development on the mitigation of LV.

Conclusion

Overall, this project raised awareness of LV through engaging stakeholders, providing education and the use of evidence-based interventions. It moved the organization forward in the mitigation of LV. The limitations identified during this pilot study allowed the educational program to strengthen its multidimensional approach, which will lead to sustainability within the small rural organization. Evidence-based interventions to reduce disruptive behaviors associated with LV suggest that effective policies to prevent disruptive behaviors, setting a standard for expected behaviors, and providing education and training to the health care staff are the key to creating a culture of civility. “Nurses eat their young” is an often quoted saying in the nursing profession. To mitigate LV, nurses need the resources to develop a healthy work environment. LV is not generally understood; therefore, applying a multidimensional approach with effective policies, education, and evidenced-based communication tools are approaches to increase understanding among nurses. The main obstacle is that there is not at present a standard, validated education program for addressing LV. The long-term goals of a multidimensional approach are sustainability of the culture of civility and the promotion a healthy work environment. Changing an existing culture takes time; but this program provides solutions that will promote sustainability of a culture of civility.

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