Cognitive Rehearsal as a Strategy to Assist New Graduate Nurses with Bullying, Harassment, and Horizontal Violence: A Pilot Study

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Required signatures are on file with the College of Nursing.

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Abstract

The concept of bullying, harassment, and horizontal violence (BHHV) has long been a part of the nursing profession, with up to a third of new graduate nurses reporting they have experienced this type of behavior in their work environment. Research with novice nurses shows significant correlations between decreased productivity, burnout, and intent to leave the organization. Moreover, in 2008 the Joint Commission issued a Sentinel Alert identifying bullying as a disruptive behavior that has the potential to lead to medical errors and adverse events. While much is known about the prevalence and consequences of BHHV, the research into how to handle the problem is lacking. This project aimed to narrow the information gap by implementing a cognitive rehearsal intervention with graduate nurses. The pilot study was conducted with a small group of graduate nurse residents at an academic medical center in the Mid-Atlantic region of the United States. The educational intervention, which included didactic and interactive segments, was evaluated by both pre- and post- intervention surveys and a focus group interview three months after the conclusion of the training. No significance was found between overall pre- and post-test scores or exposure to BHHV; increase in confidence between pre- and post-tests was significant. Focus group interview data analysis uncovered themes related to managing BHHV, rationale for not responding to BHHV, and environmental supports to aid with addressing BHHV.

Cognitive Rehearsal as a Strategy to Assist New Graduate Nurses with Bullying, Harassment, and Horizontal Violence: A Pilot Study

Chapter 1

Many nurses are able to describe situations in which they have witnessed, or were the recipient of, uncivil behavior from their peers. For many years this practice has been jokingly referred to as *nurses eating their young*, and sadly there are those within the profession who still refer to it as such. Within the last ten to fifteen years there has been increased awareness of and attention to this phenomenon, with most of the research focusing on describing the concept, its prevalence, and consequences such as intention to leave a job and burnout. Bullying, harassment, and horizontal violence (BHHV), as it is called in this project, is recognized as a significant problem not only for the victims who have endured it but also for the entire healthcare system.

Significance of Problem to Practice

In a 2013 survey of adult victims by the Workplace Bullying Institute, nursing was the largest single profession (11% of respondents), and healthcare was the largest industry (indicated by 27% of respondents) in which bullying was reported to occur (Namie, 2013). Among newly licensed registered nurses in the United States (U.S.), the prevalence rate was reported at 20.5% by Vogelpohl, Rice, Edwards, and Bork (2013) and 31% by Simons (2008). Similarly, in Canada, Laschinger, Grau, Finegan, and Wilk (2010) found a comparable rate of 33%.

Recent research shows a significant relationship between BBHV and decreased productivity, burnout, and nurses' intent to leave the organization. This relationship is particularly significant for novice nurses, those nurses in practice three years or less. Berry, Gordon, Gates, and Schafer (2012) report that novice nurses who experience a workplace

bullying event experience decreased productivity after the event and Laschinger, Grau, Finegan, and Wilk (2010) report a correlation between bullying and emotional exhaustion (burnout) among nurses who had been in practice for less than three years. Moreover, Simons (2008) found that nurses who had been in practice less than three years and experienced workplace bullying intended to leave the organization.

The problem of incivility is significant enough to have garnered the attention of the Joint Commission (J.C.), where in 2008 it was labeled "a behavior that undermines a culture of safety" (The Joint Commission, 2008, p. 1), and has the potential to lead to errors and adverse events. The Joint Commission revisited the problem in 2012 and recommended educational programs as appropriate interventions to help decrease the prevalence of BHHV in the hospital setting (The Joint Commission, 2012). However, Joint Commission did not specify the type of education that should be provided, strategies for BHHV education, or recommendations regarding who should be educated, when, and how often.

While the aforementioned studies are valuable in helping us to understand the scope of the problem and its consequences, literature to support what can be done to prevent or eliminate BHHV is lacking. Even though educational programs have been recommended by the Joint Commission, a gap in the literature exists related to the type of educational strategy that should be used to best address the issue of incivility, who should be responsible for its' implementation, and what empirical tool should be used to measure the impact of the training. More research is also needed to determine what type of intervention works best to combat BHHV – education, policy development, confrontation, or punishment. The unanswered questions beg the need for additional research in the area of BHHV so as to begin to fill the gaps in the literature.

Aim / Purpose of the Project

The purpose of this project was to investigate the impact of an educational intervention using cognitive rehearsal on new graduate nurses' knowledge of BHHV and their self-efficacy in responding to uncivil acts when they are encountered in the practice setting. Three specific aims were developed for this project. Specific Aim 1: To assess new graduate nurses' knowledge about BHHV before and after an educational intervention. Specific Aim 2: To describe to what extent the participants utilize the strategies taught during the educational intervention and their reported self-efficacy when they encounter BHHV in their practice setting. Specific Aim 3: To explore and describe the response of the BHHV perpetrator(s) (as perceived by the study participants) when the strategies were employed.

Project Question

The following PICO question was developed for this project. What is the impact of a cognitive rehearsal educational intervention program on new graduate nurses' knowledge about and their ability to respond to BHHV when it is encountered in the practice setting?

Plan for Investigation

The setting for this project was an academic medical center located in the Mid-Atlantic region of the United States (U.S.). Prior to the commencement of the project Institutional Review Board (IRB) approval was obtained. Subjects were recruited from the graduate nurse residency program and only those new graduate nurses who had been in the program for less than six months were eligible to participate. After obtaining informed consent and prior to conducting the educational session, a questionnaire was administered to obtain demographic information such as age, gender, educational preparation, and length of time in practice. Additional items in this questionnaire focused on the participants' exposure (as either a victim or

witness) to BHHV in their current employment setting. Prior to the educational program a pre-test was used to assess subject's baseline understanding of the prevalence, types, and consequences of incivility. The educational program included a didactic presentation that defined and described incivility, provided evidence from the literature about personal and professional consequences of working in an uncivil environment, and discussed strategies to address the behavior when it is encountered. An interactive strategy using case studies and role-play was used to assist the subjects to effectively respond to incivility. Three months after the educational session, a post-test was given and subjects were invited to participate in a focus group interview to discuss their experiences of BHHV since the educational session, their response to the behaviors, and how well prepared they felt to handle the situation. In addition, subjects were asked to describe how perpetrators responded after applying the techniques learned in the educational session to the situation. The focus group interviews were digitally recorded, transcribed, and analyzed for themes related to their perceptions of perpetrators' responses and the effectiveness of their responses to incivility.

Definition of Key Terms

Many different terms have been used to describe this phenomenon, including lateral violence, harassment, incivility, and relational aggression. For uniformity, this project utilized the description provided by Vessey, DeMarco, and DiFazio (2010): bullying, harassment, and horizontal violence (BHHV). Since the study population was new graduate nurses who work in an in-patient setting, this terminology was purposely selected to coincide with the terminology used by the Joint Commission (2012), the major accrediting body for hospitals in the United States. For the purposes of this project, BHHV was thought of as an umbrella term that is defined as "repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or

unfair sanctions that makes recipients upset and feel humiliated, vulnerable, or threatened, creating stress and under-mining their self-confidence" (Vessey, DeMarco, & DiFazio, 2010, p. 136).

Various definitions of new graduate nurses are found throughout the literature and there does not seem to be a consensus on what a new graduate nurse is. Laschinger, Finegan, and Wilk (2009) defined a new graduate nurse as someone who had been in practice for less than two years, while in a separate study, Laschinger, Grau, Finegan, and Wilk (2010) used a cutoff of three years. The study population for this project was nurses enrolled in the graduate nurse residency program at a single academic medical center. This particular year-long residency program is only open to Registered Nurses who have graduated within twelve months of the start of the residency; therefore this project defined new graduate nurses as Registered Nurses who have been in practice for less than two years.

Cognitive rehearsal is a technique wherein an individual imagines a scenario and then rehearses how they will respond. This strategy has been employed in various contexts such as assertiveness training and mentally practicing athletic moves. In this project, cognitive rehearsal was utilized to guide participants through different BHHV scenarios using pre-developed responses. After the educational session each participant received a Bullying Tip Card (American Nurses Association [ANA], n.d.) for their continued practice and reference.

Perceived self-efficacy is an integral to the participants' use of the strategies taught during the educational intervention. This project used Bandura's definition of perceived self-efficacy, "people's judgments of their capabilities to organize and execute courses of action required to attain designated types of performances" (Bandura, 1986, p. 391). Bandura further

cautions, “It is concerned not with the skills one has but with judgments of what one can do with whatever skills one possesses.” (Bandura, 1986, p. 391).

Summary

No matter what label is used to identify uncivil behaviors between nurses in the work environment, the practice has far-reaching and long-lasting consequences. The healthcare system, with its ever-increasing costs, cannot afford for nurses to continue to eat their young. Research shows that nurses within the first three years of employment, when exposed to uncivil (some would say toxic) work environments, experience emotional exhaustion and decreased productivity, and plan to resign from the organization. Moreover, quality of care and patient safety are affected. Educating new nurses about incivility and how to respond when they witness or are targeted by it may be a first step in alleviating these deleterious effects. Cognitive rehearsal, as an educational strategy, is one teaching method that is shown to positively affect a new nurse’s ability to respond to incivility. Effective training of new nurses may aid the organization in retaining its nursing workforce, improve quality and safety of patient care, and decrease new nurses’ levels of stress and burnout.

Chapter 2

Incivility among nurses has been a problem for many years, and there are numerous anecdotal stories claiming to prove its existence. In the last 10 to 15 years there has been an increased awareness of the problem and formal research studies have found associations between incivility and nurse burnout, intent to leave the organization, and increased risk of medical errors. More recently, intervention studies have been conducted to evaluate educational strategies to address the problem. This chapter includes a review of the literature from the last five years, a critical analysis of educational intervention studies, and a review of gaps that still exist in the published literature. The chapter concludes with the theoretical framework that will be used to guide this project.

Search Strategy

The databases PubMed, CINAHL, ERIC, PsycINFO and PsycARTICLES were searched using the terms incivility, bullying, harassment, horizontal violence, lateral violence, workplace incivility, and mobbing in combination with nurse, nursing, registered nurse, novice nurse, and graduate nurse for an initial return of 2668 citations. The time parameter of 2009 to 2015 was imposed in order to retrieve the most current evidence, yielding 1434 citations. Further limitations were placed to return only those citations written in English and published in peer-reviewed journals; this brought the number of citations down to 1337. Citations were then reviewed to eliminate duplicates and abstracts were reviewed for relevance to the topic of bullying, harassment, and horizontal violence as it applies to graduate nurses. Using these criteria, a total of 17 applicable articles were selected for inclusion in this review; a manual review of the reference pages for each of these 17 articles yielded 8 more articles that met the inclusion criteria. Griffin's (2004) intervention study was included in the review as it is

considered a landmark study. The addition of this study is important as few studies reported a specific intervention to manage incivility or teach nurses how to manage incivility.

Review of the Literature

The purpose of this review is to obtain a better understanding of the current knowledge of the incivility among nurses: the prevalence, effects, and prevention strategies. The topics that are discussed in this section are terminology and concepts, effects on the nursing profession, healthcare organizations, and individuals, positions of professional organizations, and educational strategies. A critical analysis of the educational interventions follows this section.

Terminology and Concepts

A variety of different labels are used to discuss the concept of incivility in nursing. Some common terms include workplace incivility, bullying, and horizontal violence. Other terms, although less common, are workplace aggression, horizontal hostility, and relational aggression. The literature shows a lack of consistency in defining these concepts. However, regardless of the label used, incivility in the workplace has negative consequences for both the nurse and organization.

Among the articles reviewed, the most frequent term used was workplace incivility with the definition being provided by Anderson and Pearson (1999): "low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. Uncivil behaviors are characteristically rude, discourteous, displaying a lack of respect for others" (p. 457) (Laschinger, Finegan, & Wilk, 2009; Smith, Andrusyszyn, & Laschinger, 2010; Lewis & Malecha, 2011; and Oyeleye, Hanson, O'Connor, & Dunn, 2013). Laschinger, Grau, Finegan, and Wilk (2010) used a definition of bullying provided by Kivimaki, Elovainio, and Vahtera (2000, p. 656), "situations in which someone is subjected to social isolation or

exclusion, his or her work and efforts are devalued, he or she is threatened, derogatory comments about him or her are said behind his or her back, or other negative behavior aimed to torment, wear down, or frustrate occur."

Vessey, DeMarco, Gaffney, and Budin (2009) developed a very broad definition of incivility, labeling it bullying, harassment, and horizontal violence with the acronym BHHV. They define this concept as "repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions that makes recipients upset and feel humiliated, vulnerable, or threatened, creating stress and under-mining their self-confidence" (Vessey, DeMarco, & DiFazio, 2010, p. 136). Farrell and Shafiei (2012) selected the term workplace aggression as the terminology in their study. Workplace aggression encompassed both Occupational Violence (OV) and Workplace Bullying (WB). The decision to use this specific definition was made to coincide with the vernacular of the population being studied and the Department of Human Services, Victoria, Australia, provided the definitions of OV and WB. Dellasega, Volpe, Edmondson, and Hopkins (2014) use the term relational aggression stating, "relational aggression occurs when someone uses a relationship rather than physical means to inflict social harm" (p. 212)

Study concepts that were not explicitly defined were horizontal hostility (HH) (Wilson, Diedrich, Phelps, & Choi, 2011) and horizontal violence (Sellers, Millenback, Ward, & Scribani, 2012). Wilson et al (2011) however, did state "the survey provided definitions for the participants on what constituted HH based on the descriptors provided by the Center for American Nurses" (p. 455). A limitation of these two studies is the absence of an operationalized definition for terminology that lacks consistency between researchers.

Prevalence

Prevalence of uncivil behaviors has been measured using a variety of instruments, from formalized tools with reliability and validity data to informal author-developed surveys. The formal tools used to determine prevalence in the selected studies were Guidroz's Nursing Incivility Scale (NIS), Einarsen, Raknes, Matthiesen, & Hellesoy's Negative Acts Questionnaire (NAQ), Einarsen and Hoel's, Negative Acts Questionnaire – Revised (NAQ-R), Cortina's Workplace Incivility Scale (WIS), and Manderio and Banton's Verbal Abuse Scale (VAS). All formal and informal tools administered in the following studies relied on participant recall and self-reporting for data collection.

Two studies measured frequency of bullying with the NAQ-R (Laschinger et al, 2010 and Vogelpohl, Rice, Edwards, & Bork, 2013). In a sample of 415 new graduate nurses, Laschinger, Grau, Finegan, & Wilk (2010) found 33% (n=137) were classified as bullied (exposed to at least 2 acts per week for 6 weeks). Vogelpohl et al (2013) found a slightly lower prevalence of 20.5% (n=27). Berry, Gordon, Gates, & Schafer (2012) found 21.3% (n=43) of Registered Nurses in practice less than 3 years were exposed to daily workplace bullying as measured by the original NAQ.

Budin, Brewer, Chao, and Kovner (2013) found about 49% of their sample of early career Registered Nurses (*N*=1,407) had experienced verbal abuse from coworkers at least once in the three months prior to the study, with 5% experiencing verbal abuse more than five times in the three month period. Using the NIS, Lewis and Malecha (2011) found 84.8% (n=553) experienced a workplace incivility event in the last year and 36.7% (n=239) reported themselves as a perpetrator. Leiter, Price, and Laschinger (2010), using the WIS, found differences in

perceptions of incivility between nurses of different age ranges (Generation X nurses perceived their work environment to be less civil than did Baby Boomer nurses).

Among those authors who developed their own tool for measuring incivility, prevalence rates ranged from 52% (n=777) (Farrell & Shafiei, 2012) to 96.1% (n=25) (Griffin 2004). When looking at specific nursing units and perpetrators, Vessey et al (2009) found that medical-surgical units reported the highest frequency of uncivil acts and staff nurses were the most prevalent perpetrator. Medical units were also found to be the most common site of bullying behaviors by Stagg, Sheridan, Jones, & Speroni (2011).

Effects

While it may appear that the only victim of BHHV is the individual person who is being targeted, the practice has more far reaching consequences. From tarnishing the reputation of the profession of nursing to increased costs to the healthcare system to dire consequences for individual nurses and their clients, even the most seemingly innocuous action has the potential to cause lasting harm. The results of studies from the last five years will be discussed here in terms of the nursing profession, healthcare organizations, and individuals.

The nursing profession. While no recent studies on the effect of BHHV on the overall nursing profession were located, it seems logical that negative behaviors experienced by up to one-third of nurses would have the potential to negatively affect the entire profession. Nurses are viewed as trustworthy, caring individuals and are usually thought to have a high moral code. How would the general public view nurses and the profession as a whole if individuals other than nurses knew the full-extent of the prevalence and types of BHHV? It could be argued that anyone capable of humiliating, abusing, or harassing their coworker lacks compassion and a high

moral code. If the general public knew how frequently nurses treated each other in this manner serious issues could arise with trust and patient confidence in the care they were receiving.

Organizations. Uncivil behavior between nurses has the potential to impact not just the victim but also the entire healthcare organization. Usually negative impacts to organizations are thought of in terms of monetary losses; these losses can occur due to increased staff vacancy rates and decreased productivity. Un-filled nursing positions can increase costs to the organization by necessitating overtime pay for spots to be filled as well as the costs associated with recruitment and orientation of new staff. Citing several studies that date back to 1999, Jones and Gates (2007) state the cost to the healthcare organization related to nurse turnover ranges from $22,000 to over $64,000 per vacant spot.

Vessey et al., (2009) found that of nurses who experienced BHHV in their work place, 56% (n=35) to 78.5% (n=95) resigned their position and sought employment elsewhere. Coworker incivility has been shown to be a significant predictor of organizational commitment and intent to leave the organization. (Smith et al., 2010; Oyeleye et al., 2013; Dellasega et al., 2014). Similarly, Vogelpohl et al., (2013) found 31% of 135 new graduates reported bullying had affected their job performance; 35.4% of those who had been bullied had changed jobs in the last 2 years and 29.5% had considered leaving the profession altogether. Wilson et al. (2011) also found that observing hostility was a significant predictor of intent to leave the organization with 39.6% (n=48) of participants reporting they were definitely going to leave and 19% (n=23) were considering leaving.

Lewis and Malecha (2011) found an inverse relationship between incivility and nurse productivity (the higher the incivility the lower the productivity). In that study, costs in the state of Texas were estimated to be $11,581 per nurse per year of lost productivity (Lewis and

Malecha, 2011). In contrast, Berry et al. (2012) found no overall statistical significance between exposure to bullying and productivity. However, when the results were separated out by race, there was statistical significance for white novice nurses but not non-whites. White novice nurses reported decreased productivity when exposed to bullying.

Two studies included the organization's Magnet status in their analysis. Magnet hospitals are those institutions that have met stringent criteria for exemplary nursing practice as defined by the American Nurses' Credentialing Center (ANCC). Sellers et al. (2012) found nurses in Magnet designated hospital in New York State perceived significantly less uncivil environments than nurses in non-Magnet designated hospitals. Budin et al. (2013) found similar results in that nurses who reported high levels of verbal abuse were less likely to work in Magnet designated facilities.

Individuals. Uncivil working environments are not only linked to negative outcomes for healthcare organizations. Significant emotional costs to individual victims have also been reported in the literature. Incivility was found to be a significant predictor of burnout in several studies (Laschinger, Finegan, & Wilk, 2009; Laschinger et al., 2010; and Oyeleye et al., 2013). Oyeleye et al. (2013) found statistical significance between incivility and stress.

Themes of incivility have been reported in recent qualitative studies. In a study of new graduate nurses, Simons and Mawn (2010) found two over-arching themes, feeling out of the clique (alienation) and leaving the job (either a specific nursing job or leaving the profession all together). In a qualitative study looking at nurses' perceptions of their practice, Huntington et al. (2011) found (un)collegial/self-care to be a major theme (participants felt nurses still ate their young and bullying was very prominent). Clendon and Walker (2012), studying new nurses, describe bullying as a sub-theme of a main theme, "challenges of nursing". Finally, Maddalena,

Kearney, and Adams (2012) reported, "a significant source of stress for novices was their fear of encountering 'difficult personalities' in their nursing and medical colleagues or patients and their families" (p. 77).

Position of Professional Organizations

The Joint Commission, an independent not-for-profit agency, is one of the major accrediting bodies for healthcare organizations in the U.S. with the mission, "To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value" (The Joint Commission website, 2015). In 2008 the Joint Commission released a Sentinel Event Alert regarding uncivil behaviors occurring in health care organizations. These behaviors were labeled as disruptive and were noted to increase the risk of medical errors and adverse events (The Joint Commission, 2008). In 2012, The Joint Commission released a monograph aimed at increasing patient and worker safety (The Joint Commission, 2012). BHHV was among the various topics discussed in this monograph. Although The Joint Commission (2012) stated education was an appropriate intervention to target this behavior, it did not recommend any specific type of education.

The American Nurses Association (ANA) issued a formal position statement addressing the combined issues of incivility, bullying, and workplace violence. This statement references the ANA's *Code of Ethics for Nurses with Interpretive Statements* that requires nurses to "create an ethical environment and culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect" (American Nurses Association [ANA], 2015a, p.4). The position statement affirms the ANA's commitment to addressing this issue by saying, "all RNs and employers in all settings, including practice, academia, and

research, must collaborate to create a culture of respect that is free of incivility, bullying, and workplace violence"(American Nurses Association Professional Issues Panel on Incivility, Bullying, and Workplace Violence [ANA], 2015b, p.1). The ANA goes one step further by explaining their position statement was not meant to apply only to registered nurses: "stakeholders who have a relationship with the worksite also have a responsibility to address incivility, bullying, and workplace violence" (ANA, 2015b, p.1).

Educational Programs and Strategies

Researchers have tried several different modalities and combinations of modalities in their educational interventions aimed at teaching nurses how to manage and prevent incivility in the workplace. Nikstaitis and Simko (2014) conducted a one-hour educational intervention but failed to mention exactly what this one hour consisted of. Other researchers allotted 2 hours for didactic content and cognitive rehearsal (Griffin, 2004; Stagg, Sheridan, Jones, & Speroni, 2011; Embree et all 2013). Cognitive rehearsal is a technique that allows individuals to practice how they will respond to certain situations, and in these studies participants practiced pre-developed scripted responses to the most common forms of BHHV encountered in the workplace. Although Dahlby and Herrick (2014) reported using an education program to increase staff nurses awareness of and ability to respond to incivility, they did not elaborate on the method of teaching utilized in their research.

It is evident from a review of the literature that research into the effectiveness of specific educational strategies to combat BHHV is lacking. Moreover, published studies often lack a clear description of the specific teaching method and content. Confounding the issue is the use of study populations that are vastly different from study to study, thus making generalization difficult. For example, Griffin (2004) selected new graduate nurses attending orientation to their

first nursing position while Nikstaitis and Simko (2014) used nurses from a single intensive care unit and specifically excluded nurses in practice for less than six months. Stagg et al (2011) opened participation up to all medical-surgical nurses at a particular hospital, Dahlby and Herrick (2014) used nurses from two work units (an inpatient surgical unit and the wound/ostomy/continence unit), and Embree, Bruner, and White (2013) included all professional nursing staff at an entire critical access hospital. Recruitment of participants into the study by Lasater, Mood, Buchwach, and Dieckmann (2015) was somewhat unusual in that participation in the intervention was mandatory (at the request of the specific unit managers). However, data was only collected from those who agreed to participate in the evaluation of the session.

The studies conducted by Griffin (2004) and Lasater et al. (2015) both reported positive results. Griffin used focus group questions to elicit data therefore there is no mention of statistical significance. However, this study did find 46% (n=12) of participants had lateral violence directed against them and 100% of these used the cognitive rehearsal strategies to respond. All of these participants recalled the confrontation was difficult, but all uncivil behaviors against them ceased afterwards. Lasater et al (2015) found significance for less incivility over time for both nursing work units in the study and greater self-efficacy for one of the units. No statistical significance was found for collective self-efficacy, and while the authors report *impressive increases* in results of the National Database for Nursing Quality Indicators (NDNQI) for both units a limitation of the published report is a lack of details regarding the NDNQI.

Conversely, three studies did not show statistical significance between their pre and posttest questionnaires; of note, each study measured a different concept using different tools, making any generalizations here difficult. Embree et al (2013) used the Nurse Workplace

Behavior Scale (NWS) and the Silencing the Self-Work Scale (STSS-W) to measure attitudes, beliefs, and perceptions of nurses towards BHHV. Dahlby and Herrick (2014) used the Lateral and Vertical Violence in Nursing Survey in an attempt to determine the impact of their intervention and Nikstaitis and Simko (2014) used the Nursing Incivility Scale (NIS) to look at perceptions of behaviors between intensive care unit nurses. The lack of statistical significance could be a result of small sample sizes, poor intervention, or inappropriate data collection tool. Sample sizes ranged from 21 (Nikstaitis and Simko, 2014) to 48 (Embree et al, 2013); all three of these studies lost participants between the pre-test / intervention and the post-test. Both Nikstaitis and Simko (2014) and Embree et al (2013) used formal data collection tools with good reliability data. Dahlby and Herrick used the Lateral and Vertical Violence in Nursing Survey but caution that the tool has not undergone psychometric testing.

Stagg, Sheridan, Jones, & Speroni (2013) reported surprising results with their study: the majority of nurses (83%, n=5) who witnessed a bullying event after the training failed to intervene, even though 70% (n=7) of participants answered yes to the question, "since the workplace bullying cognitive training program, has your ability to intervene in bullying improved?" (Stagg et al., 2013, p. 336). The authors give a quote from one participant that may help explain the lack of willingness to intervene, "It's too frightening; it could be your job" (Stagg et al., 2013, p. 336). It is unclear if this was a common sentiment among participants (and thus a reflection on the overall culture of this particular institution) or if there were other reasons staff did not employ the tactics they were taught. This study does raise the question of institutional culture and the role it plays in an individual's willingness to allow uncivil behavior to continue.

While generalization of the results of these six studies is difficult due to the limitations mentioned above, it appears that the method that has the most promising results is the combination of didactic and cognitive rehearsal segments as first trialed by Griffin (2004). This study reported the highest rate of success of the six studies that were located – 100% of participants who utilized the strategies taught during the intervention reported bullying behaviors against them ceased.

Critical Analysis and Synthesis of Educational Interventions

A total of six intervention studies were located in seven different published articles; Stagg et al. reported their initial findings (2011) and then their follow-up results from the same study (2013). Due to the small sample sizes and drastic differences in study content and populations it is difficult to generalize the results of these educational interventions. A common theme that did emerge throughout all six of these studies was the inclusion of a didactic educational session as part of the study protocol (Griffin, 2004; Stagg et al. 2011; Stagg et al., 2013; Embree et al., 2013; Dahlby & Herrick, 2014; Nikstaitis & Simko, 2014; Lasater et al., 2015). The caliber of the description of the didactic session varied from study to study, but most appeared to include information on definitions, theoretical basis, and consequences to individuals and organizations. Inclusion of a discussion of professional behaviors was another common theme between studies (Griffin, 2004; Embree et al., 2013; Nikstaitis & Simko, 2014) Lasater et al. (2015) went a step further and utilized the first didactic session to obtain information about specific concerns their participants had; this information was then used to tailor the next didactic session to these specific concerns.

Didactic education alone is unlikely to change behaviors or enable nurses to improve working conditions with their peers. To that end most educational interventions also offered

interactive sessions to either role-play (Lasater et al., 2015) or use cognitive rehearsal techniques to practice scripted responses (Griffin, 2004; Embree et al., 2013; Stagg et al., 2013; Dahlby & Herrick, 2014; Lasater et al., 2015). In addition to didactic and interactive sessions, Lasater et al (2015) also included a two-hour simulation 30 days after the second didactic session.

One final strategy that emerged from these studies was the distribution of reference materials for participant use. Griffin (2004), Embree et al (2013), Stagg et al (2013), and Lasater (2015) all provided handouts or cue cards of response phrases for participants; Griffin (2004) specifically mentions the cards were sized to attach to the back of the institution's identification badges. The intervention by Lasater et al (2015) also created unit specific toolkits containing coworker commitment cards and strategies for crucial conversations.

Only one study, Nikstaitis & Simko (2014), was not clear about the type of intervention that was provided. These authors provided a 60-minute educational intervention that contained background information, case studies, and recommendations for healthy workplaces along with a facilitated discussion on professionalism, behaviors, attitudes, and ways to prevent incivility. There is no description of what is meant by facilitated discussion, but given the entire session was only one hour long it seems unlikely there was any chance for participants to practice responses to uncivil acts.

Gaps in the Literature

While much is known about the prevalence, perpetrators, and victims of BHHV, there are still gaps in the literature. A gap exists in the measurement of incivility and outcomes for incivility. Currently, there is no standard measurement tool for incivility. In addition, many of the studies also have weaker observational designs and there is a lack of large sample

randomized controlled trials to evaluate specific interventions, so the level of evidence is low to moderate for the few studies that do exist.

Theoretical Framework

The theoretical framework that guided this project was Bandura's Social Cognitive Theory (SCT). Bandura's theory suggests that a person's behavior is driven by their expectations about their environment, self-efficacy, and the desired outcome. Expectations, reinforcements, and past experiences all help determine if a person will perform and maintain a certain behavior. When utilizing this framework, behaviors are viewed in the social context in which they occur (Bandura, 1986)

Concepts

The major concepts in Bandura's theory are reciprocal determinism, vicarious capability (observational learning), forethought capability (anticipation of outcomes), self-regulatory capability (internal motivators), and self-reflective capability (self-efficacy). Reciprocal determinism is the concept that behavior, personal factors (including cognitive factors), and environmental influences act as determinants of each other. Vicarious capabilities, such as observational learning, allow individuals to acquire new skills by watching others and modeling their patterns of behavior. Forethought capability explains how an individual uses anticipated outcomes as motivators of behavior. Human behavior also relies on self-regulatory capability, the idea that internal standards and personal motivators influence behavior. Self-reflective capability is utilized by the individual to process the caliber of their response to an event (self-efficacy) (Bandura, 1986).

Application of Theory to Project

The main focus of this project was an educational intervention that taught new graduate nurses techniques to respond to BHHV when it is encountered in the practice setting. All of the main concepts of the social cognitive theory were utilized in the development and implementation of the intervention and the evaluation. Background information on BHHV and its consequences was provided in an effort to develop internal standards and personal motivators. Vicarious capabilities were provided for by role-playing activities and provision of cue cards to help increase participants' feelings of self-efficacy. Finally, participants were encouraged to use forethought capability to view their use of the techniques taught in class as a means to improve the quality of their work environment.

During the three-month follow-up focus group evaluation, open-ended questions were employed to gauge participants' perceived self-efficacy. Questions included: "Did you utilize the techniques taught during the intervention and if so, how?", "What were your thoughts/feelings prior to your response?", "What were your thoughts/feelings after your response?", and "How did the perpetrator(s) respond to you?" Participants' responses were digitally recorded, transcribed, and analyzed for themes in order to evaluate their perceived self-efficacy.

Summary

This chapter focused on a review of the current published literature that addressed the topic of incivility as it applies to new graduate nurses. Included in this review was information about the definitions, prevalence, consequences of, and methods to address incivility in nursing. The studies of particular interest were those that focused on educational interventions aimed at assisting staff nurses to address incivility when it is encountered. Gaps were identified as a lack

of recommended modalities, empirical tools, and timing of the education. The information gained during this review was utilized to develop an educational intervention for new graduate nurses on the topic of BHHV.

Chapter 3

The purpose of this project was to investigate the impact of an educational intervention using cognitive rehearsal on new graduate nurses' knowledge of BHHV and their self-efficacy in responding to uncivil acts when encountered in the practice setting. This chapter discusses the study design, participant selection, methodology, and data management along with the plan for protection of human subjects. It concludes with a section detailing the proposed budget and time requirements for both the researcher and participants.

Study Design

This project used a mixed method quasi-experimental design with one group. Pre-post tests and post-intervention focus groups was used to assess the impact of a cognitive rehearsal based educational intervention on new graduate nurses' knowledge of and their ability to respond to bullying, harassment, and horizontal violence encountered in the workplace. Both qualitative and quantitative data were used to evaluate this project.

Setting

The setting for this study was a single academic medical center located in a Mid-Atlantic state in the Northeastern U.S. This tertiary care facility has 551 licensed in-patient beds, admits approximately 29,000 patients a year, employs approximately 2,200 nurses of various educational levels, and hires approximately 100 new graduate nurses into a structured residency program each year. The medical center is located in an area that has been deemed as urban by the State, however within a 20-mile radius there are also areas that meet the criteria for rural designation.

For this project, the educational session was conducted in a private conference room located in a conference center that is detached from the main hospital, away from any particular

nursing unit. The conference room is made up of large, circular tables and stationary chairs with backs. A fully computerized podium was available for use along with two projection screens. There were male and female restrooms and a water fountain immediately outside of the conference room for participant convenience. Three months after the educational session, participants returned to the same conference room in which the initial education program took place to participate in a focus group interview.

Population/Sample/Participants

The population of interest for this study was graduate nurses at one academic medical center in the Mid-Atlantic U.S. A convenience sample of 51 graduate nurses was available for participation in this study. Inclusion criteria for participation were: membership in the July 2015 Graduate Nurse Residency cohort at the host institution and employment as a Registered Nurse. There were no exclusion criteria. Since this was a quasi-experimental one-group study, there was not any randomization. As a thank you for participation, all participants received free continuing education credits and focus group participants also received a $5 gift card to the hospital coffee cart.

Protection of Human Subjects

Institutional Review Board (IRB) approval was obtained from the host facility prior to implementation of the project; a copy of this approval can be found in Appendix A. Potential participants were invited to participate during a scheduled residency meeting. They were informed the study is being undertaken as part of a doctoral program and has received IRB approval. They were also informed they had the right to refuse to participate, they could withdraw at any time, and their decisions regarding participation would not affect their employment status in any way. They were also assured their information would remain

confidential. Verbatim statements have been used to support themes that arose from interview data analysis. However, participants were assured anonymity as names are not reported or connected to the verbatim statements. The benefit of participation in this study was an increase in personal knowledge of how to address BHHV behaviors; there were no anticipated risks of participation.

Methods

Both quantitative and qualitative methodologies were used to obtain data in this project. Participants completed a demographic questionnaire (Appendix B) along with pre/post tests (Appendix C) related to knowledge of and experience with BHHV behaviors. Participants also were invited to participate in a focus group interview to discuss their experiences when using the response strategies. Data from the demographic questionnaire was used to describe the sample.

Procedure

The researcher attended the first residency orientation session in August to introduce the study and explain the purpose of the project to potential participants. Potential participants were encouraged to ask questions and were given the researcher's contact information (office phone number and email address) for any questions that arose after the initial meeting concluded.

One month later, in September 2015, the educational session was conducted during the regular residency session which was scheduled by the host organization. Prior to the beginning of the educational session, participants were invited to ask additional questions about the project; consent was implied if the participant completed the pre-test or participated in the focus group interview. Participants were also advised they could withdraw from the project at any time and their decision to participate or not would in no way impact their employment at the host institution.

Prior to the commencement of the educational session, each participant received a paper packet that included a demographic form and a pretest with instructions to complete the packet immediately and individually. They were given 15 minutes to complete the forms. Once completed, the participants were instructed to place their anonymous packet in a folder present on each group table. After all packets were placed in the folders, the didactic portion of the program began.

The researcher conducted the didactic portion of the program utilizing a PowerPoint presentation (the outline is shown in Appendix D); participants were provided with a paper handout of the slides for their use. The content of this portion included: (a) terminology, (b) background on theories that may explain why BHHV occurs, (c) consequences to the nursing profession, the healthcare organization and individuals, (d) examples of the most common forms of BHHV, and (e) professional ways to respond to BHHV. At the conclusion of the didactic portion the participants were given an opportunity to role-play seven BHHV scenarios (shown in Appendix E) with the goal of practicing the recommended responses.

Participants were paired with a partner to rehearse responses to the various forms of BHHV; since there was an odd number of participants in the educational session, three participants were assigned to one group. Each pair of participants received a stack of seven index cards, each containing a different scenario. Partners took turns playing the role of the bully or the victim so both partners had ample opportunity to practice responding to uncivil situations. The researcher moderated the session to offer feedback to the participants. The session ended with a brief, five-minute wrap-up to address any final questions participants had. Participants were then asked to use the strategies they learned if they encounter BHHV during

the course of their work and each participant was given a Bullying Tip Card (American Nurses Association [ANA], n.d.) for their personal use.

The post test and focus group interviews were conducted three months after the intervention. Two focus groups were conducted, one with six participants and one with four. One focus group was conducted immediately prior to the regularly scheduled residency session and one immediately after so as to offer participants a convenient time to participate. In order to assure consistency between focus groups, the researcher asked the same pre-determined, semi-structured interview questions (see Appendix F) in the same order, and continued to use probes as needed. Interview probes included statements or questions such as "tell us more about that experience" and "what was that like for you?", "please explain further" or "please tell us more". Focus group interviews were digitally recorded with two recorders to help decrease the possibility of technical failure.

Tapes were transcribed verbatim by the researcher as soon as possible after the focus group interview. Transcripts were labeled Focus Group 1 and Focus Group 2. The transcripts were compared with the digital tape multiple times to ensure accuracy of the transcription. To ensure confidentiality, names of participants were not be recorded in the written transcript but were replaced by a pseudonym. After confidentiality and accuracy was assured, data analysis began.

Transcripts of the focus group interviews were analyzed for common themes. Key words and elements were placed in categories to assist with identifying the overall theme.

Management of Data

This project was conducted and evaluated by a single researcher who was the only person with access to the raw data. Pre and posttests were administered on paper and have been

stored in a locked file in the researcher's locked office. Data was entered into the software system on the researcher's computer without any identifiers; both the computer and the individual data files are password protected. Recordings and transcripts of the focus group interviews are also stored on the researcher's password protected computer. All electronic files associated with the data have been individually protected with passwords. Digital recordings were destroyed in accordance with the host institution's electronic policy immediately following transcription and verification that the transcribed raw data was accurate. Raw transcript data will be maintained in a locked file for three years after completion of the project in accordance with the host institution's IRB guidelines.

Data Analysis

Both qualitative and quantitative data analysis methods were used to determine the impact of a cognitive rehearsal intervention on new graduate nurses' ability to recognize and respond to bullying, harassment, and horizontal violence when it is encountered in the work setting. All statistical analyses for quantitative data were conducted using Minitab® Statistical Software (version 17.1), Minitab Inc.

Quantitative Data

The brief demographic data form, shown in Appendix B, included questions to assess the participant's age, race, gender, highest nursing degree, and prior experience as a Registered Nurse. Racial categories were selected to be consistent with information collected by the U.S. Census Bureau. Demographic variables are reported as frequencies.

The identical pre- and post-tests (shown in Appendix C) consisted of a total of 22 items adapted with permission from Stagg et al (2011); 18 items assessed participants' knowledge of prevalence, types, consequences, and responses to common bullying behaviors using multiple

choice and true/false questions. Four items assessed participants' exposure to and confidence in responding to bullying in the workplace using a 5-point Liekert scale. The pre-test was administered immediately before the educational intervention and the post-test was administered three months later on the same day as the focus group interview. The 18 knowledge items on the pre- and post-tests were scored as either correct or incorrect with the total percentage correct on each exam being used for statistical analysis. A Mann-Whitney test was used to compare the scores on the pre and post-tests.

Qualitative Data

A semi-structured interview guide was developed for the focus group interview. The Interview Guide, shown in Appendix E, contained five open-ended questions and five interview probes. Interviews were approximately one hour in length and included a total of ten participants, six in the first session and four in the second. Focus group interview recordings were transcribed as soon as possible after each session. The typed transcript was compared with the digital recording multiple times to ensure accuracy. The data was analyzed for themes using content analysis (Graneheim & Lundman, 2004). The transcript was reviewed line by line, with the reviewer underlining key words and phrases. After the key words and phrases were identified, codes were developed to describe the concept being discussed. Codes were grouped into categories, and then an overall theme was developed for each category by a single coder.

Resources, Budget and Site Support

The time requirements for participants was estimated to be approximately four hours: two hours for the initial educational session and two hours for the post-test and focus group interview. Total time required of the researcher included explaining the study to potential

participants and obtaining informed consent, conducting the initial session and follow-up session(s), data transcription, and data analysis.

There was no cost associated with participation in this study for the graduate nurses. All costs in this project related to the provision of materials to participants, incentives, and technology for recording the focus group interviews. An estimated budget can be found in Table 1. Please note that there is no line item for the statistical software, Minitab, as the researcher had access to a free copy of this through the educational institution. The researcher did not apply for any grants to cover funding of this project.

Table 1

Budget

Description	Amount
Incentive (Gift Card)	$270
Anti-bullying Tip Cards	$50
Snacks for sessions	$75
Photocopying of handouts	$100
Sony Digital Voice Recorder (2)	$200
Total	$695

Institutional support for the project has been obtained from administrators at the host institution. Both the Coordinator of the Graduate Nurse Residency Program and the Director of Nursing Research have both offered their support and provided official letters of support. Copies of both letters are found in Appendix G.

Summary

This mixed methods quasi-experimental one group study was conducted with members of the July 2015 Graduate Nurse Residency cohort at an academic medical center in the Mid-Atlantic U.S. The methodology was chosen with the target population in mind after a careful review of the current published literature on the topic of BHHV. The tools were selected based on their availability and applicability to the project. The project was supported by the host institution and Institutional Review Board approval as an exempt study was granted.

Chapter 4

A mixed-methods approach was utilized to evaluate the impact of a cognitive rehearsal educational program on new graduate nurses' ability to recognize and respond to bullying, harassment, and horizontal violence (BHHV) in the practice environment. The identical pre- and post- tests contained 18 questions related to knowledge of BHHV, 2 questions that assessed exposure to BHHV and 2 questions that assessed confidence in handling BHHV in the workplace. Focus group discussions were conducted in order to develop a deeper understanding of participants' experiences.

Sample

The sample for this project was obtained from the July 2015 Graduate Nurse (GN) Residency Cohort (N = 51) at an academic medical center in the mid-Atlantic region of the United States. The majority of participants were female (n = 40), white (n = 49), ages 20-29 (n = 48), and held a bachelor's degree in nursing (n = 48). None of the participants had worked as an RN for another employer. Complete sample demographics can be found in Table 1.

Table 2

Demographics

Age	Gender	Race	Degree
20-29: 48 (94%) 30-39: 2 (4%) 40-49: 1 (2%) 50+: 0	Male: 9 (18%) Female: 42 (82%)	Am Ind / Alaska Native: 0 Asian: 2 (4%) Black: 0 Nat Hawaiian: 0 White: 49 (96%)	Diploma: 0 Associates: 2 (4%) Bachelors: 48 (94%) Masters: 1 (2%)

Quantitative Data

The pre- and post- tests were completed by all 51 (100%) participants. Questions one through 18 assessed knowledge of BHHV and these were scored as either correct or incorrect. Total number of correct answers were recorded for each test and descriptive statistics were calculated (see Table 2). There was no statistical difference between the pre and post test results for these 18 questions (p value = 0.26) using the Mann-Whitney test.

Table 3

Questions 1-18

	Pre Test	Post Test
Minimum Score	8	11
Maximum Score	16	16
Mean	12.96	13.28
Standard Deviation	1.48	1.28

The remaining four questions on the pre- and post- test assessed exposure to and confidence in responding to BHHV using a five-point Liekert scale (1 = very strongly disagree; 2 = strongly disagree; 3 = agree; 4 = strongly agree; 5 = very strongly agree). Table 3 contains the mean, standard deviation, and p-value (using the Mann-Whitney test) for each of the four questions.

Questions 19 and 20

These two questions assessed exposure to BHHV by asking participants to rate their agreement with the following statements: “I have observed other nurses being bullied” (question 19) and “I have bullied others” (Question 20). On the pre-test, the mean for question 19 was 2.71, indicating the group fell between “strongly disagree” and “agree” on the scale. The post-

test saw a rise is this mean up to 2.98 (p = 0.0516), indicating more GNs observed other nurses being bullied. Pre and post test means for question 20 were identical (1.53) thus there was no statistically significant change between the two tests. Results from this question indicate that participants fairly strongly believed they had not bullied others.

Questions 21 and 22

The remaining two questions on the pre- and post- tests assessed participants' feelings regarding their preparation (Question 21: "I am adequately trained to manage a workplace bully") and confidence (Question 22: "I feel confident in defending myself against bullies") in handling BHHV when it is encountered in the workplace. The pre test mean for question 21 was 2.61, indicating participants did not feel adequately trained to manage a workplace bully; post- test result demonstrated a statistically significant increase in this mean to 3.20 (p = 0.0001) indicating participants felt better trained after the intervention. The pre-test mean for the final question was 2.82 indicating participants did not agree they were confident in their ability to respond to a workplace bully. While this mean did rise to 3.04 on the post-test, this increase was not statistically significant.

Table 4

Questions 19-22

Question	Pre Test Mean (SD)	Post Test Mean (SD)	p-value
19	2.71 (0.78)	2.98 (0.79)	0.0516
20	1.53 (0.95)	1.53 (0.9)	0.815
21	2.61 (0.8)	3.20 (0.63)	0.0001
22	2.82 (1.03)	3.04 (0.8)	0.14

Qualitative Results

A total of 10 GNs (19.6%) also participated in one of two focus group discussions held the same day as the post test. Focus group questions began by asking participants to describe incidences of BHHV they had witnessed on their units. The next main question asked participants how they handled the incidences, and the following question asked what influenced their decision to not respond to the behavior when it was encountered. Probing questions were asked as needed to help clarify the participant's statements. The results of each main question topic are discussed individually with supporting evidence from the transcribed interviews.

Types of BHHV Encountered

When asked to describe incidences of BHHV they had witnessed in the practice setting, focus group participants related experiences with patient care assistants (PCAs), nurse co-workers, and physicians. PCAs were described as committing non-verbal acts of BHHV such as not offering help with patient care and pretending to be too busy. Nurse co-workers and physicians each committed similar acts of verbal and non-verbal BHHV. Nonverbal behaviors included eye rolling / lack of eye contact, impatience, being ignored / disrespected and were committed by both nurses and physicians. Verbal instances of BHHV were belittling (both nurses and physicians), spreading pre-conceptions about colleagues (nurses), criticizing (nurses), minimizing importance about report (physicians), and yelling (physicians). Examples of verbatim statements for each of these types of BHHV can be found in Tables 5 and 6.

Table 5

Behaviors Committed by PCAs

Behavior	Verbatim Statements*
Not offering help with patient care	…and they leave those patients just for you and not come help you with care or even

	turning, repositioning, whatever you need to have done (1.18.27)
Pretending to be too busy – but helping others	...they kind of push you to do everything on your own and no help from them…they'll do it for other patients but not my patients…there can be some that maybe don't care and don't want to come help you… and they kind of push you to go find you own help or not help you at all (1.3.7)

Note. *Verbatim statement locations are denoted in parentheses after the statement. The first digit refers to the focus group number, the second digit is the page number, and the third digit is the line number.

Table 6

Behaviors Committed by Nurse Colleagues and Physicians

Behavior	Verbatim Statements*
Eye Rolling / Lack of Eye Contact	…a lot of times they don't say anything but it's like eye rolling (1.3.25) …went to the charge nurse she just rolled her eyes (1.14.9) …sometimes I feel like it's … eye rolling (1.15.7) …and the doctor will give eye contact to everyone but the nurse and I just don't understand. They'll be talking about things that I'm going to do with the patient throughout the day and the plan but won't look me in the eye (1.8.23) … the nurse on nightshift who was giving us report for dayshift literally never made eye contact with me and I was like so upset (2.5.20)
Being Ignored	… I have noticed that they are much more inclined to ask anybody else to do something that's definitely a nursing role whereas they would ask me to do something that I would have done last year [as an extern] like this person needs medication given and this person's on the bedpan kind of thing (2.4.18)

	… this nurse … I'll say something to her and she will like literally just stare and me and have no response (2.21. 10)
Impatience (Report)	and just kinda standing there like, 'oh I have to like get report from you but I'm not really listening' (1.15.7)
	but the person that we were giving report to would look down at her sheet … and every time, honestly every time that she would look up … or ask a question she would look at my preceptor (2.7.9)
Pre-conceptions of colleagues (back-biting)	…my preceptor really freaked me out…she made her sound like really scary and really mean and like everyone complained about her…so I gave report and I was like terrified the whole time (1.5.16)
	...I thought this one charge nurse was so intimidating I just didn't want to go to her…but then she would come and ask me every hour if I needed help…I'm like now she's (a) totally different person I just didn't approach her because of her looks (1.6.1)
	..kind of like the backhand comments (2. 5. 15)
	… [this one nurse was] yelling how management's not fair and this is like a me and them and then like I understood her point but it wasn't the place to be upset over that (2.8.17)
Belittling	...the whole day was hectic from there and my preceptor was like 'well this is an easy assignment' and I'm like 'ok well I just don't have those skills yet'…and then she asked the nurse next to us 'don't you think this is an easy assignment' and I'm like ok I understand but I'm like working on my time management skills…like what's easy for them after like five plus years is not going to be easy for us (1.5.8)

Yelling	…we were in the patient's room [the doctor and I] and then she started yelling at me for something I didn't do (1.7.15) He just yelled at me and hung up (1.8.8)
Minimizing Importance of Report	…I went to the doctor to let them know the oxygen demands were increasing so he comes over to look at my baby and he was like 'ok well nothing's wrong' and I'm like, 'yeah but he's requiring more oxygen do you want me to do something…' and he was like, 'well stop touching them so much' (1.9.3) …there was a doctor who yelled at me because I told her my patient had 421 blood sugar…and she was like 'this could have waited' and I don't know how that could have waited. (1.10.6)

Note. *Verbatim statement locations are denoted in parentheses after the statement. The first digit refers to the focus group number, the second digit is the page number, and the third digit is the line number.

Strategies to Address BHHV

When asked how they addressed BHHV when it was encountered, three main themes emerged: communicating perceptions, diffusing, and communicating directly. Participants were most likely to use communicating directly with PCAs, communicating perceptions with nurse colleagues, and diffusing with both nurses and physicians. Examples of verbatim statements for each of these three themes can be found in Table 7.

Table 7

Strategies Used to Address BHHV

Strategy	Verbatim Statement*
Communicating Perceptions	…I think that like how you said that was unprofessional (1.15.26)
Diffusing	Just say you know I'm just trying to do what's best for the patient (1.15.19) …I still feel insecure sometimes… I'm giving her report and I know that…I probably missed

	something or made a mistake throughout the night I just ask them, 'hey I'm back tonight will you let me know if I missed anything or… please tell me if I could do something better' (1.24.22) Sometimes if I have a question of…why they are ordering something the way they are or what they're doing I'll…approach it like since I'm new…from an education standpoint I'm just curious of why… (1.10.13)
Communicating directly	Have you ever just said, 'can you please get my blood sugars'… I have then she tells me she's busy doing something else… I just have to be more firm (1.18.12)

Note. *Verbatim statement locations are denoted in parentheses after the statement. The first digit refers to the focus group number, the second digit is the page number, and the third digit is the line number.

Rationale for Not Addressing Behavior

Participants were next asked what influenced their decision to not respond to acts of BHHV that they witnessed or were the recipient of. Three main themes emerged here as well: transitioning to the RN role, feeling subordinate, and lack of confidence. Lack of confidence was articulated by most, if not all, focus group participants while feeling subordinate appears to have been mostly experienced by graduate nurses who were now employed on units where they had previously worked as externs. Examples of verbatim statements for each of these three themes can be found in Table 8.

Table 8

Rationale for Not Addressing Behavior

Rationale	Verbatim Statement
Transitioning to RN Role	I know I am always pretty passive aggressive right now (1.16.21) I feel our personalities will change over time as well … and we'll be more aggressive at putting out our point (1.20.17)

Feeling Subordinate	…I'm in a different healthcare setting and starting at the bottom (1.20.26) …so even in some way you're viewed as a bit of a subordinate and until you're less of a subordinate I guess it's kind of hard to not be treated that way (2.27.8)
Lack of Confidence	I don't feel that confident (1.13.21) I probably don't feel that confident (2.23.18)

Note. *Verbatim statement locations are denoted in parentheses after the statement. The first digit refers to the focus group number, the second digit is the page number, and the third digit is the line number.

Environmental Supports to Assist with BHHV Management

Throughout the discussions, participants provided descriptions of environmental supports that they felt were conducive to helping them address BHHV. These included support of the manager or charge nurse, positive role modeling, by preceptors, and peer support. It was apparent during both discussions that participants felt their unit supervisors were open to helping them address uncivil behaviors and they talked about several different instances where preceptors modeled professional responses to uncivil actions by others. Examples of verbatim statements for each of these can be found in Table 9.

Table 9

Environmental Supports Helpful in Managing BHHV

Support	Verbatim Statement*
Support of Manager / Charge Nurse	I did bring it up to my charge nurse … and she did welcome the comments (1.13.26) I think my manager's really receptive to that and active and like making sure it doesn't happen again (1.14.13)
Role-modeling by Preceptors	And my preceptor said, 'you don't have to take it' … as soon as the physician walked out she confronted her [and said] 'I'm precepting her and we do not accept your attitude. You cannot

	talk to us like that' (1.6.14) … actually the nurse who was in charge of the patient said something back to her nicely but sternly (1.7.5)
Peer Support	Also like having a strong peer group … I think having a good relationship with them helps … having another person with you that's kind of at the same point is helpful (1.21.1) …it's such a good feeling that even if she's not on the same wing but she's there it's like having support (1.21.17)

Note. *Verbatim statement locations are denoted in parentheses after the statement. The first digit refers to the focus group number, the second digit is the page number, and the third digit is the line number.

Summary

Both quantitative and qualitative methods were utilized to evaluate the impact of a cognitive rehearsal educational program on new graduate nurses' ability to recognize and respond to bullying, harassment, and horizontal violence (BHHV) in the practice environment. There was a significant increase in participant confidence after the educational intervention as demonstrated by a p-value of 0.0001. Qualitative analysis revealed themes related to types of behaviors observed, strategies used to manage BHHV, rationale for not managing BHHV, and environmental supports that were helpful in managing BHHV.

Chapter 5

This pilot project was conducted to evaluate the impact of a cognitive rehearsal educational program on new graduate nurses' ability to recognize and respond to BHHV in the practice setting. Findings from this project will be used to both further the knowledge base about interventions to address BHHV and determine the feasibility of the host institution continuing to offer this session. This chapter will discuss the conclusions that can be drawn from this project, limitations of the project, and implications for nursing practice and research.

Discussion

The topic of this project (responding to BHHV) and the manner in which it was conducted (via small group interactive presentation) was well received by both the graduate nurse residents and the host institution. As a result of the initial presentation, this author was contacted to conduct the session two additional times, once for another group of graduate nurse residents and once for an entire service line at the host institution. Anecdotal feedback from participants at all three sessions supported the idea that the topic was timely, relevant, and essential for those working in healthcare today.

With regards to the strategies taught during the session, focus group participants mentioned using several of them to address uncivil behaviors in the practice environment. In addition, participants also discussed strategies they had developed on their own to help foster positive relationships with their colleagues. All strategies were perceived as effective by participants and all followed guidelines of professional conduct, which was covered in the educational session. Focus group participants also mentioned positive role-modeling by preceptors when physicians behaved less than civilly towards nurses.

Overwhelmingly the participants mentioned lack of confidence as a reason for not responding to uncivil acts when they occurred. There was significant increase in self-reported confidence between the pre- and post- tests, yet, this increase was not supported by the focus group discussion. One explanation for this discrepancy is the self-selection nature of the focus groups. All 51 participants were invited to also partake in the focus group interview but only 10 volunteered. It could be that those participants who felt less confident were more compelled to participate in the focus group as a way to express their feelings on the subject.

In addition to lack of confidence, two other themes emerged as reasons for not responding to BHHV: feeling subordinate and transitioning to the RN role. All three of these themes appear to be related to participants' status as novice nurses.

It is difficult, if not impossible, to compare the results of this project to other published studies due to differences in populations studied and modalities. However, the results of this project can be looked at in comparison with Griffin's (2004) study, which this project was modeled after. Griffin (2004) found that one year after the educational intervention 46% of participants reported experiencing uncivil acts that were directed towards them. All of these victims (100%) reported using the strategies taught during the educational session and all (100%) reported the uncivil behaviors ceased. While percentages were not calculated for the focus group data collected in this study, exposure to uncivil acts appears to be similar to Griffin's findings. Where the two studies differ is in the participants' utilization (or lack thereof) of the strategies. Participants in this project were not likely to utilize the strategies due to feelings of subordination, lack of confidence, and struggles transitioning to the RN role.

Limitations

Several limitations that may have affected the outcome of this project have been identified. These limitations, which include the sample, evaluation tool, statistical test, qualitative data analysis, and follow-up interval preclude the results from being generalized to other populations. Each limitation will be discussed in depth and suggestions will be offered to address them in future studies.

Sample

The sample for this project was obtained from a single graduate nurse residency program cohort at one academic medical center. Participants were primarily white, female, aged 20-29, and held a bachelor's degree in nursing. This type of distribution is common among new graduate nurses and common for the area of the country where the project was conducted, however no information could be obtained from those of differing demographic backgrounds. It is possible that experiences with and reactions to BHHV are influenced by demographic variables and this project was unable to capture that data. In addition to this issue with lack of demographic diversity, the organizational culture of the single site may have also skewed the results. Finally, lack of a control group with randomization eliminates the possibility of this data from being used to determine the intervention's effectiveness. Future projects should consider going beyond one site and/or utilizing more than one residency cohort; inclusion of a control group and randomization of participants should be considered in order to determine the effectiveness of this program.

Evaluation Tool

Only one published evaluation tool could be located that was appropriate for the aims of this project. This particular tool was developed by a group of authors for their particular project

and as such it was only used one other time. Reliability and validity data were not located for this tool and this creates the possibility that the tool is ineffective in capturing accurate data. Some participants mentioned anecdotally that the questions seemed a bit vague, and this could have affected the outcomes of the pre- and post- tests if participants were confused about what the question was asking. Future research is needed to develop evaluation tools that accurately capture the type of data required to evaluate this type of program.

Statistical Test

Pre- and post- test scores were evaluated using the Mann-Whitney test because the individual tests were not linked to each other. Since this project was conducted with a small group of residents at one institution, identifying information was left off of the pre/post-tests due to concerns regarding confidentiality and the Liekert scale questions. If the pre/post-tests had been linked with each other, the Wilcoxon Signed Rank test could have been used, giving stronger statistical evidence for the project. It is possible that there was statistical significance between the pre- and post- test that was not discovered using the statistical test that was appropriate for this project. Future projects should consider assigning codes to participants in order to protect their confidentiality and link their pre and post-tests with each other.

Qualitative Data Analysis

The qualitative data analysis for this project was conducted by a single researcher and the results were not shared with the focus group participants for verification. It is possible that the themes discovered by the research did not truly encompass the sentiments of the focus group participants. Future projects should consider employing more than one researcher to conduct the data analysis and verifying results with focus group participants.

Follow-up Interval

Due to the time constraints of this project, a follow-up time frame of three months was utilized. However, it may be that this time frame was too soon to allow the graduate nurses adequate time to practice the strategies and increase their confidence. A longer time interval (such as the one year employed by Griffin, 2004) may have elicited different responses from participants. Future projects should consider the amount of time it may take for new graduates to feel comfortable enough in their ability to respond.

Implications

This project increased confidence among the entire participant group and helped to contribute to our evolving knowledge about bullying, harassment, and horizontal violence. Data analysis provided some insight into reasons new graduates choose not to address incivility in the workplace and environmental supports they found helpful in their efforts to respond. Additional research is needed to focus on exploring methods to increase new graduate confidence in responding to incivility and to assist new graduate transition to the RN role. Further research is also needed to expand our repertoire of effective strategies to combat BHHV in the practice environment and also determine the effectiveness of a single training session versus multiple "refresher" sessions over time.

Sustainability/Transferability

This project was well received by both the host institution and the participants themselves. The educational intervention provided is feasible to continue beyond this project as it was developed in a format that both fits well into the existing graduate nurse residency curriculum at the host institution and is able to be presented again without much revision. Initial conversations with the residency coordinator at the host institution indicate this educational

program is something the institution would like to continue to include in their residency curriculum. In addition, the educational session is very generic in nature, making it easily transferrable to other groups of healthcare providers (including students and non-nurses) and other organizations.

Summary

This project focused on an educational intervention to combat bullying, harassment, and horizontal violence faced by graduate nurses in the workplace. The results of the project have shed light on why graduate nurses may choose not to respond when faced with this type of behavior and how better studies can be developed to further our understanding. The pilot project has been determined to be feasible long term, and the educational presentation is easily adapted to multiple settings and audiences. Finally, limitations of the current project were discussed along with suggestions for future projects.

Appendix A

Institutional Review Board Approval

PENNSTATE HERSHEY Milton S. Hershey Medical Center

PENNSTATE HERSHEY College of Medicine

EXEMPTION DETERMINATION

Date: August 4, 2015

From: Daniel McBride, IRB Analyst

To: Jennifer Barton

Type of Submission:	Initial Study
Title of Study:	Using Cognitive Rehearsal Strategies to Assist New Graduate Nurses with Bullying, Harassment, and Horizontal Violence
Principal Investigator:	Jennifer Barton
Study ID:	STUDY00003017
Submission ID:	STUDY00003017
Funding:	Not Applicable
Documents Approved:	• Cognitive Rehearsal Study Pre-Post Test (2), Category: Data Collection Instrument • Cognitive Rehearsal Study Demographic Form (1), Category: Data Collection Instrument • Cognitive Rehearsal Study Powerpoint (2) (0.01), Category: Other • Cognitive Rehearsal Study Focus Group Questions (0.01), Category: Data Collection Instrument • Cognitive Rehearsal Study Protocol (2), Category: IRB Protocol • Cognitive Rehearsal Study Scenarios (0.01), Category: Other • Cognitive Rehearsal Study Bullying Tip Card (0.01), Category: Other • Cognitive Rehearsal Study SER Form (2) (0.01), Category: Consent Form • Cognitive Rehearsal Study Data Protection Plan (1), Category: IRB Protocol

The Human Subjects Protection Office determined that the proposed activity, as described in the above-referenced submission, does not require formal IRB review because the research met the criteria for exempt research according to the policies of this institution and the provisions of applicable federal regulations.

Continuing Progress Reports are **not** required for exempt research. Record of this research determined to be exempt will be maintained for five years from

PENNSTATE HERSHEY Milton S. Hershey Medical Center

PENNSTATE HERSHEY College of Medicine

the date of this notification. If your research will continue beyond five years, please contact the Human Subjects Protection Office closer to the determination end date.

Changes to exempt research only need to be submitted to the Human Subjects Protection Office in limited circumstances described in the below-referenced Investigator Manual. If changes are being considered and there are questions about whether IRB review is needed, please contact the Human Subjects Protection Office.

Penn State researchers are required to follow the requirements listed in the Investigator Manual (HRP-103), which can be found by navigating to the IRB Library within CATS IRB (http://irb.psu.edu).

This correspondence should be maintained with your records.

Appendix B

Demographic Information

1. What is your age?
    a. 20-29
    b. 30-39
    c. 40-49
    d. 50-59
    e. 60 and older

2. What is your gender?
    a. Male
    b. Female

3. What is your race? (May select more than one)
    a. American Indian or Alaska Native
    b. Asian
    c. Black or African American
    d. Native Hawaiian or Pacific Islander
    e. White

4. What is the highest nursing degree you have earned?
    a. Diploma
    b. Associate's Degree
    c. Bachelor's Degree
    d. Master's Degree
    e. Doctoral Degree

5. Have you previously been employed as a Registered Nurse?
    a. Yes
        If yes, for how long?_____
    b. No

Appendix C

Pre / Post Test

Bullying, Harassment, and Horizontal Violence in Nursing

For each of the following statements, circle your answer(s).

1. What is another term for workplace bullying?
    a. Horizontal violence
    b. Aggression
    c. Lateral violence
    d. Verbal abuse
    e. All of the above
    f. None of the above

2. An organizational consequence of workplace bullying is:
    a. Isolation
    b. Absenteeism
    c. Strained relationships with family and friends
    d. Maladaptive behaviors

3. In the United States, the prevalence of workplace bullying in nursing is:
    a. < 25%
    b. 20% to 35%
    c. 35% to 50%
    d. 50% to 65%
    e. >65%

4. A staff nurse feels he may have been bullied by a co-worker. What action should the nurse take?
    a. Informally seek advice from others about the situation
    b. Make notes of the incidence
    c. Brush it off
    d. a and b
    e. b and c

5. Which bullying behavior should always be avoided in public areas on the unit?
    a. Backstabbing
    b. Scapegoating
    c. Verbal in-fighting
    d. Nonverbal innuendo

6. What percentage of individuals targeted by bullies quit their jobs?
    a. 27%
    b. 40%
    c. 56%
    d. 70%

7. Who does the bullying in healthcare settings?
    a. Physicians
    b. Managers
    c. Patients
    d. RN peers
    e. Subordinates
    f. All of the above
    g. None of the above

8. A co-worker states, “Whenever I work with Tony, it seems like I always have to answer his call bells.” Your response should be:
    a. “Since I was not there, I do not feel right talking about him. I don’t know the facts. Have you spoken to Tony about this?”
    b. “There is more to this situation than I am aware.”
    c. “That sounds like information that should remain private.”

9. A common bullying behavior is:
    a. Being pressured into doing something you did not want to do .
    b. Isolation.
    c. Sabotage.
    d. Ignored achievements.

10. A co-worker states, “I heard Sally talking to you about her sister. What did Sally say?” Your response should be:
    a. “What we talked about is none of your business.”
    b. “It bothers me to discuss that without Sally’s permission.”
    c. “I see this may be something of interest to you. Why do you care?”

For each of the following statements, circle T if the statement is true and F if the statement is false.

11. T F Low self-esteem is a potential bullying characteristic.

12. T F Workplace bullying of new nurses is an accepted indoctrination into nursing.

13. T F Bullying from co-workers is less distressing than other types of bullying.

14. T F A person may be bullied because of his/her popularity with patients.

15. T F Nurses do not report bullying because they think they will not be believed.

16. T F Disruptive behavior affects patient outcomes
17. T F Bullying behaviors need to occur only one time to be considered workplace bullying.

18. T F Workplace bullying has personal organizational, and societal effects.

For each of the following statements, circle the letter that corresponds with your feelings.

19. I have observed other nurses being bullied.
    a. Very strongly disagree
    b. Strongly disagree
    c. Agree
    d. Strongly agree
    e. Very strongly agree

20. I have bullied others.
    a. Very strongly disagree
    b. Strongly disagree
    c. Agree
    d. Strongly agree
    e. Very strongly agree

21. I am adequately trained to manage a workplace bully.
    a. Very strongly disagree
    b. Strongly disagree
    c. Agree
    d. Strongly agree
    e. Very strongly agree

22. I feel confident in defending myself against bullies
    a. Very strongly disagree
    b. Strongly disagree
    c. Agree
    d. Strongly agree
    e. Very strongly agree

*Pre/post test was modified to remove any reference to any particular healthcare organization.

SLACK
INCORPORATED

May 1, 2015

Jennifer Barton
The Pennsylvania State University
1300 ASB/A110, 90 Hope Drive
Hershey, PA 17033

Reference #: J18466004
Material Requested: Appendix A
Usage Requested: Use in dissertation at Penn State University
Citation: Stagg S., Sheridan D., Jones R., Speroni K.(2011). Evaluation of a Workplace Bullying Cognitive Rehearsal Program in a Hospital Setting. J Contin Educ Nurs. 42(9) 395-401.

Dear Jennifer:

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Requestor accepts conditions above:

Signature: _____ **Date:** 5.1.15

Sincerely,
SLACK Incorporated
Permissions Department

Appendix D

Didactic Presentation Outline

I. Objectives
   a. Define bullying, harassment, and horizontal violence (BHHV)
   b. Explain the different theories regarding its source
   c. Discuss the effects of BHHV on the nursing profession, the healthcare organization, and individual nurses.
   d. Recognize the 10 most common forms of BHHV
   e. Describe appropriate responses to each of the 10 most common forms of BHHV.
   f. Report an increase in comfort level with addressing BHHV when it is encountered in the work setting.
II. Bullying, Harassment, & Horizontal Violence - Definition
III. Some Other Terms
   a. Incivility
   b. Workplace aggression
   c. Relational aggression
   d. Horizontal Hostility
   e. Lateral Violence
   f. “Nurses eating their young"
IV. Theories Regarding the Cause
   a. Bio-behavioral
   b. Developmental
   c. Intrapersonal
   d. Interpersonal
V. Why Should We Care?
   a. Some Statistics
   b. Effects on the Nursing Profession
   c. Effects on Healthcare Organizations
   d. Effects on Individuals
VI. What does BHHV Actually Look Like?
   a. Being yelled at in front of others
   b. Scapegoating
   c. Being the subject of gossip or rumors
   d. Being humiliated
   e. Being sabotaged or having important information withheld
   f. Non-verbal intimidation
   g. Being excluded from activities or conversations
VII. How Should a Professional Respond?
   a. Characteristics of a “Professional”
   b. Being yelled at
   c. Scapegoating
   d. Gossip and Rumors

e. Humiliation
f. Sabotage
g. Non-verbal intimidation
h. Exclusion from activities

VIII. Role-playing practice

Appendix E

Role-playing Scenarios and Responses

Scenario 1: Being yelled at in front of others

You were in a patient's room for an extended period of time because the client was severely incontinent of stool and needed to have his pressure ulcer dressing changed because it was soiled. As you were finishing that, the IV pump started malfunctioning and it took several minutes to discover the problem. You are standing in the hallway trying to catch up on your charting when one of your coworkers, Susan, storms towards you and starts yelling in a loud voice, "HOW DARE YOU HIDE OUT IN A PATIENT'S ROOM FOR THAT LONG. I HAD TO GIVE PAIN MEDS TO THE GUY IN ROOM 12 BECAUSE YOU CAN'T GET YOUR WORK DONE FAST ENOUGH TO MEET EVERYONE'S NEEDS". The whole hallway has gone dead silent. How do you respond?

Response 1: "I do not appreciate being yelled at in front of other people. If there is something you would like to discuss with me please ask me to step into a private area with you." Or "This is not the place to discuss this. Let us go to a more private space to continue this conversation."

Scenario 2: Scapegoating

One night one of the patients you are assigned to care for experiences a code. After the code is over, you follow your unit's procedures by taking the code cart to the utility room and notifying the unit secretary to call the appropriate personnel to restock it. A little while later a well meaning nurses' aide who is new to your floor removes the code cart from the utility room and places it in its designated spot on the unit. At change of shift, the two charge nurses who are responsible for verifying the card is fully stocked fail to look it over completely and just sign the tracking sheet. Later that day, another patient on the unit experiences a code and the cart is missing many important items. Afterwards, one of the nurses makes sure to tell everyone that you were the last person to use it and so it is your fault it was empty. You hear about this when you report to work the next night.

Response 2: "I do not think you have the correct information. Can we talk about what happened?" or "That is not correct."

Scenario 3: Being the subject of gossip or rumors

You are in the supply room when you overhear two co-workers talking about you. One says, "I heard he barely passed nursing school and they only hired him here because they needed another guy to make us diverse".

Response 3: "I do not appreciate you talking about me in such a manner. If there is something you feel we need to talk about please come speak directly with me."

Scenario 4: Being humiliated

Your hospital pharmacy recently changed vendors for their IV antibiotics and you were off the day the new packaging was demonstrated. You are unable to understand the directions for administering the medication that are hanging up in the med room, so you go into the hallway to ask a coworker for help. Three nurses are standing at the nurses' desk and you ask the group for help. One of the nurses starts laughing and says, "You are so dumb. Didn't they teach you anything in nursing school? How did you ever make it here if you can't even hang a simple antibiotic." One of the other nurses begins giggling too while the third one looks at the bulletin board behind the desk.

Response 4: "I learn best from people who provide clear instructions. Could we please try to set up this type of learning situation when I ask for assistance?"

Scenario 5: Being sabotaged or having important information withheld

While you are in a patient's room the attending physician for one of your other clients calls the nurses' station. This physician is coming in to perform a lumbar puncture on your client and asks that you have everything ready as the physician is running late to another appointment. Your coworker does not relay the information to you and you are unprepared when the physician arrives on the floor.

Response 5: "I understand you took the phone call from Dr. Smith and did not relay her wishes to me. Could we meet in private to discuss what happened?"

Scenario 6: Non-verbal intimidation

You are assigned to care for a client who is morbidly obese and requires full assistance to change position in bed. You ask another nurse on your unit to assist you with rolling the client so you can assess the skin on her back. The nurse rolls his eyes and walks away as if he didn't hear you.

Response 6: "I get the sense there is something you would like to say to me. It is okay to say it".

Scenario 7: Being excluded from conversations and activities

You have been working on your unit for over three months and you have been feeling as if conversations stop when you walk into the room. Yesterday you were attending a unit committee meeting and afterwards the entire committee went out to lunch without inviting you.

Response 7: "I feel as if I am not being included in activities that happen on the unit. Can we talk about this?" or "I feels as though everyone stops talking whenever I am around. Can we discuss why I feel this way?"

Appendix F

Focus Group Structured Interview

Purpose	Sample Queries	Approximate Time Allotment
Introductory Comments	Welcome Overview of purpose and process Ground rules	2-3 minutes
Opening question: introduce commonalities among group members	"Let's start with introductions. Would you please begin by telling us your first name and what unit you work on."	3-5 minutes
Introductory questions: begins focus, reflect and connect with topic	"Thank you. I would like to begin by having you recall any experiences you have had with bullying, harassment, and horizontal violence since we last met in September. Could you please describe them for us and please refrain from using names of individuals if at all possible."	7-10 minutes
Transition questions: move toward key issues; tightens focus	"Thank you for sharing those. Think for a moment about the encounters you just described and your decision to use or not use the responses we discussed in September. We will begin first by discussing those instances where you did respond to the uncivil behavior. Please explain the factors that were involved in your decision to respond to the behavior."	5-10 minutes
Key Questions: hone in on particular issues; full discussion; use probes to get details	"Thank you. I'd like to learn more about the experiences you have just described. • How well do you feel the strategies worked?" • Please tell me more about your feelings and perceptions about the instances we have been discussing. What feelings can you relate to the experience?" • How did others around you react when you addressed the behavior?" • Was there a difference in the response of those who were being uncivil and those who were bystanders?" • Tell me about the quality of your work environment since this instance." "Now I'd like to return to those scenarios where you could have used the responses but didn't. What factors influenced your decision?"	20-30 minutes

Ending: Provide closure opportunity for last comments or reflection	"Thank you for helping me to better understand your experiences with responding to bullying, harassment, and horizontal violence in the workplace. Would anyone like to add anything else?"	3-5 minutes
Closing	Thank participants; select name for gift card incentive	

Appendix G

Letters of Support

DATE: April 23, 2015

TO: DNP Program Coordinator, Penn State College of Nursing

FROM: Victoria Schirm, PhD, RN
Director of Nursing Research
Penn State Hershey Medical Center

SUBJECT: Jenn Barton—Support of DNP Project

This memo is written in support of Jenn Barton's Doctor of Nursing Practice capstone project that she will carry out at Penn State Hershey Medical Center. Jenn will be working directly with Dr. Mary Lou Kanaskie who will assist her in seeking participants for her study. Jenn has shared with me the abstract for her project. I will be happy to provide advice and consultation as appropriate in order for Jenn to successfully complete her work at Penn State Hershey Medical Center.

Sincerely,

Victoria Schirm

Victoria Schirm, PhD, RN
Director of Nursing Research
Penn State Hershey Medical Center
ASB 5302A, Mail Code A535
Hershey, PA 17033-0855
Phone: 717-531-4289

Cc: Mary Lou Kanaskie, PhD, RN-BC, AOCN

PENNSTATE HERSHEY
Milton S. Hershey Medical Center

PENNSTATE HERSHEY
Nursing

DNP Program Coordinator
College of Nursing
Pennsylvania State University

April 24, 2015

Dear DNP Program Coordinator:

I am writing in support of Jennifer Barton's Doctor of Nursing Practice capstone project that she will carry out at the Penn State Hershey Medical Center.

I will provide assistance to Ms. Barton in identifying potential subjects for her study and will provide additional resources as needed for her to successfully complete her work at Penn State Hershey Medical Center.

Sincerely,

Mary Louise Kanaskie

Mary Louise Kanaskie, PhD, RN-BC, AOCN®
Nurse Educator / Nurse Residency Coordinator
Nursing Education and Professional Development

Penn State Milton S. Hershey Medical Center
Nursing Education and Professional Development, Mail Code H102, 500 University Drive, P.O. Box 850, Hershey, PA 17033-0850
Tel: 717-531-8348 • mkanaskie@hmc.psu.edu

References

American Nurses Association Bullying and Workplace Violence website. (n.d.). http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/bullyingworkplaceviolence

American Nurses Association. (Cartographer). (n.d.). Bullying Tip Card []. : .

American Nurses Association. (2015a). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: Author.

American Nurses Association Professional Issues Panel on Incivility, Bullying, and Workplace Violence. (2015b, July 22). *Position statement on incivility, bullying, and workplace violence*. Retrieved from http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Nurse/bullyingworkplaceviolence/Incivility-Bullying-and-Workplace-Violence.html

Anderson, L. M., & Pearson, C. M. (1999). Tit for Tat? The spiraling effect of incivility in the workplace. *Academy of Management Review*, *24*(3), 452-471.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.

Berry, P. A., Gordon, L. G., Gates, D., & Schafer, J. (2012). Novice nurse productivity following workplace bullying. *Journal of Nursing Scholarship*, *44*(1), 80-87. http://dx.doi.org/10.1111/j.1547-5069.2011.01436.x

Budin, W. C., Brewer, C. S., Chao, Y., & Kovner, C. (2013). Verbal abuse from nurse colleagues and work environment of early career registered nurses. *Journal of Nursing Scholarship*, *45*(3), 308-316. http://dx.doi.org/10.1111/jnu.12033

Clark, C. (2013). *Creating and sustaining civility in nursing education*. Indianapolis, IN: Sigma Theta Tau International Publishing.

Clendon, J., & Walker, L. (2012). Being young: A qualitative study of younger nurses experiences in the workplace. *International Nursing Review*, *59*, 555-561.

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. http://dx.doi.org/10.3928/00220124-20140724-15

Dellasega, C., Volpe, R. L., Edmondson, C., & Hopkins, M. (2014). An exploration of relational aggression in the nursing workplace. *Journal of Nursing Administration*, *44*(4), 212-218. http://dx.doi.org/10.1097/NNA.0000000000000052

Embree, J. L., Bruner, D. A., & White, A. (*2013*). Raising the level of awareness or nurse-to-nurse lateral violence in a critical access hospital. *Nursing Research and Practice*, 2013, 1-7. http://dx.doi.org/10.1155/2013/207306

Farrell, G. A., & Shafiei, T. (2012). Workplace aggression, including bullying in nursing and midwifery: A descriptive study (the SWAB study). *International Journal of Nursing Studies*, *49*, 1423-1431. http://dx.doi.org/10.1016/j.nurstu.2012.06.007

Graneheim, U. H. & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*, 105-112. http://dx.doi.org/1 0.1016/j.nedt.2003.10.001

Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *Journal of Continuing Education in Nursing*, *35*(6), 257-63.

Huntington, A., Gimour, J., Tuckett, A., Neville, S., Wilson, D., & Turner, C. (2011). Is anybody listening? A qualitative study of nurses' reflections on practice. *Journal of Clinical Nursing*, 20, 1413-1422. http://dx.doi.org/10.1111/j.1365-2702.2010.03602.x

Jones, C., & Gates, M. (2007, September 30). The costs and benefits of nurse turnover: A business case for nurse retention. *OJIN: The Online Journal of Issues in Nursing*, *12*(3). http://dx.doi.org/10.3912/OJIN.Vol12No03Man04

Kivimaki, M., Elovainio, M., & Vahtera, J. (2000). Workplace bullying and sickness absence in hospital staff. *Occupational and Environmental Medicine*, *57*(10), 656-660.

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), 15-24. http://dx.doi.org/10.3928/00220124-20141224-01

Laschinger, H. K., Finegan, J., & Wilk, P. (2009). New graduate burnout: The impact of professional practice environment, workplace civility, and empowerment. *Nursing Economic*$, *27*(6), 377-383.

Laschinger, H. K., Grau, A. L., Finegan, J., & Wilk, P. (2010). New graduate nurses' experiences of bullying and burnout in hospital settings. *Journal of Advanced Nursing*, *66*(12), 2732-2742. http://dx.doi.org/10.1111/j.1365-2648.2010.05420.x

Leiter, M. P., Price, S. L., & Laschinger, H. K. (2010). Generational differences in distress, attitudes and incivility among nurses. *Journal of Nursing Management*, *18*, 970-980.

Lewis, P. S., & Malecha, A. (2011). The impact of workplace incivility on the work environment, manager skill, and productivity. *Journal of Nursing Administration*, *41*(1), 41-47. http://dx.doi.org/10.1097/NNA.0b013e3182002a4c

Maddalena, V., Kearney, A. J., & Adams, L. (2012). Quality of work life of novice nurses: A qualitative exploration. *Journal for Nurses in Staff Development*, *28*(2), 74-79. http://dx.doi.org/10.1097/NND.0b013e31824b41a1

Namie, G. (2013). *2013 WBI survey: Bullying by industry*. Retrieved from Workplace Bullying Institute: http://www.workplacebullying.org/multi/pdf/WBI-2013-Industry.pdf

Nikstaitis, T., & Simko, L. C. (2014). Incivility among intensive care nurses. *Dimensions of Critical Care Nursing*, *33*(5), 293-301. http://dx.doi.org/10.1097/DCC.0000000000000061

Oyeleye, O., Hanson, P., O'Connor, N., & Dunn, D. (2013). Relationship of workplace incivility, stress, and burnout on nurses' turnover intentions and psychological empowerment. *Journal of Nursing Administration*, *43*(10), 536-542. http://dx.doi.org/10.1097/NNA.0b013e3182a3e8c9

Sellers, K. F., Millenback, L., Ward, K., & Scribani, M. (2012). The degree of horizontal violence in RNs practicing in New York state. *Journal of Nursing Administration*, *42*(10), 483-487. http://dx.doi.org/10.1097/NNA.0b013e31826a208f

Simons, S. (2008). Workplace bullying experienced by Massachusetts registered nurses and the relationship to intention to leave the organization. *Advances in Nursing Science*, *31*(2), E48-E59.

Simons, S. R., & Mawn, B. (2010). Bullying in the workplace: A qualitative study of newly licensed registered nurses. *American Association of Occupational Health Nurses Journal*, *58*(7), 305-311. http://dx.doi.org/10.3928/08910162-20100616-02

Smith, L. M., Andrusyszyn, M. A., & Laschinger, H. K. (2010). Effects of workplace incivility and empowerment on newly-graduated nurses' organizational commitment. *Journal of*

Nursing Management, *18*, 1004-1015. http://dx.doi.org/10.1111/j.1365-2834-2010.01165.x

Stagg, S. J., Sheridan, D. J., Jones, R. A., & Speroni, K. G. (2013). Workplace bullying: The effectiveness of a workplace program. *Workplace Health & Safety*, *61*(8), 333-338. http://dx.doi.org/10.3928/21650799-20130716-03

Stagg, S. J., Sheridan, D., Jones, R. A., & Speroni, K. G. (2011). Evaluation of a workplace bullying cognitive rehearsal program in a hospital setting. *The Journal of Continuing Education in Nursing*, *42*(9), 395-401. http://dx.doi.org/10.3928/00220124-20110823-45

The Joint Commission. (2008). *Behaviors that undermine a culture of safety* [Sentinel Event Alert]. Retrieved from http://www.jointcommission.org/assets/1/18/SEA_40.PDF

The Joint Commission. (2012). *Improving patient and worker safety: Opportunities for synergy, collaboration, and innovation*. Oakbrook Terrace, IL: The Joint Commission.

The Joint Commission website. (2015). http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx

Vessey, J. A., DeMarco, R., & DiFazio, R. (2010). Bullying, harassment, and horizontal violence in the nursing workforce: The state of the science. *Annual Review of Nursing Research*, *28*, 133-157. http://dx.doi.org/10.1891/0739-6686.28.133

Vessey, J. A., DeMarco, R. F., Gaffney, D. A., & Budin, W. C. (2009). Bullying of staff registered nurses in the workplace: A preliminary study for developing personal and organizational strategies for the transformation of hostile to healthy workplace environments. *Journal of Professional Nursing*, *25*(5), 299-306. http://dx.doi.org/10.1016/j.profnurs.2009.01.022

Vogelpohl, D. A., Rice, S. K., Edwards, M. E., & Bork, C. E. (2013). New graduate nurses' perceptions of the workplace: Have they experienced bullying. *Journal of Professional Nursing*, *29*(6), 414-422. http://dx.doi.org/10.1016/j.profnurs.2012.10.008

Wilson, B. L., Diedrich, A., Phelps, C. L., & Choi, M. (2011). Bullies at work: The impact of horizontal hostility in the hospital setting and intent to leave. *Journal of Nursing Administration*, *41*(11), 453-458. http://dx.doi.org/10.1097/NNA.0b013e3182346e90