Successful Implementation of Policies Addressing Lateral Violence

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ABSTRACT

Lateral violence is a problem in nursing despite policies addressing the issue, which suggests that implementation of these policies may be ineffective. We used an evidence-based approach to locate and appraise evidence about effectively implementing lateral violence policies. Our search strategy emphasized preappraised evidence, and we found 12 sources that met our inclusion criteria. Most evidence was from low-level sources, which is not surprising due to the subjective and sensitive nature of this topic. The evidence did not indicate that there is consistent, effective implementation of lateral violence policies. The appraised evidence suggests the importance of collaboratively prepared implementation strategies. Administrator involvement and relationships with staff members and the presence of a commitment to positive behavior change before lateral violence incidents occur are factors that can lead to successful implementation of lateral violence policies. *AORN J* 97 (January 2013) 101-109. © AORN, Inc, 2013. http://dx.doi.org/10.1016/j.aorn.2012.09.010

Key words: lateral violence, policy implementation.

Lateral violence is unacceptable, disruptive, and inappropriate behavior.¹ In the clinical setting, lateral violence involves nurses either openly or secretly directing their dissatisfaction with the work setting at nurses of equal or lower levels within an organization.²⁻⁵ Lateral violence includes many low-level types of hostile behavior, including backstabbing, bullying, failing to respect privacy, infighting, using innuendo, ostracizing, sabotaging, making verbal affronts, and withholding information. Lateral violence causes dissatisfaction among personnel because it can result in poor communication, poor patient care, and increased staff turnover.²⁻⁵

Decreasing the incidence of lateral violence is beneficial to all members of the OR team as well to their employers. The benefits include less dissatisfaction in workplace culture and should lead to improvement in communication, less staff turnover, and better patient care. Disruptive behavior by any member of the group affects the whole group, such as an OR nursing team.²⁻⁵

Evidence of lateral violence is abundant in the nursing workforce. In one survey conducted in the
southeastern United States, 93% of nurses admitted to witnessing lateral violence, and 85% reported feeling that they had been victims. Results of that survey also indicated that experienced nurses are often the perpetrators, novice nurses are the most likely victims, and lateral violence is often ignored by administrators. Violent behavior in the workplace affects the organization through decreased employee productivity, employee turnover, and increased sick time.

The earliest mention of lateral violence in the literature is Freire’s oppressed group model. Lateral violence, which he termed “horizontal violence,” is one of the five dimensions described in this model. Although Freire’s model appears to accurately describe this behavior, a review by Matheson and Bobay did not reveal studies validating the model. However, these researchers described studies that examined dimensions of Freire’s model, including lateral violence. These included two studies that examined lateral violence among OR nurses. Supporters of Freire’s model believe that nurses are a traditionally oppressed group that has been rendered powerless by the medical establishment. Since the publication of Freire’s model, the problem has been extensively mentioned in the literature.

In 2006, the Joint Commission on Accreditation of Healthcare Organizations (now The Joint Commission) set a leadership standard that applies to all health care providers. This standard includes a mandate that agencies recognize and correct behaviors that are inappropriate and disruptive.

One of the authors of this article frequently observed lateral violence among OR personnel despite a facility-wide policy designed to address this problem. Thus, we decided to conduct a literature review to locate and appraise evidence about effectively implementing lateral violence policies. The clinical question guiding this review was: In the OR setting, how can a lateral violence policy be implemented to best decrease the incidence of lateral violence among personnel?

PICO
The PICO—patient or population, intervention, comparison, outcome—format is used extensively in evidence-based practice to guide the search for the current best evidence to address a problem. The PICO components guiding the search for evidence for this review were

- **Population**: OR personnel, including perpetrators and victims of such abuse.
- **Intervention**: Implementation of a lateral violence policy.
- **Comparison intervention**: We did not use a comparison because we focused the search on the most effective implementation methods.
- **Outcome**: Decrease in the incidence of lateral violence among OR personnel.

Improved scores on job satisfaction surveys and a decrease in total personnel turnover one year after the strategies are implemented are two possible measures of this outcome. Other measures include qualitative, anecdotal comments on staff surveys and random questionnaires completed by the stakeholders, such as patients and surgeons, that describe the OR personnel as a more cohesive group.

SEARCH STRATEGY
We gathered evidence by using online literature searches (1990-present), an ancestry approach, and informal networking. We examined PubMed®, Google Scholar™, and The Joint Commission material for evidence. We examined each source’s reference list for additional sources. We were also able to find sources by networking informally with experts in hospital personnel management who helped identify published and nonpublished works.

We used the following keywords and keyword strings, alone and in combination:

- **lateral violence**,
- **horizontal violence**,
- **nursing violence**,
- **policy implementation in hospitals**,
- **nursing**.
We included full-text, English sources in our search. Because of the potential for knowledge transfer, we considered evidence examining general implementation of policies (policies other than those regarding lateral violence). We took advantage of preappraised evidence and generally did not appraise studies individually if they were part of an included systematic review. However, we separately appraised one study that was included in a narrative review. None of our evidence sources were included in more than one systematic review.

CRITICAL APPRAISAL OF THE LITERATURE

Twelve evidence sources1,4,13,14,16,17-23 met our inclusion criteria: two systematic reviews,1,19 one randomized clinical trial,20 two qualitative studies,4,16 one mixed method quantitative/qualitative descriptive study,13 four narrative reviews,18,21-23 one clinical practice guideline,14 and one expert opinion from a book chapter.17 Our sources are summarized in Table 1. Most of the studies focused on staff nurses, however, nursing students were the subject of one study.4 Various qualitative research methods were used.24 Interviews were used in six of the sources,4,13,16,21-23 field observation was used in three,17,18,20 and three used document analysis.1,14,19 Because of the nature of the subject, the lack of randomized clinical trials is not surprising.

Both systematic reviews used comprehensive search strategies.1,19 The large number of evidence sources—18 in one and 29 in the other—made these reviews strong. One systematic review used one expert to appraise the evidence,1 whereas the other used two experts.19 They did not use a common approach in reporting interventions and potentially confounding factors. Neither review provided detailed inclusion or exclusion criteria, the criteria and methods used in the studies varied considerably, and interventions were frequently classed differently in different studies.1,19

The randomized controlled trial used a factorial design and provided useful information that linked education of nurses on the assessment and management of urinary incontinence to patient outcomes. Its strengths included concealed randomization and blinding of researchers and data collectors to participant allocation. However, the trial’s sample sizes fell short because of attrition. Also, because there was not a no-intervention control arm in the randomized clinical trial, it was unclear to what extent educational materials improved care relative to the second group when using audit and feedback (ie, the nurses received a summary of their clinical performance).20

The mixed qualitative/quantitative study13 and two qualitative4,16 studies used several sources for data, including direct participant field observation, individual interviews, and group interviews. This diversity of sources is a strength because it allowed the researchers to investigate how participants describe and explain workplace violence issues. This diversity of sources also allowed the researchers to observe behavioral changes. A potential weakness of this type of research is the possibility that observation and interviews by the researchers will affect the actions of the respondents.24 Another weakness of these studies is the possibility that the convenience sample did not represent the population from which it was drawn.4,13,16

The four narrative sources provided traditional reviews of lateral violence. These evidence sources offered background information on lateral violence behaviors and included findings from researcher observations18 and interviews.21-23 The main weakness of these narrative reviews is the potential for researcher bias.

The clinical practice guideline14 and expert opinion17 were both from recognized authorities in policy implementation. Clinical practice guidelines can help reflect national standards and minimize the task of policy formulation.25

When examining evidence relating to behavior, such as lateral violence, we found that there are subjective responses that are not observed in less-emotional clinical topics, such as examining
<table>
<thead>
<tr>
<th>Evidence source</th>
<th>Evidence type</th>
<th>N</th>
<th>Major findings/author recommendations/comments</th>
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<tbody>
<tr>
<td>Anderson et al(^{18}) (2009)</td>
<td>Narrative review</td>
<td>Not applicable (NA)</td>
<td>A “best practice council” is effective to legislate and standardize practice change based on evidence.</td>
</tr>
<tr>
<td>Bero et al(^{19}) (1998)</td>
<td>Systematic review</td>
<td>18 evidence sources (primary care settings)</td>
<td>Specific strategies to implement research-based recommendations are necessary to ensure practices change.</td>
</tr>
<tr>
<td>Cheater et al(^{20}) (2006)</td>
<td>Randomized clinical trial</td>
<td>194 community nurses</td>
<td>Multilevel logistic models showed that, although the odds ratios for improvement are more consistently positive for educational outreach than for audit and feedback, they are not statistically significant. Odds ratios for self-rated health: audit and feedback 0.81 (95% confidence interval 0.52–1.24); educational outreach: 1.33 (95% confidence interval 0.86–2.05)</td>
</tr>
<tr>
<td>Dopson et al(^{21}) (2002)</td>
<td>Narrative review</td>
<td>NA</td>
<td>Administrators must engage clinicians in professional communities and social networks to effectively implement research evidence into practice.</td>
</tr>
<tr>
<td>Henderson(^{16}) (2003)</td>
<td>Qualitative study</td>
<td>30 nurses</td>
<td>Verbal abuse reporting guidelines must be developed and disseminated. Perception among clinical nurses is there is a lack of follow-up by administrators.</td>
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<td>Hutton(^{1}) (2006)</td>
<td>Systematic review</td>
<td>5,182 nurses (29 studies)</td>
<td>Interventions tailored to the situation and environment related to significant reduction in the number of incivility incidents ((P &lt; .0006)). Interventions worked when 1. No group was singled out 2. Everyone took part of the blame for the problem 3. Groups within the hospital felt empowered by assuming they had the ability to deal with incivility issues</td>
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<td>Joint Commission Resources(^{14}) (2006)</td>
<td>Clinical practice guideline</td>
<td>NA</td>
<td>Administrators must be determined about enforcement and be involved for policies to work.</td>
</tr>
<tr>
<td>Randle(^{4}) (2003)</td>
<td>Qualitative study</td>
<td>56 nursing students</td>
<td>Bullying will only change if nurses and educators transform practice and the context in which bullying occurs.</td>
</tr>
<tr>
<td>Stanley(^{13}) (2007)</td>
<td>Mixed method quantitative/qualitative descriptive study</td>
<td>663 nurses</td>
<td>Involvement by chief nurse executives cannot be underestimated in the successful elimination and prevention of lateral violence—leaders must be committed to maintaining standards.</td>
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techniques for testing blood glucose levels. Recognizing the importance of implementing the results of sound research and the problems of generalizing across different health care settings, there are relatively few studies that specifically address perioperative nursing interventions to change behaviors. It may not be valid to generalize these findings to other nurses because of the organization of health care systems, barriers to change, and societal values and cultures.19

Common methodological problems in the literature included the failure to adequately report criteria for selecting participants included in the evidence sources, the failure to take steps to avoid bias in the selection of participants, and the lack of or failure to adequately report criteria to assess the reliability and validity of the data. Inconsistencies in the research methods and a lack of longitudinal data have limited the evidence in nursing with respect to lateral violence. Some sources used instruments that measure selected aspects of lateral violence, such as verbal abuse and sabotage. Some did not focus specifically on nurse-to-nurse behavior, and others used qualitative methodologies that are difficult to replicate in large health care institutions.13

DISCUSSION
Overall, the evidence somewhat supported the following interventions for successfully implementing a lateral violence policy:

- changing behavior in ways that encourage a culture that supports lateral violence policies19;
- involving nursing administration with nursing personnel frequently and consistently, including in matters relating to lateral violence4,13,14,22;
- intentionally changing policy and the environment1,18,21; and
- implementing multiple interventions simultaneously that may not be effective when used alone.19

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<tr>
<td>Stanley and Martin22 (2008)</td>
<td>Narrative review</td>
<td>NA</td>
<td>The role of the nurse manager in preventing lateral violence was confirmed.</td>
</tr>
<tr>
<td>Thomas17 (2007)</td>
<td>Expert opinion</td>
<td>NA</td>
<td>Incorporating evidence-based research into an organization’s policies and procedures can help change practice.</td>
</tr>
<tr>
<td>Woelfle and McCaffrey23 (2007)</td>
<td>Narrative review</td>
<td>5 evidence sources including 1 study surveying OR nurses</td>
<td>Inappropriate and unprofessional behaviors are common in the perioperative environment. The authors did not describe a search strategy. There is a lack of support from managers to staff nurses. Cognitive rehearsal techniques may be effective in protecting against the negative effects of lateral violence. Managers and their staff members need to be educated in recognizing lateral violence behaviors and knowing how to take appropriate action.</td>
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CHANGING BEHAVIOR

One way to change behavior is to demonstrate that feedback, both from administrators to staff and from staff to administrators, serves as a stimulus for improvement. Those who view feedback as threatening and demotivating are often less convinced of the need to change. The atmosphere for giving and receiving feedback must be mutually respectful and nonthreatening.

Another way to change behavior is to educate. Lateral violence education strengthens coping skills for nurses who deal with disruptive behavior. Nursing students witness bullying and are bullied by staff nurses. New nurses reported that they were afraid to ask questions of more experienced nurses because of the generalized climate of workplace bullying. This type of situation could lead to these inexperienced nurses making mistakes. Nursing education should include instruction on how to deal with lateral violence.

One evidence source described a study in which researchers showed cognitive rehearsal to be an effective educational method to address lateral violence. Twenty-six new nurses were instructed on aspects of lateral violence as part of their orientation at a large hospital. In addition, participants rehearsed responses to 10 common forms of lateral violence and were given a laminated card with responses to lateral violence scenarios. One year after the training, these nurses participated in focus groups in which they were asked open-ended questions about lateral violence and the effect of their training, including the rehearsal. More than 95% of the participants reported that they saw lateral violence occur on a variety of nursing units, and approximately half said the lateral violence was directed at them. Surprisingly, 100% of the participants said they confronted the perpetrator and that the lateral violence stopped. All of the participants indicated that the rehearsed responses and those on the laminated card helped, and all but one said that all hospital nurses should be educated about lateral violence.

ADMINISTRATOR INVOLVEMENT

Executive management plays a key role in addressing the issue of disruptive behavior. In a survey of more than 600 nurses in southeastern United States, the investigator reported that the largest number of open-ended comments indicated that respondents observed that ineffective leadership worsens lateral violence. Staff members reported resentment when managers attempted to start a relationship with them only after there is an occurrence of lateral violence. The staff members must perceive administrators as actively participating in daily activities in the workplace for a lateral violence policy to be effective. Managerial leadership aimed at improving the quality of the work environment sends a message to the staff that the leaders are committed to maintaining certain standards. Managerial leadership aimed at improving the quality of the work environment sends a message to the staff that the leaders are committed to maintaining certain standards. This was one of the strategies used for lateral violence policy implementation specifically in an ambulatory surgery center.

POLICY AND ENVIRONMENTAL CHANGE

The evidence emphasized the importance of the workplace culture. One source stated that, for managers to effect positive change, they must engage clinicians in these professional communities and social networks. Individuals and groups involved in setting clinical policy are part of a
highly complex network of social relationships that affect their practice. While working together, the teams develop relational skills that improve patient care through better communication.1,18,21

The structure provided by the evidence-based practice model used by St Luke’s Episcopal Hospital in Houston, Texas, gave a consistent roadmap for dealing with areas identified with performance improvement.18 This model guided the replacement of the traditional “nursing quality council” with a “best practice council” to legislate and standardize practice change across the hospital by using evidence of best practice, which was documented in the narrative review as an effective method of policy implementation.18 These policies may include those that address lateral violence. The success of professional communities can be attributed to clear directions, an aggressive timeline, interventions specific to the situation and environment, and to the short-term commitment required of the participants.1,18,21

IMPLEMENTING MULTIPLE INTERVENTIONS

Some interventions (ie, audit and feedback, local consensus processes, marketing, reminders) may not be effective when used alone but may be effective when used in combination.19 For example, in a randomized clinical trial involving 194 nurses, the odds ratio for improvement was consistently more positive for educational outreach than for audit and feedback, but the results were not statistically significant.20 However, the use of these interventions together appears promising.

Audit and feedback is a measuring performance of clinicians (such as in terms of patient outcomes) over a specific period of time and reporting that performance to the clinicians.27 This usually is a summary of clinical performance but can also include a summary of interpersonal performance. Audit and feedback must be done with the attitude that the information will be used for improvement and not punishment. The local consensus process includes involving local health care professionals when deciding the approach to clinical problems. Administrators play a key role in marketing the institution’s commitment to decrease lateral violence to the nursing staff members.

INEFFECTIVE METHODS

Some strategies for policy implementation were not supported by the evidence. Zero tolerance policies and passive dissemination of information are not likely to promote implementation of lateral violence policies.16 Policy makers are abandoning the concept of relying solely on zero tolerance policies. The focus is now on prevention in the form of the development of best practices in the areas of anticipating violent incidents, de-escalation techniques, and improved training in how to manage incidents when they occur.16

Passive dissemination of information was generally ineffective in altering practices, regardless of the importance of the policy subject matter.6 Policy makers are intensifying their focus on development of best practices to manage lateral violence incidents when these incidents occur. Better use of empathetic communication, active listening, and improved assessment techniques regarding people’s emotional responses to the situations in which they find themselves might help defuse many incidents before they occur.16

EVALUATING RESULTS

The evidence suggests that lateral violence policies exist in most facilities only to comply with the standards of accrediting agencies and does not indicate effective implementation of these policies. After the managers at a facility have implemented plans to decrease lateral violence, they should assess the plans’ effectiveness by using several approaches. The Lateral Violence in Nursing Survey can be used to measure lateral violence directly.13 Managers can also measure improvement indirectly by using measures such as a decrease in staff turnover due to attrition3 or improved staff communication and working relationships resulting in fewer patient safety incidents4,13,14 Scores reflecting better job
satisfaction on employee surveys also measure effectiveness. Qualitative changes can include anecdotal comments by stakeholders, such as patients and surgeons, that OR personnel appear to be more cohesive in their social and professional roles.

Effectiveness assessment also can include using unit evaluations and research-related outcome data compiled from employee questionnaires and surveys. Situational evaluations can be used after mandatory staff training sessions and debriefing from lateral violence incidents. Managers can use these results to alter and improve future sessions and to serve as an indicator of effectiveness. We expect that this type of evaluation can identify positive and satisfying lateral violence training sessions that are educational and rewarding, and that benefit both administrators and staff members.

FUTURE RESEARCH

There is insufficient evidence to assess the effectiveness of most interventions such as the usefulness of evidence-based criteria for policy implementation to improve lateral violence behavior. There is minimal evidence-based information available that addresses effective implementation strategies for lateral violence policies. This void in the research leaves managers at a loss for best practice techniques to manage lateral violence behavior and prevent proliferation of toxic work environments.

The evidence from the literature comes mostly from expert opinion and literature reviews. Only two systematic reviews1,19 and one randomized clinical trial20 offered high-level evidence. Future evidence-based lateral violence implementation research needs to be conducted and the results documented in peer-reviewed journals. Future research should specifically address strategies for effective policy implementation to prevent lateral violence behavior. The challenge facing future investigators is to identify the management-level interventions that best result in effective implementation of lateral violence policies.

The ultimate outcome of the effective implementation of a lateral violence policy is the promotion of safer patient care through an improved work culture. This culture includes improved employee job satisfaction, a more cohesive work group, and more effective staff communication, all of which results in an increase in the quality of patient care.4,13,14

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References


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