A Safe Environment for Nurses and Patients: Halting Horizontal Violence

Dianne Ditmer, PhD, RN, CFN, CRM, CMI-III, SANE, DABFN, FACFE

Workplace violence has become a public health problem of epidemic proportion that has implications for health-care providers, regulators, consumers, and society at large. To understand the magnitude of the problem facing nurses today, one must recognize that workplace violence includes not only physical assault but a range of disruptive behaviors, such as intimidation and bullying. These nonphysical disruptive behaviors are called horizontal or lateral violence. This article evaluates the scope and implications of this violence, including its effects on patient safety, quality clinical outcomes, nurse retention, and the nursing profession.

**Scope of Horizontal Violence**

During their working careers, 75% of nurses have experienced aggression, harassment, and intimidation, and 80% have experienced bullying (Hader, 2008; Hutchinson, Wilkes, Jackson, & Vickers, 2010). Landmark research by the Institute for Safe Medication Practices (ISMP, 2004b) revealed intimidating behaviors from physicians are not isolated events: 69% of staff members have felt pressured to complete an unsafe medication order. Considerable evidence shows that such behavior does not occur only amongst nurses and physicians but also with pharmacists, therapists, support staff, and administrators (Rosenstein & O’Daniel, 2005). In 2008, The Joint Commission (TJC) issued a Sentinel Event Alert to hospitals, nursing homes, and other health-care institutions in an effort to combat disruptive workplace behaviors that undermine a culture of safety and threaten quality care to patients (TJC, 2008).

Although boards of nursing (BONs) do not discipline nurses directly for horizontal violence, it can be a contributing factor in BON investigations because it undermines the nurse’s performance and threatens the safety of patients. Regulators also need current information on horizontal violence when they collaborate with Occupational Safety and Health Administration (OSHA), TJC, individual states, and major nursing organizations regarding laws, regulations, and positions related to patient safety. As professional leaders, nurse educators and managers need evidence-based information on the problem, too. Educators must teach nursing students that horizontal violence is serious and must be reported, and nurse managers must deal with the problem daily.

Understandably, nurses find this an unpleasant topic of discussion. After all, most nurses enter the profession because they want to help others, and most do so in accordance with standards. But health-care professionals, including nurses, cannot remain silent. Failing to address horizontal violence indirectly promotes it (Hickson, 2007).

Nurses, both victims and perpetrators of horizontal violence, frequently do not recognize it. Interpersonal conflict can be subtle and is often ingrained in nursing’s organizational culture (Sellers, Millenbach, Kovach, & Yingling, 2009–2010). Nurses also may not recognize or acknowledge the problem because of their status in the workplace, a lack of understanding of the consequences, or a lack of training on handling such behavior (see Table 1). Yet, the frequency of horizontal violence against nurses is significant. Reports indicate that 51.9% of nurses inflict intimidating behaviors on other nurses (Hader, 2008).
Uncivil work environment, resulting in burnout, lack of collegiality, and impeded professional development (Bigony et al., 2009). Nurses who are subjected to considerable stress and frustration begin to have low self-esteem, hold a negative opinion of themselves as nurses and feel inferior to other health-care professionals (Hutchinson, Vickers, Jackson, & Wilkes, 2006). Left unchecked, this environment can lead to a decrease in the quality of patient care, patient dissatisfaction with care, increased errors, and more lawsuits (Rosenstein & O’Daniel, 2005).

Quality Care and Patient Safety
In a hostile environment, quality patient care and safety become compromised. New nurses needing answers about unfamiliar procedures, treatments, or drugs will receive unprofessional answers or criticism instead. Such treatment causes nurses to deliver care without the answers they need (Bigony et al., 2009; Rosenstein & O’Daniel, 2005). TJIC attributes lack of teamwork and ineffective communication to 24% of sentinel events resulting in death, injury, or permanent loss of function (Rosenstein & O’Daniel, 2005).

In a study by Rosenstein and O’Daniel (2005), 94% of 1,474 respondents said disruptive behavior negatively affects patient outcomes. About 60% were aware of an adverse event that resulted from disruptive behavior, and 78% believed the event could have been prevented.

Unstable environments where nurses are subjected to intimidating or threatening behaviors are also associated with patient falls and medication errors (Roche, Diers, Duffield, & Catling-Paull, 2010). All forms of horizontal violence are linked to late administration of medications, and the number of nursing tasks not completed each shift is associated with verbal violence (Bigony et al., 2009; Roche et al., 2010).

Stress and Emotional Distress
The level of distress from psychologically disturbing, inappropriate behaviors was rated as very serious by 57% of seasoned nurses (Stanley, Martin, Michel, Welton, & Nemeth, 2007). The most distressing peer incidents are described as abusive or humiliating comments, rudeness, and inadequate support by managers when a nurse is given too much responsibility (Stanley, Martin, et al., 2007). Belittling, professional humiliation, and failure to acknowledge good work contribute to dissatisfaction and poor psychological health (Hutchinson et al., 2006).

Working in a continually stressful environment can cause anorexia, overeating, hypertension, arrhythmias, gastric problems, headaches, insomnia, and chronic fatigue (Bigony et al., 2009). Long-lasting effects include signs and symptoms of posttraumatic stress disorder, such as anxiety, impaired work performance, depression, substance abuse, and insomnia (Friel, White, & Hull, 2008; Longo & Sherman, 2007).

Recruitment and Retention
Horizontal violence also has serious consequences for the future of the nursing profession. Studies conducted by Longo (2007) and Curtis, Bowen, and Reid (2007) confirm the pervasiveness of horizontal violence among nursing students. More than half reported feeling demeaned by nurses using cruel words and humiliation, talking behind their backs, and showing a lack of respect.

TABLE 1
Code of Silence

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<th>Despite the emotional pain and psychological stress caused by horizontal violence, 50% to 80% of events go unreported (Geig, 2010). New graduates do not report events because they fear retaliation and simply want to fit in (Curtis, Bowen, &amp; Reid, 2007; Longo &amp; Sherman, 2007). Seasoned nurses underreport horizontal violence because the offender is often the immediate supervisor or the nurse does not understand the reporting process (Geig, 2010). A survey on intimidation conducted by the Institute for Safe Medication Practices found that 40% of clinicians have kept quiet or remained passive while witnessing events rather than question the intimidator (Institute for Safe Medication Practices, 2003).</th>
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Roots of Horizontal Violence
Nursing has a tradition of a hierarchical power structure in which novice nurses become the target of victimization. Bullying is perpetrated as part of the socialization of the nursing profession (Sellers et al., 2009–2010; Woelfle & McCaffrey, 2007). Demeaning nursing students often spills over as a rite of passage into the nursing profession. It is common knowledge among seasoned professionals that nurses “eat their young” through intimidation and other such abusive behaviors.

Oppressive behavior related to the perception of being subordinate to a more powerful group affects nurse-physician relationships as well as nursing peer relationships (Roberts, Demarco, & Griffin, 2009). Acts of horizontal violence between experienced nurses often result from the hierarchical system in the nursing profession itself. Nursing specialties, advanced degrees, and certifications are admired and honored among health-care professionals and health-care institutions, and advanced skills and knowledge lead to higher status and often preferential treatment. The resulting inequalities and perceptions regarding varying degrees of importance in the profession can create intercollegial hostility. Critical-care nurses, emergency department nurses, and surgical nurses are often perceived as more valuable than their peers who work in medical units.

Effects of Horizontal Violence
Verbal abuse or other intimidating behaviors can quickly negate teamwork and an organizational culture of benevolence. Uncaring, unprofessional behavior can create an unsatisfying, uncivil work environment, resulting in burnout, lack of collegiality, and impeded professional development (Bigony et al., 2009). Nurses who are subjected to considerable stress and frustration begin to have low self-esteem, hold a negative opinion of themselves as nurses and feel inferior to other health-care professionals (Hutchinson, Vickers, Jackson, & Wilkes, 2006). Left unchecked, this environment can lead to a decrease in the quality of patient care, patient dissatisfaction with care, increased errors, and more lawsuits (Rosenstein & O’Daniel, 2005).
respect. Gradually, the lack of respect undermined the students’ self-confidence, resulting in a feeling of powerlessness.

About 90% of nursing students said these experiences influence their future career and employment choices. They identified positive characteristics of the work environment, such as feeling supported and valued, as critical to their decisions regarding where they will work. This sample of students reported their intention to avoid specific facilities, nursing units, and specialty areas based on observed interactions and personal encounters during their clinical experiences (Curtis, Bowen, & Reid, 2007). Thus, having a reputation as a negative practice environment makes recruitment difficult.

New nurses too often are targets of unethical and unprofessional behavior, and 60% leave their first position within 6 months (Stanley, Dulaney, & Martin, 2007). According to early research by McKenna, Smith, Poole, and Coverdale (2003), 34% of nurses in the study group considered leaving nursing, and 14% required days off to recover from distress and physical symptoms.

Frustration, disillusionment, and burnout cause seasoned nurses to abandon their career, with 14% of nurses reporting horizontal violence as a major factor in their decision to leave the nursing profession (Bigony et al., 2009; Roche et al., 2010; Stanley, Martin, et al., 2007).

Financial Implications

According to data from the seminal work of the Bureau of Labor Statistics (National Institute for Occupational Safety and Health [NIOSH], 1999), staff members exposed to stressful environments take an additional 20 sick days per year, and health-care expenses average 50% more for staff who work in psychologically unhealthy, stressful environments (NIOSH, 1999).

Depending on the geographic location and specialty area, the turnover cost for one nurse can be as high as $145,000 (Bigony et al., 2009; Wojick et al., 2005 [as cited by Stanley, Dulaney, et al., 2007]). Based on a nursing turnover cost calculation, the cost of turnover in 2007 was $88,000 for a new nurse and $82,000 for an experienced nurse (Jones, 2008).

Seminal work conducted by the St. Paul Fire and Marine Insurance Company (as cited by NIOSH, 1999) indicates that stress in the hospital environment leads to nursing malpractice and lawsuits. When hospitals implemented stress-prevention activities, medication errors declined by 50%, and malpractice claims declined by 70%.

**Duty to Stop Horizontal Violence**

All nurses have a duty to comply with appropriate standards of care, regulatory guidelines, and ethical codes of conduct. In situations involving workplace horizontal violence, nurses must be aware of the rights of patients and coworkers and the practice standards that govern their decision-making process.

**Table 2**

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<th>Joint Commission Requirements on Safety in the Workplace</th>
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<td>The Joint Commission addresses specific requirements for hospitals to maintain a safe environment (Joint Commission Resources [JCR], 2010). The environment of care has three components: the physical plant, equipment and, most importantly, people. Effective management of the key components includes developing policies and procedures that reduce and control physical hazards and risks, prevent accidents and injuries, and maintain safe conditions for patients, staff, and others.</td>
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According to The Joint Commission Standard EC.02.01.01 (JCR, 2010), hospitals are required to maintain a safe environment by creating and maintaining a culture of safety. Regular environmental assessment of hazards and unsafe practices is essential. Hospitals are required to continuously evaluate current procedures for managing patient, public, and staff safety.

Nursing leaders are required to create and maintain a culture of safety under Standard LD. 03.01.01. Elements of performance include the development of a code of conduct that defines acceptable and inappropriate behaviors and implementation of a process for managing disruptive behaviors.

Health-care institutions and nursing leaders have moral, ethical, and legal obligations to provide a safe workplace and a duty to report horizontal violence (see Table 2). TJC’s Sentinel Event Alert of July 2008 captures the importance of recognition and standardized accounting as the first steps to preventing violence (TJC, 2008). The significance of events is often minimized or unrecognized, resulting in underreporting, with only 256 sentinel events involving violence being reported since 1995 (TJC, 2010a). Nursing leaders must not only acknowledge the potential for violence among staff but also document and report every incident.

**Employers**

According to the Guidelines for Preventing Workplace Violence for Health-Care and Social Service Workers (Occupational Safety and Health Administration [OSHA], 2003), the Occupational Safety and Health Act of 1970 (PL. 91596, amended by PL. 101-552, Section 3101) mandates, “... in addition to compliance with hazard-specific standards, all employers have a general duty to provide their employees with a safe workplace environment.”

Court cases reviewed by Erdmann (2009), Harthill (2008), and Viollis, Roper, and Decker (2005) indicate that employers have a legal duty to provide a safe workplace and to protect and warn others of reasonably foreseeable harm. Federal and state statutes establish that employers have a duty to intervene and take reasonable actions to stop or prevent an incident of workplace violence under the general duty clause of the OSHA Act of 1970 and the Violence Against Women Act.
Employers are also responsible for ensuring safety by using due diligence during the hiring process under the common law doctrine of respondeat superior. Negligent hiring or negligent retention of an employee has resulted in successful litigation against employers. Preemployment background checks often prevent hiring an employee who poses a threat to others. Supporting open communication and formal reporting procedures will allow timely dismissal of disruptive staff members.

Nursing Leaders

Inadequate leadership was identified as the causal factor attributed to 62% of violent sentinel events (TJC, 2010a). Creating and maintaining a culture of safety begin with leadership and a commitment to zero tolerance of unhealthy work environments.

Nursing leaders have an obligation to provide a safe and healthy workplace and to know employment laws, safety guidelines, and regulatory standards related to preventing all forms of workplace violence. A deliberate approach to policy and procedure development focused on consistent hiring practices, including background checks, competency assessment, and staff education, must be supported by nurses at all levels of the organization.

Practicing Nurses

Despite an understandable fear of reprisal, nurses have an ethical and legal duty to report horizontal abuse. Section 11 (c) (1) of the OSHA Act of 1970 (OSHA, 2003) protects victims who report health and safety matters:

No person shall discharge or in any manner discriminate against any employee because such employee has filed any complaint or instituted any proceeding under or related to the Act or has testified or is about to testify in any such proceeding or because of the exercise by such employee on behalf of himself or others of any right afforded by this Act. (p. 4)

The American Nurses Association (ANA) has developed position statements regarding workplace violence in the form of checklists, codes of conduct, and a nurses’ bill of rights. This bill of rights (ANA, 2001a) provides nurses the right to work in an environment that is safe and that empowers them to expect a safe, respectful, and supportive environment. Nurses also have the right to advocate for themselves without fear of retribution and the right to work in an environment that supports ethical practice in accordance with the Code of Ethics for Nurses.

The Code of Ethics for Nurses with Interpretive Statements (ANA, 2001b) outlines the ethical obligations that nurses have to their colleagues and patients. Conduct befitting and expected of a nursing professional is described in detail. Nurses are expected to practice with respect for everyone while advocating for safety. Collaboration and intraprofessional integrity are valued as means to resolve concerns and move toward shared goals. Nurses are held accountable for creating a moral environment that supports peers, identifies issues that need to be addressed, and maintains respectful interactions with colleagues.

Strategies for Reducing Horizontal Violence

Breaking the cycle of horizontal-violence behaviors requires an effective educational process that involves personal reflection and professional commitment. Implementing a program that teaches nurses to recognize all forms of horizontal violence enhances awareness and promotes collegiality among nursing peers. A program that equips staff members with behavior-management techniques improves professional relationships. Moreover, providing nursing staff with preventive techniques, nonviolent crisis interventions, and team interventions enhances the care, safety, and security of patients.

Based on findings and suggestions from Allen (2009), ISMP (2004a), Joint Commission Resources (JCR, 2002), OSHA (2003), and TJC (2008, 2010a), a horizontal violence–prevention and healthy workplace education program must address the following:

- Leadership’s commitment to zero-tolerance with policy development, including mandatory reporting of all events
- Code of conduct
- Identification of the prevalence of violence against nurses using surveys, reports, and monitoring
- Analysis of trends and prevalence of illness or injury caused by acts of horizontal violence
- Staff participation in educational offerings
- Support for and facilitation of postevent debriefing

Leadership Commitment

Having nursing leadership’s commitment to zero-tolerance for any acts of violence by any health-care team member formalized as a written policy and code of conduct is the foundation for change (ISMP, 2004a; Longo, 2010; TJC, 2010a). A shared governance council should be established to champion workplace safety with support from multidisciplinary leaders during all phases of development, implementation, and monitoring of this significant policy.

In collaboration with multidisciplinary leaders, Human Resources can standardize the approach to prescreening job applicants, including the use of background checks and licensure verification. This multidisciplinary approach must include comprehensive procedures for handling disciplinary actions and termination of offenders (TJC, 2010a).

Code of Conduct

Unacceptable behaviors that undermine a culture of safety, impact staff satisfaction and physical well-being, and contribute to errors are identified as the basis for an organization-wide code
of conduct. The mission and values of the organization and the ANA’s Code of Ethics for Nurses with Interpretive Statements and Bill of Rights for Registered Nurses serve as the underpinning for job descriptions, bylaws, and performance appraisals (ANA, 2001a, 2001b; ISMP, 2004a).

Surveying, Reporting, and Monitoring Events
Regulatory compliance is achieved by monitoring and reporting events (JCR, 2010; OSHA, 2003). Conducting periodic confidential surveys of staff will establish prevalence, type of behaviors experienced, sources, consequences to staff, and patient safety (TJC, 2010a). Policy development must also include establishing a confidential uniform violence reporting system and regular review of reports (ISMP, 2004a; OSHA, 2003). Analysis of trends and prevalence of horizontal violence should be compared to baseline rates and national benchmarks.

Providing this information to leaders and frontline staff will increase awareness of the problem, recognition of perpetrators, and implementation of corrective measures in a timely manner (ISMP, 2004a; Maxfield, Grenny, McMillan, Patterson, & Switzler, 2005).

Staff Education
Policy development alone will not eradicate horizontal violence or enhance the nursing staff’s ability to recognize, respond, and prevent incidents. Nursing education and hospital orientation must be redefined to include professional development and understanding of the complexity of violence in health care.

The need for evidence-based educational programs is evident by the fact that 58% of nurses surveyed by Stanley, Martin, and colleagues (2007) had formal training specific to coping with emotionally difficult staff relationships. Only 20% rated the focused training as very effective (Hutchinson et al., 2006; Stanley, Martin, et al., 2007). Changing the cycle of negative, stressful behaviors entails a comprehensive educational process, including educating nurses to recognize all forms of horizontal violence, to enhance awareness and promote collegiality among their peers.

Learning objectives of such a program based on guidelines and recommendations of Allen (2009), ISMP (2004a), JCR (2002), OSHA (2003), and TJC (2008, 2010a) include:

- Define horizontal violence and provide examples.
- Discuss the prevalence of events based on survey results and completed occurrence reports compared to national trends.
- Identify early warning behaviors and deescalation strategies.
- Discuss organizational policies and regulatory reporting and documentation requirements.
- Discuss the significance of staff debriefing after an incident.

Participation in educational programs allows nurses to become more sensitive to the complex interrelationships and predisposing factors that contribute to aggression and violence. Mutual respect, increased wisdom, and professional responsibility to a nurturing environment through shared governance can lead to a caring environment and ensure safety.

Conclusion
The prevalence of horizontal violence and the severity of its consequences compel the nursing profession to immediately address horizontal violence by implementing a zero-tolerance policy. The physical health and emotional well-being of staff nurses, the safety of patients, and the long-term retention of nurses can only be ensured by recognizing the continuum of violence. Educational programs must be developed, and supportive services must be made available to newly graduated nurses, seasoned professionals, and nursing leaders. Regulators, as our policy makers, need to continue to support policies and influence the development of legislative initiatives, regulations, and standards that promote a culture of safety for patient care, thereby discouraging all forms of horizontal violence. Creating a safe, nurturing, and healing environment can only be accomplished by nurses drawing together and living up to their code of ethics.

References


Dianne Ditmer, PhD, RN, CFN, CRM, CMI-III, SANE, DABFN, FACFE, is Manager of Nursing Performance Excellence and Nurse Residency Program at the Kettering Medical Center in Kettering, Ohio.