Empowerment Strategies for Medical-Surgical Nurses Dealing with Lateral Violence

Cindy has been an RN for 20 years and a preceptor for 10. She prides herself on being a good preceptor and an excellent clinician on her medical-surgical unit. She has been orienting Kacee for six weeks and today they have a five patient assignment. Cindy asked Kacee to review the policy and procedure (P&P) for inserting an indwelling catheter. Kacee had inserted a couple of catheters in school and felt confident in this skill. She quickly scanned the P&P, excited to place her first catheter as a nurse. At the bedside, it becomes clear that Kacee brought in the catheter kit but not the patient education sheet or the insertion form. Cindy is visibly upset due to time constraints and sends Kacee to obtain the missing paperwork, which she then gives to the patient to read. Kacee is nervous but proceeds to insert the catheter with minimal guidance. After the task is completed, Cindy asks Kacee to discuss care of the catheter with the patient but she forgets to have the patient verbalize understanding of teaching she provided.

After leaving the room, Cindy talks to Kacee in the hallway. Her facial expression and strained voice convey to Kacee that she is disappointed in her lack of preparation for the task. Kacee is upset and later tells another nurse she doesn’t understand why her preceptor was upset with her when she did a good job of placing the catheter.

Lateral violence, also termed horizontal violence, creates an unhealthy work environment and is all too common in many clinical settings. Lateral violence not only affects novice nurses but also experienced nurses. One survey (Stokowski, 2010) reported that medical-surgical nurses were bullied more than their counterparts on other specialty units. Lateral violence includes covert behaviors, such as sabotage, verbal and physical intimidation, and bullying, which are unwillingly or willingly imposed on the “bullied” nurse (Farrell, 1997; Griffin, 2004; Patterson, 2007). Many nurses may not realize they are guilty of these behaviors.

The literature suggests covert behaviors are just as detrimental as openly aggressive behaviors (Farrell, 1997; Griffin, 2004; McKenna,Smith, Poole, & Coverdale, 2003; Patterson, 2007; Woelfle & McCaffrey, 2007). Covert behaviors include failure to cooperate, failing to respect privacy, making untoward facial expressions, discouraging new staff, undermining staff abilities, providing minimal guidance during orientation, and gossiping. The easiest targets for these behaviors are novice nurses. Ineffective relationships between nurses contribute to instances of lateral violence, making it imperative that nurses recognize and deal with the issue.

Effects on Novice Nurses

Novice nurses are more susceptible to lateral violence than seasoned nurses due to their lack of experience. New-to-practice nurses rely on the more experienced nurses to assist them in their professional growth (Griffin 2004; Sheridan-Leos, 2008). The bullied nurse may stay quiet or may vent to other new-to-practice nurses. Over time, these ineffective coping mechanisms cause chronic stress leading to stress-related illness, callouts, transfer to another unit, or resignation (Sheridan-Leos, 2008; Woelfle & McCaffrey, 2007).

Strategic Implementation for Organizations

Organizations such as The Joint Commission and the American Association of Critical Care Nurses (AACN) are taking an active role in addressing the issue of lateral violence by advocating for healthy work environments. Awareness of lateral violence is the common theme to address in organizations—starting with education in classes for upper management, new hire orientation, and in preceptor, mentor, and charge nurse workshops (Longo, 2010; Patterson, 2007).

Strong leadership support is essential to achieve “zero-tolerance” for lateral violence in any organization. The Joint Commission (2008) mandates that organizations develop and implement processes to offset lateral violence that enforce a code of conduct, teach employees effective communication skills, and support staff members affected by bullying.

The AACN (2009) identified 6 essential standards, one of which is skilled communication, to offset behavior that leads to lateral violence. The AACN further advocates that nurses’ communication skills should be as proficient as their clinical skills.

Kupperschmidt, Kientz, Ward, and Reinholz (2010) reviewed Parse’s Theory of Human Becoming and developed a framework for effective communication. The authors posit, “Nurses choose patterns of relating to each other and are responsible for the consequences of these choices” (p. 1). Skilled communication is essential to new nurses because they are more focused on tasks. Although it is necessary for organizations to combat lateral violence, it is equally important for each nurse to take personal responsibility in becoming an efficient and skilled communicator to combat lateral violence in the clinical setting.

Strategic Implementation for Medical-Surgical Nurses

Farrell (1997) conducted taped interviews that revealed participants were most upset with the lack of interpersonal relationships. The author queried the literature and found that interpersonal relationships in clinical setting are based on rules. Argyle and Henderson (1985) outlined 15 rules that co-workers should engage in with each other. These rules include: accept a fair work load, respect privacy, assist and support one another, work together despite personality differences, and refrain from gossiping and criticizing. When these rules are not in place, lateral violence is more likely to occur.

Griffin (2004) included lateral violence education in an orientation utilizing “cognitive rehearsal” with a group of 26 new-to-practice nurses. The participants were given cue cards with the ten most common lateral violence behaviors and suggested responses.
The participants were evaluated on cue card utilization and experience with lateral violence. The majority of the participants did not use the cue card but recalled what they had learned in orientation. Although the participants were afraid of confronting the offender, as a result of the “cognitive rehearsal,” the majority of the offenders stopped bullying. Examples of a response to bullying from the Griffin study (2004), included: when a staff member makes a facial gesture (such as raising an eyebrow), the participant was instructed to say, “I see from your facial expression that there may be something you wanted to say to me. It’s OK to speak directly to me.” This approach allows the individual to address the behavior and not misinterpret the gesture for something else. Empowerment through knowledge and skilled communication was the important outcome to this research.

Kupperschmidt and colleagues (2010) constructed a framework utilizing five components in developing an effective communication model: becoming aware of self-deception, becoming reflective, becoming authentic, becoming mindful, and becoming candid. These components are all needed to become a skilled communicator. Self-deception involves not recognizing and owning one’s part in communication with others. According to the introductory exemplar, Cindy was guilty of covert lateral violence behaviors when she made faces and spoke to Kacee critically in the hallway. These actions contributed to Kacee’s nervousness. Cindy failed to recognize her frustration and failed to talk to the orientee in a way that validated her catheterization skill.

Being reflective is two-part: “reflection-in-action,” or the ability to look at circumstances during the event and make it better; and “reflection-on-action,” whereby the person reflects on the situation after the event and devises ways to improve. To be reflective in action when Cindy noticed that Kacee was not prepared, Cindy should have walked out with Kacee and gone over the necessary educational components associated with catheter insertion in their facility.

Being authentic means “the combination of self-discovery and reflection” (Kupperschmidt et al., 2010, p. 3), thus, knowing ones’ strengths, weaknesses, biases, and prejudices. Authentic knowledge enables the nurse to be true to self and others. For example, if Cindy was true to herself, she would realize that she gets stressed when she is rushed and perhaps could have done the task herself or given Kacee the task to do earlier.

Being mindful means “being aware of words and actions of one’s self and others” (Kupperschmidt et al., 2010, p. 3). Cindy did not pay attention to her body language or how her words would affect Kacee. Being candid means “being open to talk freely about situations without repercussions from other nurses or management” (Kupperschmidt et al., 2010, p. 3).

Kacee was nervous about discussing the situation with Cindy but she knew she had to address it since Cindy had previously displayed these behaviors during Kacee’s orientation. Kacee had learned about lateral violence in school and asked Cindy to talk to her in the break room. Kacee asked Cindy to not discuss any problems in the hallway, as she found this embarrassing. Cindy was shocked but apologized for her actions. Cindy respected Kacee for speaking up and they left the meeting on good terms. Cindy talked with trusted colleagues and discovered that she did get impatient with staff when she gets busy. Cindy made a decision to read about lateral violence since she did not want to be considered a bully.

Conclusion

Covert behaviors are just as detrimental as overt behaviors. Many nurses unwittingly may not be aware they are exhibiting lateral violence. Regardless, these negative behaviors are destructive. It is imperative that nurses become aware of their behaviors and make a conscious decision not to perpetuate lateral violence toward staff. Becoming a skilled communicator is essential to developing good interpersonal relationships. It is helpful that organizations are taking a stand to eradicate lateral violence, but nurses must take responsibility and accountability for caring for self and others by confronting staff members who are causing the problem. By not speaking up, nurses risk the chance of devaluing themselves. Skilled communication is the common thread that weaves relationships together; lending itself to the prevention of lateral violence.

References


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