

TriService Nursing Research Program Final Report Cover Page

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Address of Applicant Organization	917 Pacific Avenue, Suite 600, Tacoma WA 98402

Signatures

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Abstract

Purpose: Horizontal violence (HV) consists of repeated behaviors over time that intimidate or demean another individual. The purpose of this study was to explore the experience of HV by military nursing staff and to determine if education changed the experience.

Design: This interventional study used a two group, pre-test and post-test design at three military treatment facilities (MTF).

Methods: Anonymous survey data on HV behaviors, personal effects, perpetrators, job satisfaction, and intention to leave were collected both before and at 1-3 months after the provision of a 30-minute educational intervention throughout each MTF.

Sample: E-mail survey invitations were sent to the nursing staff at each facility. The respondents (n=1301) were primarily female (78%), civilian (62%), and staff nurses (61%). Nursing staff participation in the intervention ranged from 15%-30%.

Analysis: The data from each MTF were analyzed separately. Descriptive statistics were calculated. A non-parametric Mann-Whitney test was used to compare scores between pre- and post-intervention responses. Relationships of demographic, job satisfaction, and intent to leave items to HV were explored using correlations.

Findings: At all 3 MTF's, the average occurrence of HV behaviors was between once and twice in the past 3 months. Respondents experienced personal effects from HV behaviors an average of once in the past 3 months. The most frequent perpetrators were females, nurses and supervisors. There were no significant between-group differences pre and post-intervention. Job satisfaction and intent to leave either position or government employ were significantly correlated with HV.

Implications for Military Nursing: Within military nursing, HV occurs at a lower frequency than in civilian nursing. The educational intervention alone was not an effective method. Military nursing leaders are encouraged to engage in conflict management, establishment of positive work environments, holding staff members accountable for their behaviors, and providing clear guidance on how to manage reported HV.

TSNRP Research Priorities that Study or Project Addresses**Primary Priority**

Force Health Protection:	<input type="checkbox"/> Fit and ready force <input type="checkbox"/> Deploy with and care for the warrior <input type="checkbox"/> Care for all entrusted to our care
Nursing Competencies and Practice:	<input type="checkbox"/> Patient outcomes <input type="checkbox"/> Quality and safety <input type="checkbox"/> Translate research into practice/evidence-based practice <input type="checkbox"/> Clinical excellence <input type="checkbox"/> Knowledge management <input type="checkbox"/> Education and training
Leadership, Ethics, and Mentoring:	<input type="checkbox"/> Health policy <input type="checkbox"/> Recruitment and retention <input type="checkbox"/> Preparing tomorrow's leaders <input checked="" type="checkbox"/> Care of the caregiver
Other:	<input type="checkbox"/>

Secondary Priority

Force Health Protection:	<input type="checkbox"/> Fit and ready force <input type="checkbox"/> Deploy with and care for the warrior <input type="checkbox"/> Care for all entrusted to our care
Nursing Competencies and Practice:	<input type="checkbox"/> Patient outcomes <input type="checkbox"/> Quality and safety <input type="checkbox"/> Translate research into practice/evidence-based practice <input type="checkbox"/> Clinical excellence <input type="checkbox"/> Knowledge management <input type="checkbox"/> Education and training
Leadership, Ethics, and Mentoring:	<input type="checkbox"/> Health policy <input checked="" type="checkbox"/> Recruitment and retention <input checked="" type="checkbox"/> Preparing tomorrow's leaders <input type="checkbox"/> Care of the caregiver
Other:	<input type="checkbox"/>

Progress Towards Achievement of Specific Aims of the Study or Project

Findings related to each specific aim, research or study questions, and/or hypothesis:

Results are presented below by Specific Aim and Site. Tables following overall discussion show details and statistical significance.

Based on the Horizontal Violence Workplace Index (Dumont, 2012), items included in the survey described HV behaviors as overt (10 items) and covert (8 items), personal effects from HV (8 items), and HV perpetrators (13 items). The 3 subscales of overt HV behaviors, covert HV behaviors, and personal effects from HV behaviors have demonstrated internal reliability (Cronbach's Alpha = 0.92 to 0.96; C. Dumont, personal communication, January 3, 2013; Hopkinson, Langdon, Merrill, & VanDeWalle, 2018).

Five items referring to either job satisfaction or intent to leave were also included. These items included a qualifier indicating that the response was to be made as if not limited by obligation or position length. An additional two items measured the participant's perceived impact of HV on the job satisfaction or intent to leave answers using a 4-point Likert scale from no impact at all to completely impacted.

For questions about HV, respondents were requested to indicate their experience in the previous 3 months, based on the following six-point Likert scale:

0 = never, 1 = once, 2 = a few times, 3 = monthly, 4 = weekly, 5 = daily

For questions about overall job satisfaction, respondents were requested to answer using the following four-point Likert scale:

1 = very dissatisfied, 2 = dissatisfied, 3 = satisfied 4 = very dissatisfied

Intent to leave either the current position or government service overall was assessed using the following four-point Likert scale:

1 = very unlikely, 2 = unlikely, 3 = likely 4 = very likely

Specific Aim #1: Describe the perceived experience of HV in the military nursing work environment

A. Womack Army Medical Center (WAMC): The overall average occurrence of overt (Pre-Mean = 1.8; SD = 1.4/Post-Mean = 1.6; SD = 1.4) and covert (Pre-Mean = 1.6; SD = 1.4/Post-Mean = 1.4; SD = 1.4) HV behaviors on a scale of 0 (never) to 5 (monthly), respectively, was once to twice in the past 3 months.

The least common reported overt and covert behaviors, respectively, were that of "Being verbally threatened" (Mean = 0.5; SD = .9-1.1) and "Allowing a co-worker to make a mistake that could be harmful" (Mean = 0.5; SD = 1.1-1.2), occurring an average of never to once in the past 3 months. The most common reported overt and covert behaviors, respectively, were "Complaining about someone to others instead of attempting to resolve a conflict directly" (Mean = 2.4-2.8; SD = 1.8- 1.9) and "Belittling co-workers behind their backs" (Mean = 2.2-2.5; SD 1.9-2.0), occurring an average of twice to almost monthly in the past 3 months. Cronbach's Alpha for the subscales were 0.94 (overt) and 0.92 (covert).

Respondents experienced personal effects from HV behaviors an average of just over once in the past 3 months (Pre-Mean = 1.3, SD = 1.4/ Post-Mean = 1.1, SD = 1.3). The most common was feeling discouraged (Mean = 1.8-2.1; SD 1.9-2.0) and the least common was not asking for help (Mean = 0.6; SD = 1.3). Cronbach's Alpha for the personal effects subscale was 0.91.

The most common reported perpetrators were nurses and women (Mean = 2.6-2.7; SD = 1.7-1.8). The least common reported perpetrators were Junior Officers, Junior and Senior NCO's, and other staff (Mean = 0.4 to 0.7; SD = 1.1 to 1.4).

B. Walter Reed National Military Medical Center (WRNMMC): The overall average occurrence of overt (Pre-Mean = 1.8; SD = 1.5/Post-Mean = 2.3; SD = 1.5) and covert (Pre-Mean = 1.6; SD = 1.5/Post-Mean = 2.0; SD = 1.4) HV behaviors on a scale of 0 (never) to 5 (monthly), respectively, was initially between once to twice in the past 3 months, with an increase to monthly at the post time period.

The least common reported overt and covert behaviors, respectively, were that of "Being verbally threatened" (Mean = 0.8-1; SD = 1.3) and "Allowing a co-worker to make a mistake that could be harmful" (Mean = 0.7-0.9; SD = 1.3-1.5), occurring an average of never to once in the past 3 months. The most common reported overt and covert behaviors, respectively, were "Complaining about someone to others instead of attempting to resolve a conflict directly" (Mean = 2.6-3.1; SD = 1.8) and "Belittling co-workers behind their backs" (Mean = 2.3-3.0; SD 1.9-2.0), occurring an average of twice to monthly in the past 3 months. Cronbach's Alpha for the subscales were 0.95 (overt) and 0.92 (covert).

Respondents experienced personal effects from HV behaviors an average of between once and twice in the past 3 months (Pre-Mean = 1.4, SD = 1.4/ Post-Mean = 1.4, SD = 1.4). The most common was feeling discouraged (Mean = 2.2-2.5; SD 2.0) and the least common was not asking for help (Mean = 0.7; SD = 1.2-1.4). Cronbach's Alpha for the subscale was 0.92.

The most common reported perpetrators were nurses and women (Mean = 2.3- 3.0; SD = 1.8-2.0). The least common reported perpetrators were other staff (Mean = 0.3 to 0.9; SD = 1.0 to 1.6).

C. Brooke Army Medical Center (BAMC): The overall average occurrence of overt (Pre-Mean = 1.9; SD = 1.5/Post- Mean = 1.8; SD = 1.5) and covert (Pre-Mean = 1.7; SD = 1.5/Post-Mean = 1.6; SD = 1.5) HV behaviors on a scale of 0 (never) to 5 (monthly), respectively, was between once to twice in the past 3 months.

The least common reported overt and covert behaviors, respectively, were that of "Being verbally threatened" (Mean = 0.7-0.8; SD = 1.2-1.4) and "Allowing a co-worker to make a mistake that could be harmful" (Mean = 0.7-0.8; SD = 1.4-1.5), occurring an average of never to once in the past 3 months. The most common reported overt and covert behaviors, respectively, were "Complaining about someone to others instead of attempting to resolve a conflict directly" (Mean = 2.6-2.7; SD = 1.9) and "Belittling co-workers behind their backs" (Mean = 2.5-2.6; SD 1.9-2.0), occurring an average of twice to almost monthly in the past 3 months. Cronbach's Alpha for the subscales were 0.95 (overt) and 0.93 (covert).

Respondents experienced personal effects from HV behaviors an average of once to twice in the past 3 months (Pre-Mean = 1.5, SD = 1.5/ Post-Mean = 1.4, SD = 1.5). The most

common was feeling discouraged (Mean = 2.0-2.1; SD 1.9-2.0) and the least common was not asking for help (Mean = 0.9-1.0; SD = 1.6). Cronbach’s Alpha for the subscale was 0.94.

The most common reported perpetrators were nurses and women (Mean = 2.5-2.8; SD = 1.8-1.9). The least common reported perpetrators were Senior NCO’s and other staff (Mean = 0.4 to 0.9; SD = 1.1 to 1.6).

Figure 1. Median of most frequent HV Behaviors and personal effects

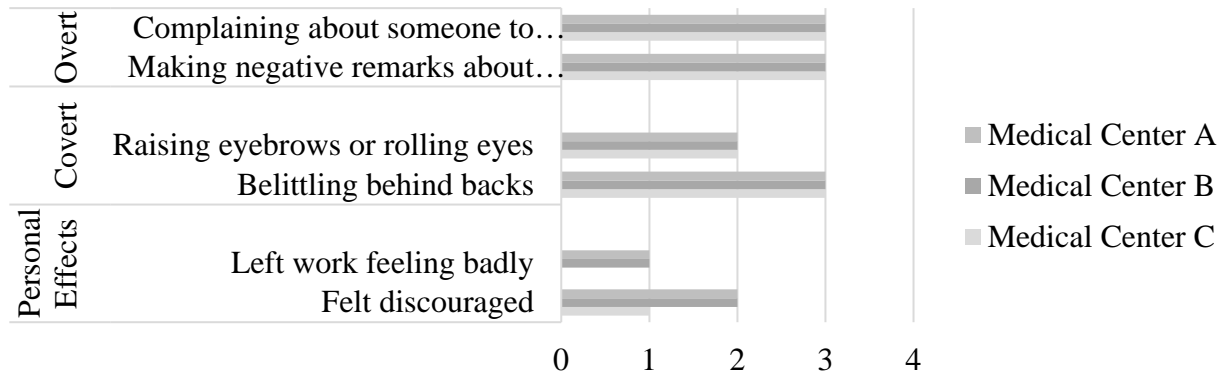
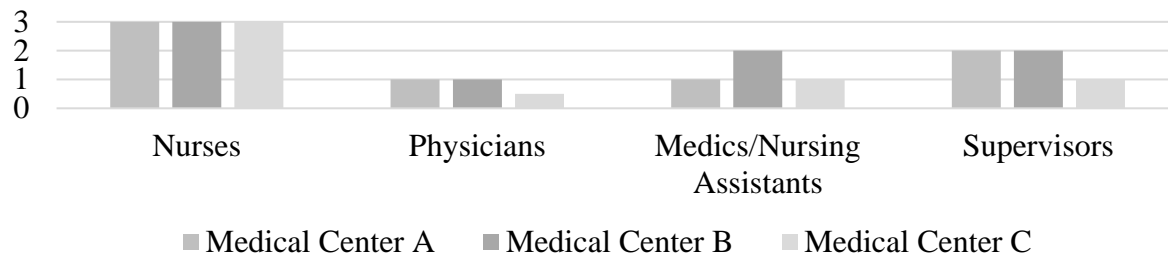


Figure 2. Median of frequent perpetrators by medical center.



Specific Aim #2: Measure the relationship between HV and job satisfaction and intent to leave.

Overall, participants reported satisfaction with their position, with 64.5%, 68.5%, and 74.2% reporting either “Satisfied” or “Somewhat satisfied” at WRNMMC, BAMC, and WAMC, respectively. However, over half of all participants indicated that they would be likely to leave their current position in the next year (WRNMMC 62.7%, BAMC 58.5%, and WAMC 46.4%). Although the question was written to discount military obligation or position length influences, it is possible that this higher percentage reflects at least in part the normal rotation of staff at military hospitals. A lower but similar number of respondents indicated they would be likely to leave military/government employ in the course of the next year (WRNMMC 48.8%, BAMC 40.8% , WAMC 31.8%), not limited by obligation or position length. Data are shown below in Table 1.

Pearson r correlations for the HV scales and job-related items by site were done in lieu of polyserial correlation as the findings were not thought to deviate markedly in final results. For all sites, both the Overt and Covert HV subscale had the highest correlation with the item that captured the impact HV had on current job satisfaction (r = 0.58-0.60, p <.001). All of the other job satisfaction and intent to leave items had the highest correlation with the personal effects subscale (p<.001).

Table 1. *Valid percent (%) of response to job satisfaction and intent to leave items (dichotomized)*

	Dissatisfied	Satisfied
Overall, how satisfied are you with your current position?		
- WRNMMC	35.5%	64.5%
- BAMC	31.5%	68.5%
- WAMC	25.8%	74.2%
	Likely	Unlikely
How likely would you be to leave your current position in the next year?*		
- WRNMMC	62.7%	37.3%
- BAMC	58.5%	41.5%
- WAMC	46.4%	53.6%
How likely would you be to leave military/government employ in the next year?*		
- WRNMMC	48.8%	51.2%
- BAMC	40.8%	59.1%
- WAMC	31.8%	68.2%

*Qualifier included “not limited by obligation or position length”

Specific Aim #3: Determine if there is a difference in the perceived experience of HV before and after the intervention.

A total of 962 individuals received the HV education across all three sites with the fewest at WRNMMC (n=116 out of an estimated 800; 14.5%), the next at BAMC (n=429 out of an estimated 2200; 19.5%) and the largest percentage at WAMC (n=317 out of an estimated 1100; 28/8%). When conducting a non-parametric Mann-Whitney test comparing the pre vs post-education groups for each site separately there were no significant between-group differences on any of the three HV subscales. The largest effect size was found for the Overt subscale for WRNMMC (which actually went from a mean of 1.8 to 2.3, a non-significant increase), and even that was small. Running of the Mann-Whitney test produced similar results. Actual results for each site are given below in Table 2.

Table 2. *Average frequency of overt and covert HV behaviors and personal effects by subscales*

Subscale	WRNMMC		BAMC		WAMC	
	Pre (n = 202)	Post (n = 63)	Pre (n = 363)	Post (n = 311)	Pre (n = 147)	Post (n = 215)
Overt						
-Mean (SE)	1.8 (0.1)	2.3 (0.2)	1.9 (0.1)	1.8 (0.1)	1.8 (0.1)	1.7 (0.1)
-Valid n (%)	168 (83%)	51 (81%)	290 (80%)	263 (85%)	118 (80%)	189 (88%)
- Pre/Post Sign.	U = 3589, p = .08		U = 36,836, p = .49		U = 10356, p = .29	
Covert						
-Mean (SE)	1.6 (0.1)	2.0 (0.2)	1.7 (0.1)	1.6 (0.1)	1.6 (0.1)	1.4 (0.1)
-Valid n (%)	168 (83%)	51 (81%)	289 (80%)	263 (85%)	118 (80%)	188 (87%)
- Pre/Post Sign.	U = 3668, p = .12		U = 36,760, p = .50		U = 10,247, p = .26	

Personal Effects

-Mean (SE)	1.4 (0.1)	1.5 (0.2)	1.5 (0.1)	1.4 (0.1)	1.3 (0.1)	1.1 (0.1)
-Valid n (%)	167 (83%)	51 (81%)	289 (80%)	262 (84%)	119 (81%)	186 (87%)
-Pre/Post Sign.	U = 4037, p = .57		U = 36,101, p = .34		U = 10,265, p = .28	

Relationship of current findings to previous findings:

In comparison to the previous studies the 89% experiencing or witnessing HV is slightly less than the 95% reported in the pilot study (Hopkinson et al., 2019) and is comparable to the 88% encountering incivility in another MTF (Spiri et al., 2017). Yet, the average reported frequency of witnessing or experiencing HV behaviors was less (once to twice in 3 months) than the reported average between monthly and weekly for a US civilian nurse sample (n = 950; Dumont et al., 2012). Respondents indicated they were personally affected by the HV an average of once to twice in 3 months as well, although with a lower overall average. This was similar to the pilot study findings (Hopkinson et al.) and slightly less than in the civilian sample (Dumont et al.). There was also similarity across all studies using the same items in the most frequent HV behaviors (complaining about someone to others, feeling discouraged, leaving work feeling bad), personal effects (feeling discourage, leaving work feeling bad), and perpetrators (nurse and supervisor) reported. Nursing staff peers were identified as the most common perpetrators of incivility, as well, in the military nursing environment (Spiri et al., 2017). Additionally, findings supported that HV does have an impact on job satisfaction and intent to leave as previously identified (Lee et al., 2014).

The educational intervention did not have the same impact as in the pilot study previously conducted (Hopkinson et al., 2018). The pilot study had the advantage of nursing leadership encouragement of staff participation. Whereas the current study, although conducted with leadership approval, was conducted independent of the same influence. Additionally, implementing the educational intervention across a large population in the real world setting differed from the small relatively contained sample sizes used in the earlier studies using cognitive rehearsal techniques (Griffin, 2004; Griffin & Clark, 2014).

Effect of problems or obstacles on the results:

There was a substantial time gap in the approval to start at the primary sites and the secondary sites. This delayed the release of the pre- questionnaire at WRNMMC and BAMC. The education began in March 2017 and finished in April 2017 at both of these sites. The education at WRNMMC was limited by problems with access of the educator to the intended site population. An IRB amendment was approved to have the post survey distributed at the same time at all sites to minimize the bias caused by staff turbulence and change of population during the summer PCS season. Also, at WRNMMC when reviewing and updating the distribution lists prior to sending the post-education survey invite, new distribution lists had been created that reached junior enlisted personnel on a broader scope than the previous distribution lists. As such, junior enlisted personnel represent a higher percentage of respondents in the post-education results at this site. There was also a similar reduction in the prevalence of more senior civilian employees in the post-education responses at this site. Any

changes in patterns of HV and its effects could have been due in part to this shift to younger, more junior, and more predominantly military personnel.

Limitations:

In an attempt to increase participation and limit problems of implied coercion across sites, this study was designed to be completely anonymous and include a voluntary training session open to nurses and non-nurses. As such, individuals were not required to participate in training and the number of individuals who completed the pre-education survey, education session, and the post-education survey is limited, giving limited data on which to found definitive conclusions about causation. However, the similarity of results across sites both pre and post-education imply a consistent military institutional culture with significantly less HV than seen in a similar civilian population.

While the electronic survey method allowed for a pre-survey announcement and an ease of distribution, it may have contributed to survey fatigue among the recipients. Other competing surveys were also initiated during the same time frame at each of the medical centers. Although respondents could not be identified, a lack of confidence in the anonymity of the study and fear of reprisal may have also contributed to the low response rate.

The discriminate validity of the instrument is a limitation. The instrument asked whether the respondent experienced and/or witnessed the behavior without discriminating between being a victim of HV versus a witness to HV. The validated Negative Acts Questionnaire – Revised (Einarsen, Hoel, & Notelaers, 2009) was not used for this study in an effort to investigate the aspect of co-worker to co-worker behaviors, rather than power-related bullying behaviors. While our study used a consistent HV definition, variation within the literature makes synthesis across studies difficult. There may also be unique aspects of the US military nursing population that may limit the generalizability.

Conclusion:

Although HV exists within the military nursing environment, it is at a lower frequency than that reported in the civilian nursing sector. Even with the lower frequency, however, the existence of overt and covert HV has a demonstrable effect on current job satisfaction. In addition, the degree to which the recipient is personally affected by HV has a significant effect on that individual's likelihood to leave their current position or leave government service entirely. The educational intervention used in this study, and validated elsewhere, was not an effective method to change the experience of HV in the military nursing community.

Significance of Study or Project Results to Military Nursing

This study was the first to measure the experience of HV within the military nursing workplace at multiple MTFs representing a Tri-Service nursing population. Previous studies describing HV or incivility in military nursing were conducted within one facility (Hopkinson et al., 2019; Spiri et al., 2017). The nursing staff respondents had some expected demographic variances between the MTFs, primarily related to the military branch staffing the MTF. One notable exception is the difference in the respondents at WRNMMC for the post-intervention survey when shifted from a majority of civilian staff nurses to Navy corpsmen. It is suspected that this shift was due to a change in e-mail distribution lists obtained from the leadership for the post-intervention e-mail invitations. With this shift in representative sample there was also an overall increase in reported HV behaviors compared to the decrease experienced at the other participating medical centers. Further exploration and analyses of the experience of HV specifically within the population of military medical technicians as well as other healthcare professionals is merited based on this finding.

Recognizing that the definition used for HV includes a repeated nature over time, witnessing or experiencing HV behaviors once to twice in 3 months may not seem excessive. This study also supported the findings of the pilot study that the overall frequency of HV is less in the military nursing population than the civilian sector. Even so, the amount of HV reported did have a significant correlation with job satisfaction and intent to leave. Unfortunately, for the relatively few individuals who experience HV on a regular basis the impact can be devastating, especially when the behaviors escalate (Sanchez, 2017). Higher level guidance recommends or mandates the development of facility level policies addressing the inappropriateness and lack of tolerance for the disruptive behaviors that make up HV (DoD, 2012; IMCOM, 2012). A gap in the guidance and knowledge of specific actions to take as a staff member or as a leader when HV is experienced or reported was an anecdotal finding from this study. This led to the development of a whitepaper with relevant recommendations for senior nursing leadership (Hopkinson, 2018). It argues that disruptive behavior policies should also include executable actions for nursing staff and nursing leaders to take when they become aware of HV behaviors, as well as provides examples to replicate.

The impact of a nursing population based educational intervention was also explored. The lack of a significant difference in the experience of HV after the educational intervention highlights some realities of establishing training. When attempting to implement a cultural change for an organization the right conditions must be present, to include destabilization of the status quo, communication of the new ideas, receptiveness to change, effort focused on the change, and experiences of success related to the change (Batras, Duff, & Smith, 2014). Without leadership championing the cause, there is less buy-in and urgency in the need to change the existing culture in relation to HV. Additionally, focusing the education on how individuals can respond on a personal level when experiencing HV left a gap in teaching nursing leaders appropriate steps to take when encountering HV amongst their staff. Future endeavors could build on lessons learned from this study or encourage investigation of alternative interventions to make a difference in the experience of HV.

Quality & Generalizability:

The descriptive findings from this study provide a solid basis for the frequency of assorted types of HV behaviors, personal effects, and identified perpetrators of HV within the military nursing environment. The descriptive results from each of the sites at both time points was similar, with the exception of WRNMMC. The fact that it was relatively straightforward to identify the aberrancy in the intended recipients highlights the consistency across the entire population of the nursing staff. It is likely that these findings are generalizable to nursing staff throughout the TriService MTF's.

Challenges with the execution of the educational intervention at each of the sites brings into question whether the intervention may have been effective if it had reached more of the intended population. At the same time, the findings appear to have captured the impact of the real world application of the intervention. The generalizability of these findings depends on the intended environment for the educational intervention. As shown in the one unit or limited sample studies in civilian nursing, cognitive rehearsal training may be promising in a more focused environment.

Changes in Clinical Practice, Leadership, Management, Education, Policy, and/or Military Doctrine that Resulted from Study or Project

None to date.

A Whitepaper was submitted to the ANC Corps Chief on the topic with recommendations for more detailed horizontal violence response algorithms available to nursing staff and leadership. (Included with report.)

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Summary of Dissemination

Type of Dissemination	Citation	Date and Source of Approval for Public Release
Publications in Press	Hopkinson, S. G., Dickinson, C. M., Dumayas, J. Y., Jarzombek, S. L., & Blackman, V. S. A multi-center study of horizontal violence in military nursing. Submitted to Nursing Outlook	TAMC December 2018
Podium Presentations	<p>“Test of an Intervention to Decrease Horizontal Violence within Military Nursing” at the Tri-Service Nursing Research Program Evidence Based Practice and Research Dissemination Course, San Antonio TX, April 2018.</p> <p>“Horizontal Violence in Military Nursing” at WRNMMC Quality Grand Rounds & Nursing Grand Rounds, Bethesda MD, November 2018.</p> <p>“Horizontal Violence in Military Nursing” at SAMMC Nursing Grand Rounds, San Antonio TX, November 2018.</p> <p>“Horizontal Violence in Military Nursing” at TAMC Nursing Grand Rounds, Honolulu HI, February 2019</p>	<p>TAMC April 2018</p> <p>n/a</p> <p>n/a</p> <p>n/a</p>
Poster Presentations	<p>“Evaluating an Intervention to Decrease Horizontal Violence in the Nursing Work Environment” at Womack Army Medical Center Research Symposium, Fort Bragg, NC, May 2018.</p> <p>"Nursing Staff Survey of Horizontal Violence in Military Treatment Facilities" at the Tri-Service Nursing Research Program Evidence Based Practice and Research Dissemination Course, April 2017.</p>	<p>WAMC 2017</p> <p>WAMC 2017</p>

	<p>“Evaluating an Intervention to Decrease Horizontal Violence (HV) in the Nursing Work Environment” at 35th Global Nursing Care and Education Conference, Atlanta, GA Sep 2017</p> <p>“Evaluating an Intervention to Decrease Horizontal Violence in the Nursing Work Environment” at Army Nurse Corps Association, San Antonio, TX, October 2018.—1st Place Research Award</p>	WAMC 2017
Other	<p>Invited lecture by RA Davidson for the Navy Senior Nurse Executive monthly meeting July 2018 – “Lateral Violence in Military Nursing”</p> <p>White Paper – “White Paper On Incivility, Bullying and Workplace Violence in Military Nursing”</p>	<p>n/a</p> <p>n/a</p>

Reportable Outcomes

Reportable Outcome	Detailed Description
Applied for Patent	None
Issued a Patent	None
Developed a cell line	None
Developed a tissue or serum repository	None
Developed a data registry	None

Recruitment and Retention Table

Recruitment and Retention Aspect	Site (MTF)			Total
	WRNMMC	WAMC	BAMC	
Subjects Projected in Grant Application	800	1400	1500	3700
Subjects Available (estimated)	800	1100	2200	4100
Subjects Contacted or Reached by Approved Recruitment Method	800	1100	2200	4100
Subjects Screened	800	1100	2200	4100
Subjects Ineligible	Unknown	Unknown	Unknown	Unknown
Subjects Refused	Unknown	Unknown	Unknown	Unknown
Human Subjects Consented (completed survey)*	274	391	731	1396
Subjects for Between Groups (assumed different pre and post surveys)	Pre = 265 Post = 63	Pre =147 Post =215	Pre = 363 Post = 311	1301
Subjects for Within Groups (same at pre and post surveys)	9	29	57	95
Subjects Used for Between Groups Analyses	265	362	674	1301
Subjects Used for Within Groups Analyses	9	29	57	95

**May not match totals presented in demographics totals as this is number of surveys returned vs number of individuals*

Demographic Characteristics of the Sample*Demographic Characteristics as a Percentage of the Sample by Hospital*

Characteristic	WRNMMC		BAMC		WAMC	
	Pre (n = 202)	Post (n = 63)	Pre (n = 363)	Post (n = 311)	Pre (n = 147)	Post (n = 215)
	N (Valid %)					
Age	Not collected					
Gender						
Male	44 (22.1)	23 (36.5)	105 (29.2)	78 (25.4)	16 (11.1)	23 (10.9)
Female	155 (77.9)	40 (63.5)	254 (70.8)	228 (74.6)	128 (88.9)	188 (89.1)
Setting						
Inpatient	97 (49.0)	31 (50.0)	137 (38.3)	152 (49.5)	86 (59.7)	147 (69.7)
Outpatient	101 (51.0)	31 (50.0)	221 (61.7)	155 (50.5)	58 (40.3)	64 (30.3)
Current Position						
Staff nurse*	113 (57.9)	13 (21.7)	201 (56.5)	183 (60.4)	97 (67.4)	165 (77.8)
Medic/UAP**	14 (7.2)	18 (30.0)	57 (16.0)	43 (14.2)	3 (2.1)	5 (2.4)
Admin assistant	2 (1.0)	6 (10.0)	26 (7.9)	31 (10.2)	2 (1.4)	0 (0.0)
Unit manager	26 (13.3)	13 (20.6)	44 (12.4)	27 (8.9)	17 (11.8)	12 (5.7)
Supervisor	24 (12.3)	6 (10)	18 (5.0)	10 (3.3)	14 (9.7)	15 (7.1)
APN***	16 (8.2)	4 (6.7)	8 (2.2)	9 (3.0)	11 (7.6)	15 (7.1)
Time in Position						
Up to 12 months	34 (17.2)	25 (41.3)	74 (20.6)	51 (16.4)	37 (25.2)	46 (21.4)
> 1 to 5 years	85 (43.0)	21 (33.)*	179 (49.7)	146 (47.2)	50 (34.0)	71 (32.9)
> 5 years	79 (39.9)	16 (25.8)	107 (29.7)	113 (36.5)	60 (40.8)	97 (45.3)
Education Level						
No college degree	41 (20.7)	20 (32.3)	164 (45.9)	72 (23.3)	20 (13.8)	58 (27.2)
Associate degree	0 (0.0)	7 (11.3)	0 (0.0)	70 (22.7)	35 (24.1)	49 (23.0)
Bachelor degree	93 (47.0)	20 (32.3)	136 (38.0)	118 (38.3)	61 (42.1)	77 (36.2)
Graduate degree	54 (32.3)	15 (24.2)	58 (18.2)	48 (15.6)	29 (20.0)	29 (13.6)
Component						
Civilian	128 (64.3)	12 (19.7)	186 (52.0)	195 (63.3)	104 (71.2)	176 (82.2)
Army	27 (13.6)	15 (24.6)	91 (25.4)	60 (19.5)	42 (28.8)	37 (17.3)
Navy	39 (19.6)	34 (55.7)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Air Force	0 (0.0)	0 (0.0)	63 (17.6)	36 (11.7)	0 (0.0)	0 (0.0)
Other	5 (2.5)	0 (0.0)	18 (5.0)	17 (5.5)	0 (0.0)	1 (0.5)
Rank/Pay Grade						
Junior enlisted	10 (5.1)	18 (29.5)	26 (7.4)	25 (8.2)	2 (1.4)	0 (0.0)
Senior enlisted	7 (3.6)	10 (16.4)	38 (10.8)	21 (6.9)	11 (7.7)	7 (3.3)
Junior Officer	28 (14.4)	0 (0.0)	54 (15.3)	37 (12.1)	19 (13.2)	0 (0.0)
Senior Officer	27 (13.8)	11 (18.0)	24 (6.8)	10 (3.3)	11 (7.6)	17 (8.0)
GS Civilian 1-6	13 (6.7)	10 (16.4)	72 (20.5)	74 (24.3)	26 (18.1)	6 (2.8)
GS Civilian ≥ 7	103 (52.8)	0 (0.0)	106 (30.1)	112 (36.7)	72 (50.0)	74 (34.9)
Other	7 (3.5)	12 (19.7)	32 (9.1)	26 (8.5)	3 (2.1)	108 (50.9)

*Registered nurse or license practical nurse (RN/LPN). **Military medical technician/nursing assistant. ***Advanced practice nurse, such as nurse practitioner or clinical nurse specialist.

Program Budget Summary Report

Company: The Geneva Foundation
User: etappero@corp.genevusa.org

Period Start Date: 3/1/2016
Period End Date: 3/31/2019

Current Fringe Rate: 35.50%
Current G&A Rate: 19.80%



Contract: 10451 - Intervention to Decrease Perception
Award Amount: 228,436.00
Total Estimated: 228,436.00
Total Funded: 228,436.00

Contract PoP: 3/1/2016 - 2/28/2019
Customer: TRISERVICE NURSING RESEARCH PROGRAM
Customer Contract ID: HU0001-16-1-TS06
Contract Manager: Robinson, Kathleen

Category	Budget	Period	Cumulative	Commitments	Cumul. + Commit.	Remaining Balance
Direct Expenditures						
Personnel						
Personnel Salary & Wages	159,249.62	117,754.79	117,754.79	0.00	117,754.79	41,494.83
Fringe Benefits (Burden)	0.00	41,494.83	41,494.83	0.00	41,494.83	-41,494.83
Total Personnel	159,249.62	159,249.62	159,249.62	0.00	159,249.62	0.00
Non-Personnel						
Equipment	0.00	0.00	0.00	0.00	0.00	0.00
Travel	17,753.07	17,212.98	17,212.98	540.09	17,753.07	0.00
Supplies	1,634.55	1,634.55	1,634.55	0.00	1,634.55	0.00
Other	907.79	907.79	907.79	0.00	907.79	0.00
Consultant	11,454.97	8,887.50	8,887.50	0.00	8,887.50	2,567.47
Subcontractor	0.00	0.00	0.00	0.00	0.00	0.00
Total Non-Personnel	31,750.38	28,642.82	28,642.82	540.09	29,182.91	2,567.47
Total Direct Expenditures	191,000.00	187,892.44	187,892.44	540.09	188,432.53	2,567.47
Indirect Expenditures						
G&A Burden	37,436.00	37,145.78	37,145.78	91.89	37,237.67	198.33
Other Indirect Costs	0.00	0.00	0.00	0.00	0.00	0.00
Total Indirect Expenditures	37,436.00	37,145.78	37,145.78	91.89	37,237.67	198.33
Total Dir. + Indir. Expenditures	228,436.00	225,038.22	225,038.22	631.98	225,670.20	2,765.80
Fee Amount	0.00	0.00	0.00	0.00	0.00	0.00
Total Expenditures + Fee	228,436.00	225,038.22	225,038.22	631.98	225,670.20	2,765.80

White Paper
On
Incivility, Bullying and Workplace Violence in Military Nursing

COL Susan G Hopkins, PhD, AN



Cover Art
by Aerial Rouse

Purpose – Background

Workplace violence (WPV) is an umbrella term that is typically used to cover a variety of disruptive behaviors ranging from violent and aggressive acts to ongoing incivility while at work or on the job.¹⁻³ A common element is that the behaviors pose a substantial risk of physical or emotional harm to individuals, often causing fear for personal safety or psychological distress.^{2,3}

The origin of the WPV is varied. The National Institute for Occupational Safety and Health (NIOSH) has identified 4 types⁴ (described in relation to a healthcare setting):

Type 1: Criminal Intent: The perpetrator does not have a relationship to the healthcare facility or to any of the employees, and may be violent during the commission of a crime such as trespassing or robbery.

Type 2: Customer/Client: The perpetrator is a patient, family member or visitor engaging in violence towards an employee of the healthcare facility.

Type 3: Worker-on-Worker: The perpetrator is another healthcare facility employee. This type is often discussed using terms such as incivility, bullying, or lateral violence; it can also include violent acts.

Type 4: Personal Relationship: The perpetrator has a relationship with the employee outside of work, yet the violent act occurs at the healthcare facility.

In healthcare settings, Type 2 is the most common and Type 1 is the least common. Type 2 behaviors are frequently addressed through facility level initiatives such as employee education in the prevention and management of disruptive behaviors, code programs designed to respond to escalating patient behaviors, or systems to report disruptive patient behaviors. Although these initiatives may have variations in success,⁵ prevention and management of Type 2 WPV are generally recognized by health care leaders as an integral part of ensuring a safe workplace in accordance with accrediting bodies such as The Joint Commission.⁶

The Joint Commission recognizes that Type 3 behaviors such as incivility and bullying impact the workplace in terms of overall work environment and patient safety.⁷ The American Nurses Association describes incivility as being rude or discourteous, gossiping, spreading rumors, and failing to assist; whereas bullying refers to repeated behaviors intended to humiliate, offend or cause distress.⁸ Higher level guidance recommends or mandates the development of a facility level policy addressing the inappropriateness and lack of tolerance for the disruptive behaviors that make up WPV.^{2,3,6,9,10} Suggestions for WPV prevention include establishing reporting systems, response plans, threat assessment teams, employee and supervising training programs, WPV committees and data tracking mechanisms. Likely due to the lower incidence and reporting of Type 3 WPV, however, the same recognition and emphasis is not experienced as with Type 2. Unfortunately, escalation of worker-on-worker WPV

can have devastating outcomes for the employee, the facility leadership, the perpetrator and all others involved.¹¹

In the process of the development and conduct of studies on horizontal violence (repeated behaviors that intimidate or demean another) in military healthcare settings,¹² it was discovered that there is a gap in addressing Type 3 WPV within the military treatment facilities. Although there are policies in place prohibiting disruptive behaviors such as bullying,¹³ descriptive procedures and leadership knowledge on how to implement the policies was lacking. The higher level recommendations to address WPV overall are general in nature so that they can be adapted to individual facility environment and characteristics.¹⁰ A primary gap exists in front-line supervisor prescriptive guidance and knowledge regarding how to respond when encountering incivility, bullying or other acts under the umbrella of workplace violence.

Workplace Violence in Military Nursing

Within U.S. military nursing, incivility and horizontal violence are beginning to receive needed recognition. In a study published in 2017, approximately 88% of 155 nurse respondents encountered incivility in the workplace in the past year.¹⁴ Over half of the respondents experienced strong verbal abuse (52%) or negative/threatening body language (55%). The impact on patient safety included 31% of respondents assuming an order was correct rather than interact with the prescriber and 37% feeling pressured to accept an order despite safety concerns. In this study, nurse peers were found to be the most common perpetrators. Similarly, in studies investigatin

g horizontal violence in four separate medical healthcare facilities, nurse coworkers were identified as the most frequent perpetrators.^{12,15} At each of the facilities, the nursing staff experienced horizontal violence behaviors once to twice in a 3 month period, with the most frequent behaviors identified as complaining, making negative remarks, and belittling coworkers to others. Comparatively, these behaviors occurred less often than in the U.S. civilian nursing population.¹⁶

Nursing Staff Training is Not Enough

In the multi-site study, an educational intervention for staff nurses regarding horizontal violence awareness and response was tested. At the pilot site, the overall report of horizontal violence decreased significantly. The other 3 sites did not experience a significant change. Training alone is not enough to change the culture, even when targeted to a specific population within the health care environment. When attempting to implement a cultural change for an organization the right conditions must be present, to include destabilization of the status quo, communication of the new ideas, receptiveness to change, effort focused on the change, and experiences of success related to the change.¹⁷

Culture Contributing to Gap

For military service members, the Army command policy (AR620-20) directs commanders to initiate command directed investigations as well as to record and track allegations of hazing or bullying through the Equal Opportunity Reporting System.¹³ For civilian employees, the recommended actions include contacting a supervisor, security, human resources, and the employee assistance program.³ The follow-on actions are consistently described in a series of general recommendations. Also, the policies and guidelines do not address the procedures or options for handling lower level behaviors that cannot be easily categorized as blatant hazing, bullying, threats, or violent actions.

Within the military culture there is an expectation that problems or issues are handled at the lowest level, with going above an immediate supervisor to the next level supervisor only acceptable in limited circumstances.¹⁸ Efforts by higher-level leaders that encourage direct reporting to them, especially anonymously, actually undermines trust within the unit.¹⁹ This leaves employees, and even leaders, hesitant to speak up regarding behavioral issues that cannot necessarily be easily labeled as WPV.

Without clear procedural direction within policies or training on response for the management of disruptive behaviors, front-line leaders lack the knowledge on how to appropriately respond. This lack of knowledge may translate into inaction on the part of leaders at all levels, which further contributes to the lack of trust in leadership response when behaviors are reported.

Standardized Guidance for Staff, Front-line Leaders, and Mid-level Leaders

The proposed algorithms (Appendices 1-3) are based on:

The American Nurses Association (ANA) provides more prescriptive recommendations for how a leader can handle a report of incivility or bullying.⁸ Existing guidelines providing general recommendations for prevention and management of workplace violence have merit as well. Subject matter experts in conflict resolution, behavioral health, and leadership as well as front-line leaders are needed team members in the development of a tool that can be used as a reference for lower-level leaders to prevent and manage WPV.

Initially, staff need guidance in how to respond, including differentiating WPV from other issues such as equal opportunity discrimination or sexual harassment. If the staff member determines they are experiencing WPV, they should be empowered to report it to their supervisor and have appropriate expectations of their role in reporting and their supervisor's role in assisting with the situation.

Part of the front-line leader response is knowing how to guide the subordinates who are experiencing the WPV. Similarly, mid-level leaders must be aware of their responsibility in both guiding the front-line leader in the process and reporting the incident to higher levels as well.

Implementation and Sustainment

The algorithms should be integrated into the existing workplace violence training that occurs at a minimum during onboarding/orientation, and annually as recommended. Policies can be adapted to include the more prescriptive measures as applicable to each individual facility environment.

Enclosures:

Appendix 1 - Employee / Staff Member Workplace Violence Reporting

Appendix 2 - Front-Line Leader Employee-to-Employee Workplace Violence Response

Appendix 3 - Mid-Level Leader Employee-to-Employee Workplace Violence Response

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- ¹ The National Institute for Occupational Safety and Health (NIOSH). Occupational Violence, 2018. Retrieved from <https://www.cdc.gov/niosh/topics/violence/default.html>
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- ⁹ United States Office of Personnel Management, Office of Workforce Relations. dealing with workplace Violence: a Guide for Agency Planners, February 1998.
- ¹⁰ Interagency Security Committee. Violence in the Federal Workplace: A Guide for Prevention and Response, 1st edition, 2013.
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- ¹³ Department of the Army. Army Regulation 600-20: Army Command Policy, pg.30-31.
- ¹⁴ Spiri, C., Brantley, M., McGuire, J (2017). Incivility in the workplace: A study of nursing staff in the military health system. Journal of Nursing Education and Practice, 7(3). 40-46. doi:10.5430/jnep.v7n3p40.
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¹⁶ Dumont, C., Meisinger, S., Whitacre, M.J., & Corbin, G. (2012). Horizontal violence survey report. *Nursing 2012*, 42(1), 44-49.

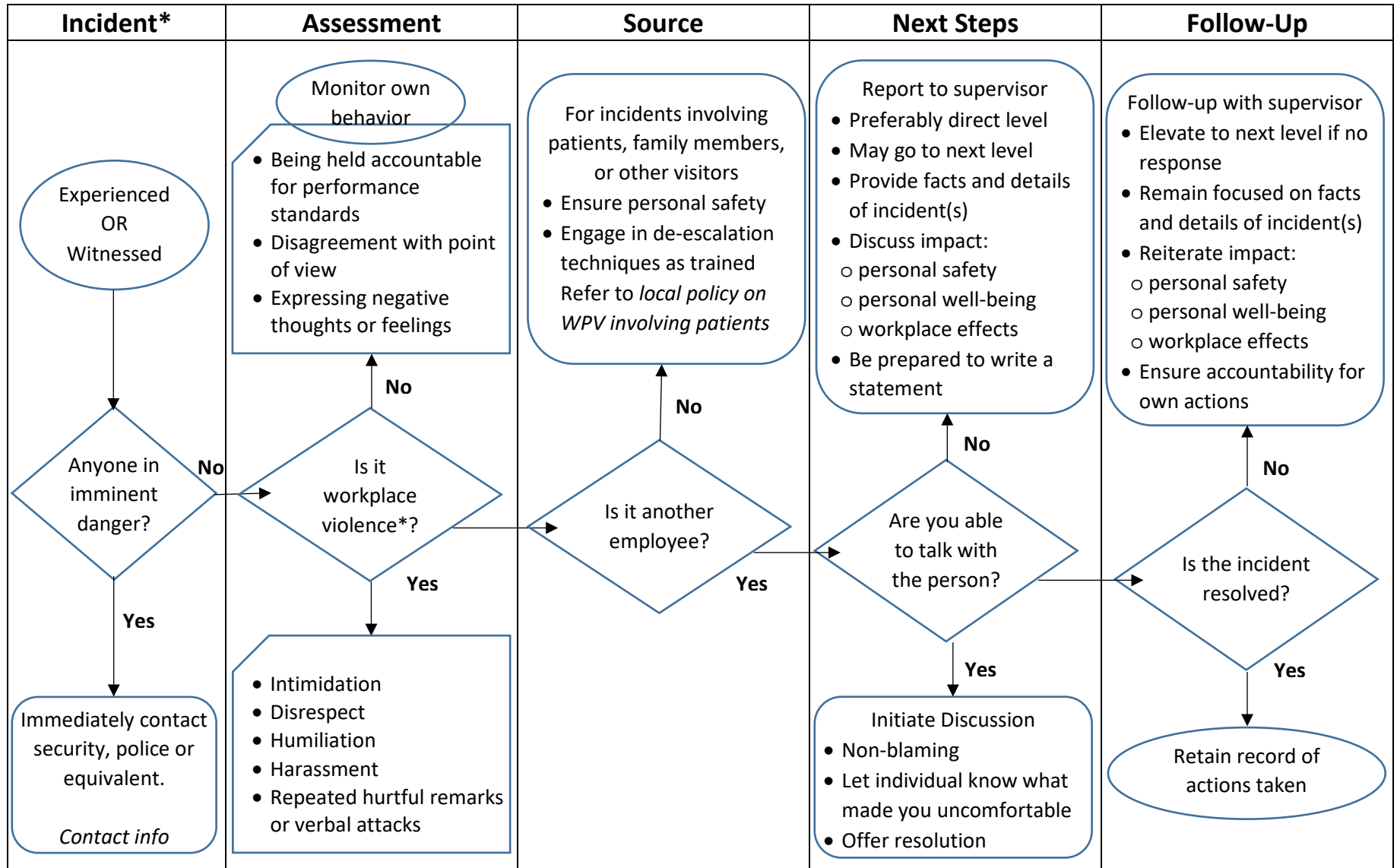
¹⁷ Batras, D., Duff, C., & Smith, B. J. (2014). Organizational change theory: implications for health promotion practice. *Health Promotion International*, 31(1), 231-241.

¹⁸ Substance Abuse and Mental Health Service Administration. *Understanding the Military: The Institution, the Culture, and the People*, 2010.

¹⁹ Young, B. 8 Symptoms Of A Toxic Command Climate, 2015. Retrieved from <https://taskandpurpose.com/8-symptoms-of-a-toxic-command-climate/>

Appendix 1

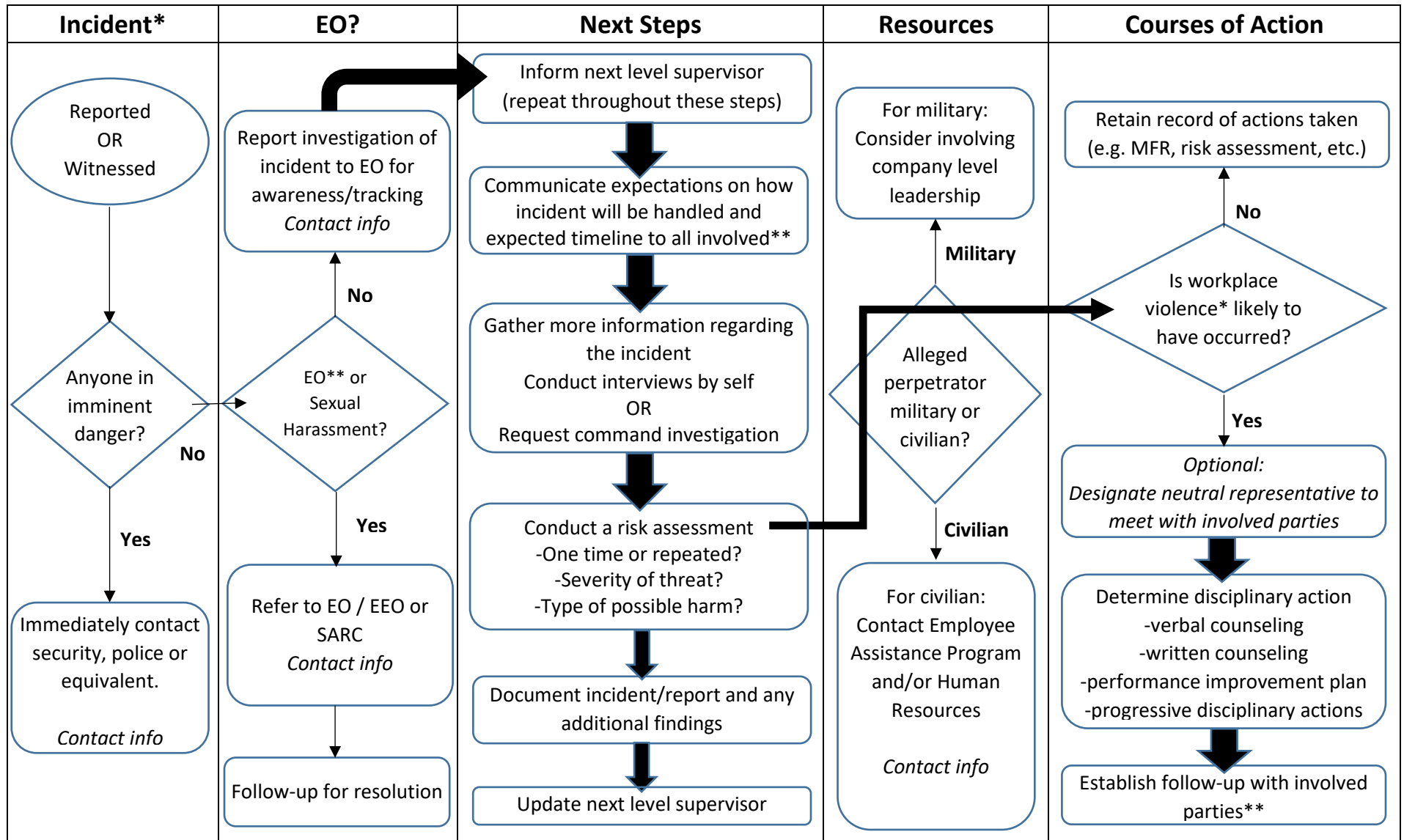
Employee / Staff Member Workplace Violence* Reporting



* Workplace violence = violence, threats, harassment or other disruptive behavior (e.g. incivility, lateral violence, bullying)

Appendix 2

Front-Line Leader Employee-to-Employee Workplace Violence* Response



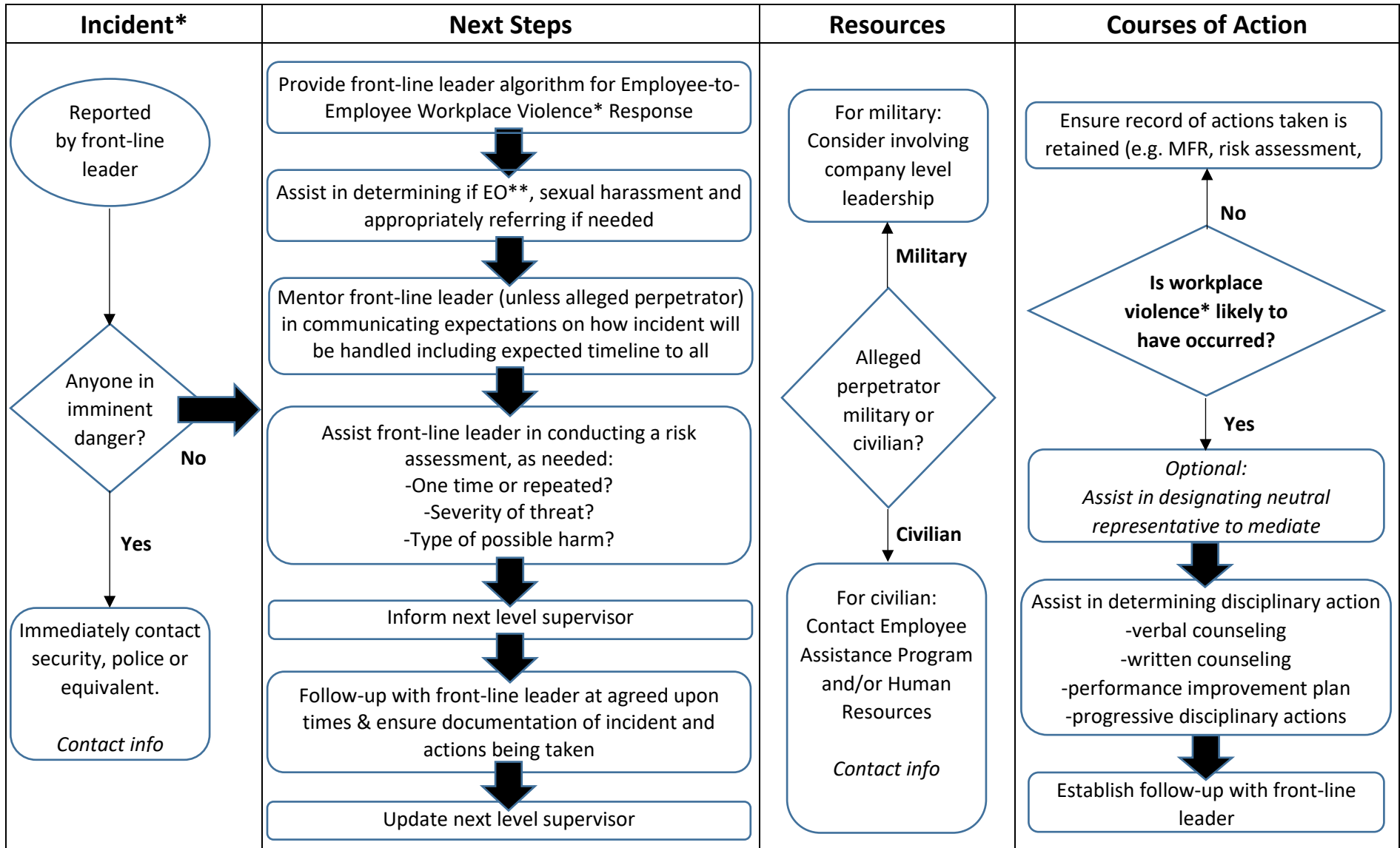
*Workplace violence = violence, threats, harassment or other disruptive behavior (e.g. incivility, lateral violence, bullying)

**Involved parties = victim, alleged perpetrator, next level supervisor

***Equal opportunity = discrimination based on race, sex, religion, national origin, color, or sexual orientation

Appendix 3

Mid-Level Leader Employee-to-Employee Workplace Violence* Response



*Workplace violence = violence, threats, harassment or other disruptive behavior (e.g. incivility, lateral violence, bullying)

**Equal opportunity = discrimination based on race, sex, religion, national origin, color, or sexual orientation