

Workplace Hostility and Nurses' Perceptions of the Value of Interventions and Supportive Structures

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**Abstract**

Workplace and nurse-to-nurse hostility are now well-known phenomena in healthcare organizations. While costs and consequences are well defined in the literature, nurses' perceptions of interventions and supportive structures are lacking. Lack of supportive structures and ineffective interventions by managers have been cited by nurses as being primary concerns. This qualitative pilot study attempted to present a representative panel of active and passive supportive structures, as well as authoritative and collaborative interventions for nurses to evaluate as being valuable or controversial. This work was conducted to inform on reasonable next steps in policy development and staff support as the interventions and structures deemed most valuable by nurses are likely to be both well-received and effective.

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## **Chapter 1: Introduction of the Problem**

### **Introduction**

This research was about nurses' perceptions of specific elements related to workplace hostility within an organizational culture. A problem of discourtesy continues within the nurse workforce setting. There are many names to which the phenomena of discourtesy, disrespect, incivility, or hostility are referred. Some scholars have identified the lack of consistent nomenclature as a barrier to literature reviews (Bartholomew, 2006; Paterson, McComish, & Aitken, 1997). Terms such as lateral or horizontal violence, aggression, verbal abuse, trauma, conflict, incivility, lateral or horizontal hostility, harassment, and bullying among others have all been used to describe this pervasive phenomenon (Haselhuhn, 2005). Of the various terms "violence," "hostility," "bullying" and "abuse," each paired with "nurse," "nursing," or "workplace" provided the majority of literature for this research associated with nurses and workplace hostility within the environment of healthcare organizations.

Horizontal hostility, also known as lateral violence, has been defined as "a consistent pattern of behavior designed to control, diminish, or downgrade a peer (or group) that creates a risk to health and/or safety" (Bartholomew, 2006, p. 4). This hostility can be overt or covert, physical or verbal, and can involve superiors, peers, and subordinates. Overt damaging behaviors include arguing, blaming, criticism, fault finding, gossip, and ridicule among others. Covert destructive behaviors include, but are not limited to exclusion, fabrication, ignoring, refusing to help, withholding information, and active sabotage (Haselhuhn, 2005).

In nursing, primary hostilities have been noted as being overt verbal aggression and come from many sources including patients, providers, and staff, though nurse-to-nurse hostility has been reported as being the most troubling to nurses (Farrell, 1999). More covert or unspoken behaviors that are difficult to measure may play an increasing role. The horizontal or lateral nature of the abuse defines it as being peer-to-peer, nurse-to-nurse, or at the same level within healthcare. While vertical hostilities may be

exchanged between superiors and/or subordinates, a large number of reported cases are horizontal, peer-to-peer, and nurse-to-nurse (Bartholomew, 2006).

Bullying has been described as the persistent belittling and downgrading of humans through malicious words and cruel acts that gradually and progressively undermine confidence and self-esteem (Adams, 1997). For the purposes of this research, any form of mistreatment, whether secretive, implied, or obvious that leaves the recipient feeling personally or professionally violated, humiliated, or devalued qualified as hostility, violence, incivility, and bullying. This included but was not limited to verbally abusive statements that were condemnatory, designed to cause distress, or received as punitive or cruel.

### **Choice of Topic**

The author's choosing to study nurse hostility was motivated by a need to address the issue. The author believed the problem of nurse hostility may be exacerbated by a lack of managerial, administrative, or executive direction, use of non-standardized responses, administrative uncertainty as to supportive structures and interventions, and zero-tolerance policies that lack clear process and consequences. As an administrative nursing supervisor for a large healthcare system, and as a nurse, the author was obligated to participate in finding solutions for this epidemic. Additionally, the author's bias in this research is as a nurse who has experienced the deleterious effects of horizontal hostility first hand and witnessed as well as intervened in numerous other occurrences.

### **Rationale and Significance of the Study: Importance to Nursing**

This study was intended to evaluate nurses' perceptions of structures and interventions utilized in addressing workplace hostility. Workplace hostility has become a now well-known phenomenon in healthcare organizations with many devastating physical, fiscal, and psychological consequences detailed in the literature (Nance, 2009; Paterson et al., 1997; Pearson & Porath, 2009; Wagner, Capezuti, & Rice, 2009; Wienberg, 2003). How to combat this behavioral pandemic continues to be a current topic of interest to many researchers (Institute of Medicine [IOM], 2011).



There were numerous symptoms ascribed to hostility in the literature, any of which would be reason enough individually to address it. These included poor nurses' satisfaction surveys (Cleary, Hunt, & Horsfall, 2010), decreased nurse retention (Weaver, 2013), fearfulness while at work (Namie & Namie, 2009), wasting of organizational resources (Lewis, 2006), increased reported illnesses and sick days (Farrell, 1997; Farrell, 1999; Ortega, Christensen, Hogh, Rugulies, & Borg, 2011), increased errors in patient care (Matt, 2012; Simons & Mawn, 2010; Joint Commission, 2008), decreased work productivity (Berry, Gillespie, Gates, & Schafer, 2012), and nurse burnout and psychological distress up to and including suicide (Rodwell & Demir, 2012).

The author presented options to nurses of supportive structures and interventions that may have been deemed valuable for prevention or mediation in cases of identified hostilities. Among other diversity assessments, a qualitative comparison of direct manager mediation versus alternative mediation structures was assessed by nurse survey to elicit perceptions, opinions, and experiences (Simons, Roland, & DeMarco, 2011). This work's contribution to solving the problem of nurse-to-nurse hostility was to establish the potential value of any given structure or intervention. This research was advisable prior to a more quantitative review of outcomes for best practices or recommendations to standardize approaches in hostility interventions. How supportive structures are perceived by the staff for which they are intended will be pivotal to their acceptance and successful implementation.

### **Outline of the Current Problem**

The deterioration of normal and expected professional behaviors that workplace hostility and all related terms represent, is known to manifest insidiously, persistently, and often recurs cyclically (Felblinger, 2008; Namie & Namie, 2009). It is pervasive enough that many nurses refer to it as being epidemic. In 2008, HCPro, Inc., reported a benchmark survey to *Strategies for Nurses Managers* citing statistics as high as 97% of nurses reporting having witnessed hostilities and as many as 75% reporting having experienced bullying firsthand at least once in their career. The ANA (2012) reported more conservative estimates of 18% to 31% of hostility within the nursing workforce. The lower values as

represented in other studies may actually be higher than reported or represent areas with more institutional or organizational support in matters of hostility. Consequences of any tolerated hostilities manifest in both financial burden to facilities and a human cost to patient care and the nurses that provide that care (Joint Commission, 2008). As such, this remains a topic of much research and attention currently (Institute of Medicine [IOM], 2011).

### **Background to the Problem**

In previous studies conducted by Gerald A. Farrell, PhD, RN, nurse respondents' main concerns regarding workplace hostility was their nurse managers' failure to implement supportive structures when incidents of hostility were reported or to take appropriate actions to prevent the reoccurrence of hostilities (Farrell, 2001). Farrell reviewed contributing causes to nurse hostility in the context of oppression and feminist theories. Cases were then further divided into micro-, meso-, and macro-level analyses. Micro-level perception acknowledged an individual determinant to aggression and hostility. Meso-level assessments of hostility focused on organizational structures and disenfranchising practices. Macro-level perspectives focused on nursing within the greater context of other professional or power structures. Oppression theory further explained a macro-level feature of hostility by highlighting nurses' marginalization and disempowerment within healthcare.

Nurse survey responses mentioned above speak to a deficiency in meso-level or organizational structures. It is the author's opinion that nurse managers, supervisors, and directors do not all have the tools required to effectively intervene in cases of reported hostilities. It is also possible that managers, as well as administrators, simply need more training and structure when supporting staff through conflict. The author's role in this research was to collect, analyze, and evaluate responses related to structures and interventions deemed valuable by nurses for further consideration in designing and implementing such structures for management and staff.

### **Possible Causes and Contributing Factors**

Evidence suggests that bullying is fostered by the characteristics of the victim and the bully, the social system, and the organizational culture (Haselhuhn, 2005). Exacerbations to this epidemic include generalized oppression, limited resources, increased stress and job burden, inequity of positional power within the institution, lateral transference of frustrations, and organizational tolerance for hostilities (Joint Commission, 2010). One study found that perpetrators of workplace hostility were shocked to discover their behaviors were considered inappropriate. This may have been due to a lack of awareness, because such behaviors were viewed as normal, or because hostilities had been tolerated for so long without repercussion (Griffin, 2004).

Furthermore, a lack of supportive structures and ineffective interventions by managers have been cited by nurses as being primary concerns for ongoing and recurring conflict (Farrell, 2001). Likewise, managers themselves can be the victims or perpetrators of bullying (Johnson & Rea, 2009). As of this thesis (2013) there were no nationally mandated or standardized formal methods for reporting incidences of emotional or verbal abuse that occurs in the workplace. Additionally, emotional or verbal abuse is not uniformly perceived as violence or bullying, nor are there standardized responses or Federal laws prohibiting such behaviors in the United States (American Nurses Association [ANA], 2012).

### **Research Questions**

#### **Primary Question**

1. Of the presented set, which interventions and supportive structures to hostilities do nurses perceive as being the most valuable *and why*?

#### **Secondary Question**

2. What trends in the data, if any, correlate participant characteristics with perceptions of value?

The stated nature of this research is qualitative, though an opportunity for quantitative measurements has been made by way of perceptions being correlated along a Likert scale. As a

qualitative study without causal investigation, a hypothesis was deferred as unnecessary. The research intended to inform on next steps by determining which structures and interventions are considered valuable by nurses and which, if any, are not valued.

A combination of closed (ordinal-polytomous) and open-ended (narrative) questions were included on the survey asking nurses why they value specific structures and interventions in order to add depth and possible significance to responses. Themes within the answer sets are then intended to provide direction to the overall endeavor of curbing workplace hostility. Trends correlating participant characteristics and their perceptions of value related to interventions were also reviewed.

### **Best Practices**

An excellent review of what it takes to translate workplace violence intervention research into evidence-based programs was conducted by *The Online Journal of Issues in Nursing* (2013). These recommendations were a compilation of best practices with regard to effectively addressing and mediating workplace hostility (McPhaul, London, & Lipscomb, 2013) based on OSHA (2004) guidelines. The five primary categories of best practices included: (1) Management Commitment and Employee Involvement, (2) Hostility Analysis or Assessment, (3) Employee Training, (4) Recordkeeping and Evaluation, and (5) Hostility Controls or Interventions.

In addition to these recommendations collected and presented by OSHA (2004) and elaborated on in OJIN (2013) in Chapter 2 of this thesis, the ANA (2012) endorsed each nurse taking six specific actions. The ANA recommended that each nurse faced with hostility: (1) Inform the bully that the behavior will not be tolerated, (2) maintain a record of the bullying incidents, (3) increase awareness of bullying by discussing the issue of bullying at staff meetings, (4) handle conflict positively and creatively, (5) promote positive, professional behaviors, and (6) support the development of anti-bullying behaviors and policies.

Griffin (2004) proposed the most widely known intervention for individual nurses to date. This work taught new nurses how to protect themselves against hostilities by means of prepared reactions,

statements, non-verbal cues, and processes. The method was referred to as cognitive rehearsal and significant success has been demonstrated with its usage. A representative summary of the professional literature focusing on nurse hostilities and additional structures and interventions will be presented in Chapter 2.

## **Chapter 2: Literature Review**

### **Causes of Hostility within Nursing**

Again, evidence suggests that bullying is fostered by the characteristics of the victim and the bully, the social system, and the organizational culture (Haselhuhn, 2005). Lack of supportive structures and ineffective interventions by managers have been cited by nurses as being primary concerns (Farrell, 2001). This study attempted to present a representative panel of active and passive supportive structures, as well as authoritative and collaborative interventions for nurses to evaluate as being valuable or a waste of resources.

How nurses feel about any given traditional or alternate pathways intended to resolve conflict or hostilities may help to determine which structures might be best received and accepted by staff. Collecting a representative sample of supportive structures and asking nurses what they think about their likelihood of success and value to the profession may provide insight into which supportive structures or interventions may be most likely to succeed. This work was intended to intelligently inform on reasonable next steps by asking nurses who know this phenomenon best, those who witness or experience it regularly.

### **Costs and Consequences**

As stated previously, there are numerous symptoms ascribed to hostility in the literature, any of which would be reason enough to address the issue. Listed below is a representative though not exhaustive summary.

When reviewing the costs of hostility within organizations, sources focused on nurse satisfaction survey results indicating dissatisfaction related to collegiality. These often indicated a negative trend of non-collegiality or incivility (Yildirim, 2009). Such trends were followed closely by nurse satisfaction survey results indicating dissatisfaction with interventions and support on the part of management and the healthcare organization (Cleary et al., 2010; Farrell, 1997; Farrell 1999; Farrell, 2001).

Beyond these telling surveys were poor nurse retention rates, high nurse turnover, and increased new hire training and related expenses (Weaver, 2013). Increased utilization of company resources to address discrete reports of hostility as tracked by human resources or specific departments (Lewis, 2006) and increased sick day utilization or reported illnesses (Farrell, 1997; Farrell, 1999; Ortega et al., 2011) added to the costs borne by healthcare organizations. Additionally, decreased work productivity often occurred as a result of hostilities (Berry et al., 2012) decreasing an organization's ability to compete or maintain financial viability.

Beyond the financials were the human costs. These included employee fearfulness while at work (Namie & Namie, 2009), nurse burnout as evidenced by a lack of willingness to pick up shifts, cover, or work overtime due to physical and psychological distress (Rodwell & Demir, 2012), and an increase in mistakes associated with distraction, with or without negative patient outcomes (Joint Commission, 2008; Matt, 2012; Simons & Mawn, 2010). The human cost was no more evident, however, than with the loss of life. Nurses have both been distracted to catastrophic results for their patients and driven to suicide when psychological distress peaked and all coping mechanisms failed (Griffin, 2004; Namie & Namie, 2009). All of the above factors are recorded as symptoms of nurse hostility and each were considered in the development of the survey.

### **Prevalence**

The number of reported instances of hostility may rise if previously underreported or as actual hostility increases. Likewise, the reports may fall as incidents decrease or simply as reports decrease. Therefore, the number of reported incidences of hostility whether increasing or decreasing was not a useful measurement of change without more standardized reporting mechanisms (Hendershot, Dake, Price, & Lartey, 2006; Iennaco, 2013; Rucker, 2012). As mentioned previously, the ANA (2012) reported conservative estimates of 18% to 31% of hostility within the nursing workforce while HCPro Inc. (2008) survey estimates approached 100% for at least one exposure during a nurse's career.

A 2007 poll of adult Americans conducted by Zogby International determined that 49.1% (or nearly half) of all American workers have been affected by bullying (Namie & Namie, 2009). The Bureau of Labor Statistics that same year confirmed that 37% of American workers reported having currently or previously experienced hostilities at work. OJIN in 2013 added that 50% to 92% of all nurses surveyed indicated having experienced verbal aggression within the past year and that 38.2% to 54.2% had experienced it within their past five work shifts (Iennaco, 2013). As of 2009, estimates of lateral violence in the nursing workforce ranged from 46% to 100% (Stanley, Martin, Michel, Welton, & Nemeth, 2007).

### **Best Practices and Recommended Structures**

No comprehensive summaries of interventions or supportive structures intended to mediate hostility were found in the literature, save one (McPhaul et al., 2013), though recommendations for best practices were found in recent years (ANA, 2012; OSHA, 2004). These recommendations generally included or expanded on the five categories presented by OSHA (2004) and incorporated 20 or more specific best practices.

### **Management Commitment and Employee Involvement**

Healthcare facilities were asked to adopt a zero-tolerance stance toward workplace hostilities. This was to facilitate addressing all incidences of reported hostilities without justifying any as being just part of the job, which required management's commitment to address the issue of hostility. Furthermore, all healthcare organizations were strongly encouraged to abide by all Federal and State regulations (McPhaul et al., 2013).

### **Hostility Analysis or Assessment**

Expanding on OSHA guidelines included recommendations to implement a system of hostility or hazard assessment by way of surveys, focus groups, or other means. Information gathered could be used to assess identified contributors to stress such as levels of staffing, overtime, supervisor support, teamwork, safety climate, and job demands. Establishment of an advisory group or task force composed



of top management, union representatives, and direct care workers was further recommended, as was institutional transparency with regards to issues of violence and hostility (McPhaul et al., 2013).

### **Employee Training**

Consistent with OSHA guidelines, McPhaul et al. (2013) and the American Nurses Association (2012) recommend that each healthcare facility or organization develop and implement a code of conduct that outlines acceptable and unacceptable behaviors. Once this code was in place, organizations were encouraged to provide education to staff regarding communication skills, provide coaching and mentoring to staff related to behavioral deviance from the code of conduct, and provide mediation services in instances of unresolved disputes.

### **Recordkeeping and Evaluation**

In order to track the progress of any hostility intervention program facilities were to document interventions up to and including disciplinary action and demonstrate evidence of management support and employee involvement. The goal of recordkeeping was to develop a framework for comprehensive workplace violence prevention based on scientific evidence, regulatory guidance, and specific organizational practices. To this end, organizations would do well to incorporate periodic evaluation and benchmark, monitor, and reevaluate program effectiveness (McPhaul et al., 2013).

### **Hostility Controls or Interventions**

Supportive programs and structures were defined as best practices when based on data-driven violence or hostility controls and interventions. Many facilities already incorporated the best practices of security features such as electronic surveillance, security personnel, and access control, but standardized workplace violence policies and resources or tool kits for management and staff were thought to be lacking (McPhaul et al., 2013).

### **Methodological Approach**

The guiding works selected for the development and implementation of this qualitative research study include Sharan Merriam's (2009) book, *Qualitative Research: A Guide to Design and*

*Implementation* and Ian Dey's (1993) book, *Qualitative Data Analysis: A User Friendly Guide for Social Scientists*. Each source brought valuable and specific insights into the organization, conduct, and execution of qualitative research.

### **Summary: Conclusion and Interpretation of Literature**

The causes and consequences of hostility were the mainstay of the literature on this topic. What appeared to be lacking almost completely were specific recommendations for interventions and structures designed to mediate or prevent hostilities and support staff and management through the process of hostility resolution. While the problem of nurse hostility has been clearly identified, it is in and of itself too broad a problem to be adequately treated in its entirety within the scope of a nursing master's thesis. Hostility, violence, and incivility have been well defined and the literature is full of examples, case studies, contributing factors, and consequences. Less readily evident in the literature were nurses' perceptions of supportive structures and opinions about interventions that could be useful in mediating hostilities.

There were two notable mentions, however, that structures were lacking and management was ineffective (Cleary et al., 2010; Farrell, 2001). There was also one highly cited intervention regarding cognitive rehearsal as a means for new nurses to shield themselves against lateral violence (Griffin, 2004). Additional structures could be inferred through such agencies as the Occupational Safety and Health Administration (2004), the American Nurses Association (2012), and the Joint Commission (2008), though few recommendations for specific interventions were cited prior to recent years (Longo, 2010; McPhaul et al., 2013; Schulte, 2009) and fewer references to nurses' perceptions of structures and interventions were found.

The author circulated a questionnaire to gauge nurses' perceptions of interventions and supportive structures in order to (1) better define the zero-tolerance to hostility concept, (2) aid in the development of tools kits for managers and staff, and (3) standardized responses at the facility level after (4) ascertaining

which structures and interventions nurses' perceived as being most valuable and therefore likely having the greatest potential for success.

The researcher intends to present the results of this work to improve the environment of care at the facilities of his current employment and share any supportive structures deemed valuable with nursing and nursing administration beyond immediate and affiliated healthcare organizations. It is only by being informed, working collaboratively, and accepting accountability that we as a profession will solve this problem and resolve ongoing and damaging hostilities between nurses. And as nurse leaders, we can help lead the way in addressing workplace violence as a whole.

### Chapter 3: Methodology

#### Evaluation Methods and Instruments

The author employed purposeful sampling by way of an embedded link to a questionnaire that was open to nurses who were registered with a healthcare consulting organization. The researcher-developed online survey tool was created with *SurveyMonkey.com* and distributed through [REDACTED].llc. *SurveyMonkey.com* was then utilized to deliver the informed consent, safeguard the anonymity of participants, and collect the raw data for analysis.

The survey was limited to twenty questions in an attempt to keep it brief enough to complete in ten minutes (Tarran, 2010). This was to minimize testing fatigue and respect the time of participants. Four nurse participant characteristics (age, gender, years in nursing, and state of primary RN practice) were requested. Sixteen statements related to workplace hostility interventions and organizational supportive structures were offered for evaluation. Nurses were asked to rate each statement on a four-point Likert scale indicating whether they agreed or disagreed. Participants were specifically asked to strongly disagree, disagree, agree, or strongly agree with each statement of value and explain their answer.

A four-point scale without a middle neutral value was selected to force a trend. This is referred to as a “forced choice” method in that the option to “remain neutral” or “neither agree nor disagree” has been removed. Four-point results are consistent with those achieved by using five-point scales (Allen & Seaman, 2007; Armstrong, 1987). Each question was presented with a text box requesting an explanation as to why participants selected any particular rating (see Appendix A - Survey with Informed Consent).

Statements represented four active and four passive supportive structures, as well as four collaborative and four authoritative interventions based on the literature review of best practices (ANA, 2012; McPhaul et al., 2013; OSHA 2004) and local practices encountered by the researcher. The four-point scale provided a collapsible yet slightly more detailed response than would a yes/no survey and the open-ended component was intended to explore possible rationales underpinning participant perceptions of value.

Nurse participants were surveyed from a variety of disciplines and workforce populations within the US. A broad request for participation was sought in order to make the results more generalizable to and representative of the nursing workforce as a whole. The survey was open to nurses of all ages, ethnicities, specialties, educational levels, and other defined characteristics to be as inclusive as possible. Trends between requested participant characteristics and perceptions of value were assessed by groupings or themes in the data. Interventions and structures were also reviewed for comparative perceived value individually and within the four subsets of active, passive, collaborative, and authoritative. The data has been visually and narratively represented for discussion in Chapters 4 and 5 of this thesis.

Distribution lists were utilized containing registered nurses in several states. Survey methodology allowed delivery of a questionnaire or other information collecting tool to a relatively large sample of potential participants in a short period of time with minimal cost (Gay, Mills, & Airasian, 2008). Target audience for results will focus on nurse managers, supervisors, administrators, and executives, as well as clinical nurse specialists and professionals in human resources and organizational development within healthcare settings.

A hypothesis, while possible, was not considered necessary or particularly valuable due to the qualitative and informational nature of the research. Rather than hypothesizing which supportive structures might have been of most value prior to collecting survey results, the work focused on the collection and analysis of data for informed and reasonable next steps in addressing workforce hostility among nurses.

### **Reliability and Validity of Evaluation Methods and Instruments**

As a stand-alone instrument, the survey is considered highly reliable in that the questions are presented in a consistent manner to each participant allowing consistent measurement (Burns & Grove, 2007). Reliability is the consistency of the measurement, either across like participants or across interviewers using a questionnaire (Dey, 1993). Participants may also perceive greater anonymity than in

interviews, decreasing potential bias in responses, and increasing candor (Gay et al., 2008). Asking similar questions about the same interventions or structures, such as participant's perceptions of any given intervention being wasteful, expensive, or cost-effective was deferred to minimize the length of the survey. This was considered a trade off as a researcher-developed questionnaire composed of twenty questions or less was intended to minimize testing fatigue and maximize the probability of survey completion and return (Tarran, 2010).

Adding the participant characteristic of state of professional RN practice was intended to measure the geographic diversity of respondents and thus give insight into the generalizability of the data. Broad geographic representation was designed to minimize any potential colloquial bias or predisposition to perceptions based on local social, community, or facility-specific norms. Use of open-ended questions for matters of perception, value, and opinion was ideal for collecting the most valid qualitative information. Validity is the degree to which the instrument measures what it is intended to measure (Dey, 1993). In this case the researcher attempted to measure nurses' perceptions of value.

Distribution of the instrument online further increased the potential randomness of the sample size by uncoupling the survey from a specific geographic region. Online tools decrease the time and costs required to deliver the questionnaire to participants and return responses instantly to the researcher for evaluation. Distribution specifically to nurses in a purposeful sampling was intended to narrow responses to the perceptions of individuals within this specific profession, making any conclusions more specifically suited to applications in matters of nurse-to-nurse hostility.

While adding interviews to this study may have made it more robust, by means of triangulating data collection, a combination of pre-structured (deductive) and open-ended (inductive) questions was considered sufficient for this pilot study (Jansen, 2010). Piloting the study was intended to increase both the validity and reliability of future inquiries on the topic. The open-ended survey questions in this case were designed to parallel data collection that could otherwise have been collected from focus groups and interviews by way of ethnography and narrative analysis. Each associated closed-ended question was

asked in order to guide the overall interpretation of the diversity found within the data sets and suggest a general direction of opinion (Merriam, 2009).

### **Integrity and Security of Data**

Data collected by *SurveyMonkey.com* did not include any personal identifiers such as name, address, place of employment, social security number, birth date, email, phone number or other contact information. Additionally, access to the data was secured with a password known only by the researcher. Any potential paper survey information collected was also devoid of identifying information and kept in a locked cabinet at the researcher's place of employment. The vast majority of surveys were collected online. The survey was open for one week. Requested characteristics included age, gender, years in nursing, and state of RN practice. Identifying characteristics were neither required nor desired for this research. General perceptions of nurses were collected as narratives or keywords and analyzed collectively for trends and themes. Trend identification was secondary to the primary study focus, which were nurses' perceptions regardless of their characteristics.

### **Research Design**

The research design chosen for this thesis was qualitative in nature. Qualitative research is ideal for exploring the perceptions, thoughts, feelings, opinions, values, and beliefs of participants. A qualitative approach allows a humanistic analysis of feelings and opinions that are experienced by individuals. Why nurses state they perceive interventions as having or lacking value can be explored beyond the number of responses or mean values as themes distill from open-ended inquiry. Qualitative designs are popular in social science inquiry as they foster a greater understanding of human behavior and the motivations that govern such behavior (Dey, 1993).

The majority of research into nurse and workplace hostility to date focused on defining hostilities, elucidating possible causes, identifying harmful and costly consequences, and determining prevalence. Little was known about how nurses perceive interventions on an organizational or individual level.

Structures and techniques for addressing the actual issue of hostility were minimally represented in the literature and even less was published on nurses' perceptions of interventions.

Employing a survey methodology allowed both quantitative (distribution) and qualitative (diversity) applications. Qualitative categories emerged in the collected data that allowed a greater understanding of participants and their perceptions. The survey was not intended to evaluate social interactions, but rather focused on participants' accounts and evaluations of social interactions (Jansen, 2010).

While surveys of both quantitative and qualitative varieties are best served by empirical cycling or iteration, this pilot was intended to establish a foundation and point of inquiry for further study and analysis. Initial qualitative analyses focused on patterns within nursing characteristics. Secondary analysis attempted to elucidate the relationships of those patterns to interventions. And a tertiary analysis was made to determine what associations may exist between characteristics, interventions, and categories of value.

Saturation, or a full representation of diversity, may or may not have been reached in this pilot. Both downward (differentiating) and upward (synthesizing) coding were considered as the data were analyzed (Jansen, 2010).

### **Choice of Research Methodology**

The sampling technique chosen was random purposeful in that it explicitly targeted nurses as the group of interest. Purposeful sampling was appropriate as nurses have been called upon as leaders within healthcare organizations to address workplace hostility by developing and directing interventions and supportive structures (ANA, 2012). A nursing sample was also appropriate as some studies suggest that nurses experience twice the hostility within healthcare organizations as other employees do within the general US workforce (HCPro Inc., 2008; Namie & Namie, 2009).

A qualitative study methodology was chosen to investigate the reasons, motivations, or experiences behind nurses' perceptions of value. An online survey format was adopted to facilitate the



inquiry as it was cost-effective, quick to produce and distribute, convenient to participants, non-geographic in sampling, captured immediate raw data, and assured confidentiality by design.

*SurveyMonkey.com* was specifically selected as it allowed the inclusion of informed consent as a precursor to the questionnaire. Social science researchers are fond of survey methodology due to its inherent reliability, ease of use, and immediate capture of data. Qualitative methodologies, likewise, allow the elucidation of themes within intrinsically human elements beyond quantifiable data (Dey, 1993).

### **Participants**

The study focused on adult nurses of either gender practicing within the United States. Characteristics such as education, income, and certification were not requested due to their controversial nature. Age, gender, years in nursing, and geographic location of primary RN practice were maintained as relevant. Nurses of any age range were invited to participate regardless of gender, experience, or geography. Nurses with disabilities were not omitted unless those disabilities also prohibited professional practice and thus prevented them from being represented in the distribution lists.

Any participant's relationship to the researcher was simply as professionals within the same profession. Coworkers or fellow students may have been participants, but none were identified in the study or known to the researcher by data collection as having participated. The survey was open for one week and utilized two distribution lists, one northwest-specific list and one national distribution list. Since studies of prevalence report nurses' exposure to workplace hostility as approaching 100% at least once in their professional career, all nurse participants were credited with some expertise on the value of interventions and supportive structures.

### **Organizational Permission**

The author completed certification for the *Protection of Human Subject Research Participants* through the National Institutes of Health and obtained permission to utilize [REDACTED] resources for data collection before submitting this thesis proposal to Western Governors University for IRB approval. The study was granted expedited status.

The email distribution lists were unknown to the researcher save that they contain email addresses of nurses residing and practicing in the United States. These DLs, or distribution lists, were shared between [REDACTED] and *SurveyMonkey* for the collection of data. The author had access to the anonymized raw data that was provided by returned surveys. The letter of informed consent was electronically presented as the first page of the survey along with the instructions for completion of the survey (see Appendix A - Survey with Informed Consent).

The author originally intended to utilize multiple organizations as points of distribution to nurses. Rather than pursuing multiple venues, the current pilot study format was proposed for initial data collection and augmented reliability of future studies that may include quantitative or mixed methodologies and larger samples. Two healthcare organizations in particular were approached for possible inclusion in the study. Each organization was presented an overview of the study goals and an early version of the questionnaire by *PowerPoint*. Both organizations agreed to participate in data collection, but only one of the two contributed to the initial pilot.

Again, this work was intended to inform on next steps as those interventions and structures deemed most beneficial or valuable by nurses are likely to be the best received and therefore the most appropriate. Findings will be discussed in Chapter 4.

## **Chapter 4: Findings**

### **Survey Scope and Engagement**

As a pilot, this study attempted to collect data that would be representative of diverse nursing populations. The study was limited to nurses in the United States. Both survey collectors were accessible to nurses from all 50 states. A facility-specific concentration was deferred in order to foster greater diversity in responses, as well as create a qualitative baseline for future inquiries.

Two survey collectors were utilized. The first collector employed a national distribution list that contributed 50 completed surveys collected from nurses in 24 states. The second collector was paired with a distribution list focused on the US Pacific Northwest that contributed 40 surveys collected from seven states. Most notably Washington State contributed 22 surveys between the two collectors. It is also remarkable that the national collector passively acquired two additional participant characteristics that were not requested in the survey. These characteristics included level of education and household income. Since education and income were passively acquired and represented only 44.44% of participants, these ancillary results have been displayed for reference only in the overall data set.

Proposed interventions and structures were analyzed for comprehensive support from nurses, as well as for trends within data sets. The 16 interventions and supportive structures were presented in a non-randomized format. After the Informed Consent and agreement to participate (page 1), each successive page contained Passively Supportive Structures (page 2), Collaborative Interventions (page 3), Actively Supportive Structures (page 4), and Authoritative Interventions (page 5). The stated intent was to offer structures and interventions in order from the most passive to the most authoritative practices. Four participant characteristics were collected at the end of the survey (pages 6 and 7).

Some survey attrition was noted. Of the 90 participants who began the survey, 80 were noted as having completed all seven pages. This is a completion rate of 88.89%. The Informed Consent page and Passively Supportive Structures were assessed by 100% of participants. Collaborative Interventions and Actively Supportive Structures were assessed by 98% and 92% of participants, respectively. The final

three pages including Authoritative Interventions and Characteristics were completed by 88.89% of participants. Thus, for the closed-ended inquiries the number of participants (N) ranged from 80 to 90.

Attrition was likely due to requiring responses for the first few days that the two collection venues were active since participants could not progress through the survey unless all questions were addressed on each page. Once a minimum of 30 surveys had been completed with all open- and closed-ended questions addressed, the surveys were amended by making each question optional. This adaptation was executed for both collectors on the advice of the national distribution list proprietor, *SurveyMonkey.com*, in order to maintain the quality of results and decrease further attrition. Open-ended responses ranged from 74.44% to 50% with steadily decreasing engagement from Passively Supportive Structures to Authoritative Interventions and finally Characteristics. For the open-ended inquiries the number of participants (N) ranged from 45 to 67.

Brief descriptions of the structure sets headed each survey page preceding the proposed intervention statements and questions. Passively Supportive Structures were defined as structures and interventions to workplace hostility focusing on organizational support with a cultural focus. Collaborative Interventions were described as structures and interventions to workplace hostility focusing on organizational and individual awareness and having a preventive focus. Actively Supportive Structures were defined as structures and interventions to workplace hostility focusing on training and skills with an educational focus. Authoritative Interventions were described as structures and interventions to workplace hostility focusing on organizational support and having a crisis management focus.

### **Value Analysis**

The grading of each structure or intervention for relative value was accomplished in two ways. The data were both collapsed and expanded. Collapsing the data simply involved adding the number of Agree and Strongly Agree responses together from each question and then dividing this sum by the total number of responses for that inquiry. As an indicator of favor or value, this was referred to as Consensus of Value (or CV) and recorded as a percent. For example, 33 Agree + 46 Strongly Agree = 79 in favor,

N=90, therefore  $79/90 = 87.78\%$  consensus. This methodology produced results as would a yes/no survey and showcased the general consensus among nurses. However, as two or more interventions resulted in the same consensus scores a slightly more sophisticated methodology was required for the ordinal ranking of value perceptions.

Expanding the data provided higher resolution and more detailed information allowing the interventions to be ranked by relative value. Expansion was a process similar to standardized calculations for grade point averaging. Grading within educational institutions is a process of applying standardized measurements of varying levels of achievement in a course of study. Grades are essentially units of achievement or value and can be assigned letters (for example, A, B, C, D, or F), as a range (for example 4, 3, 2, 1, 0), as a percentage of a total number, or as descriptors (excellent, good, satisfactory, poor).

While the assertions of value in the survey were offered as descriptors or linguistic qualifiers (Strongly Disagree, Disagree, Agree, and Strongly Agree) the ordinal nature of the terms allowed for conversion to whole numerical units in the same way that letter grades are converted to grade point averages. Grades from cumulative coursework can be averaged to create a grade point average (or GPA). The GPA is calculated by taking the number of grade points a student has earned in a given period of time divided by the total number of credits taken.

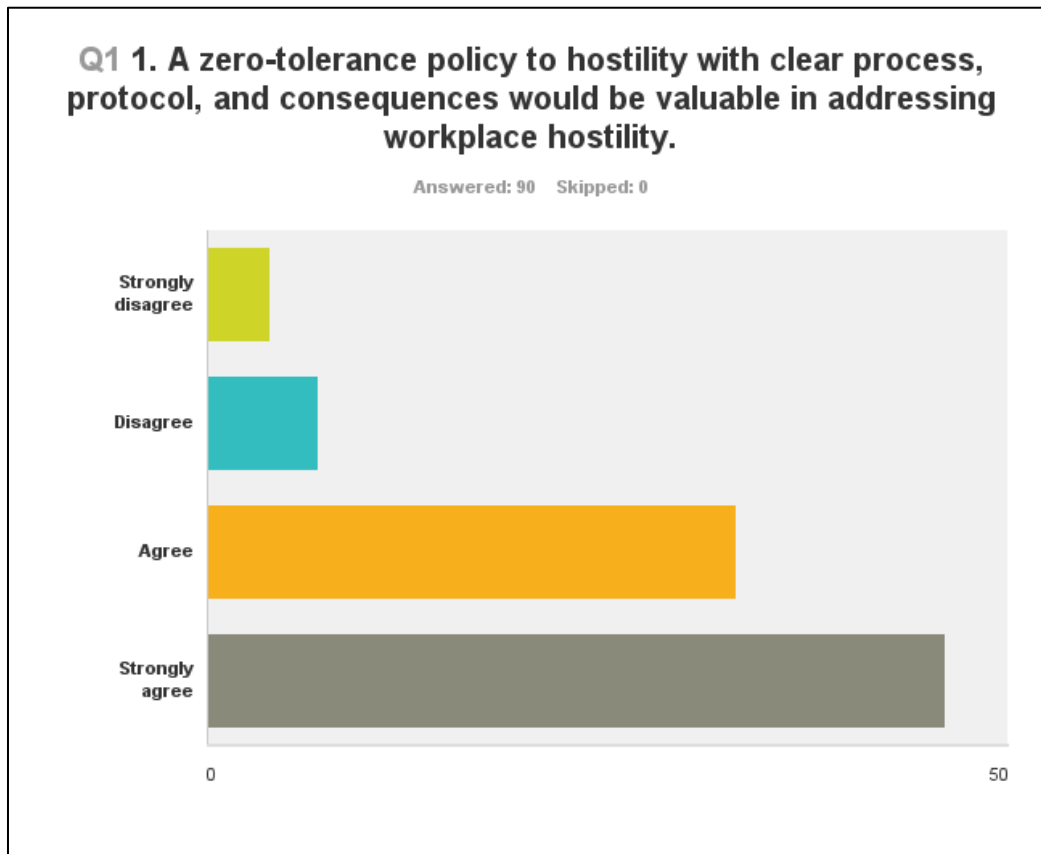
A calculated score, or Perceived Value Index (VI), for each potential intervention was arrived at by ascribing each item on the Likert scale a corresponding linearly ordered numerical value or coefficient (1, 2, 3, 4). Strongly Disagree was given a value of one, while Disagree was ascribed a value of two. Agree and Strongly Agree were each assigned to three and four, respectively. This provided an effective method for comparative analysis with numerical values relative only to each other. While the use of relative values allowed the data to be sorted it did not allow for measurements of the relative degree of difference between each value. However, the expanded data provided higher resolution as to the relative value of each intervention or structure than did the compressed data. Use of alternate numerical sets (such as -2, -1, 1, 2 or 0, 1, 3, 4) would have produced different discrete values and means, but the relative order

of perceived value would have been maintained as long as the numerals were applied as an ordinal scale and the linguistic qualifiers were perceived as equidistance and symmetrical. These criteria were considered in the survey development.

In order to attain the Perceived Value Index, the number of responses within each category of value was multiplied by its designated coefficient (1, 2, 3, or 4). These weighted category values were then added together and the value sum divided by the total number of responses for that question. This methodology allowed each of the 16 interventions to be ranked relative to each other by the collective nursing perception of value. For example, in the first question four respondents Strongly Disagreed, another seven respondents Disagreed, while 33 respondents Agreed, and 46 respondents Strongly Agreed. A Value Index of 3.344 was attained in the following manner:  $(4 \times 1) + (7 \times 2) + (33 \times 3) + (46 \times 4) = 301$ , and since  $N=90$ ,  $301/90 = 3.344$ .

A score of 1.0 was the minimum and 4.0 the maximum potential values for any given intervention. A value of 2.5 was noted as being a true neutral or 50% benchmark. A Value Index score of less than 2.5 would indicate a negative trend or *greater disagreement than agreement* among nurses as to the value of any presented structure or intervention. Likewise, a Value Index score of higher than 2.5 would indicate positive trend or *greater agreement than disagreement* among nurses as to the value of any presented structure or intervention.

The following charts depict the results attained from responses to each of the statements offered and questions asked in the survey, as well as the passively collected information. The questions with responses have been presented in the order that they appeared on the survey. Each chart is accompanied by several quotes that represented qualitative themes in the descriptive data. It is worth noting that all interventions scored higher than 2.5 indicating a positive trend in the tendency to agree. This may suggest that any intervention would be appreciated, while some proposals were clearly more agreeable than others. The narrative data provided more critical evaluations by nurses and will be reviewed for conclusions in Chapter 5.

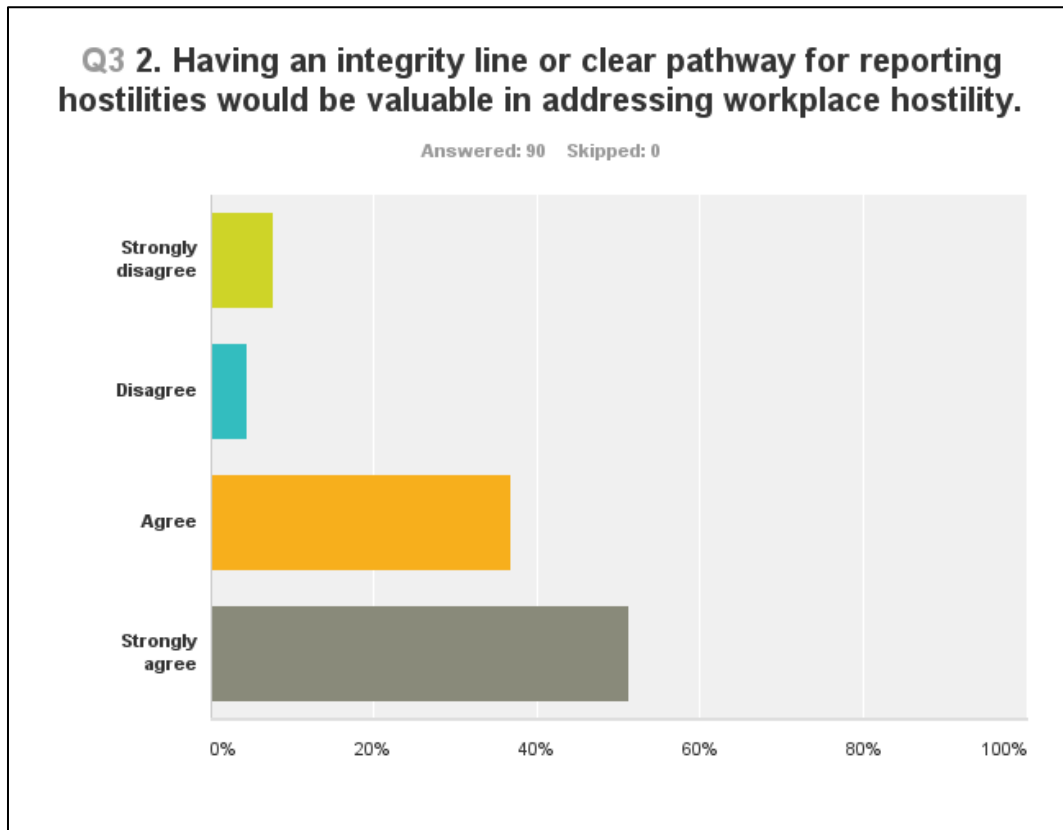
**Passively Supportive Structures**

Answer Choices	Responses
Strongly disagree	4.44% 4
Disagree	7.78% 7
Agree	36.67% 33
Strongly agree	51.11% 46
Consensus <b>87.78%</b>	Value Index <b>3.344</b> N=90

“The value lies in establishing a company’s clear rules and expectations that align with its mission, vision and values, for a professional and productive work environment.”

“People, including nurses, are currently not accountable for their actions towards each other. And inconsistent accountability creates confusion in the workplace environment.”

“It would be helpful to have clearly set guidelines as you would in a sick time or attendance policy.”



Answer Choices	Responses
Strongly disagree	7.78% 7
Disagree	4.44% 4
Agree	36.67% 33
Strongly agree	51.11% 46
Consensus <b>87.78%</b>	Value Index <b>3.311</b> N=90

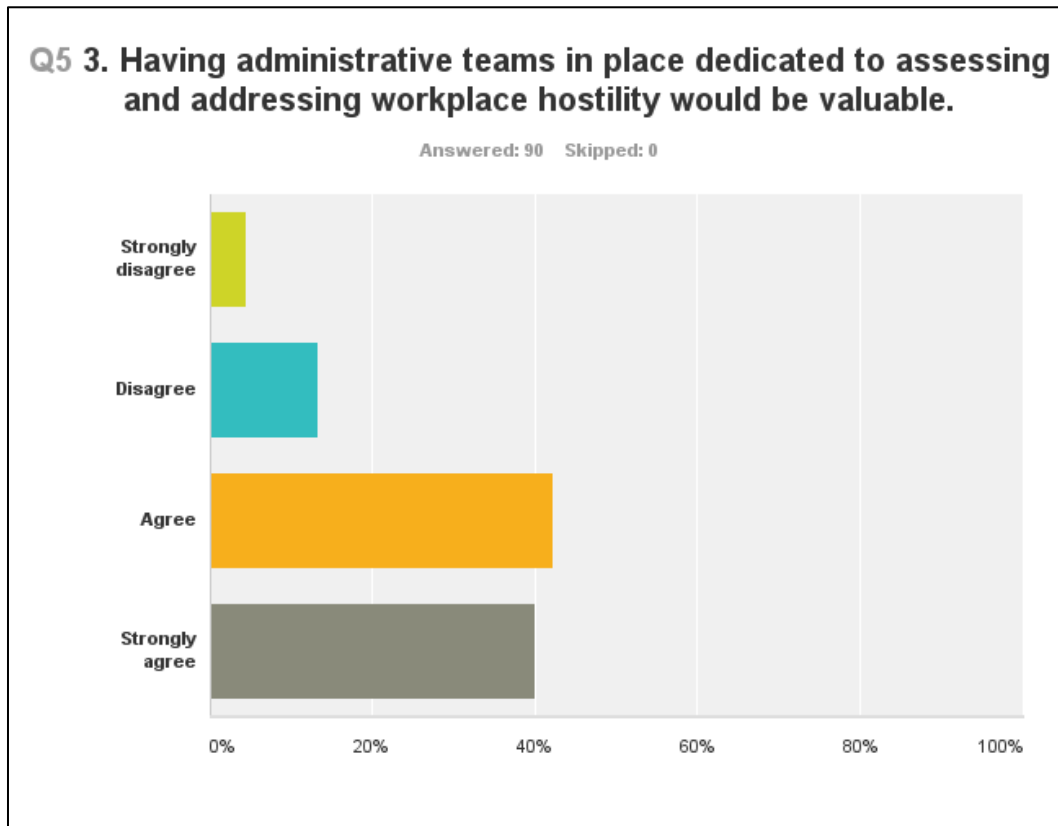
“Some nurses may fear retaliation, so having a safe way to report is important.”

“Employees need to know the exact procedures to follow to report workplace hostilities.”

“It can be difficult to report fellow coworkers that are hostile. It would be nice to report the problem to a source other than your manager so a set action will be taken.”

“Sometimes reporting to a direct supervisor may conflict, causing punitive action.”





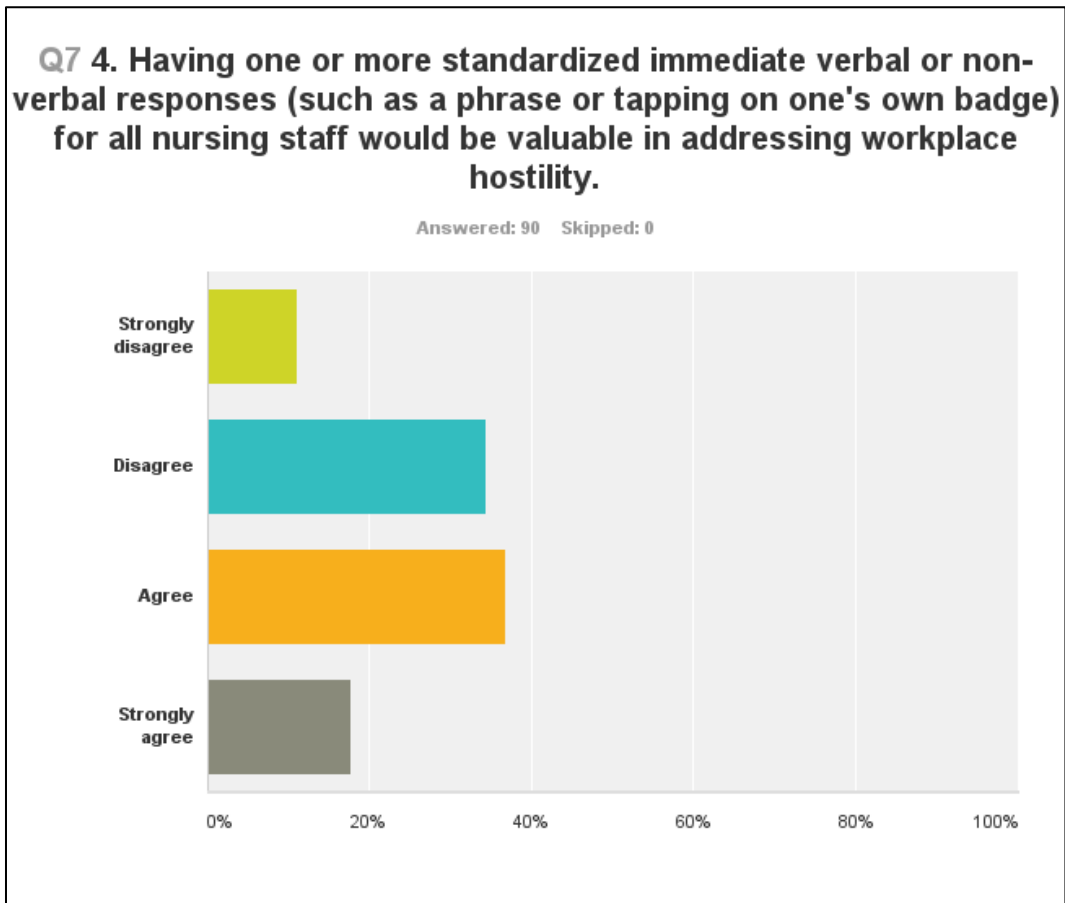
Answer Choices	Responses
Strongly disagree	4.44% 4
Disagree	13.33% 12
Agree	42.22% 38
Strongly agree	40% 36
Consensus 82.22%	Value Index 3.178 N=90

“Most of the time it is your word against theirs. By designating someone you give staff the flexibility to express concerns, though it really depends who is on the team.”

“It would depend on the team and if they had the authority to act. Generally, teams such as “patient relations” use therapeutic listening and do little to rectify the situation.”

“Does it have to be administration?” ... “Would only be valuable if all staff is invited to join.”

“Having someone to enforce the proper policy and procedures would be valuable.”



Answer Choices	Responses
Strongly disagree	11.11% 10
Disagree	34.44% 31
Agree	36.67% 33
Strongly agree	17.78% 16
Consensus <b>54.45%</b>	Value Index <b>2.611</b> N=90

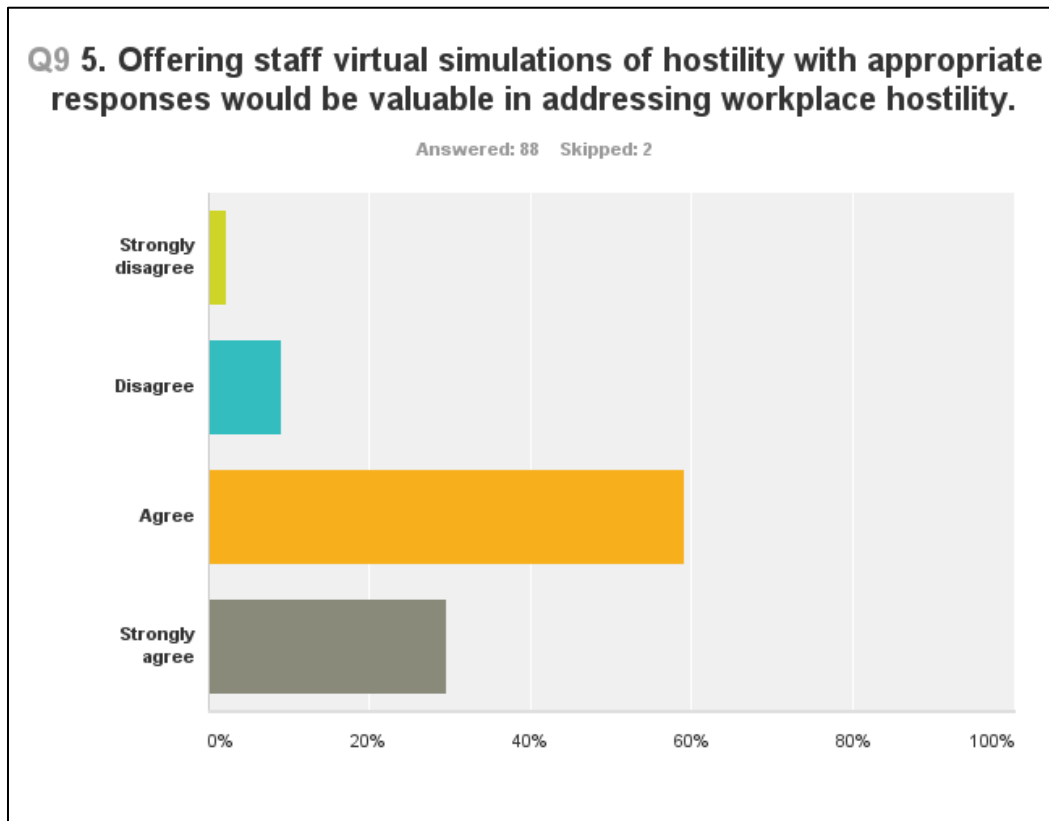
“In the heat of the moment, this would be at best annoying.”

“Not likely to be taken seriously.” ... “Could communicate the need for help to other coworkers.”

“This would only work if the hostile party was unaware of their hostility.”

“I know you have to start somewhere, but the hostile person is probably not going to change their behavior because someone is tapping their badge.” ... “Not effective in a crisis situation.”

### Collaborative Interventions

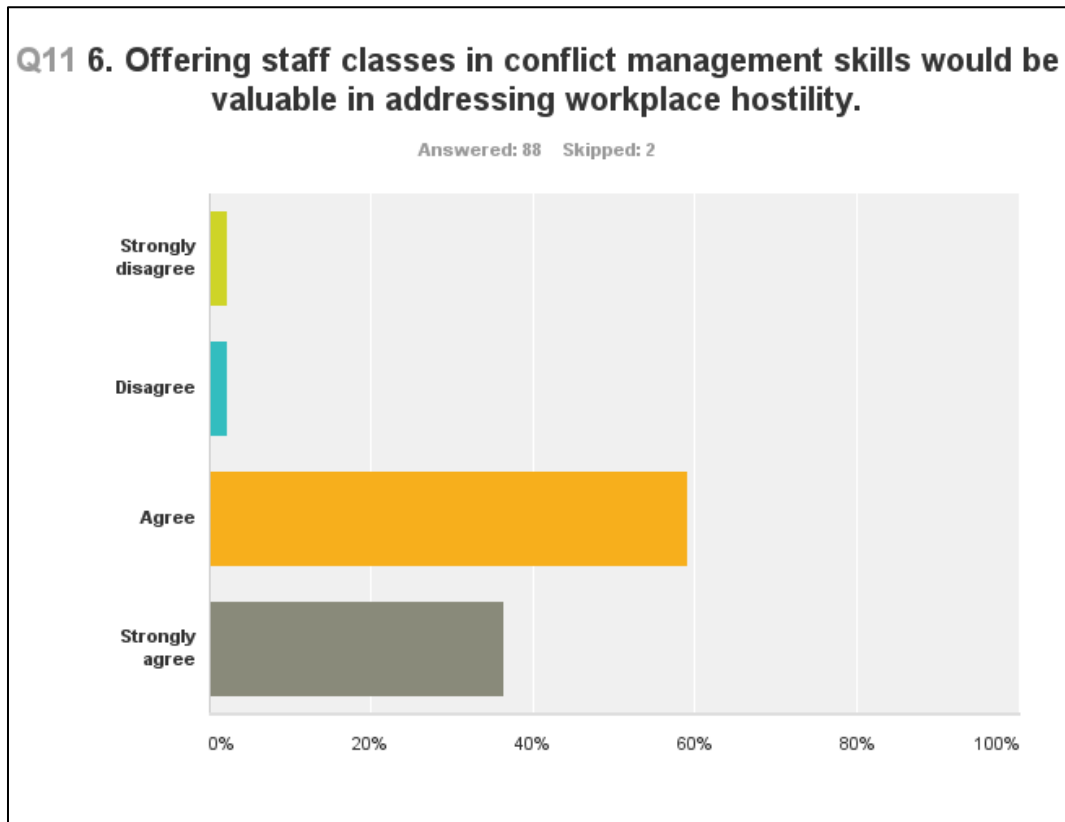


Answer Choices	Responses
Strongly disagree	2.27% 2
Disagree	9.09% 8
Agree	59.09% 52
Strongly agree	29.55% 26
Consensus 88.64%	Value Index 3.159 N=88

“Visual examples are valuable as people can see what is meant by positive and negative behaviors.” ... “Practice and preparedness for unexpected situations is always useful.”

“Examples would help. Some people are not always aware they are coming across as hostile.”

“This would be valuable as a learning experience in handling hostile situations and in teaching what a correct response should be.”



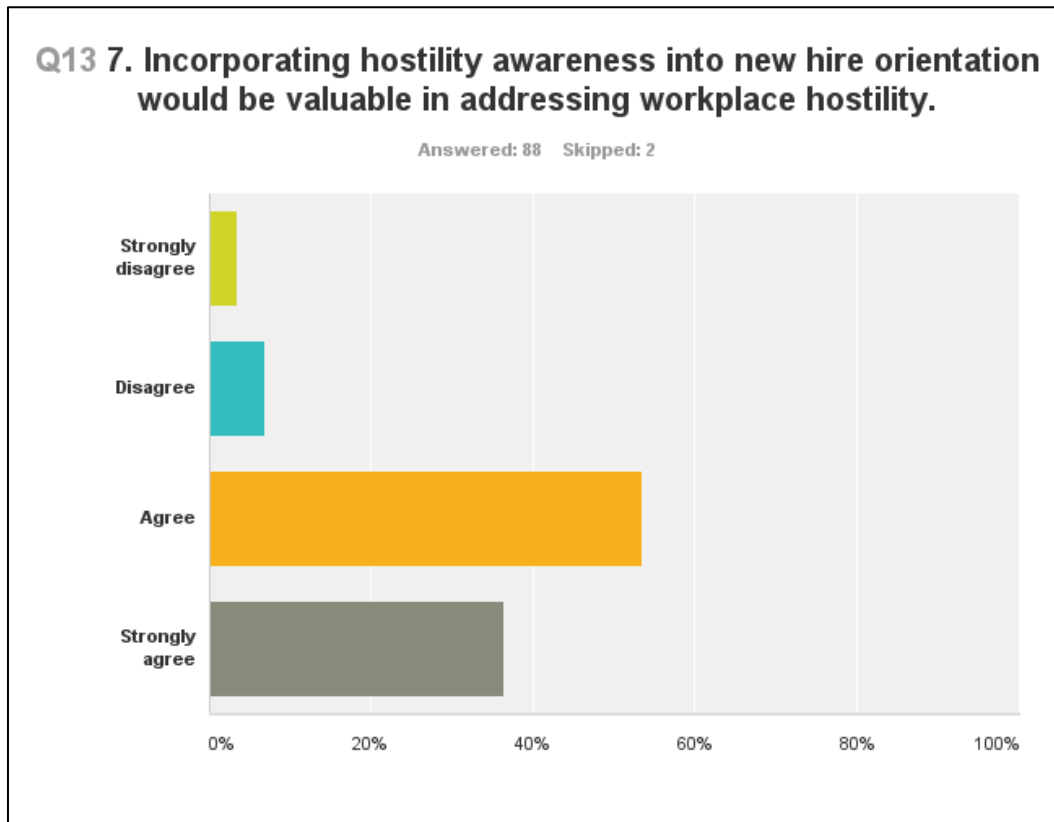
Answer Choices	Responses
Strongly disagree	2.27% 2
Disagree	2.27% 2
Agree	59.09% 52
Strongly agree	36.36% 32
Consensus <b>95.45%</b>	Value Index <b>3.295</b> N=88

“Conflict management skills are invaluable. And these are skills that have to be learned.”

“People do not get trained in school for these situations and may not have the interpersonal skills to handle the high stressors in healthcare.” ... “It should probably be mandatory.”

“It is important for nurses to manage conflict in a professional manner.”

“Valuable, yes. Education is the key!” ... “May reduce conflict occurrences.”



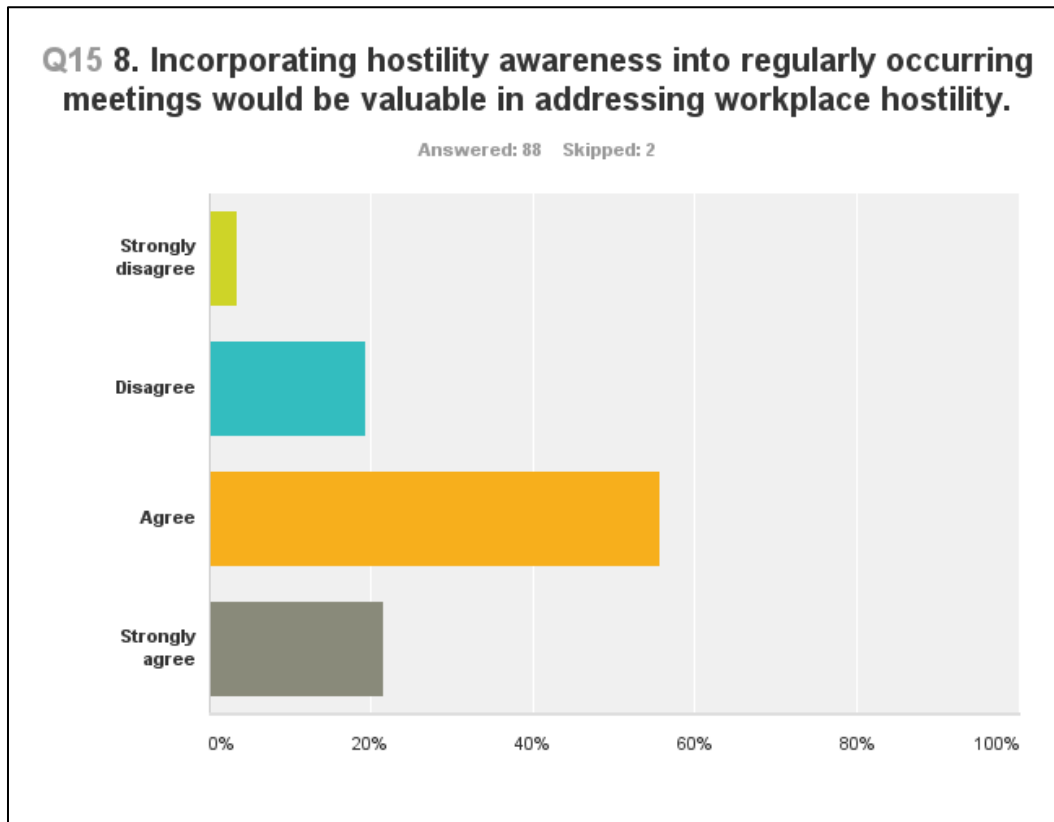
Answer Choices	Responses
Strongly disagree	3.41% 3
Disagree	6.82% 6
Agree	53.41% 47
Strongly agree	36.36% 32
Consensus 89.77%	Value Index 3.227 N=88

“New hires should know they don’t have to fear hazing.” ... “Sets the standard.”

“Knowing immediate there was a process would serve to make the new employees aware of the organization’s stance and importance it places on the subject.” ... “All get the same training.”

“let’s staff know right up front how important the issue is.” ... “Increases awareness.”

“It could send a message from the start that hostility is not tolerated and may grounds for termination.”



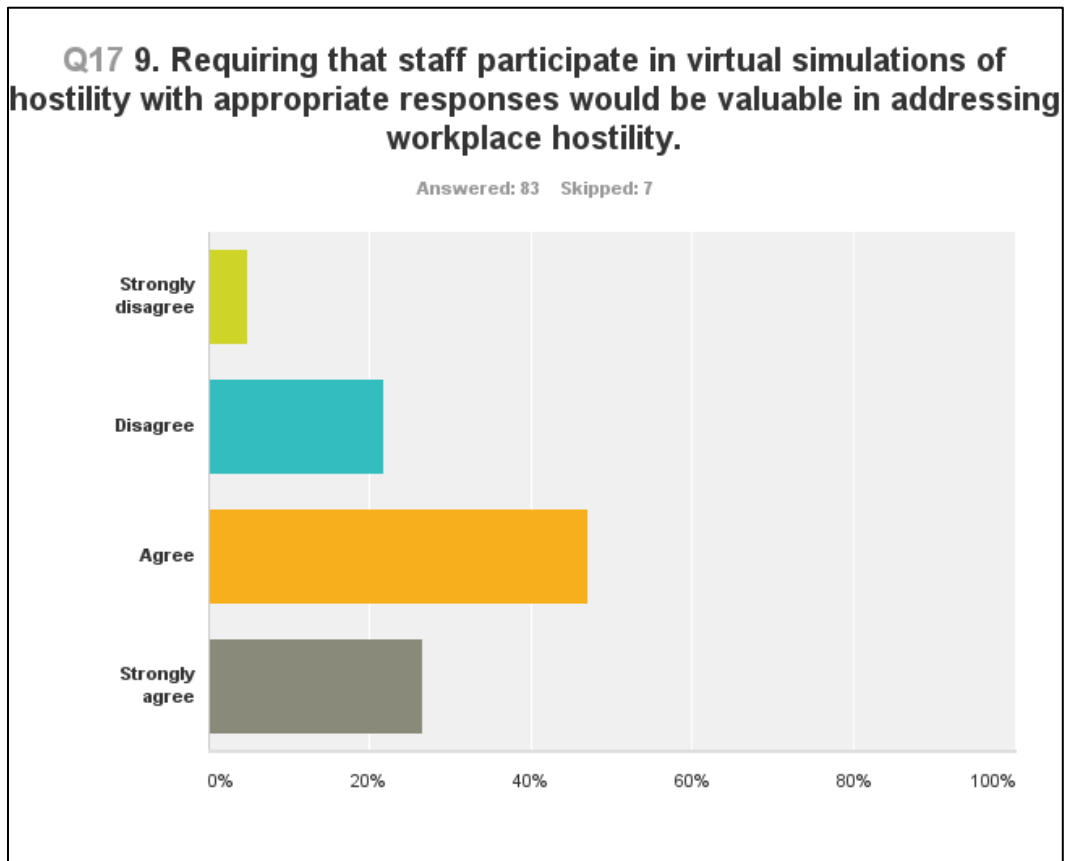
Answer Choices	Responses
Strongly disagree	3.41% 3
Disagree	19.32% 17
Agree	55.68% 49
Strongly agree	21.59% 19
Consensus 77.27%	Value Index 2.955 N=88

“Keeps the issue on peoples’ minds.” ... “Continuing support for managing hostilities.”

“This way no one can forget the policy or what is expected of them.”

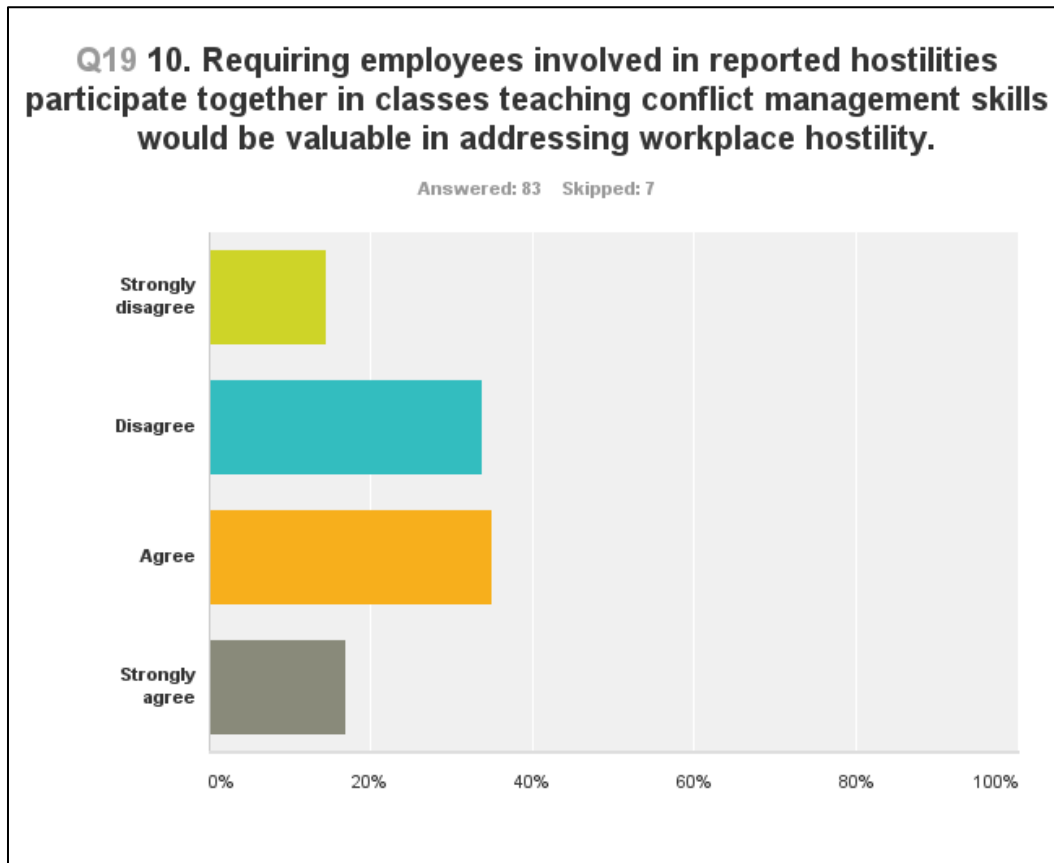
“Establishes ground rules.” ... “I wouldn’t address it at every staff meeting, but quarterly to keep the skills current and so that situations that have occurred can be discussed between staff.”

“Important to establish consequences for bad behavior.” ... “Maybe annually would be better.”

**Actively Supportive Structures**

Answer Choices	Responses
Strongly disagree	4.82% 4
Disagree	21.69% 18
Agree	46.99% 39
Strongly agree	26.51% 22
Consensus <b>73.5%</b>	Value Index <b>2.952</b> N=83

“It’s a solid professional way to handle hostilities that hopefully would be consistent.” ... “This would work for some, but for others it could be too real and too stressful.” ... “Examples and simulation help ensure readiness.” ... “See one. Do one. Teach one.” ... “It is important to see appropriate behavior modeled both virtually and by the leadership.”



Answer Choices	Responses
Strongly disagree	14.46% 12
Disagree	33.73% 28
Agree	34.94% 29
Strongly agree	16.87% 14
Consensus <b>51.81%</b>	Value Index <b>2.542</b> N=83

“It would help provide teambuilding and closure for staff.” ... “Maybe not require.”

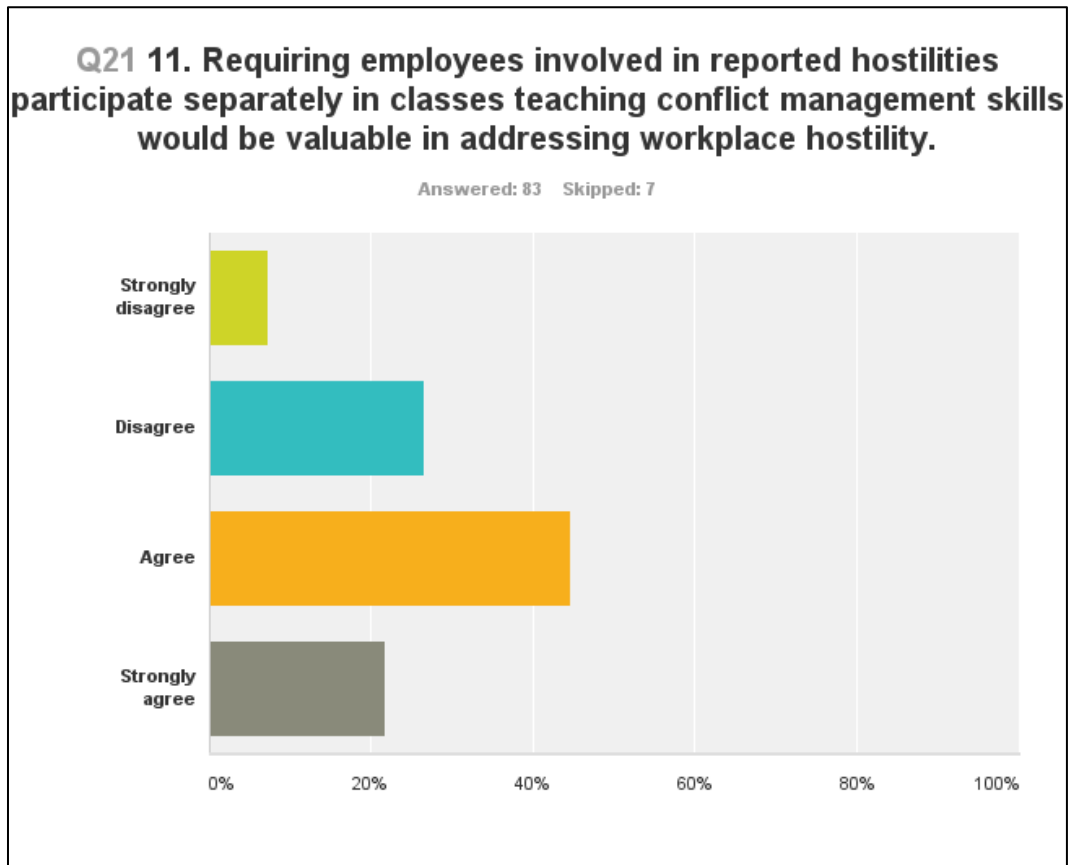
“This would punish the person who was the victim of the hostility.”

“One-on-one counseling for the hostile individual, if identified, might be more effective.”

“Everyone on the floor or in the department should be included in the teachings.”

“This would make me not want to report it.” ... “Could be like a support group.”





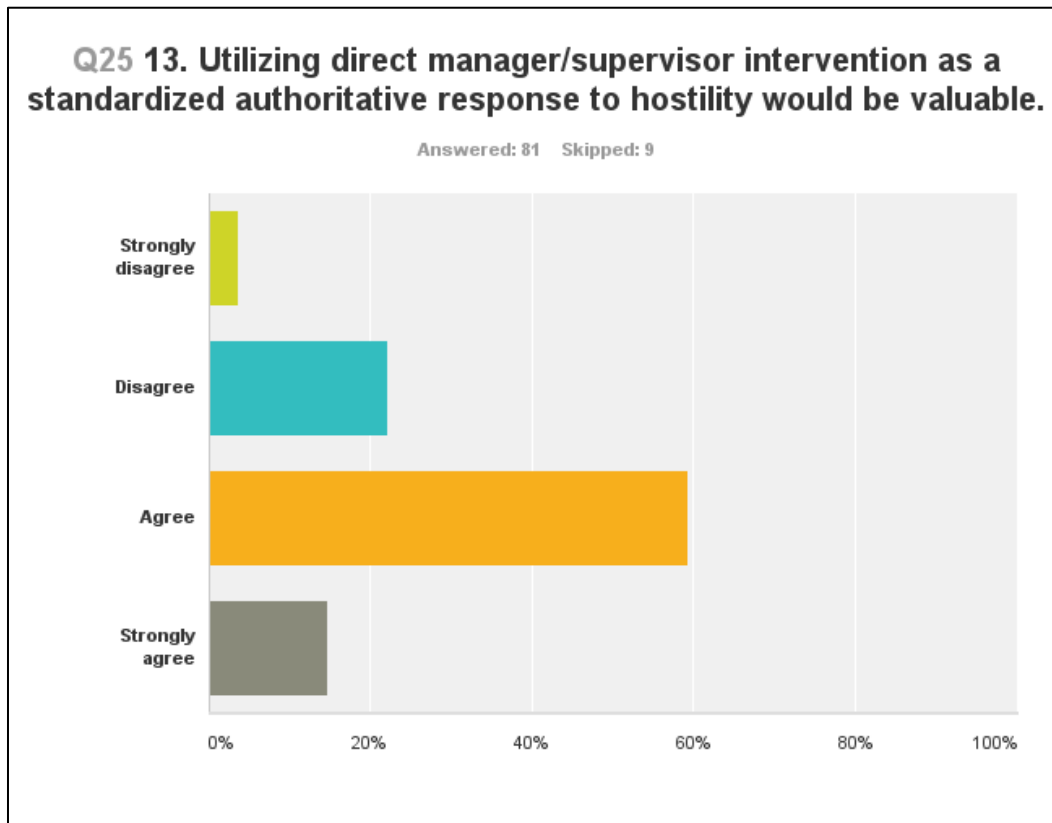
Answer Choices	Responses
Strongly disagree	7.23% 6
Disagree	26.51% 22
Agree	44.58% 37
Strongly agree	21.69% 18
Consensus <b>66.27%</b>	Value Index <b>2.807</b> N=83

“Starting separately may relieve tensions.” ... “If you insist on doing this, then at least keep the involved parties together. Makes them feel like they are NOT being singled out.” ... “This would give folks a chance to be more open about their feelings.” ... “Whether together or separate, the more important consideration is an effective mediator.” ... “This could provide an unbiased approach, promote reconciliation/resolution, and equal accountability.”



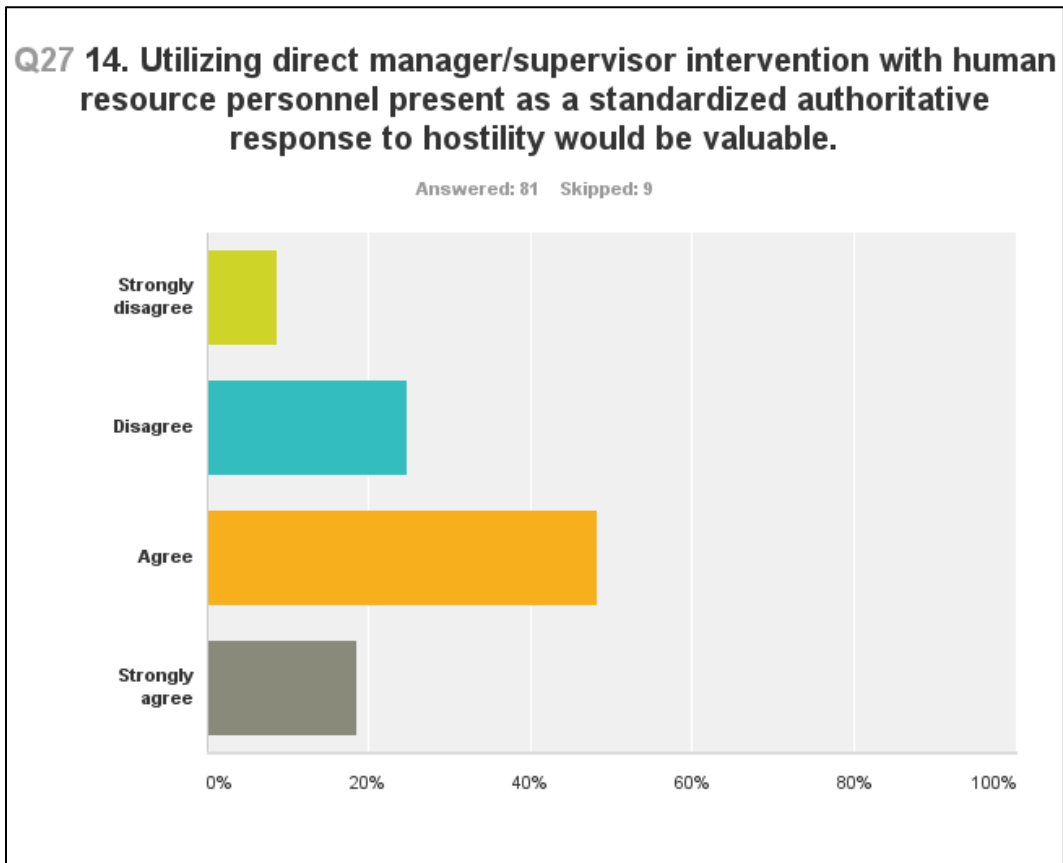
Answer Choices	Responses
Strongly disagree	3.61% 3
Disagree	3.61% 3
Agree	44.58% 37
Strongly agree	48.19% 40
Consensus <b>92.77%</b>	Value Index <b>3.373</b> N=83

“This seems the least taught field of management in nursing.” ... “Many managers do not recognize or know how to address these situations when they arise.” ... “The front line needs to be standardized so managers are applying the same rules.” ... “Managers and supervisors should be able to mentor their nurses through conflict resolution.” ... “The leaders must lead by example.” ... “As a new manager, this would be extremely helpful in my role.”

**Authoritative Interventions**

Answer Choices	Responses
Strongly disagree	3.70% 3
Disagree	22.22% 18
Agree	59.26% 48
Strongly agree	14.81% 12
Consensus <b>74.07%</b>	Value Index <b>2.852</b> N=81

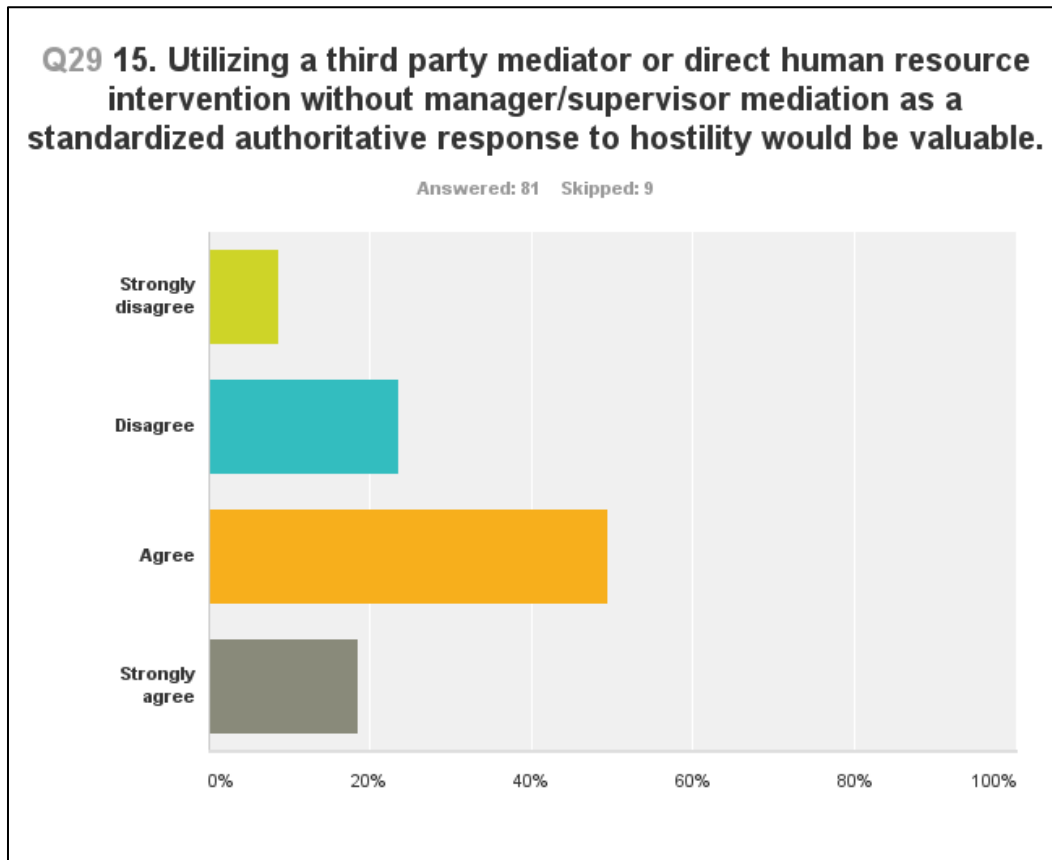
“This would only work if the manager had training in resolving these conflicts and could be objective.” ... “I think it could help if they had more training.” ... “Having an authority figure present often diffuses hostilities.” ... “This would be valuable as long as the direct supervisor was not the problem.” ... “In an ideal situation, your manager should be the one to initiate the complaint process.” ... “In my experience this is hard to avoid.”



Answer Choices	Responses
Strongly disagree	8.64% 7
Disagree	24.69% 20
Agree	48.15% 39
Strongly agree	18.52% 15
Consensus <b>66.67%</b>	Value Index <b>2.765</b> N=81

“Too intimidating.” ... “More acknowledgment equals greater awareness.”

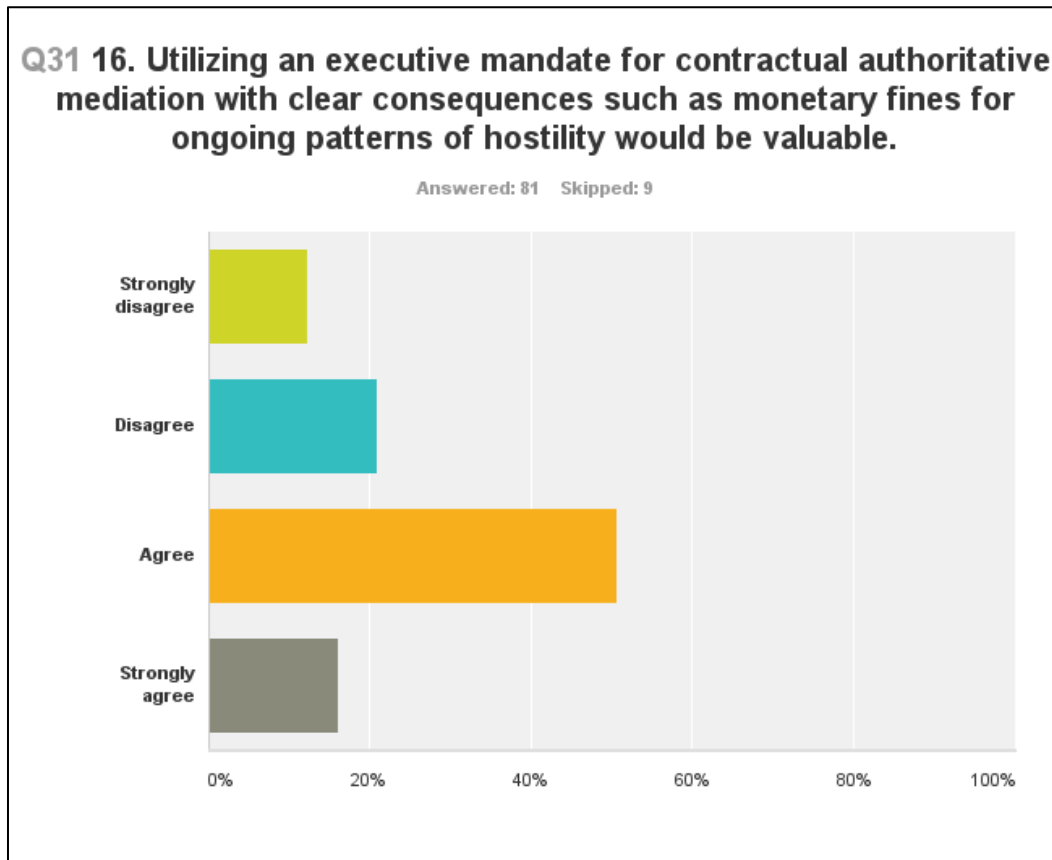
“This would make an intervention appear more serious and possibly get the attention of the participants.” ... “Group management in regards to hostile behavior reduces the problem of favoritism or fear of reprisal.” ... “HR does seem much more equipped to handle the problem than management does.”



Answer Choices	Responses
Strongly disagree	8.64% 7
Disagree	23.46% 19
Agree	49.38% 40
Strongly agree	18.52% 15
Consensus 67.9%	Value Index 2.778 N=81

“More objectivity. Less intimidating.” ... “This breaks the chain of command and continuity of enforcing policy and procedures.” ... “A third party might be more impartial and less invested.”

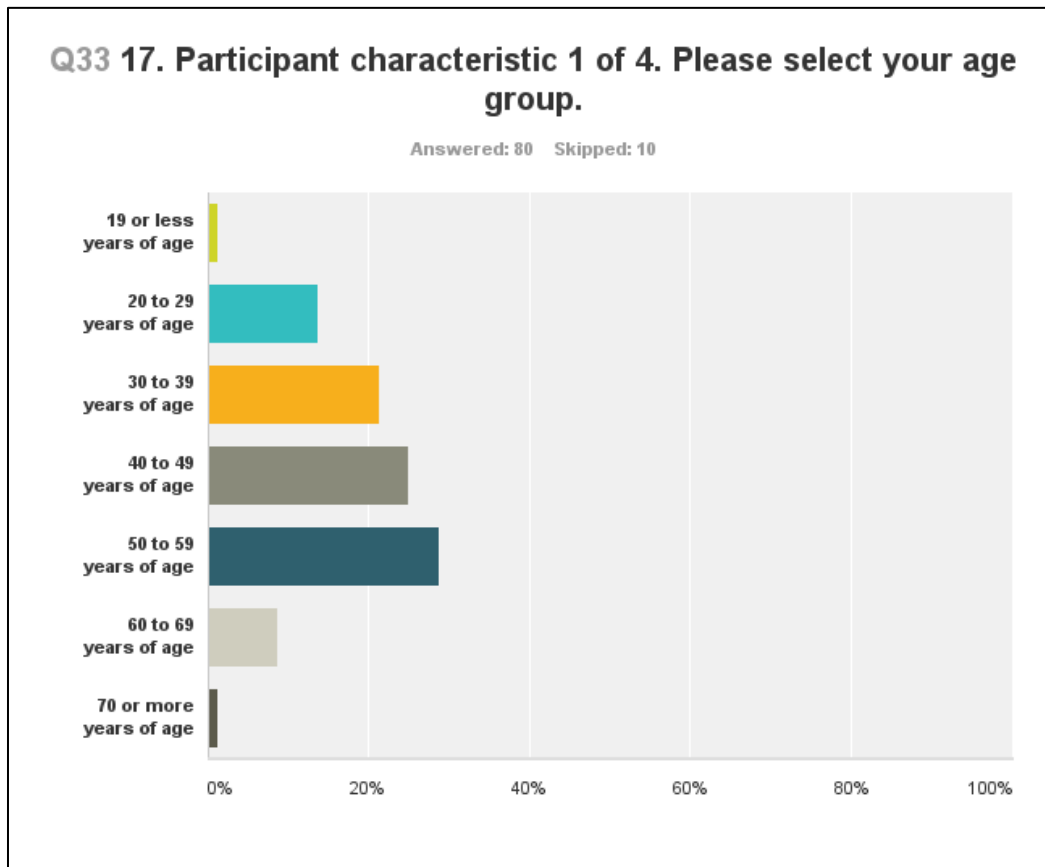
“A mediator should be a last resort.” ... “Could minimize retaliation.” ... “All involved should participate, especially one’s direct supervisor.” ... “Could avoid or reduce political agendas.”



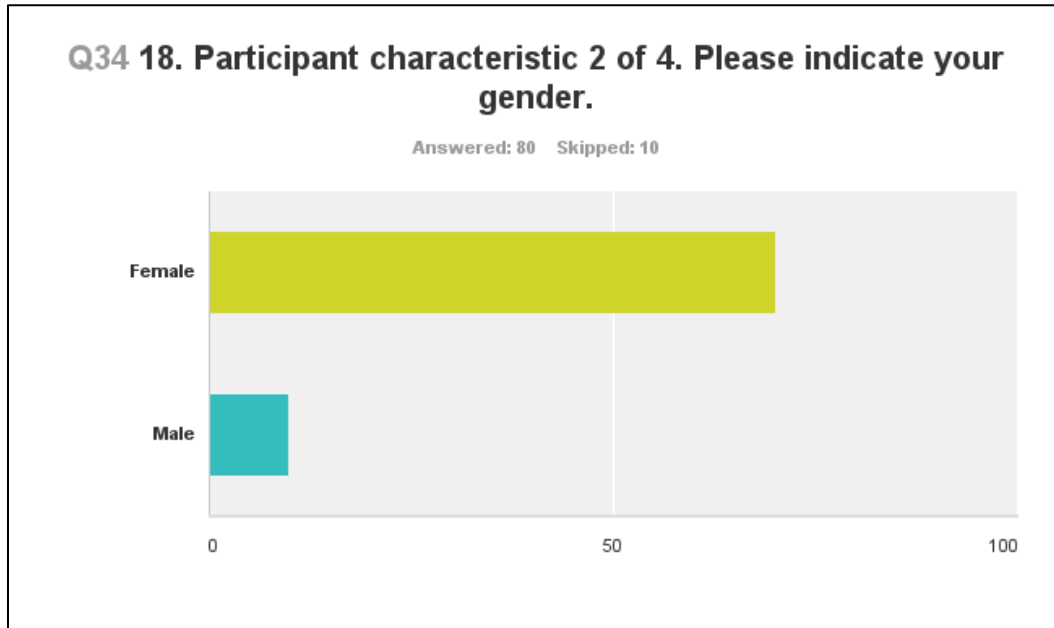
Answer Choices	Responses
Strongly disagree	12.35% 10
Disagree	20.99% 17
Agree	50.62% 41
Strongly agree	16.05% 13
Consensus 66.67%	Value Index 2.704 N=81

“This might decrease overt hostilities, but it could also increase covert actions.” ... “Monetary fines could help pay for third party mediators.” ... “It should never get this far.” ... “Do we really want to send the message that we allow hostility if you have enough money?” ... “This could provide a clear boundary as a consequence for behaviors.” ... “At this point, someone should be transferred or let go.”

### Participant Characteristics

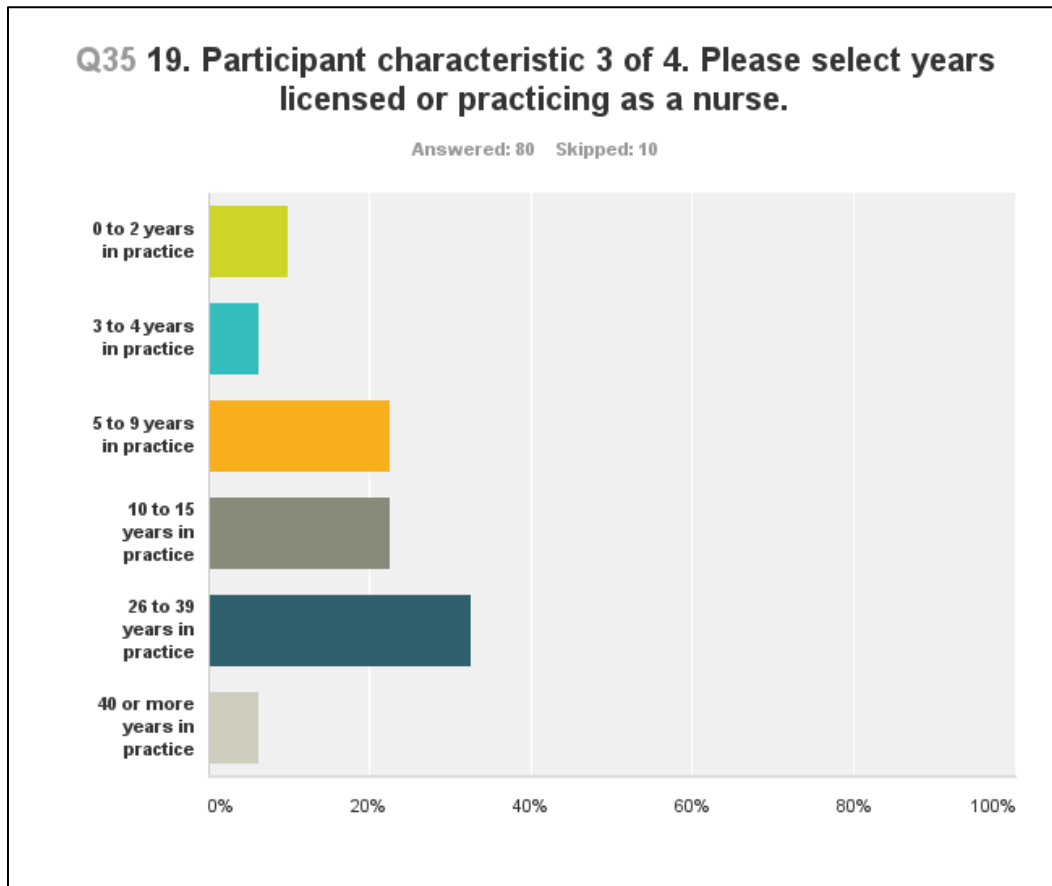


Answer Choices	Responses
19 or less years of age	1.25% 1
20 to 29 years of age	13.75% 11
30 to 39 years of age	21.25% 17
40 to 49 years of age	25% 20
50 to 59 years of age	28.75% 23
60 to 69 years of age	8.75% 7
70 or more years of age	1.25% 1
Total	N=80



Answer Choices	Responses
Female	87.50% 70
Male	12.50% 10
Total	N=80

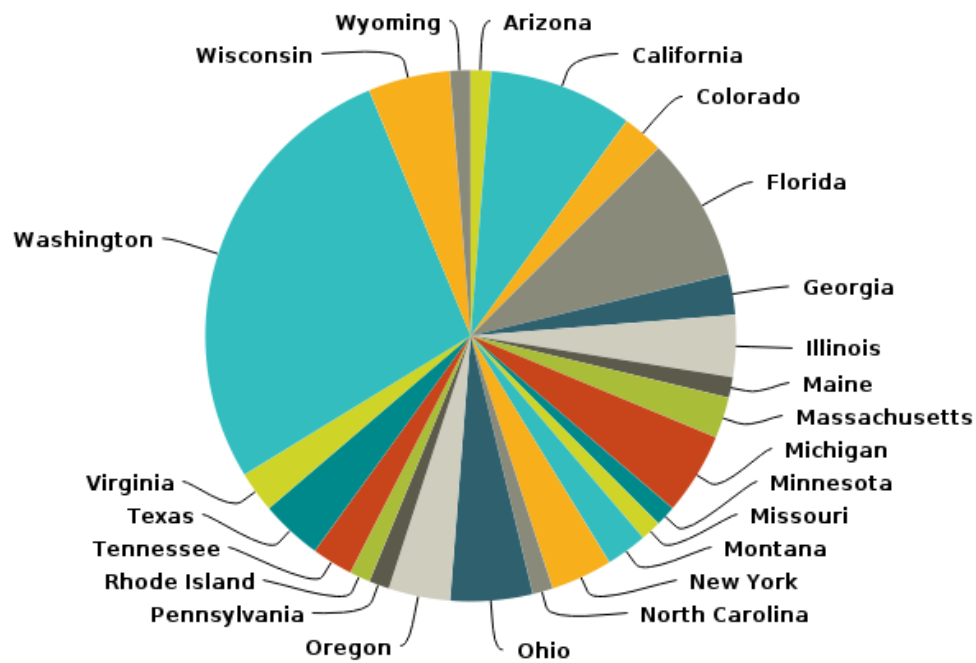




Answer Choices	Responses
0 to 2 years in practice	10% 8
3 to 4 years in practice	6.25% 5
5 to 9 years in practice	22.50% 18
10 to 15 years in practice	22.50% 18
26 to 39 years in practice	32.50% 26
40 or more years in practice	6.25% 5
Total	N=80

**Q36 20. Participant characteristic 4 of 4. Please select US State of primary practice as a nurse.**

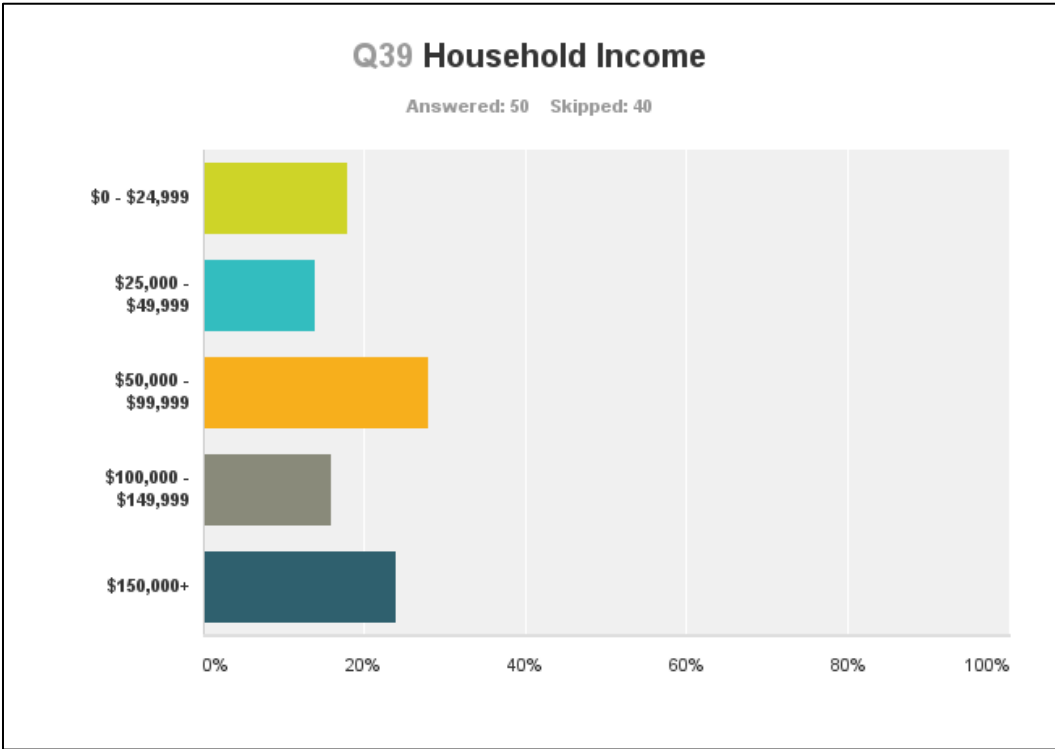
Answered: 80 Skipped: 10



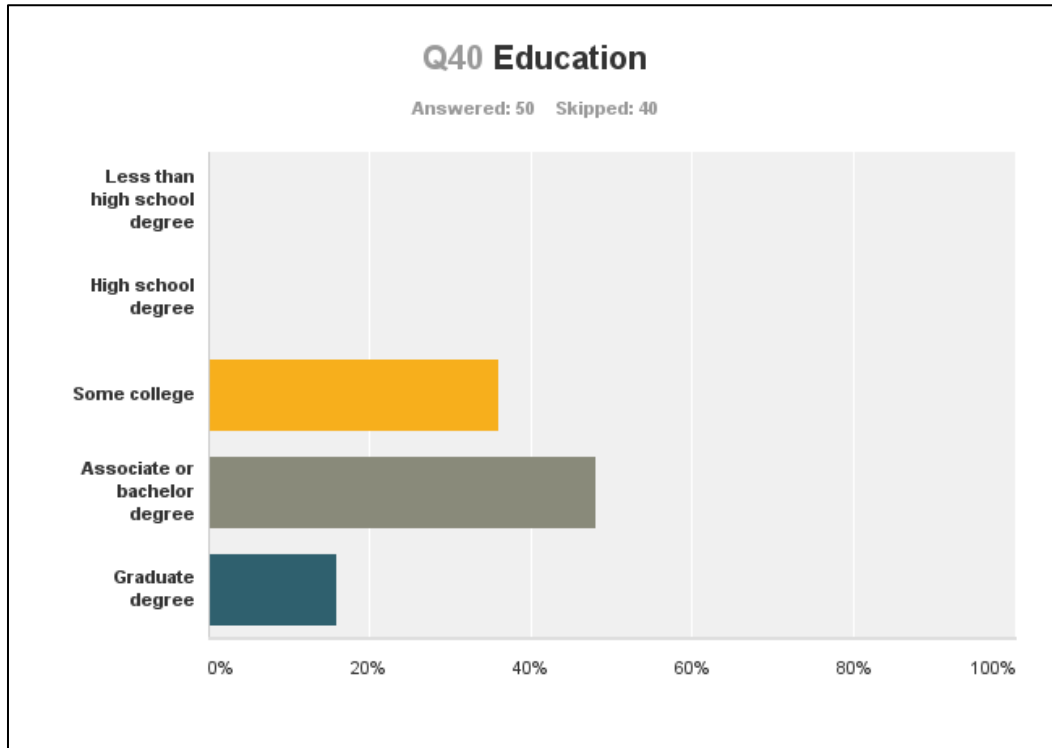
Answer Choices	Responses
Arizona	1.25% 1
California	8.75% 7
Colorado	2.50% 2
Florida	8.75% 7
Georgia	2.50% 2
Illinois	3.75% 3
Maine	1.25% 1

Answer Choices	Responses
Massachusetts	2.50% 2
Michigan	5% 4
Minnesota	1.25% 1
Missouri	1.25% 1
Montana	2.50% 2
New York	3.75% 3
North Carolina	1.25% 1
Ohio	5% 4
Oregon	3.75% 3
Pennsylvania	1.25% 1
Rhode Island	1.25% 1
Tennessee	2.50% 2
Texas	3.75% 3
Virginia	2.50% 2
Washington	27.50% 22
Wisconsin	5% 4
Wyoming	1.25% 1
Total	N=80

Passively Acquired Characteristics

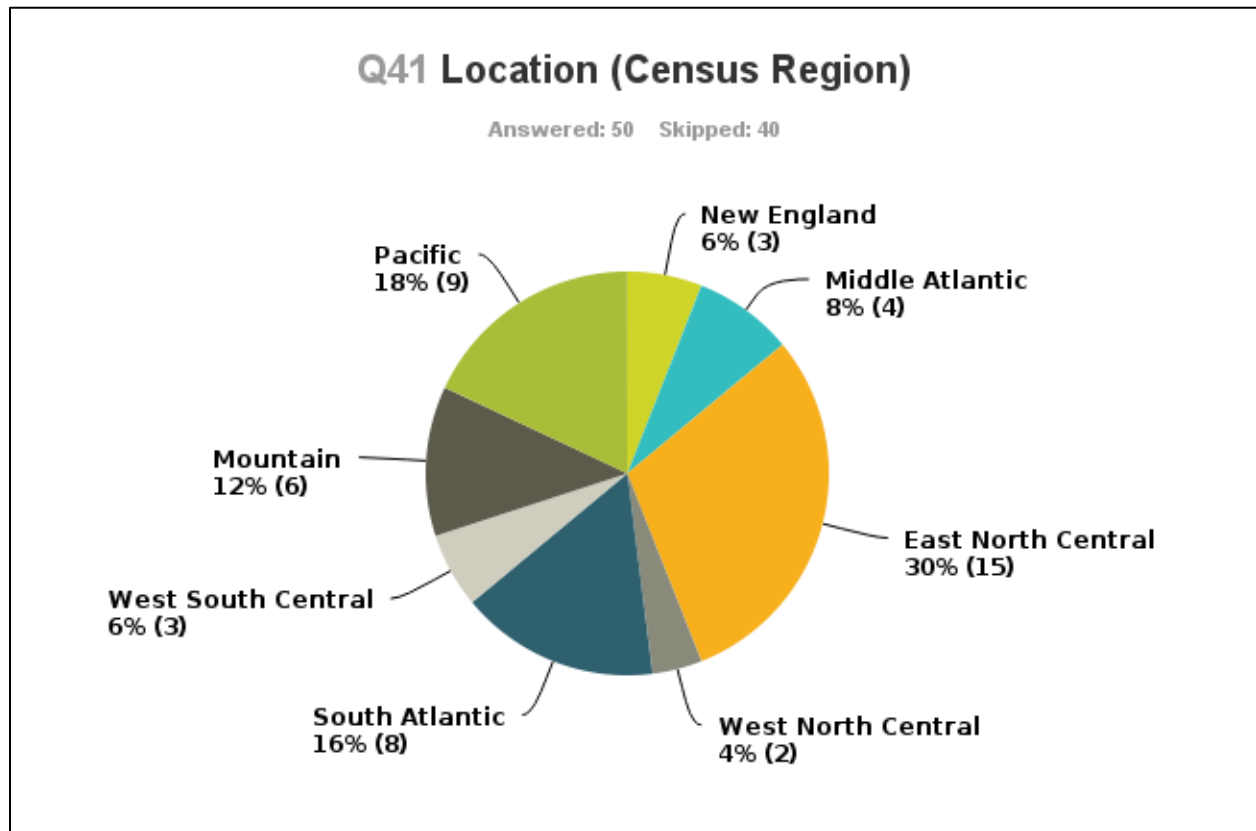


Answer Choices	Responses
\$0 - \$24,999	18% 9
\$25,000 - \$49,999	14.00% 7
\$50,000 - \$99,999	28.00% 14
\$100,000 - \$149,999	16% 8
\$150,000+	24% 12
Total	N=50



Answer Choices	Responses
Less than high school degree	0% 0
High school degree	0% 0
Some college	36% 18
Associate or bachelor degree	48% 24
Graduate degree	16% 8
Total	N=50

## National Collector Representation



Answer Choices	Responses
New England	6% 3
Middle Atlantic	8% 4
East North Central	30% 15
West North Central	4% 2
South Atlantic	16% 8
East South Central	0% 0
West South Central	6% 3
Mountain	12% 6
Pacific	18% 9
Total	N=50

### **Data-Driven General Summary**

All structures and interventions offered received greater than 50% Consensus of Value from nurse participants. Passively Supportive Structures and Collaborative Interventions generally achieved the greatest support from nurses by way of both Consensus of Value and Previewed Value Index. Actively Supportive Structures and Authoritative Interventions received less support, while still maintaining a positive trend.

Terms such as “offering” (passive/collaborative) were more popular and valued than “requiring” or “mandating” (active/authoritative). Notable exceptions to these initial trends included the most and least popular interventions by Perceived Value Index. The four most valued interventions included one Actively Supportive Structure, two Passively Supportive Structures, and one Collaborative Intervention.

Nurses reported mixed feelings on their managers' ability to identify or resolve conflict. Some were very supportive of their manager's or supervisor's skill set, while others feared retaliation, unfair treatment, and political agendas when reporting hostilities. These, as well as specific training in conflict resolution, were cited as reasons to consider third party mediation.

Nurses expressed a general distrust of administration, while acknowledging that the problem of hostilities would not be solved without the enforcement of policy and additional conflict resolution training primarily for managers and supervisors and secondarily for staff. Many respondents conveyed a preference for peer mediation over administrative or Human Resource (HR) interventions. HR was seen as an extension of administration, though a theme was observed involving the notion that the more people who knew about any given conflict would increase awareness of the problem and thus the likelihood of resolution rather than obfuscation.

Nurses generally don't like attending meetings. Educational offerings and classes, however, were highly valued. Offering support was generally appreciated over requiring actions. Having defined policies with clear process, protocol, and consequences, clear pathways for reporting hostilities, and conflict resolution training for management and staff were the most valued structures and interventions.

### Research Question 1

#### Primary Question

Of the presented set, which interventions and supportive structures to hostilities do nurses perceive as being the most valuable *and why*?

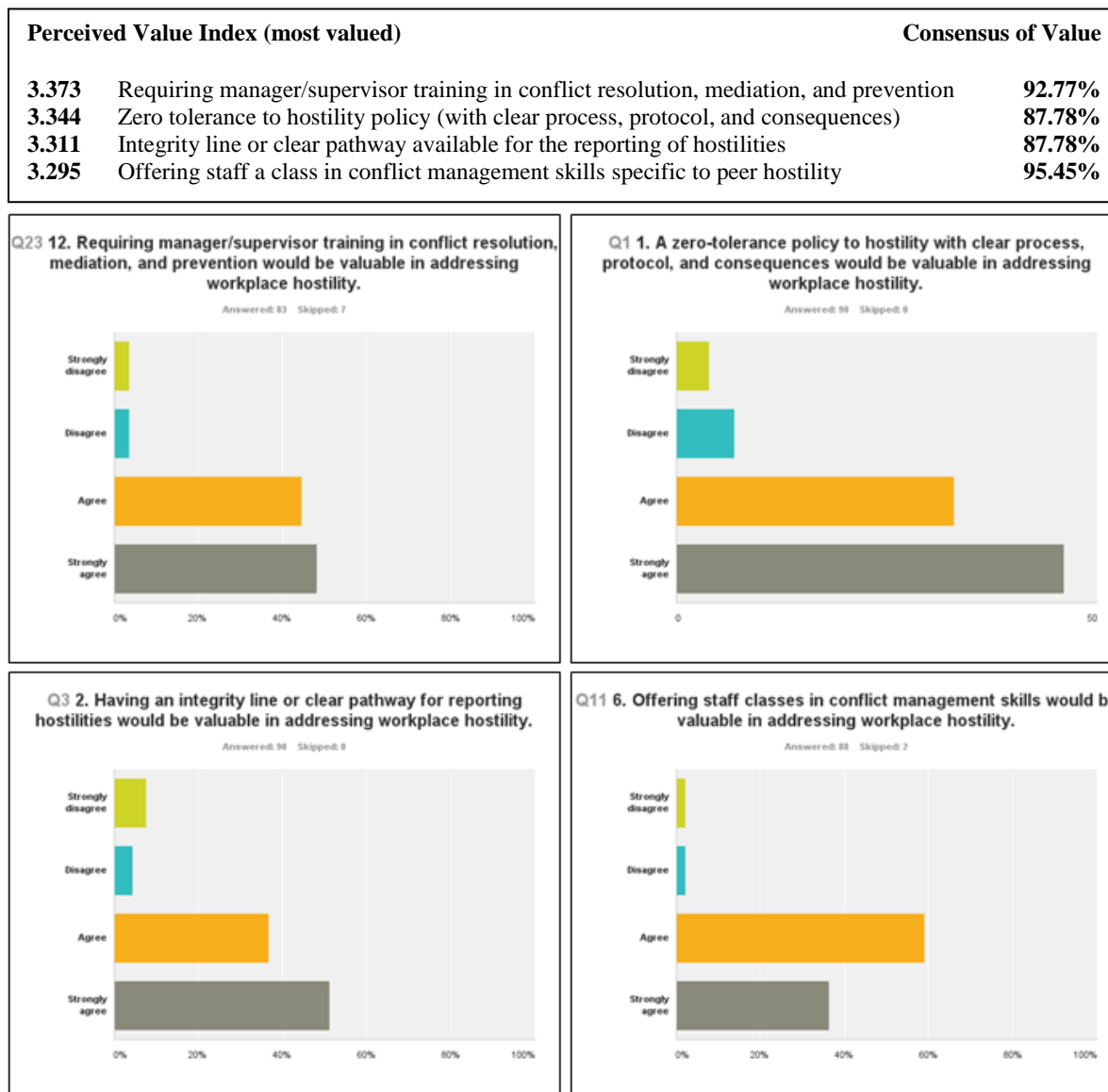
While the Collaborative Intervention of offering a class in conflict management skills received the highest Consensus of Value from nurses at 95.45% agreement, the Actively Supportive Structure of requiring manager/supervisor training in conflict resolution scored at 92.77% CV. However, requiring manager training received the highest Perceived Value Index at 3.373 compared to the optional class in conflict management at a VI of 3.295. This supports previous studies indicating dissatisfaction with management interventions (Farrell, 2001). The Authoritative Intervention of direct manager/supervisor intervention as a standardized authoritative response to hostility was rated at 74.07% Consensus of Value and a VI of 2.852, placing it in the lower half of value on both the CV and VI scales. This does suggest a nursing perception that managers could benefit from additional training in conflict resolution. This is also a notion that was supported by nurse managers who identified themselves as such in the survey.

The two Passively Supportive Structures of a zero tolerance policy and an integrity line were also among the highest four valued structures and interventions by Perceived Value Index, each attaining 87.78% Consensus of Value. A zero tolerance policy received a VI of 3.344 and was noted by many as being necessary for establishing clear expectations, behavioral standards, and consequences. Consequences are perhaps still lacking in most zero-tolerance policies. This may be due to a lack of developed protocol, clear pathways for reporting, and training required of management or offered to staff that would help identify and mitigate hostilities. An integrity line or clear pathway for reporting of hostilities was equally valued by consensus at 87.78%, but slightly lower on the Value Index at 3.311.

These most valued interventions and structures provided insight into techniques that nurses perceived as offering the greater chance of success in dealing with the problem of hostility. Next steps could involve a cost assessment followed by detailed protocol development for each cited structure.



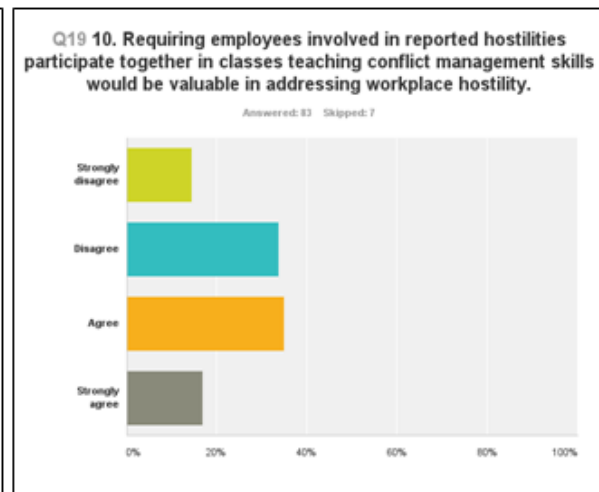
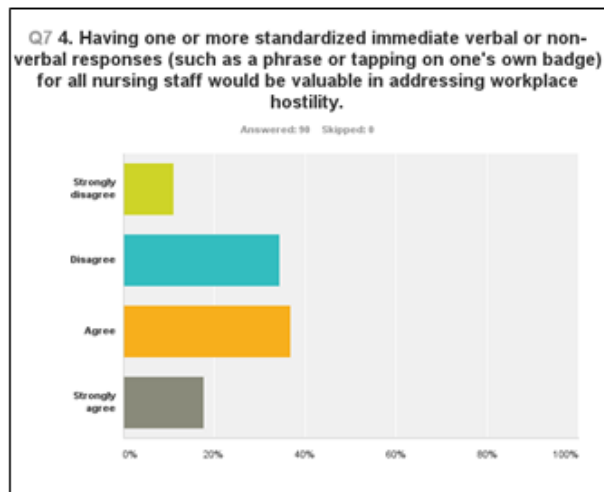
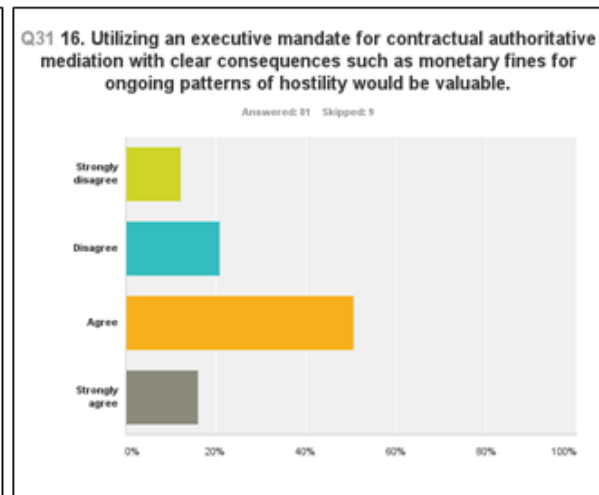
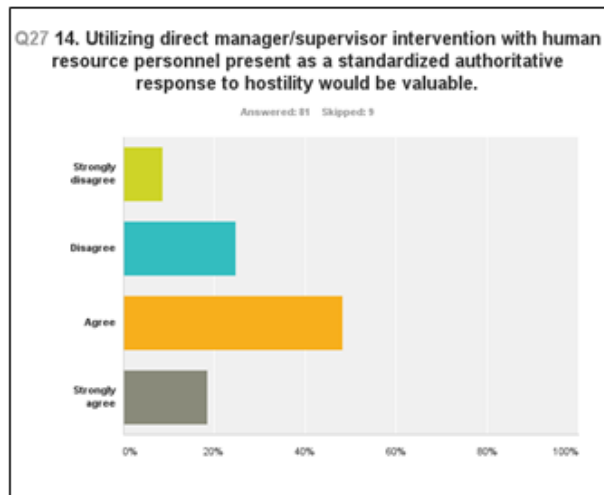
Again, having defined policies with clear process, protocol, and consequences, clear pathways for reporting hostilities, and conflict resolution training for management and staff were the most valued structures and interventions by nurse participants surveyed in this pilot.



While reviewing data trends, the least four valued interventions (though still valued) included two Authoritative Interventions, one Actively Supportive Structure, and one Passively Supportive Structure. As noted previously, direct manager/supervisor intervention as a standardized authoritative response to hostility was rated at 74.07% Consensus of Value and placed as intervention number 10 of 16 on the ranked structures (VI of 2.852). Slightly less popular than manager mediation was involving HR (VI of

2.765) or mandating fines (VI 2.704) each at 66.67% Consensus of Value. Surprisingly unpopular were the specific examples of cognitive rehearsal at 54.45% CV and a VI of 2.611, though other research defends this as a valid strategy (Griffin, 2004). The required class in conflict management shared between the aggressor and target of hostilities was, not surprisingly, the least valued intervention with a near even split of perception (CV of 51.81% and VI of 2.542).

Perceived Value Index (least valued)		Consensus of Value
<b>2.765</b>	Direct manager/supervisor intervention as a standardized authoritative response (with HR present)	<b>66.67%</b>
<b>2.704</b>	Executive mandate for contractual authoritative mediation with clear consequences such as fines	<b>66.67%</b>
<b>2.611</b>	Standardized responses to hostility (cognitive rehearsal such as a phrase or tapping on one's badge)	<b>54.45%</b>
<b>2.542</b>	Requiring a class in conflict management skills specific to peer hostility (with antagonist)	<b>51.81%</b>



It is important to note that even these least valued structures and interventions maintained a positive trend as being valuable, although they do appear controversial.

## Research Question 2

### Secondary Question

What trends in the data, if any, correlate participant characteristics with perceptions of value?

Very few trends were observed. However, it was clear that male nurses (N=10) valued Authoritative Interventions higher than female nurses (N=70). One exception to this was female nurses over the age of 60 (N=8), who valued two of the four Authoritative Interventions as did male nurses. On average, male nurses of all ages and female nurses over the age of 60 rated Authoritative Interventions higher except direct manager mediation. Both categories, rated direct manager/supervisor intervention as a standardized authoritative response the lowest in this category. Male nurses maintained a positive trend (CV at 70%) while female nurses over the age of 60 disclosed only a 43% Consensus of Value for direct manager mediation. Female nurses in general supported manager mediation with a CV of 74%. Mediation by Human Resources or a third party without management was valued similarly by female nurses of all ages. Of the 90 participants, 31 (or 34.44%) reported being in practice for 26 or more years. This sub-set trended between all participants and female nurses over 60 years of age.

<b>Authoritative Interventions (Crisis Management) by Consensus of Value</b>		
<b>All male nurses and female nurses over 60 years of age</b>		<b>Female nurses less than 60 years of age</b>
<b>70%, 43%</b>	Direct manager/supervisor intervention as a standardized authoritative response to hostility	<b>74%</b>
<b>90%, 86%</b>	Direct manager/supervisor intervention as a standardized authoritative response (with HR present)	<b>67%</b>
<b>90%, 71%</b>	Third party or HR without manager/supervisor standardized authoritative responses to hostility	<b>67%</b>
<b>90%, 86%</b>	Executive mandate for contractual authoritative mediation with clear consequences such as fines	<b>65%</b>

Parallel trending was noted relative to two of the four presented Actively Supportive Structures. Male nurses valued required classes higher than female nurses, regardless of whether the aggressor and target had the class together or separately. Female nurses over the age of 60 were also more supportive of the required classes without distinguishing whether individuals engaged in conflict took the classes together or separately.

<b>Actively Supportive Structures (Training/Skills) by Consensus of Value</b>		
<b>All male nurses and female nurses over 60 years of age</b>		<b>Female nurses less than 60 years of age</b>
<b>90%, 86%</b>	Requiring virtual simulations of hostility and appropriate responses (mandatory education)	<b>74%</b>
<b>80%, 71%</b>	Requiring a class in conflict management skills specific to peer hostility (with antagonist)	<b>47%</b>
<b>80%, 71%</b>	Requiring a class in conflict management skills specific to peer hostility (without antagonist)	<b>66%</b>
<b>100%, 86%</b>	Requiring manager/Supervisor training in conflict resolution, mediation, and prevention	<b>95%</b>

Otherwise, participant sub-groups tended to rate structures and interventions similarly. A review of the narrative responses offered deeper insight into these findings.

### **Narrative Analysis**

Beyond the diversity and trending data, the researcher reviewed each open-ended question for descriptive information. These narratives were essential for exploring themes underlying perceptions of value or possible assumptions that may have been made by nurses participants based on the wording of specific questions. Each question presented has been presented as it was on the survey in the exact order as viewed by nurse participants. Results focus on key words and repeating phrases and offer insight into why nurses perceived structures and interventions as being more or less valuable.

### **Passively Supportive Structures**

These structures and interventions to workplace hostility focus on organizational support and have a cultural focus.

**Please briefly explain why a zero-tolerance policy to hostility with clear process, protocol, and consequences may or may not be valuable.** Key words in these responses included “accountability,” “consequences,” and “standardized.” Narratives focused on defining behavior that was acceptable as well as what was not acceptable. Additional recurring commentary focused on decreasing gray areas and possibly reducing retaliation against reporting employees. Had this question not included “clear process, protocol, and consequences” it would likely have scored lower in the Value Index. This is important information to consider when developing a zero-tolerance policy.

**Please briefly explain why having an integrity line or clear pathway for reporting hostilities may or may not be valuable.** Key words in these responses included “confidential,” “anonymous,” “protection,” and “standardized.” Narratives continued to express value in reducing gray areas of policy and protocol as

well as reducing the likelihood of retaliation when reporting hostilities. This question was deliberately *not* defined as being anonymous or confidential in order to solicit perceptions. It appears from the data that many nurses assume it is anonymous, while others perceive it as being confidential. While confidentiality is likely in a reporting system, anonymity would make it difficult to investigate concerns. This is important information to consider when developing a clear pathway for reporting hostilities.

**Please briefly explain why having administrative teams in place dedicated to assessing and addressing workplace hostility may or may not be valuable.** Key words in these responses included “team,” “peer,” “mediation,” “authority,” “enforce,” and “administration.” Many respondents expressed value for team interventions, while expressing reservations about the team being composed of administration. Mediation of reported events and enforcement of the zero-tolerance policy were mentioned repeatedly, though several nurses articulated a desire to have teams that were broadly representative of the nursing staff. The published recommendations for such administrative teams are consistent with these preferences (McPhaul et al., 2013). This structure may have scored higher if the question was worded to include peer review and support.

**Please briefly explain why having one or more standardized immediate verbal or non-verbal responses (such as a phrase or tapping on one's own badge) for all nursing staff may or may not be valuable.** Key words in these responses included “immediate,” “annoying,” “ineffective,” and “standardized.” While many nurses did acknowledge this intervention as having value for instances in which the hostile party was unaware of their hostility, a greater focus was paid to hostile parties that were fully aware. This intervention seems to have scored poorly as it was not an effective crisis management tool, nor was it designed as such (Griffin, 2004). A theme was observed, however, in which this technique could be used to attract the attention of others who might come to the aid of the victim or target of hostilities.

**Collaborative Interventions**

These structures and interventions to workplace hostility focus on organizational and individual awareness and have a preventive focus.

**Please briefly explain why offering staff virtual simulations of hostility with appropriate responses may or may not be valuable.** Key words in these responses included “visual,” “examples,” “practice,” “preparedness,” “defining,” and “awareness.” Recurring phrases included “practice makes perfect” and “a picture is worth 1,000 words.” A few respondents stated that this should be taught in nursing school and that modeling acceptable behavior contrasted with what was not acceptable was valuable.

**Please briefly explain why offering staff classes in conflict management skills may or may not be valuable.** Key words in these responses included “education,” “empower,” “practice,” “safety,” “skill,” and “expensive.” A few participants commented that this could provide a venue to debrief as well as share experiences with others. Several nurses pondered the cost-to-benefit ratio. As this intervention was noted in the top four most valued by nurses, the cost-to-benefit ratio was likely worthwhile by nurses’ perceptions.

**Please briefly explain why incorporating hostility awareness into new hire orientation may or may not be valuable.** Key words in these responses included “fair,” “expectations,” “consequences,” “foundation,” “termination,” and “awareness.” The general narrative focused on “a level playing field” and increasing awareness for what would constitute “grounds for termination.” Considerable concern was expressed about overloading new hires with negative information, which was balanced by others insisting that the problem had to be acknowledged and awareness of behavioral expectations had to begin at day one of orientation.

**Please briefly explain why incorporating hostility awareness into regularly occurring meetings may or may not be valuable.** Key words in these responses included “support,” “repetition,” “tedious,” “awareness,” “monthly,” “quarterly,” and “annually.” The general consensus was that nurses attend too many meetings and that meetings indicate time away from the bedside. Many respondents, however, stated that quarterly or annual reminders would be preferable and valued over discussions at every monthly staff meeting.

### **Actively Supportive Structures**

These structures and interventions to workplace hostility focus on training and skills and have an educational focus.

**Please briefly explain why requiring that staff participate in virtual simulations of hostility with appropriate responses may or may not be valuable.** Key words in these responses included “mandate,” “requiring,” “readiness,” “practice,” “consistent,” and “expensive.” This intervention differed from offering virtual simulations of hostility and appropriate responses in that it *required* participants to attend. It was interesting to note that nurses did not want to be mandated to attend another class, meeting, or intervention. It is also worth noting that “expense” was not a key word when this intervention was offered and not required. Requiring this intervention reduced the Consensus of Value from 88.64% to 73.5%.

**Please briefly explain why requiring employees involved in reported hostilities participate together in classes teaching conflict management skills may or may not be valuable.** Key words in these responses included “reporting,” “punishment,” “punitive,” “teambuilding,” and “closure.” This was the lowest scoring intervention by both CV and VI. General consensus was split between perceiving value in having the two adversaries work out their differences with perceiving this as needless additional punishment for the target or hostilities. Many respondents stated they would not report hostilities if this

were the intervention. Clearly, this was the most controversial option, though it did maintain a slight positive trend.

**Please briefly explain why requiring employees involved in reported hostilities participate separately in classes teaching conflict management skills may or may not be valuable.** Key words in these responses included “mandating,” “reporting,” and “confidentiality.” While this intervention was more popular than requiring a class *with the antagonist*, statements such as “would decrease reporting” and “together or separate” predominated the narrative. Several respondents noted that separating the adversaries would allow more confidential disclosures, though other nurses felt there to be value in keeping the parties together to work out their differences. Most thought it should not be mandated.

**Please briefly explain why requiring manager/supervisor training in conflict resolution, mediation, and prevention may or may not be valuable.** Key words in these responses included “mentor,” “front line,” “modeling,” “non-punitive,” and “confidence.” General consensus by narrative focused on the manager as being the “first responder,” “needing to lead by example,” and “requiring a skill set in conflict management.” This appears to be a critical characteristic by the perception of nursing staff when evaluating a manager or supervisor for adequacy in their leadership role. Commentary overall was very supportive and respectful of nurse managers. A few nurse managers who identified themselves as such in the narratives expressed a desire for greater confidence when dealing with staff in conflict, while other participants desired greater confidence that their leaders could support them through hostilities.

### **Authoritative Interventions**

These structures and interventions to workplace hostility focus on organizational support and have a crisis management focus.



**Please briefly explain why utilizing direct manager/supervisor intervention as a standardized authoritative response to hostility may or may not be valuable.** Key words in these responses included “chain of command,” “awareness,” “first responder,” “politics,” and “trained.” Many respondents valued that the manager knew his or her direct reports, while several also expressed concern about their manager’s lack of training in identifying and resolving conflict as well as possible political agendas. A few nurses expressed that their managers were the hostile parties and therefore recommended third party mediation.

**Please briefly explain why utilizing direct manager/supervisor intervention with human resource personnel present as a standardized authoritative response to hostility may or may not be valuable.** Key words in these responses included “distrust,” “awareness,” and “administration.” This intervention was the most favored of the four least preferred options. Adding HR was valued by many as increasing the awareness of the problem and making it more difficult for any specific manager to ignore or allow hostilities to continue without intervention. Beyond, that concerns were cited about administration and HR acting on behalf of the facility and not in support of the staff.

**Please briefly explain why utilizing a third party mediator or direct human resource intervention without manager/supervisor mediation as a standardized authoritative response to hostility may or may not be valuable.** Key words in these responses included “objectivity,” “knowledge,” “decreased bias,” “expertise,” and “expense.” Respondents communicated that this should be either a first or last resort. Many stated they would prefer their manager to intervene as long as they had the appropriate skill set for conflict resolution. While third party mediation was generally acknowledged as being less biased and meriting less fear of retaliation, it was also cited as being more expensive and less available.

**Please briefly explain why utilizing an executive mandate for contractual authoritative mediation with clear consequences such as monetary fines for ongoing patterns of hostility may or may not be valuable.** Key words in these responses included “court [of law],” “doctors,” “excessive,” “[law] enforcement,” “fear,” “counseling,” and “ticket.” Respondents indicated general support while also offering that if this was being considered, then someone should probably simply be terminated. Concerns were also expressed that doctors or others with higher perceived incomes might be able to buy their way out of trouble and continue hostilities. A general theme emerged that “counseling” would be valued over “fear tactics.” However, several respondents also noted that this intervention could pay for third party mediation or some of the other supportive structures deemed “expensive.”

## **Chapter 5: Results and Conclusion**

### **Overview**

The general purpose of this study was to explore a knowledge deficit within the literature on nurse hostility. Cost, causes, and consequences flooded the literature on nurse-to-nurse as well as workplace hostility. Lacking almost completely were specific recommendations for interventions and structures designed to mediate or prevent hostilities and support staff and management through the process of hostility resolution.

The researcher proposed to determine nurses' perceptions of value specific to a presented collection of interventions and supportive structures intended to mediate or prevent workplace hostilities. The primary research question involved an attempt to identify which interventions and supportive structures to hostilities nurses perceived as being the most valuable and why? A secondary research question attempted to identify trends in perceptions of value that were correlated to participant characteristics. Both inquiries produced results.

It was the author's stated opinion, or bias, prior to this investigation that nurse managers, supervisors, and directors did not all have the tools required to effectively intervene in cases of reported hostilities. This opinion was based on more than twenty years of experience and observations, on the ongoing prevalence of workplace hostilities, and on an appreciation of the technical, fiscal, and cultural challenges faced by healthcare organizations, management, and administration.

The author's role in this research was to collect, analyze, and evaluate responses related to supportive structures and interventions deemed valuable by nurses for further consideration in designing and implementing such structures for management and staff. To this end, the author developed and circulated a questionnaire designed to gauge nurses' perceptions of interventions and supportive structures in order to rank them by a compressed Consensus of Value (CV), as well as an expanded Perceived Value Index (VI).

In order to determine if nurses preferred specific styles of structures and interventions, these were offered in sets with a description of the style heading each survey page. Passively Supportive Structures were defined as structures and interventions to workplace hostility focusing on organizational support with a cultural focus. Collaborative Interventions were described as structures and interventions to workplace hostility focusing on organizational and individual awareness and having a preventive focus. Actively Supportive Structures were defined as structures and interventions to workplace hostility focusing on training and skills with an educational focus. Authoritative Interventions were described as structures and interventions to workplace hostility focusing on organizational support and having a crisis management focus.

The researcher's own bias of value occurred on a continuum that increased from passively supportive structures to authoritative interventions. However, feedback prior to the study indicated that the researcher's own views were not necessarily aligned with other nurses and that active and authoritative structures might be more controversial. Structures were, therefore, offered in order of increasing authority in an attempt to maintain participant engagement.

The presented supportive structures and interventions offered in categories were reordered, once analyzed, to reflect their relative value as ascribed by nurses. This reclassified information, combined with narratives of explanation, offered insights into next steps. These next steps include the development of (1) more clearly defined zero-tolerance policies to hostility, (2) tools kits for managers and staff, and (3) standardized responses at the facility level likely to be well-received by nursing.

The author was not principally interested in knowing whether or not nurses had confidence in their manager's or supervisor's ability to support them through crisis, conflict, and hostilities. Such had been previously established in studies as being a primary concern of nurses along with a lack of supportive structures (Farrell, 2001). Indicting nurse managers for not having the training required to manage conflict did not seem particularly useful or productive.

Instead, a set of interventions and supportive structures were collected and presented for evaluation by nurses that might benefit all nurses, including those in management and administration. One of the 16 presented interventions was utilizing direct manager/supervisor intervention as a standardized authoritative response to hostility. The lower-tiered value scoring of this intervention at 74.07% Consensus of Value (VI of 2.852), combined with higher CV and VI scores for offering staff a class in conflict management skills specific to peer hostility (CV at 95.45%, VI of 3.295) and requiring manager/supervisor training in conflict resolution, mediation, and prevention (CV at 92.77%, VI of 3.373) aligned with previous studies.

### **Results and Conclusions**

The interventions and structures most valued by nurses included requiring manager/supervisor training in conflict resolution, mediation, and prevention (CV at 92.77%, VI of 3.373), a zero tolerance to hostility policy with clear process, protocol, and consequences (CV at 87.78%, VI of 3.344), an integrity line or clear pathway available for the reporting of hostilities (CV at 87.78%, VI of 3.311), and offering staff a class in conflict management skills specific to peer hostility (CV at 95.45%, VI of 3.295). These results draw from three of the four sets of interventions and therefore do not represent a favored style. Any interested facility might do well to focus on these four interventions and supportive structures as having the most buy-in from nurses.

The Actively Supportive Structure of requiring manager/supervisor training in conflict resolution was rated the second most valued intervention by CV and the most valuable by VI. This skill set appeared to be a critical characteristic by the perception of nursing staff when evaluating a manager or supervisor for adequacy in their leadership role. Again, commentary overall was very supportive and respectful of nurse managers. A few nurse managers identified themselves as such in the narratives and expressed a desire for greater confidence when dealing with staff conflict. Other participants desired greater confidence that their leaders could support them through hostilities.

The Collaborative Intervention of offering staff a class in conflict management was the most valued intervention by CV and the fourth most valuable by VI. It is interesting to note that one of the key words for this intervention in the narrative analysis was “expensive,” whereas requiring manager training did not include that key word. A few participants commented that this could provide a venue to debrief as well as share experiences with others. Several nurses pondered the cost-to-benefit ratio of offering a class to staff who did not ponder this when considering requiring management to acquire this skill set. As this intervention was noted in the top four most valued by nurses, the cost-to-benefit ratio was likely worthwhile by nurses' perceptions.

The two Passively Supportive Structures of a zero tolerance to hostility policy with clear process, protocol, and consequences and an integrity line or clear pathway available for the reporting of hostilities rated as the second and third most valued structures by VI and tied for the fifth most valuable by CV. The two Collaborative Interventions of (1) incorporating hostility awareness incorporated into new hire orientation (CV at 89.77%, VI of 3.227) and (2) offering staff virtual simulations of hostility and appropriate responses (CV at 88.64%, VI of 3.159) scored slightly higher by the compressed data and slightly lower when the data expanded allowing higher resolution.

“Accountability,” “consequences,” and “standardized” were reoccurring key words and themes in the narrative data for a zero tolerance policy. Participants were focused on defining behavior that was acceptable as well as what was not acceptable. Recurring commentary also focused on decreasing gray areas and reducing potential retaliation against reporting employees. Again, had this question not included “clear process, protocol, and consequences” it would likely have scored lower in the Value Index.

“Confidential,” “anonymous,” “protection,” and “standardized” dominated the narratives on clear pathway for reporting. Participants continued to express value in reducing gray areas of policy and protocol as well as reducing the likelihood of retaliation when reporting hostilities. This question was deliberately *not* defined as being anonymous or confidential in order to solicit perceptions. Again, it appears from the data that many nurses assumed it was anonymous, while others perceived it as being

confidential. While confidentiality is likely in a reporting system, anonymity would make it difficult to investigate concerns.

### **Trends**

Male nurses in this study reported being between 30 to 59 years of age. On average, male nurses of all ages and female nurses over the age of 60 rated Authoritative Interventions higher. An exception to this was when asked the value of utilizing direct manager mediation. Both male participants and female participants over the age of 60 rated direct manager/supervisor intervention as a standardized authoritative response the lowest in this category. Male nurses maintained a positive trend (CV at 70%) while female nurses over the age of 60 disclosed only a 43% Consensus of Value for direct manager mediation. Female nurses in general supported manager mediation with a CV of 74%. Mediation by Human Resources or a third party without management was valued similarly by female nurses of all ages.

The similar trending for perceptions of value between male nurses under the age of 60 and female nurses over the age of 60 is interesting. This could be explained in part or completely by the phenomenon of gender role reversal within the discipline of developmental psychology. The phenomenon suggests that as men and women age, they tend to take on the ascribed personality characteristics and values of the other gender. This is generally considered to be a gradual transformation.

Of the 90 participants, 31 (or 34.44%) reported being in practice for 26 or more years. This subset trended between all participants and female nurses over 60 years of age. Parallel trending was noted relative to two of the four presented Actively Supportive Structures. Male nurses valued required classes higher than female nurses, regardless of whether the aggressor and target had the class together or separately. Female nurses over the age of 60 were also more supportive of the required classes without distinguishing whether individuals engaged in conflict took the classes together or separately. Otherwise, participant sub-groups tended to rate structures and interventions similarly.

**Implications and Limitations**

The primary implication of this study was that it shed some light what nurses value in terms of interventions and supportive structures designed to address workplace hostility. As such it also suggested that specific interventions may be more effective in developing policy and protocol than others. The primary limitation was that as a pilot it involved a relatively small number of nurses. The smaller population, however, lent itself to the analysis of qualitative data and allowed an initial exhibition of the researcher-developed survey.

The most highly valued interventions by way of this pilot may be summarized as (1) providing training in conflict resolution for staff and managers alike, (2) instituting and enforcing a zero tolerance policy with clear expectations and consequences, and (3) utilizing an integrity line or other clear reporting pathway to minimize both ambiguity and fear of retaliation. Additional research might involve teasing out whether structures such as training in conflict management should be optional or required, as well as whether reporting venues should be anonymous or simply confidential.

**Strengths**

While the sample size was small (N=90), there was broad geographic representation of nurses practicing in 24 states. Even the collector localized to the Pacific Northwest included several travelers who reported their primary licensure as being elsewhere, most notably the Southeast (N=7). Nurses were represented by diverse group with levels of experience ranging from zero to over forty years of experience and both male and female nurses participated in the study. The narrative data allowed for greater insight into why nurses valued particular structures.

Furthermore, nurses in this pilot concurred that nurse managers as well as staff would benefit from training in conflict management. Supportive structures and interventions ranged in value from controversial (CV at 51.81%) to approaching nearly unanimous value (CV at 95.45%).



### **Weaknesses**

In developing the survey tool, the researcher did not consider what is referred to as “acquiescence bias.” This is a general predisposition of respondents to agree with a survey item. It is possible that all presented interventions were truly valued by nurses and that the least valued interventions and structures were simply controversial. It is also possible that presenting each statement of value in the positive by indicating that they “would be valuable” biased respondents to agree. However, since all interventions shared this exact terminology, it is unlikely that the relative order of perceived value was affected.

It is more likely that using terms such as “offer” and “require” affected the results. Indeed, these terms were cited numerous times in the narratives as being decisive considerations when evaluating Collaborative Interventions and Actively Supportive Structures. Future studies may benefit from balancing statements such as “requiring” manager/supervisor training in conflict resolution and “offering” staff a class in conflict management with alternates such as “offering” manager/supervisor training in conflict resolution and “requiring” staff a class in conflict management. For the purposes of this pilot, however, statements “requiring” interventions were less valuable if followed the value trending of passive and collaborative structures over active and authoritative interventions.

### **Lessons Learned**

Problems encountered in this study included the development of the survey tool as no standardized or previously vetted product was available for use. *SurveyMonkey.com* requested a slight modification to the Informed Consent that would allow it to fit on one page. This was achieved by deleting repetitious information while maintaining the overall clarity and integrity of the message. Survey consultants also urged the researcher to unlock all previously required questions, allowing participants to bypass questions they had no interest in answering. Questions were unlocked after 30 surveys had been completed including answers to all open-ended questions.

The open-ended questions provided invaluable insights as to why participants did or did not value any particular intervention. These insights were necessary in establishing a reasonably informed baseline

and point of inquiry for further research. These questions, however, were very time consuming for participants.

The presentation of 16 structures may have been ambitious for a pilot. Presenting ten or fewer structures and interventions would have significantly reduced the time required to take the survey. The survey was anticipated to require less than ten minutes of participant's time. Forty-nine respondents required greater than ten minutes to complete the survey with 26 participants taking more than 20 minutes and another 15 requiring more than 30 minutes. These longer periods of time may also have been required to answer all survey questions thoughtfully relative to 16 structures.

A potential acquiescence bias may have been nullified by changing the format of statements from ending in "would be valuable" to a more neutral presentation and by changing the response options from agree/disagree to a direct scale of value such as one through four, one being the least valuable and four being the most. This would also have created a direct Value Index without needing to weight responses.

Statement themes such as "offer" (Collaborative Interventions) and "require" (Actively Supportive Structures) could have been explored more symmetrically by presenting the same interventions and structures with their alternate imperatives. Similarly, themes such as "anonymous" and "confidential" with respect to reporting and a zero tolerance policies with and without clear process, protocol, and consequences may have been worth evaluating for comparative perceptions of value. Incorporating all of the above changes would likely decrease the time required to complete the surveys, maintain or augment the validity of results, and reduce ambiguity as to whether the optional or mandated nature of any given intervention had more impact on perceived value than the intervention itself.

Future research will likely incorporate these improvements as would a parallel study if presented again. It is advisable that future research incorporates a larger sample of nurses. In doing so, a mixed or strictly quantitative methodology may be more appropriate. Additional qualitative components could be incorporated, as needed, by interviewing participants and reviewing case studies. Future studies may also

wish to incorporate question randomization to ensure better coverage of all questions in light of attrition, a single survey collector, and either a national or facility-specific sample.

### **WGU Reflection**

My time at WGU has been well spent. I had taken online classes prior to WGU, but this was my first experience with an entirely online program. Having completed two bachelors and a clinical doctorate at brick and mortar universities, I can say with confidence that Western Governors University required every bit of engagement and commitment to succeed. Since beginning academics at WGU, I have spent a minimum of 28 hours a week reading course materials, reviewing journals, and writing papers in addition to full time employment. For the first five weeks I averaged 43.5 hours of study and writing. This was exhausting, but allowed accelerated progress.

I had reviewed graduate options for several years before deciding on WGU. I compared the MSN coursework offered at WGU to both the University of Central Florida and the University of Washington. The programs were quite similar, lending support to the venue (online) as being the primary difference. Cost was a secondary, but important, consideration. The complete absence of commute time combined with six month rolling terms and options for accelerated progress sold me. My only hesitation was the thesis requirement.

I have until now consciously avoided pursuing research-based programs of study. I believe I simply considered them to be more difficult and ultimately less practical than an applied course of study. In retrospect, the thesis option was indeed more difficult. It was also incredibly worthwhile. Having an understanding of research methodology, an appreciation of quantitative and qualitative inquiry, and experience in reviewing literature will be invaluable as I attempt to support my facility in implementing evidence-based practices. My thesis, specifically, will help guide the development of a zero tolerance policy to workplace hostilities, open dialogue on creating tool kits for management and staff, and possibly encourage funding for classes in conflict management.

The following are skills that I feel I have developed and will utilize in my role as an MSN-prepared RN and as a result of my enrollment and matriculation from WGU. The roles that follow are much as they appeared in SMT2 with some refinement.

**Nurse Researcher**

In addition to thesis-driven work, I will use my refined research abilities to more clearly identify needs at my facility and represent these needs in the form of clinical questions designed to improve quality, patient satisfaction, and clinical outcomes. Specifically, I will review deficiencies as identified in GAP analyses by way of PICO questions. I will consider these clinical inquiries in terms of the population, interventions, relevant comparisons or best practices, and clinical outcomes or quality improvement measures. I will analyze process errors and deficiencies for definable characteristics and use these definitions to create measurable data sets or metrics for further review and trending. The goal of my research efforts will be to improve patient care delivery, cost-effectiveness, efficiency, and clinical outcomes.

**Nurse Collaborator**

I will develop, implement, participate in, and coordinate high performance interdisciplinary teams composed of clinical, financial, and ancillary providers. As a graduate nurse, I will lead by example in my own pursuit of professional excellence and learn from as well as share with other providers on my team. I will be Informed, Collaborative, Accountable, Reliable, and based in Evidenced-Based scientific practices as my facility's nursing model requires.

**Clinical Nurse**

As a master's prepared nurse, I will bring a refined element to triage and the clinical practice of assigning patients to the correct unit, physician, and service as part of a clinical admissions system. I will likely continue to govern or oversee the seam between the emergency department and the in-patient and ambulatory care units. I will attempt to function as a role model for other nurses who may be considering graduate education and freely discuss the benefits of MSN preparation in alignment with Magnet recommendations by the ANCC.

**Consumer Advocate**

I will continue to anticipate the needs of my patients, staff, and all end-users of clinical care. I will be my role to facilitate the care delivery and policy incorporation set forth by the executive teams at my facility. I will carefully assess the psychosocial, economic, cultural, human, and health factors of patients and clients and incorporate these factors into my collaborative approach to care.

**Manager of Systems**

I will be well-versed in healthcare policy, organization, and financing, in addition to strictly clinical areas and systems. I will assume a leadership role and participate in the implementation of care in the management healthcare systems that I influence. Based on current training-in-progress at [REDACTED], I will utilize process improvement tools such as Change Acceleration Process and Six Sigma to analyze and diagnose the impact of systems on patient outcomes and adjust process accordingly for quality improvement. I will demonstrate knowledge and expertise in assessing my organization, facilitating changes, and addressing errors in care delivery as well as areas needing improvement.

**Nurse Consultant**

I will collect data, analyzes trends, and synthesizes new knowledge that can be applied by my healthcare organization for the benefit of our patients, their family, and our staff. I will offer a supportive role to bedside nursing, address areas of failure or error with clinical and statistical tools, and maintain a focus on clinical care, outcomes, process development, as well as appropriate policy development.

**Change Agent**

I intend to lead continuous improvement efforts based on my acquisition of translational research skills, knowledge acquisition and dissemination, comfort in working within collaborative groups, and the application change management theories. I already engage in such processes, but my training from WGU has furthered my understanding of key elements and principles.

My roles as researcher and manager of systems will support my change efforts as I identify clinical questions that need measureable answers. I plan to assist in developing the much needed new model of healthcare; one that is focused on preventive care, early intervention, and evidence-based best practices. I will incorporate my experiences as a natural physician with the skills set I acquire in my consecutive MSN and MBA programs at WGU to align front line nursing with my facilities strategic plan and the direction of healthcare as determined by current and future legislation.

### **Improving Healthcare Delivery and Outcomes**

As quality consultant and nurse leader, I will utilize a variety of research tools, statistical models, nursing theories, and applied concepts to clinical inquiries designed to refine clinical practices. I will continue to diagnose the patient's response to therapies and consider relevant nursing care plans.

This role will be supported by my manager of systems skill set and will utilize Six Sigma and Change Facilitator methods in order to bring about meaningful and lasting buy-in for stakeholders in considering new and better clinical processes. I will entertain more sophisticated and systematic clinical inquiries intended to improve the outcomes, trends, efficiency, and quality at my facility and share any developed best practices with affiliated facilities such as [REDACTED]. I intend to assist in the development of policy and protocol that supports affordable and safer care.

### **Negotiator as Nurse Leader**

As negotiator and nurse leader, I will attempt to facilitate successful outcomes in the context of informational, clinical, financial, and human systems. I will pursue the development of safe, clinically appropriate, and financially sound policies that protect both facility and patient from liability and injury. I will do my best to support and safeguard my bedside nursing staff in an environment of unionization and litigation, while honoring and abiding by our collective bargaining agreements.

### **Director of Nursing**

I am more comfortable, as a result of my studies at WGU, with budgets and financially based policies. I will be able to assist management with appropriate stewardship and budgeting, as needed. I

may also offer greater assistance with volunteer coordination and giving activities since these are vital programs and crucial to patient services. In 2014, I intended to broaden my financial knowledge by enrolling in WGU's Healthcare MBA. The MSN and MBA degrees have been alluded to as being particularly valuable together.

**Summary**

I have and will continue to highly recommend WGU to peers, friends, and family. The staff and mentors are supportive and dedicated to assisting students through to completion. While far from easy and at many times exhausting, my time at WGU has been both valuable and rewarding. As for the thesis option, I was surprised to discover how practical it really was. I will continue to research matters within nursing and healthcare long after my matriculation. I am grateful to my mentors and other supporters to have had this opportunity.



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## Appendix A

### Survey and Informed Consent

Workplace Hostility and Nurses' Perceptions
Informed Consent
<p>Western Governors University Master of Science in Nursing Thesis Research Ryan Hosken, ND, BSΨ, BSN, RN</p>
<p><b>INTRODUCTION</b></p> <p>Dr. Hosken is conducting research to determine the most valuable interventions and supportive structures as perceived by nurses, to prevent, mediate, or address workplace hostilities.</p>
<p><b>PURPOSE</b></p> <p>This study will attempt to present a representative panel of active and passive supportive structures, as well as authoritative and collaborative interventions for nurses to evaluate as being valuable or a waste of resources. This work is intended to inform on reasonable next steps.</p>
<p><b>OVERVIEW</b></p> <p>This research is being conducted to determine nurses' perceptions. How nurses feel about any given traditional or alternate pathways intended to resolve conflict or hostilities will help to determine which structures might be best received and accepted by staff.</p>
<p><b>PARTICIPANTS</b></p> <p>The survey will be open to nurses of all ages, ethnicities, specialties, education, and other defined characteristics to be as inclusive as possible. This survey is voluntary and the participants will remain anonymous. Participation and withdrawal is voluntary.</p>
<p><b>RISKS</b></p> <p>There are no known risks to participants in this study.</p>
<p><b>CONFIDENTIALITY</b></p> <p>Confidentiality will be maintained by the use of survey that does not require personal identifying information. Only four participant characteristics will be collected (age group, gender, years in nursing, and State of primary nursing practice). These characteristics will then be aggregated and analyzed for trends.</p>
<p><b>QUESTIONS, RIGHTS, and COMPLAINTS</b></p> <p>For questions, comments, or concerns please contact Ryan Hosken at <a href="http://www.iophysician.com">http://www.iophysician.com</a>. All participants are entitled to the results of the study upon completion. Such information may be requested personally or by way of your affiliated nursing organization.</p>
<p><b>INSTRUCTIONS</b></p> <p>Each participant will be asked to evaluate 18 supportive structures and interventions related to addressing workplace hostility. Participants will be presented with statements of value and asked to AGREE or DISAGREE and then briefly explain with A FEW DESCRIPTIVE WORDS or sentences.</p>
<p><b>CONSENT STATEMENT</b></p> <p>By acknowledging this form you are consenting to participate in the survey. Together, as nurses, we can improve our workplace environment.</p>

## Workplace Hostility and Nurses' Perceptions

### Passively Supportive Structures

These structures and interventions to workplace hostility focus on organizational support and have a cultural focus.

**1. A zero-tolerance policy to hostility with clear process, protocol, and consequences would be valuable in addressing workplace hostility.**

☐ Strongly disagree ☐ Agree  
☐ Disagree ☐ Strongly agree

**Please briefly explain why a zero-tolerance policy to hostility with clear process, protocol, and consequences may or may not be valuable.**

**2. Having an integrity line or clear pathway for reporting hostilities would be valuable in addressing workplace hostility.**

☐ Strongly disagree ☐ Agree  
☐ Disagree ☐ Strongly agree

**Please briefly explain why having an integrity line or clear pathway for reporting hostilities may or may not be valuable.**

**3. Having administrative teams in place dedicated to assessing and addressing workplace hostility would be valuable.**

☐ Strongly disagree ☐ Agree  
☐ Disagree ☐ Strongly agree

**Please briefly explain why having administrative teams in place dedicated to assessing and addressing workplace hostility may or may not be valuable.**

**4. Having one or more standardized immediate verbal or non-verbal responses (such as a phrase or tapping on one's own badge) for all nursing staff would be valuable in addressing workplace hostility.**

☐ Strongly disagree ☐ Agree  
☐ Disagree ☐ Strongly agree

### Workplace Hostility and Nurses' Perceptions

Please briefly explain why having one or more standardized immediate verbal or non-verbal responses (such as a phrase or tapping on one's own badge) for all nursing staff may or may not be valuable.

### Collaborative Interventions

These structures and interventions to workplace hostility focus on organizational and individual awareness and have a preventive focus.

**5. Offering staff virtual simulations of hostility with appropriate responses would be valuable in addressing workplace hostility.**

☐ Strongly disagree

☐ Agree

☐ Disagree

☐ Strongly agree

Please briefly explain why offering staff virtual simulations of hostility with appropriate responses may or may not be valuable.

**6. Offering staff classes in conflict management skills would be valuable in addressing workplace hostility.**

☐ Strongly disagree

☐ Agree

☐ Disagree

☐ Strongly agree

Please briefly explain why offering staff classes in conflict management skills may or may not be valuable.

**7. Incorporating hostility awareness into new hire orientation would be valuable in addressing workplace hostility.**

☐ Strongly disagree

☐ Agree

☐ Disagree

☐ Strongly agree

Please briefly explain why incorporating hostility awareness into new hire orientation may or may not be valuable.



**Workplace Hostility and Nurses' Perceptions**

**8. Incorporating hostility awareness into regularly occurring meetings would be valuable in addressing workplace hostility.**

☐ Strongly disagree

☐ Agree

☐ Disagree

☐ Strongly agree

**Please briefly explain why incorporating hostility awareness into regularly occurring meetings may or may not be valuable.**

**Actively Supportive Structures**

These structures and interventions to workplace hostility focus on training and skills and have an educational focus.

**9. Requiring that staff participate in virtual simulations of hostility with appropriate responses would be valuable in addressing workplace hostility.**

☐ Strongly disagree

☐ Agree

☐ Disagree

☐ Strongly agree

**Please briefly explain why requiring that staff participate in virtual simulations of hostility with appropriate responses may or may not be valuable.**

**10. Requiring employees involved in reported hostilities participate together in classes teaching conflict management skills would be valuable in addressing workplace hostility.**

☐ Strongly disagree

☐ Agree

☐ Disagree

☐ Strongly agree

**Please briefly explain why requiring employees involved in reported hostilities participate together in classes teaching conflict management skills may or may not be valuable.**

**11. Requiring employees involved in reported hostilities participate separately in classes teaching conflict management skills would be valuable in addressing workplace hostility.**

☐ Strongly disagree

☐ Agree

☐ Disagree

☐ Strongly agree

### Workplace Hostility and Nurses' Perceptions

Please briefly explain why requiring employees involved in reported hostilities participate separately in classes teaching conflict management skills may or may not be valuable.

**12. Requiring manager/supervisor training in conflict resolution, mediation, and prevention would be valuable in addressing workplace hostility.**

☐ Strongly disagree

☐ Agree

☐ Disagree

☐ Strongly agree

Please briefly explain why requiring manager/supervisor training in conflict resolution, mediation, and prevention may or may not be valuable.

### Authoritative Interventions

These structures and interventions to workplace hostility focus on organizational support and have a crisis management focus.

**13. Utilizing direct manager/supervisor intervention as a standardized authoritative response to hostility would be valuable.**

☐ Strongly disagree

☐ Agree

☐ Disagree

☐ Strongly agree

Please briefly explain why utilizing direct manager/supervisor intervention as a standardized authoritative response to hostility may or may not be valuable.

**14. Utilizing direct manager/supervisor intervention with human resource personnel present as a standardized authoritative response to hostility would be valuable.**

☐ Strongly disagree

☐ Agree

☐ Disagree

☐ Strongly agree

Please briefly explain why utilizing direct manager/supervisor intervention with human resource personnel present as a standardized authoritative response to hostility may or may not be valuable.

### Workplace Hostility and Nurses' Perceptions

**15. Utilizing a third party mediator or direct human resource intervention without manager/supervisor mediation as a standardized authoritative response to hostility would be valuable.**

☐ Strongly disagree

☐ Agree

☐ Disagree

☐ Strongly agree

**Please briefly explain why utilizing a third party mediator or direct human resource intervention without manager/supervisor mediation as a standardized authoritative response to hostility may or may not be valuable.**

**16. Utilizing an executive mandate for contractual authoritative mediation with clear consequences such as monetary fines for ongoing patterns of hostility would be valuable.**

☐ Strongly disagree

☐ Agree

☐ Disagree

☐ Strongly agree

**Please briefly explain why utilizing an executive mandate for contractual authoritative mediation with clear consequences such as monetary fines for ongoing patterns of hostility may or may not be valuable.**

### Participant Characteristics

Please select your age group, gender, years as a nurse, and State of primary nursing practice.

**17. Participant characteristic 1 of 4. Please select your age group.**

☐ 19 or less years of age

☐ 50 to 59 years of age

☐ 20 to 29 years of age

☐ 60 to 69 years of age

☐ 30 to 39 years of age

☐ 70 or more years of age

☐ 40 to 49 years of age

**18. Participant characteristic 2 of 4. Please indicate your gender.**

☐ Female

☐ Male

**Workplace Hostility and Nurses' Perceptions****19. Participant characteristic 3 of 4. Please select years licensed or practicing as a nurse.**

- |  |  |
|--|--|
| <input type="radio"/> 0 to 2 years in practice | <input type="radio"/> 10 to 15 years in practice   |
| <input type="radio"/> 3 to 4 years in practice | <input type="radio"/> 26 to 39 years in practice   |
| <input type="radio"/> 5 to 9 years in practice | <input type="radio"/> 40 or more years in practice |

**20. Participant characteristic 4 of 4. Please select US State of primary practice as a nurse.**

- |                                     |                                      |
|-------------------------------------|--------------------------------------|
| <input type="radio"/> Alabama       | <input type="radio"/> Montana        |
| <input type="radio"/> Alaska        | <input type="radio"/> Nebraska       |
| <input type="radio"/> Arizona       | <input type="radio"/> Nevada         |
| <input type="radio"/> Arkansas      | <input type="radio"/> New Hampshire  |
| <input type="radio"/> California    | <input type="radio"/> New Jersey     |
| <input type="radio"/> Colorado      | <input type="radio"/> New Mexico     |
| <input type="radio"/> Connecticut   | <input type="radio"/> New York       |
| <input type="radio"/> Delaware      | <input type="radio"/> North Carolina |
| <input type="radio"/> Florida       | <input type="radio"/> North Dakota   |
| <input type="radio"/> Georgia       | <input type="radio"/> Ohio           |
| <input type="radio"/> Hawaii        | <input type="radio"/> Oklahoma       |
| <input type="radio"/> Idaho         | <input type="radio"/> Oregon         |
| <input type="radio"/> Illinois      | <input type="radio"/> Pennsylvania   |
| <input type="radio"/> Indiana       | <input type="radio"/> Rhode Island   |
| <input type="radio"/> Iowa          | <input type="radio"/> South Carolina |
| <input type="radio"/> Kansas        | <input type="radio"/> South Dakota   |
| <input type="radio"/> Kentucky      | <input type="radio"/> Tennessee      |
| <input type="radio"/> Louisiana     | <input type="radio"/> Texas          |
| <input type="radio"/> Maine         | <input type="radio"/> Utah           |
| <input type="radio"/> Maryland      | <input type="radio"/> Vermont        |
| <input type="radio"/> Massachusetts | <input type="radio"/> Virginia       |
| <input type="radio"/> Michigan      | <input type="radio"/> Washington     |
| <input type="radio"/> Minnesota     | <input type="radio"/> West Virginia  |
| <input type="radio"/> Mississippi   | <input type="radio"/> Wisconsin      |
| <input type="radio"/> Missouri      | <input type="radio"/> Wyoming        |

## Appendix B

### Value Tables

Perceived Value Index within Intervention Sets		Consensus of Value
<b>Passively Supportive Structures (Organization/Culture)</b>		
3.344	Zero tolerance to hostility policy (with clear process, protocol, and consequences)	87.78%
3.311	Integrity line or clear pathway available for the reporting of hostilities	87.78%
3.178	Administrative team(s) in place dedicated to assessing and addressing hostilities	82.22%
2.611	Standardized responses to hostility (cognitive rehearsal such as a phrase or tapping on one's badge)	54.45%
<b>Collaborative Interventions (Awareness/Preventive)</b>		
3.159	Offering staff virtual simulations of hostility and appropriate responses	88.64%
3.295	Offering staff a class in conflict management skills specific to peer hostility	95.45%
3.227	Incorporating hostility awareness into new hire orientation (preventive, awareness, resources)	89.77%
2.955	Incorporating hostility awareness into regular meetings (preventive, awareness, resources)	77.27%
<b>Actively Supportive Structures (Training/Skills)</b>		
2.952	Requiring virtual simulations of hostility and appropriate responses (mandatory education)	73.5%
2.542	Requiring a class in conflict management skills specific to peer hostility (with antagonist)	51.81%
2.807	Requiring a class in conflict management skills specific to peer hostility (without antagonist)	66.27%
3.373	Requiring manager/Supervisor training in conflict resolution, mediation, and prevention	92.77%
<b>Authoritative Interventions (Crisis Management)</b>		
2.852	Direct manager/supervisor intervention as a standardized authoritative response to hostility	74.07%
2.765	Direct manager/supervisor intervention as a standardized authoritative response (with HR present)	66.67%
2.778	Third party or HR without manager/supervisor standardized authoritative responses to hostility	67.9%
2.704	Executive mandate for contractual authoritative mediation with clear consequences such as fines	66.67%

Ordered from Highest to Lowest Perceived Value Index		Consensus of Value
3.373	Requiring manager/supervisor training in conflict resolution, mediation, and prevention	92.77%
3.344	Zero tolerance to hostility policy (with clear process, protocol, and consequences)	87.78%
3.311	Integrity line or clear pathway available for the reporting of hostilities	87.78%
3.295	Offering staff a class in conflict management skills specific to peer hostility	95.45%
3.227	Incorporating hostility awareness incorporated into new hire orientation	89.77%
3.178	Administrative team(s) in place dedicated to assessing and addressing hostilities	82.22%
3.159	Offering staff virtual simulations of hostility and appropriate responses	88.64%
2.955	Incorporating hostility awareness incorporated into regular meetings	77.27%
2.952	Requiring virtual simulations of hostility and appropriate responses (mandatory education)	73.5%
2.852	Direct manager/supervisor intervention as a standardized authoritative response to hostility	74.07%
2.807	Requiring a class in conflict management skills specific to peer hostility (without antagonist)	66.27%
2.778	Third party or HR without manager/supervisor standardized authoritative responses to hostility	67.9%
2.765	Direct manager/supervisor intervention as a standardized authoritative response (with HR present)	66.67%
2.704	Executive mandate for contractual authoritative mediation with clear consequences such as fines	66.67%
2.611	Standardized responses to hostility (cognitive rehearsal such as a phrase or tapping on one's badge)	54.45%
2.542	Requiring a class in conflict management skills specific to peer hostility (with antagonist)	51.81%

**Appendix C**

**NIH Protecting Human Research Participants Certificate**





## Appendix D

### Organizational Permission

[REDACTED] llc



#### Organizational Study Approval Letter

Western Governors University  
Institutional Review Board

The purpose of this letter is to grant Ryan Hosken, a graduate nursing student enrolled in the MSN in Leadership and Management program at Western Governors University, permission to conduct research through [REDACTED]. The Capstone project, "**Workplace hostility and nurses' perceptions of the value of interventions and supportive structures,**" proposes distribution of an electronic survey intended to collect anonymous information related to nurse participant characteristics and their perceptions of organizational structures designed to prevent, mediate, and resolve workplace hostilities.

Lack of supportive structures and ineffective interventions by managers have been cited by nurses in previous studies as being primary concerns. This study will attempt to present a representative panel of active and passive supportive structures, as well as authoritative and collaborative interventions for nurses to evaluate as being valuable or a waste of resources. This work is intended to inform on reasonable next steps.

The questionnaire is voluntary and will be emailed to potential participants by the organization. The email will contain a link to the survey. Completed surveys will be captured by an online tool such as *SelectSurvey* or *SurveyMonkey*. More than thirty completed surveys will be required, though more than 100 nurse respondents will be preferred. [REDACTED] was selected because this is the student/researcher's employer.

I understand that the Capstone project research is anticipated to take place between September 1<sup>st</sup>, 2013 and December 15th, 2013.

I understand that Ryan Hosken will receive informed consent from all research participants as needed, that any identifying data collected will be kept confidential, and that this student/researcher will receive Western Governors University IRB approval before research participants are recruited or data is collected.

Results of this study will be made available to the participants through [REDACTED].

As the owner of [REDACTED], authorized to act on behalf of [REDACTED] on all operational and research matters, I do hereby grant permission for Ryan Hosken to conduct this proposed data collection by way of questionnaire at A [REDACTED]

  
[REDACTED]

08/13/2013  
Date

[REDACTED]