Horizontal Hostility

A Threat to Patient Safety

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ABSTRACT

Objective: *The objective of this study was to determine the perceived level of horizontal hostility (HH) in a 220-bed acute care community hospital and whether the threat of or experience with HH influenced nurse behaviors directly related to patient safety.* *Background:* *While the acknowledgement and presence of HH in nursing are gaining prominence, little is known about how a nurse's experience with HH directly influences his/her actions with patients under their care, even when the nurse realizes these actions may not be in the patient's best interest.* *Methods:* *We used a 28-item survey tool aimed at determining the level of perceived HH in an acute care Magnet-aspiring hospital in the Southwest and then asked about nurses' actions as a result of that experience. Almost 500 nurses were surveyed over a 2-month period in 2011.* *Results:* *Of the nurses who had personally experienced HH, a high number reported performing interventions or actions that could compromise patient care and/or safety, including (a) failing to clarify an unreadable order, (b) lifting or ambulating heavy or debilitated patients without assistance rather than asking for help, (c) using an unfamiliar piece of equipment without asking for clarification, and (d) carrying out an order that the nurse did not believe was in the best interest of the patient, among other behaviors.* *Conclusion:* *The presence of HH has clear implications for patient safety. Recommendations for addressing and managing HH are provided and geared to the hospital leadership level.*

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Although the concept of peer incivility or ''horizontal hostility'' (HH) is not a new phenomenon in healthcare settings, studies demonstrating a relationship between HH and adverse patient outcomes are gaining prominence.[1–3] One statewide survey from South Carolina revealed that greater than 85% of the licensed nurses surveyed were victims of HH,[4] whereas other studies indicate that healthcare professionals who feel bullied or intimidated are less likely to speak out when they see an error in patient care[5] or may engage in ''workarounds'' in order to avoid the bullying individual. The magnitude of nurses who feel threatened or bullied at work coupled with behaviors they may exhibit in order to avoid those bullying behaviors suggests that the elimination of HH may be one of the most significant strategies used by nurse managers to curb potentially adverse patient events, known to cause prolonged hospitalizations, delays in treatments, and catastrophic outcomes.

Joint Commission implemented a standard in January 2009 requiring hospitals to define disruptive behavior and have a process in place for dealing with it[6]; however, because most disruptive behavior is assumed to be physician to nurse, nurse-to-nurse hostility is often underrecognized and may not be reported.

Therefore, the purpose of this study was to survey registered nurses (RNs) at a 220-bed community hospital in the Southwest to determine the degree of perceived HH in the workplace, and (if present) to determine the extent that HH behaviors from either RN-to-RN or physician-to-RN influenced nurse behaviors directly related to patient care. Selected nurse demographics were also examined to determine if certain nurse characteristics (eg, age group or unit of employment) were associated with higher levels of perceived hostility. It was hoped that this information would allow a thorough environmental assessment in compliance with Joint Commission's standard on disruptive behavior and inform subsequent educational strategies at this hospital on how HH could best be addressed to optimize patient safety.

Working with a nurse research consultant and the manager of professional practice, members of the hospital's Nursing Research Council helped in the distribution of a 28-item survey to RNs throughout the hospital, with each Nursing Research Council member assigned to cover specific units to ensure that all RNs were given the opportunity to participate. The survey was modeled after the American Association of Critical Care Nurses from the study ''Seven Crucial Conversations in Healthcare''[7] and the ''Lateral Violence in Nursing Survey'' by Stanley et al.[8] Using the ''Lateral Violence in Nursing Survey'' of Stanley et al, which contains ordered and dichotomous survey items,[8] information was gathered to examine nurses' perceptions of whether HH existed in their work environment.

Survey participants were first provided definitions of what constituted HH based on explanations from the Center for American Nurses[9] and American Association of Critical Care Nurses[7] and included various descriptors of bullying and incivility ranging from eye rolling, direct verbal ''put downs,'' and demeaning behaviors, to sabotage and failure to maintain confidences. To obtain nurse demographics, respondents were asked their age, unit they worked on, current role (eg, charge nurse, staff nurse, or unit director), years of experience in their current role, gender, and educational preparation. In addition to providing information in each category, nurses also had the option to select ''I choose not to answer'' on each survey question.

It should be noted that an additional demographic variable of respondent ethnicity was also desired by the research team, but ultimately the institutional review board (IRB) requested this demographic be dropped from the questionnaire. Study approval through the IRB itself was fairly arduous, as IRB members were concerned about protecting the anonymity of the respondents given the volatility of the topic and nature of the questions. Other changes to the survey were implemented as a result of IRB members' concerns; for example, units were grouped together under like services (eg, mother-baby couplet care and nursery were combined; as were postanesthesia care unit and the operating room) so that no single ''unit of analysis'' had less than 30 potential respondents. ''Letters of participation'' were also stapled to each survey, which reiterated that participation in the survey was voluntary and that responses would be anonymous. In addition, the IRB required that the letter of participation include a link to the hospital's Compliance Hotline and the human resources department.

To determine the degree of perceived ''hostility,'' nurses were asked how frequently they had witnessed a peer or physician demonstrate bullying behaviors, if they had seen this behavior in the past 6 months, and if they had witnessed this behavior on their own unit. Nurses were asked to choose the frequency they observed bullying or hostile behaviors with ''never,'' ''very infrequently,'' ''monthly,'' weekly,'' ''daily,'' and ''I choose not to answer'' as potential responses. Participants were asked to think about the most recent times they had seen this behavior and whom they had spoken with about the problem (multiple responses possible). They were also asked whether they reported this problem to their immediate supervisor and, if not, what was the reason for failing to do so.

The final series of questions asked nurses to think about their behaviors as a result of bullying behaviors, including ill calls, intent to leave employment,[10] and specific actions related to patient care. The following question was posed: ''If you have personally experienced HH by a coworker or physician, circle all the statements that reflect your behavior as a result of that experience.'' Seven behaviors were provided, such as using equipment they were unfamiliar with, performing unfamiliar procedures or lifting debilitated patients without asking for help, or carrying out an order (including medication administration) that they did not believe was in the best interest of the patient. Nurses could select multiple responses and also had an option to check ''I personally have not experienced HH,'' and ''I choose not to answer.''

Methods

Surveys were distributed to all RNs used by the hospital (n = 500) (excluding registry and traveling nurses) during a 2-month period. Nurses were asked to return completed surveys in a sealed envelope to one of several marked locked survey boxes located throughout the hospital. Boxes were located strategically to provide nurses with an opportunity to submit the completed surveys away from their home unit, including the cafeteria, near time clocks, and down main halls. As used in previous HH studies,[7,8] descriptive statistics (using SPSS version 17, IBM, Armonk, New York) were used to summarize demographic characteristics and item responses of participants. To determine frequencies (eg, frequency of witnessing someone demonstrate HH), numeric values were assigned to each question, with "0" indicating "never" and higher scores indicating increasing frequency. When appropriate, a mean score was obtained (adding up scores and dividing by the number of responses) for each question. Inferential statistical methods were not used given causation was not an intended focus of the study.

Surveys were collected twice a week from the locked survey boxes by the principal investigators (authors) and kept in a locked file cabinet. Completed surveys were reviewed, and items transcribed only by the PhD-prepared nurse researcher, who was not a hospital employee and not familiar with specific patient care units or individual nurses.

Results

The overall response rate was 26% (n = 130) and varied between and among patient care areas.

Nurse Demographics

Of the nurses who responded to the survey and provided their age, there was relatively equal distribution between the ages of 30 and 39 years (n = 30; 23.1%), 40 and 49 years (n = 33; 25.3%), and 50 years or older (n = 34; 26.2%). These results are representative of state's nursing workforce demographics: in 2011, 21.7% of the state's RNs were between 30 and 39 years old (n = 13 104) and 24.8% between the ages of 40 and 49 years (n = 14 927), and 31.5% were 50 years or older (n = 19 075).[11] Of the remaining RNs who participated in the study, slightly greater than 19% (n = 25) selected "I choose not to answer this question," and therefore their age is not known. The remaining respondents (n = 9; 7%) were younger than 30 years.

The majority of respondents (58%; n = 75) had at least 10 years of experience in their current role, and most (58%; n = 75) had at least a baccalaureate degree in nursing. Gender was predominantly female at 90% (n = 117), reflecting the demographics of the state's RN workforce of 89.6% female (n = 54 011).[11] It should be noted that 22 RNs taking the survey did not respond to this question (marking "I choose not to answer"), so it is unclear whether the nonresponders' gender is consistent with those who answered this question.

Participants were asked about their role at the hospital. Responses included (*a*) provide direct patient care, (*b*) unit-based charge nurse (supervises others routinely), (*c*) clinical supervisor or house supervisor, (*d*) director level or above, (*e*) "other," and (*f*) I choose not to answer. Most of the respondents were direct patient care providers (n = 80), followed by charge nurses (n = 17), "other" (n = 7), director level or above (n = 3), and clinical supervisor or house supervisor with only 1 respondent. As with the gender question, 22 nurses chose not to answer. The final question asked about which unit the respondent worked. Unfortunately, 32 (25%) of the nurses did not list their home unit, selecting "I choose not to answer" as their response to this item.

Horizontal Hostility and Nurse Behaviors

When asked how frequently the respondent had witnessed a peer or physician demonstrating bullying behaviors, nearly 60% (n = 78) of those who responded observed HH at least monthly, with the majority of those reporting they witnessed hostile behaviors weekly. Respondents were asked whom they had seen exhibit HH to another person at the hospital with potential responses including (*a*) a nurse from my department, (*b*) a nurse from another department, (*c*) an employee (not a nurse) from my department, (*d*) an employee (not a nurse) from another department, (*e*) charge nurse, (*f*) clinical supervisor, (*g*) director, (*h*) physician, or (*i*) other. Many had multiple responses to this question, with the most common being "a nurse from my unit" (n = 66); followed by "a physician" (n = 53), "a charge nurse" (n = 29), and "a nurse from another department" (n = 26) (Figure 1). There were 17 who noted they had not seen this behavior and therefore skipped the question.

Participants were asked to think about the most recent times they had seen this behavior and whom they had spoken with about the problem (Figure 2). Multiple responses were possible. Because the answer was not applicable for 17 respondents and an additional 9 chose not to answer, there were 104 represented in the question. Coworkers were the most common person nurses turned to when talking about perceived HH at work, with nearly 58% (n = 60) of those who responded to this question indicating that they had talked to a peer or coworker over all other responses, including their director, a representative from human resources department, the charge nurse, and even family/friends. It was noteworthy that only 17.3% (n = 18) stated that they had addressed the person directly and completely expressed their concerns, which may suggest an area for future nurse training and education.

Respondents who had experienced HH but failed to confront the abuser were asked the reason(s) for failing to confront. Of the 130 who completed a survey, this question

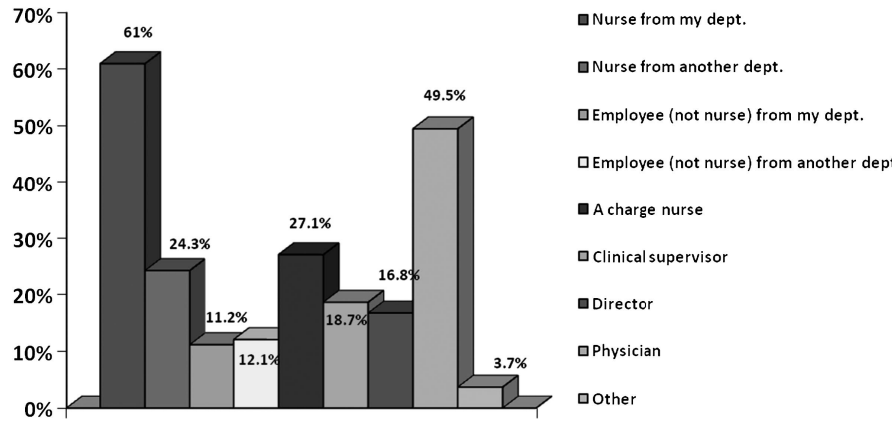

Figure 1 • Who have you seen exhibit bullying or hostile behaviors at this hospital? (n = 107[a]). [a]Note: 17 had not seen this behavior; and 6 chose not to answer.

did not apply to 28 (they either did confront the person or had not seen someone abuse their authority), and an additional 18 chose not to answer, leaving 84 respondents (Figure 3). The most common reason given why someone failed to confront is that ''I didn't think anything would change if I confronted them, and it would only make my work situation worse'' (n = 62; 73.8%). This was followed by ''I thought the person might retaliate against me'' (n = 31; 36.9%); ''I've seen them get angry at other people who confronted them'' (n = 22; 26.2%); and ''There wasn't a time or opportunity to confront them'' (n = 20; 23.8%).

For those respondents who personally witnessed what they perceived to be hostile behavior (n = 104), the vast majority (44.2%; n = 46) did not report it. Only 16 (15.4%) were told that the situation was resolved, and 40.4% (n = 42) were not told that the situation was addressed or resolved. In summary, most nurses who witnessed HH do not report it, and for those who did, most did not receive any follow-up, indicating that the situation has been addressed or resolved.

Most alarming was the behaviors that these nurses noted they exhibited as a result of feeling bullied (Figure 4). One final question related to behaviors that the nurses might exhibit as a result of HH. Specifically, the question asked, ''If you have personally experienced HH by a coworker or physician, circle all of the statements that reflect your behavior as a result of that experience.'' Of the 130 respondents, 53 circled ''Does not apply—I have never personally experienced HH.'' This question did not ask if they had seen this behavior, only if they had ever experienced it personally. Of the remaining 77 potential respondents, 44 chose not to answer this question, leaving 43 respondents. While the reason for the 44 nonrespondents is not known, it is interesting that this was by far the largest

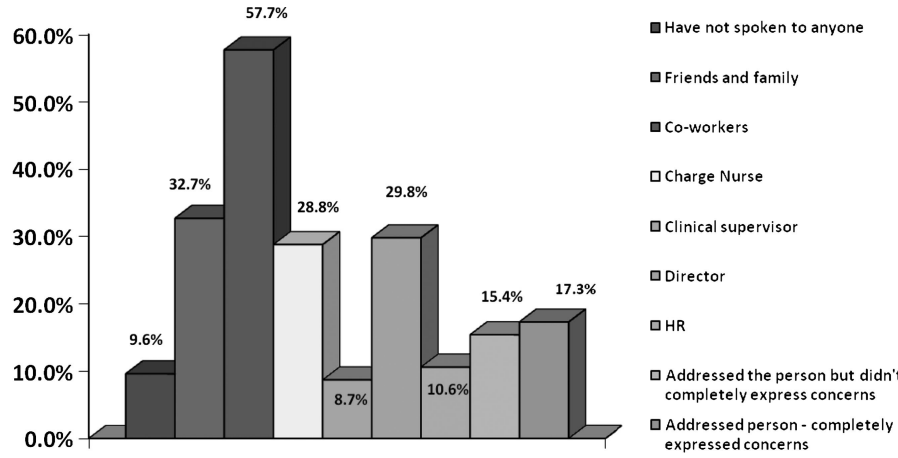

Figure 2 • Think about the most recent time you have seen this behavior. Whom have you spoken with about the problem? (n = 104).

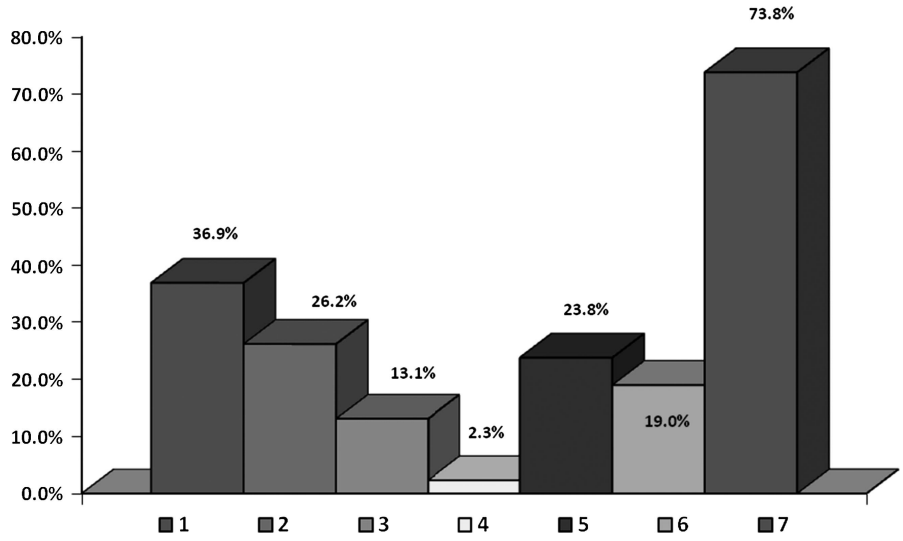

Figure 3 • If you have experienced HH at this hospital but failed to confront the person, what were your reasons for failing to confront? (n = 84[a]). [a]Note: This question did not apply to 28 respondents; and 18 chose not to answer. (1) I thought the person might retaliate against me. (2) I've seen them get angry at other people who confronted them. (3) My peers warned me not to confront them. (4) My charge nurse or clinical supervisor warned me not to confront them. (5) There wasn't a time or opportunity to confront them. (6) I would have been in trouble with management here if I had confronted them. (7) I didn't think anything would change if I confronted them, and it would only my work situation worse.

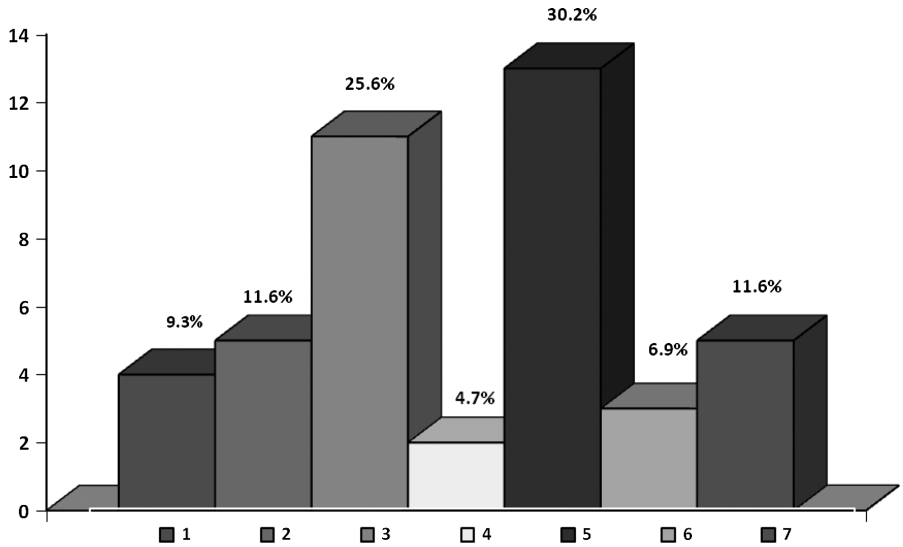

Figure 4 • If you have personally experienced HH by a coworker or physician, circle all of the statements that reflect your behavior as a result of that experience? (n = 43). The questions corresponding to each number are as follows: (1) I have muddled through patient procedures that I felt unclear about rather than ask for someone to teach me or show me. (2) I have used a piece of medical equipment that I was unfamiliar with or only partly familiar with rather than seek help from a coworker. (3) I have lifted or ambulated heavy or extremely debilitated patients alone rather than ask for assistance. (4) I have given medication dose or performed a treatment I was unsure about rather than call a physician to obtain clarification or new/different orders. (5) I have interpreted an unreadable order the best I could rather than calling for clarification (''I *think* it says''). (6) I have held a medication or not performed a treatment and waited for the nursing staff following me to clarify. (7) I have carried out an order that I did not feel was in the best interest of my patient without challenging it.

number of participants who chose not to answer any question, so the frequency of nurses who exhibited behaviors that may not be in the best interest of safe patient care due to workplace HH was unfortunately still unknown.

Of those who responded to this question, greater than 30% (n = 13) noted that ''I have interpreted an unreadable order the best I could rather than calling or asking for clarification.'' The second most common behavior as a result of bullying behaviors was ''I have lifted or ambulated heavy or extremely debilitated patients alone rather than ask for assistance'' (25.6%; n = 11). More than 10% (n = 5) acknowledged other concerning behaviors as a result of witnessing HH in the workplace, including ''I have used a piece of medical equipment that I was unfamiliar with or only partly familiar with rather than seek help from a coworker'' and ''I have carried out an order that I did not feel was in the best interest of my patient without challenging it'' (at 11.6% each). While other responses were less common, 9.3% (n = 4) of respondents noted that ''I have muddled through patient procedures that I felt unclear about rather than ask for someone to teach me or show me''; ''I have held a medication or not performed a treatment and waited for the nursing staff following me to clarify'' (6.9%; n = 3); and ''I have given a medication dose or performed a treatment I was unsure about rather than call a physician to obtain clarification or new/different orders'' (4.7%; n = 2).

Discussion

We were able to demonstrate a connection of bullying in the workplace to behaviors exhibited by the nurse that may ultimately compromise patient safety (as well as nurse well-being), including (*a*) muddling through a procedure that was unclear, (*b*) using an unfamiliar piece of medical equipment, (*c*) lifting or ambulating heavy or extremely debilitated patients alone, (*d*) giving medications or performing a treatment the nurse was unsure about, (*e*) trying to interpret an unreadable order rather than calling for clarification, (*f*) holding a medication or not performing a treatment, and (*g*) carrying out an order that was not in the best interest of the patient without challenging it. These nurse behaviors clearly have the potential to cause serious adverse outcomes for patients and their families, including delayed care and prolonged hospitalizations. The effects of bullying are equally catastrophic for the nurses themselves, leading to nurse burnout,[12] intent to leave,[10,13] low self-esteem,[14] ill calls,[15] and deterioration of physical and mental health.[16]

While determining what strategies the nursing leader can take to address HH in the healthcare setting, several approaches are currently being implemented with promising results. Patterson[17] has offered excellent strategies geared at the nursing leadership team on ways to address HH, including:

a. Educate the staff nurses about HH and why it exists. Patterson notes that ''as a manager or director, you are charged to see that your key people, your managers or your charge nurses, are educated, can handle conflict, and can set a standard of professional behavior.''[17(p9)]
b. Examine your own leadership style (adopt a style that moves from hierarchical to one of consensus building).
c. Set behavior standards and hold employees accountable to them.
d. Provide ongoing training for managers and charge nurses.
e. Provide nurses with the skills to be able to address conflict with peers, like conflict management and assertiveness.
f. Give new nurses a ''shield'' (provide coaching to nurses on methods for deflecting HH).
g. Give new nurses a chance to bond with one another.
h. Offer 2-way feedback (where new staff also provide feedback to their preceptors).
i. Practice self-evaluation—how does this organization function, and what part do I play in that?

Limitations

One of the major limitations of this study was the number of nurses who completed the survey but selected the ''choose not to answer'' option for several of the study variables, thus severely limiting the kinds of analysis that was possible. For example, it was hoped that we could look at documented adverse events by unit (including hospital-acquired pressure ulcers [HAPUs], catheter-acquired urinary tract infections, patient falls, and medication errors) and determine whether units that had higher levels of perceived hostility also had higher incidences of adverse outcomes, including the nurse-sensitive indicators such as HAPUs and catheter-acquired urinary tract infections. Because of the number of nurses who did not identify their unit, ultimately this was not possible. We had hoped to examine both nurse behaviors (as we have reported here) and actual documented adverse events and establish a link between HH and poor patient outcomes. We were unable to have the statistical power to accomplish this because of limited sample size, and it is an area we believe merits further research. It is also a study limitation.

It is also not clear if the respondents (26% of the total hospital's nursing workforce) represent the nonrespondents (those nurses who did not complete the survey), or if the nurses who completed the survey were more likely to take this survey on HH because they experienced or witnessed it and therefore ''had a story to tell'' that would have skewed the results. Hence, no assumptions were made on the generalizability of these results to other nurses who did not respond. It is concerning that among the nurses who completed the survey and had personally experienced (not just witnessed) HH in the workplace (n = 77), well over half (n = 44) chose not to answer the question about specific behaviors they may have exhibited as a result of bullying behaviors, by far the largest number of nonresponses for any of the survey questions. Role disparity may have also influenced the results; the majority of respondents were direct patient care providers (n = 80, 62%), 17 (13%) were charge nurses, and 10 (7.7%) were

''other'' or a director-level position. The responses of study participants may have been influenced by perceived or real inequity of power within the organization and must be taken into account.

In obtaining nurse demographics, 25% (n = 32) did not list their home unit, selecting ''I choose not to answer'' as their response to this item. The unwillingness to answer home unit may have reflected a lack of trust on the part of the nurse respondents or possible fear of retribution; regardless, it eliminated the opportunity to link greater levels of perceived hostility to an increased incidence of adverse patient events by unit (if such a relationship existed) and therefore was another limitation of the study. It could also be that asking participants for their home unit was a design flaw, given that few nurses would want to report committing actual or potential patient errors if there was the remote possibility that they would be identified. However, until we can directly link HH to specific actual adverse events (eg, HAPUs or patient falls), which can be analyzed most directly at the unit level, we will not understand the full scope of HH on patient safety.

Conclusion

Clearly, nurses play a pivotal role in reducing errors and advocating for patient safety. As the healthcare provider most continuously presents with patients, the nurse is often the last layer of defense in error occurrence. When nurses knowingly participate in behaviors that may compromise safety because of workplace hostility, the profession must stand up, and take note: HH in the workplace poses potential threats to patient safety. Managers play a critical role in setting the environment where hostile behaviors are quickly acknowledged, addressed, and managed through all appropriate levels of the organization.

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