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Exploring the Prevalence of Horizontal Violence in Nursing Between Magnet and non-Magnet Hospitals

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EXPLORING THE PREVALENCE OF HORIZONTAL VIOLENCE IN NURSING BETWEEN MAGNET AND NON-MAGNET HOSPITALS

BY

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Approval of Successful Defense

Doctoral Candidate, **Cathleen Janzekovich**, has successfully defended and made the required modifications to the text of the doctoral dissertation for Ph.D. during the **Spring Semester 2016**.

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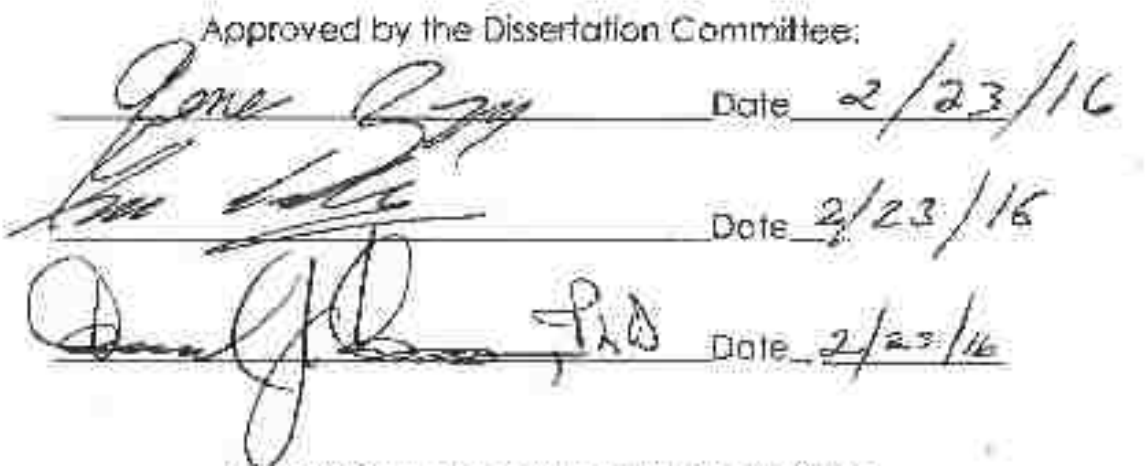

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Exploring the Prevalence of Horizontal Violence in Nursing Between Magnet and non-Magnet Hospitals

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Abstract

Statement of the Problem: The nurses work environment influences patient, nurse and organizations outcomes. The majority of the literature confirms that Magnet hospitals produce environments resulting in positive outcomes, however, the prevalence of horizontal violence (HV) within Magnet and non-Magnet hospitals is not clearly understood. To understand the frequency of HV within these two environments would provide nurse leaders insight into the bedside nurses work environment resulting in data that could improve the bedside RNs work environment and ultimately impact outcomes. This study examined the prevalence of HV within Magnet and non-Magnet hospitals amongst bedside nurses.

Methods: Utilizing a concurrent embedded design, bedside RNs at a Magnet and non-Magnet hospital completed the Briles' Sabotage

Savvy Questionnaire in order to ascertain both qualitative and quantitative information.

Results: Surprisingly, HV at non-Magnet hospitals were less than Magnet hospitals. HV at non-Magnet hospitals for RNs with a BSN or higher degree was less than Magnet hospitals. HV experienced in the Critical Care, Medical Surgical and Perioperative Divisions at non-Magnet hospitals was less than Magnet hospitals. The Maternal Child Health Division and nurses with equal to or less than 7 years of experience showed no differences in HV between both environments. Nonphysical behaviors in the form of gossip, aggressive verbal communication, manipulating the environment were commonly exhibited. The RNs evaluated the environment and depending on their assessment resulted in whether a response to a HV event was rendered.

Conclusion: Magnet status supports positive outcomes however an unforeseen negative by product of the magnet environment is that it requires nurse administrators to consistently have their bedside RNs produce outcomes that meet and exceed benchmarks which may result in inward fighting between the bedside nurses and potential results in HV.

Chapter I

INTRODUCTION

Background of the Problem

Horizontal Violence (HV) amongst nurses in the workplace is a growing concern in the literature. Instinctually, the words nursing and violence when used in the same sentence appear to be contradictory. How can a profession dedicated to caring for others – be considered violent towards each other? The question remains as to what factors are influencing nurses such that they engage in HV.

Horizontal Violence in nursing is an area of continued interest for the profession both nationally and internationally. For the last three decades, it has been well documented in the literature, that varying degrees of frequency regarding negative behaviors are experienced by hospital bedside nurses in their current work environments. These negative behaviors originate from peers, nurse managers, doctors, or hospital administrators causing a growing concern regarding the nurse's work environment and its impact on patient care outcomes, nursing outcomes and organizational outcomes. The impact of the effects of HV has caught the attention of professional nursing

organizations and researchers and is beginning to catch the serious attention of hospital administrators. Horizontal Violence is defined as the sometimes ambiguous, always divergent behavior displayed by a staff nurse towards another staff nurse (peer), who provides direct care at the bedside.

Magnet Certification is currently the highest award for a hospital to receive acknowledging nursing excellence. The process of Magnet Certification results in changes in the nurses work environment that are associated with patient, nursing and organizational outcomes that exceed industry standards. This then leads this researcher to investigate whether the impact of the Magnet environment could result in different incidence rates of HV as opposed to non-Magnet environments. Horizontal Violence and Magnet Certification have separately been associated with either positive, negative or neutral impacts on patient care, organizational and nursing outcomes but the impact of Magnet Certification on HV prevalence rates has not been explored thoroughly, thus making this an important topic in healthcare.

Purpose of the Study

The central purpose of this study is to explore what is currently known about HV in nursing literature as well as the impact that Magnet Certification has on changing the nurses work environment and whether these changes have an impact on the prevalence rates of HV.

More specifically, the purpose of this study is:

1. To examine whether RNs of Magnet Hospitals in NJ produce different prevalence rates of HV than their counterparts in non-Magnet Hospitals in NJ.
2. To examine whether licensed years, education levels & specialty division produce different prevalence rates of HV between RNs working at Magnet and non-Magnet Hospitals.
3. To explore the written responses of RNs obtained on the BSSQ surrounding their experiences and responses to HV and develop themes associated with each in order to enhance our understanding of the topic.

Significance of the Study

Violence in the workplace is not a new issue. In response to this problem, The Occupational Safety and Health Act (OSHA) (1970) was designed in an attempt to improve the working conditions for

employees within the business community. The healthcare industry responded with publications from The Joint Commission (TJC) called Sentinel Event Alert (2008) and created a Leadership Standard (2009) that holds hospital executives accountable for providing work environments that stigmatize violence and allow employees to report incidences without consequences. Workplace violence has been defined and described by the nursing profession as bullying, incivility and horizontal violence. Each of these has a different source from which the negative behavior originates from towards the staff nurse. Griffin (2004) notes that the behaviors exhibited by nurses are described as either covert or overt in nature. Covert are more psychological and somewhat more subtle to the observer, while overt are more obvious to the observer. The study presented here focused on the peer to peer behavior relationship of staff nurses at work known as Horizontal Violence. Subsequent to OSHA and TJC, several nursing organizations have followed suit and have published position statements denouncing Horizontal Violence. One example is The Organization of Nurse Executives of New Jersey (2010).

A disconnect continues to exist between the nursing professions identity and the actual issues surrounding HV. Nursing is considered a caring profession involved in the direct care of patients. Nurses are

responsible for monitoring patients care 24 hours a day and intervening when a patient's condition changes. Nursing professionals working in environments prevalent with HV presents cause for concern surrounding outcomes for nurses, organizations and patients. Woelfe & McCaffrey (2007) reported that organizations struggle because the use of staff sick time and turnover rates increase when horizontal violence is not managed properly. Rowell (2005) reported that organizations will also receive an increase in patient and family complaints surrounding a lack of staff initiative. In today's healthcare organizations, this could potentially translate into lower Hospital Consumer Assessment of Healthcare Provider and System (HCAHPS) patient satisfaction scores regarding care and concern by staff toward patients as perceived by patients and family members. Thomas (2003) also reported higher rates of burnout amongst nurses who experience such conflict. Negative psychological outcomes and depression were also found in nurses who experienced bullying a form of HV. Rodwell & Demir (2012) noted higher depression rates in aged care nurses and higher psychological distress in hospital nurses due to a trait called Negative Affinity (NA) which acted as a significant covariate in their study. NA was defined as a persistent underlying "negative emotional state" (p. 540), in which an individual engages their environment. Rodwell and Demir (2012)

argued that consequently higher levels of NA yield higher levels of negative emotions resulting in the negative behaviors experienced when these types of nurses are under stress (as cited in Mikkelson & Einarsen, 2002, p. 540). Granstra (2015) noted Teske's experience in 1975 regarding different levels of education. Teske reports "differences in education levels can lead nurses to attack each other" (p. 253). Teske's experience summarized that "diploma graduates often perceive bachelor degree nurses as book smart and lack patient care experience. Diploma nurses often wait for BSN to make mistakes. BSN's also assume that diploma nurses lack sufficient knowledge for the profession overall. Additionally, many nurses today graduate from Associate Degree Programs and the assumptions noted between the BSN and diploma nurses continues to be observed in ASD nurses and thus fosters workplace differences" (p. 253). The setting or nursing unit in which the Registered Nurse works on also contributes to workplace violence. Spector & Che (2013) conducted a meta-analysis of the literature worldwide and found that one third of the nurses experienced physical violence and bullying, while one third experienced nonphysical violence. Physical and non physical violence was most prevalent in the Emergency Department, followed by the hospital setting overall, Geriatric and Psychiatric Units/Facilities. Seventy eight

percent of bullying was most prevalent in the hospital setting overall. For all of the aforementioned reasons it becomes quite clear that the work environment of the nurse is important not only to the organization, but to the nurse and to the patient. Magnet Certification stipulates that the framework surrounding the Magnet Model changes the nurses work environment, thus improving outcomes for patients, nurses and organizations. Numerous research investigations support significant positive Magnet outcomes (Aiken's, Clarke, Sloane, Sochalski and Silber, 2002; Kelly, McHugh and Aikens, 2011; Laschinger, Shamian and Thomson, 2001; Smokler Lewis & Malecha, 2011; Hickson, 2013; Buffington, Zwink & Fink, 2012; & Ulrich, Buerhaus, Donelan, Norman & Dittus, 2007) as well as non-significant studies (Trinkoff, Johantgen, Storr, Han, Liang, Gurses & Hopkinson ,2010; Goode, Blegan& Park, 2011; Mills & Gillespie, 2012; Buffington, Zwink & Fink, 2012). However, minimal studies exist in the United States that examine and tie together the impact of the Magnet Model and the prevalence rates of HV.

Research Questions and Hypotheses

The hospital environment plays an important role in regards to patient, nurse and organizational outcomes. The Magnet Model has been documented to change the nurses work environment, yet few studies have examined whether HV is different at Magnet Hospitals than non-Magnet. The research questions were designed to close this gap in the literature and guide this study.

Research Questions:

1. Are the prevalence rates of Horizontal Violence experienced by RNs different between Magnet and non-Magnet hospitals?
2. Are the prevalence rates of Horizontal Violence experienced at Magnet Hospitals less than non-Magnet hospitals?
3. Are the prevalence rates of Horizontal Violence higher in nurses with less than seven years of experience?
4. Are the prevalence rates of Horizontal Violence experienced by Registered Nurses with less than seven years of experience at N.J. Magnet Hospitals less than non-Magnet hospitals?
5. Are the prevalence rates of HV experienced by RNs with B.S.N or higher academic degrees at NJ Magnet hospitals less than those at non-Magnet hospitals?

6. Are the prevalence rates of Horizontal Violence different between like specialty divisions at Magnet and non-Magnet hospitals?

Hypotheses:

Ho1: There will be no difference in the prevalence rates of HV experienced by Registered Nurses at Magnet and non-Magnet hospitals.

Ha1: The prevalence rates of HV experienced by Registered Nurses in N.J. Magnet Hospitals will be significantly less than non-Magnet Hospitals.

Ho2: There will be no difference in the prevalence rates of HV for nurses with less than seven years of experience at Magnet and non-Magnet Hospitals.

Ha2: The prevalence rates of HV experienced by Registered Nurses in N.J. Magnet Hospitals with less than 7 years of licensed experience will be significantly less than non-Magnet Hospitals.

Ho3: There will be no difference in the prevalence rates of HV experienced by RNs with B.S.N. or higher degrees at NJ Magnet and non-Magnet Hospitals.

Ha3: The prevalence rates of HV experienced by RNs with B.S.N or higher academic degrees at NJ Magnet hospitals will be significantly less than those at non-Magnet Hospitals.

Ho4: There will be no difference in the prevalence rates of HV experienced by RNs working in like specialty divisions at Magnet and non-Magnet Hospitals.

Ha4: The prevalence rates of HV between like specialty divisions at Magnet Hospitals will be significantly less than non-Magnet Hospitals.

Conceptual Framework

Bandura's Social Learning Theory works synergistically with the Magnet Model. Bandura postulates that learning occurs because behavior is modeled. In order for modeling to occur four elements need to be present: attentiveness of the observer, remembering the behavior, repetition of the behavior and motivation of the observer. These four elements in combination with the impact of the environment

and cognitive abilities of the individual will influence behavior. Human beings are social beings by nature. Because we are social beings there is a desire to belong and to be accepted by the group. In this research study the human beings would be the staff nurses and the group in which they desire to be accepted by are their peers or fellow staff nurses. In order to gain acceptance, negative and positive decisions are made regarding behavioral choices. This is called Self- Regulation. Once these types of decisions have been formulated a choice needs to be made as to which one to implement. This is called Self-Determination. Having the confidence to actually make the choice is called Self-Efficacy.

The Theory of Oppression plays a role in Horizontal Violence and has been well established in the literature for more than thirty years. Roberts (1983) has referred to the nursing profession as an oppressed group of individuals who are subordinate and lack autonomy and control over their environment (Friedson, 1970). Woelfe & McCaffrey (2007) noted that nursing is an oppressed profession functioning in a male dominated system whereby the male outranks the female. Oppression is the scenario describing the relationship in which the dominant group (males) secretly abuses the less dominant group (females). This patriarchal system consists of direct care nurses reporting

and answering to physicians, nurse managers, directors of ancillary departments and hospital administrators. As a result, nurses involved in direct patient care react to bullying by exhibiting negative behaviors towards their peers because they lack control over their environment. Leap (1997) notes that oppressed groups direct their frustrations towards their peers because the system in which they work has broken down. The environment is unhealthy and does not lend itself towards a professional exchange of ideas.

Bandura refers to change agents as being the needed element in modifying the cycle of behavior. The Magnet Model is the change agent being introduced into this conceptual framework. Once the Magnet Model is implemented the environment of the nurse should change towards becoming healthier and the nurses cognitive abilities should also change because they are now involved in organizational decisions that directly impact themselves and patient care. Magnet Certification also requires organizations to employ bedside/staff RNs with a Bachelor of Science Degree in Nursing and a Master's of Science in Nursing for nursing leaders. By instituting educational requirements upon nurses working in the acute care setting, the cognitive abilities of the nurse should expand and critical thinking should follow. In order to understand the full impact of Magnet on the nurses work environment

the reader needs to have an understanding of how Magnet originated and currently works.

In the early 1980's there was an acute RN shortage across America. The American Academy of Nurses (AAN) conducted a research study with the purpose of identifying those characteristics in organizations that were able to retain their nursing from those unable to retain their nursing staff. There were 14 characteristics identified (ANCC, 2008). In the early 1990's the Magnet Certification Program was implemented. The core characteristics are embedded in these 14 characteristics are now referred to as "The Fourteen Forces of Magnetism" (ANCC, 2008), (TABLE 1). Magnet's Vision statement is powerful stating that "they will be the fount of knowledge internally and nationally for the nursing profession" (ANCC, 2008). The Magnet Model then followed the Magnet Vision in order to further operationalize the Vision. It consists of five elements: structural empowerment of the bedside nurse, new knowledge and skills of the bedside nurse, transformational leadership of the bedside nurse, exemplary professional practice of the bedside nurse ultimately culminating in empirical outcomes for the nurse, organization and patient (ANCC, 2008). The Fourteen Forces of Magnetism have embedded within them sub-standards which an organization is required to meet by submitting

examples of patient care and meeting the criteria as outlined. These standards can be met once the Magnet Model has been fully implemented at all levels of the organization. Magnet provides a framework for changing the nurses work environment.

Chapter II

REVIEW OF THE LITERATURE

Definition of Terms

The literature currently contains several terms that intend to describe the hostility that nurses experience from their peers in the workplace. The limitation regarding the lack of clarity with each of these definitions surrounds the confusion as to who is the saboteur and who is the victim in the relationship. As a result the lack of one unified, clear and consistent definition to describe the hostility experienced by the nurse exists. The most common terms found include bullying, incivility and horizontal or lateral violence. McKenna, Smith, Poole, & Coverdale (2003), as well as, Woelfe & McCaffrey (2007) defined horizontal violence as simply the "interpersonal conflict amongst nurses" (p. 90) and the "destructive behavior of nurses against each other" (p. 123). In this relationship the saboteur is the nurse and the victim is the nurse. However, Rodwell, & Demir, (2012) defined bullying as "a situation in which a person perceives himself/herself as the target of negative actions that persists over time and administered by one or several individuals" (p. 539). In this relationship the saboteur was not

clearly defined as a peer and the victim is the nurse. Oppression involves a dominant group exerting their authority unjustifiably upon a less dominant group. Oppression is an underlying reason as to why bullying is prevalent in nursing. Smokler - Lewis, & Malecha (2011) defined incivility as a "low intensity, deviant behavior with ambiguous intent to harm the target, in violation of the workplace norms for mutual respect" (p. 41). This is similar to HV but again the saboteur was not clearly defined and inferences are made to conclude that the saboteur was the nurse's peer and the victim was the nurse.

Behaviors

Horizontal Violence in nursing occurs across peer groups (Farrell, 1997; Freshwater, 1998; McKenna et al., 2003; Fudge, 2006; Woelfe et al., 2007) and consists of behaviors that can be covert or overt in nature (Griffin, 2004; Fudge, 2006). Covert behaviors are mainly psychological and examples of these behaviors include excessive criticism, the raising of eyebrows, innuendos, and passive aggression. Overt behaviors are more visible in nature and examples include the scapegoating, antagonism, in-subordination, verbal and physical aggression (Griffin, 2004; Baltimore, 2006). Although, covert and overt behaviors are the primary behaviors exhibited or experienced between nursing peers, it is

important to be able to differentiate further between the overall exposure rates and types of exposures experienced by bedside nurses in order to fully understand the work environment experienced by the nurse while caring for patients.

Prevalence Rates

Prevalence rates have been discussed by Spector, Zho & Xuan Che (2013); Johnson (2009) and Simons (2008). Spector, Zho & Xuan Che, 2013 conducted a quantitative review of the nursing violence literature "to determine exposure rates by type of violence, setting, source and world region" (p. 72). They discovered that "36.4% of nurses reported being physically assaulted, with 67.2% reported being non-physically assaulted, 37.1% report being bullied, 27.9% reported sexual harassment and 50.5% reported general violence not broken down by type" (p.75, 76). Articles for review for bullying and sexual harassment were limited in this study although those reviewed showed differences in incidence rates. Five settings were included in the study which consisted of the Emergency Department, General Samples, Geriatric, Hospital and Psychiatric Departments. Although HV exposure was spread throughout all settings it is important to note that physical violence occurred more frequently in the emergency department,

psychiatric and geriatric settings. Nonphysical violence was more prevalent than physical violence in all settings with the exception of the Geriatric Departments. For example, Emergency Department nurses experienced nonphysical violence at a rate of 81.3% and physical violence at a rate of 49.5%. Hospital nurses experienced nonphysical violence at a rate of 65.5% and physical violence at a rate of 26.7% and bullying at a rate of 78.3%. Interestingly, 64.3% of physical violence was experienced directly from patients followed by 30.2% from the patient's family/friend. Only 3.2% of physical violence was experienced from a nursing peer. Nonphysical violence rates were distributed more evenly with the patient 53.9%, family/friend 47.3%, nursing peer 21.8%, physician 28.5% and other clinical staff 39.2%. When physical and nonphysical violence rates were combined the most common sources included the patient 62.2%, other clinical staff 54.7% and the nurse's peer 44.8%. These high prevalence rates across the five care areas support further investigation concerning the prevalence rates of horizontal violence between the environments at Magnet and non-Magnet hospitals. International differences were also noted: "The Anglo region was highest for physical violence and sexual harassment, and the second highest for non-physical violence and bullying. Asia was lowest for non-physical, and second lowest for physical, bullying and

sexual harassment. The Middle East was lowest for physical violence and highest for non-physical violence and bullying. Thus, it seems that nurses in the Anglo region have the highest overall exposure rates, nurses in Asia have the least and nurses in the Middle East experience relatively high levels of non-physical violence and relatively low levels of physical violence" (p. 78). Perhaps these results can be attributed to the differing roles that males and females have in these cultures.

Johnson (2009) and Simons (2008) have also reported prevalence rates similar to Spector, Zho & Xuan Che (2013) ranging between 5%-38% in Scandinavia, the United States and the United Kingdom and as high as 86.5% in Turkish studies.

Business/Healthcare Response to Workplace Issues

As mentioned earlier and briefly, Horizontal Violence is not isolated to the nursing profession. The Occupational Safety and Health Organization's (OSHA) primary function is to help ensure that workers across America have the right to a safe work environment. The safe workplace environment includes the elimination of verbal or other violent behaviors up to and including death. OSHA has set forth guidelines and recommendations for employers to follow in order to create and manage such preventative programs. In 2010, OSHA

reported that annually, two million United States workers experienced workplace violence and healthcare workers particularly nurses, pharmacists and therapists, have been targeted for increased workplace violence (p. 1). This is important due to the direct role that the nurse has as it pertains to patient care. For example an intimidating work environment that inhibits a nurse from asking questions could potentially lead to poor patient outcomes and higher turnover rates. In response, position statements from numerous nursing organizations have evolved denouncing horizontal violence within the nursing profession. The Organization of Nurse Executives of New Jersey's (ONENJ), (2010) position statement titled "Disruptive Behavior in the Workplace Setting," is one such example and includes support from the American College of Physician Executives against Horizontal Violence in the workplace. The ONENJ calls for leaders to create work environments that support collaboration resulting in the safe delivery of patient care. The Joint Commission Sentinel Event Alert (2008) introduced the leadership standard, LD.03.01.01, which took effect in January 2009 requiring leaders in acute care organizations to develop codes of conduct and processes for managing disruptive behavior for healthcare workers (p.2). The Joint Commission Sentinel Event Alert (2008) further concluded that forty percent (40%) of clinicians report

being silent regarding their experiences for fear of retaliation (p. 1). This silence coupled with increasing demands for higher productivity, cost containment, shift work and staff's perception surrounding a lack of autonomy contributes to a nursing environment that could be conducive to producing these negative horizontal violent behaviors. The Center for American Nurses (2008), now a sector of the American Nurses Association (ANA), provides the nursing profession with access to tools and research available for dealing with workplace violence. In 2008, their position statement included recommendations to help address this issue. Some of these include that "nurses and nurse leaders need to adopt and model professional ethical behaviors, design nursing continuing education and academic programs regarding HV and teach the nurse interventions to address the issue, implement zero tolerance policies and continue to conduct nursing research an effort to learn more about the factors contributing to this phenomena" (p. 5). In 2001 the ANA conducted their first Health and Safety Survey which was repeated in 2011. The intent if the 2011 survey was to see if any notable differences were evident in the nurse's work environment as compared to the 2001 survey. Improvements in the nurses work environment included access to safe-patient lift devices and safe needle/needless devices. Continued problems surrounding acute and

chronic complications involving stress increased from seventy percent (70%) in 2001 to seventy four percent (74%) in 2011. On the job assaults also increased from twenty five percent (25%) in 2001 to thirty four percent (34%) in 2011. This survey's result provides additional justification for the importance of this proposed study.

Dumont, Meisinger, Whitacre & Corbina (2012) followed the ANA Health and Safety Survey (2011) and published a horizontal violence survey report which assessed the frequency with which American nurse's experienced and/or witnessed horizontal violence in the workplace. Several major limiting factors surrounding the sample were noted thus causing concerns regarding generalizability and clinical significance of the study. First, the sample was not defined clearly until the limitations of the study were discussed. At that time the flaws in the sample became evident and subsequently the sample was defined as American. This is important because the data would be reflective of the frequency rates of HV for nurses working in the United States. The sample size was also too small. It contained 955 responses. According to Dumont et al., (2012), the American Nurses Association reported that there were greater than 3 million licensed RNs and over 750,000 licensed LPN's in the United States at that time. Additionally the sample was mixed and contained 878 RNs, 18 Certified Nurse's Aide's, 4

students and 55 other. It was also a convenience sample and because of the sample limitations, it is hard to infer that the survey actually represented the frequency in which most American Registered Nurses experience and witness HV in their work environment. The survey design included a 6-point Likert scale and was offered both on the Internet and on paper during March, April and May 2011. The 6-point Likert scale was designed as follows: 1= never, 2= once, 3= a few times, 4= monthly, 5 = weekly and 6 = daily. In addition to the survey, fourteen (14) written letters were separately received by the researcher and were qualitatively analyzed. Questions 1-5 included examples of harshly criticizing someone, belittling someone, complaining about a coworker, raising eyebrows/rolling eyes at a coworker and pretending not to notice a coworker struggling with their workload. Griffin, 2004 & Fudge, 2006 reported these to be covert types of behaviors associated with horizontal violence. The findings included an overall monthly frequency of 4.5 (standard deviation =1.1 and Cronbach's alpha = 0.88). Eighty-two percent (82%) of respondents reported witnessing or experiencing at least one of these behaviors weekly or daily while thirty-four percent (34%) reported witnessing or experiencing all five behaviors weekly or daily. Complaining about a coworker (N=939, M= 4.85, SD = 1.2) and raising eyebrows/rolling eyes at another coworker (N=939, M=4.72, SD=

1.3) were the two most frequently reported behaviors experienced and witnessed. Respondents were asked how they were personally affected by these behaviors during the last 12 months and responded, "I've felt discouraged because of a lack of positive feedback" (N=944, M= 4.35, SD 1.5), (p. 45). Respondents also reported that they felt this way several times to monthly during this time period (N= 951, M= 3.67, SD = 1.3). This study also reported who the saboteur was and the most frequently scored was the nurse's peers (M= 4.67, SD = 1.7), followed by the nurse's supervisor (M= 4.2, SD = 1.5), unlicensed assistive personnel (M= 3.84, SD = 1.7) and physicians (M= 3.4, SD 1.6). There were no relationships found between years in nursing and frequency of personal affects. Males experienced higher frequencies of horizontal violent behaviors and personal affects. An ANOVA was conducted to determine if differences existed between the frequency of witnessing/experiencing horizontal violence and the frequency in personal affects based on age. Bonferroni tests were further conducted and revealed that the frequency of witnessing/ experiencing such behaviors from 41-50 years old was significant as well as over 60 years old but that the 60 year and older group was less frequent (M = 4.61, SD = 1.2 versus M = 4.21, SD = 1.2, $p<.015$). Nurses of all ages reported experiencing horizontal violence on average between weekly and

monthly. The HV frequency is representative of this sample and generalizability is restricted due to the limitations previously discussed surrounding a convenience sample design and small sample size. In contrast to most of the literature (McKenna, Smith, Poole & Coverdale, 2003; Smith, Andrusyszyn & Spence Laschinger, 2010), the younger nurses between 21-30 years old reported the lowest frequency in personal affects (M = 3.2, SD = 1.3) vs. the older nurses between the ages of 41-50 (M= 4.61, SD = 3.87, p<.001) and 51 – 60 (M = 4.53, SD = 1.4, p<.004), (p. 47). This finding may indicate that the preventative strategies put forth in the industry are not helping the experienced nurse deal with HV as this finding represents that the longer an RN is exposed to the work environment the higher the rates of HV that will be experienced. The means associated with education were similarly distributed across all levels for witnessing/experiencing horizontal violent behaviors and personal affects. The qualitative data revealed three important themes: the stress and complexity of the care caused powerlessness and victimization; the environment produced by management is one containing the horizontal violent traits if they use their position of power to bully or turn a blind eye to what is occurring; and last a fear of retaliation if anyone found out what they had written. These three themes support that the nurses work environment is

complex and because of this complexity negative behaviors may result as a means for the nurse to cope and gain control. Dumont et al., 2012 concluded that although the above clinical significance may appear weak, the impact of the findings support that most nurses are exposed to horizontal violence and that until healthy work environments are created to correct this phenomena, the problem will continue to exist. This writer then asks the question "Is Magnet the answer?"

During the same time period that the Dumont, Meisinger, Whitacre & Corbina (2012) report was published, the Institute for Safe Medical Practices (ISMP), (2012) issued a safety alert which included a call to action for a culture of respect to exist between healthcare professionals (p. 2). This call to action compliments the work of Dumont, Meisinger, Whitacre & Corbina (2012) and acts as a testament to the prevalence of HV. It also stresses the importance of HV and results in specific recommendations to help healthcare professionals and organizations address HV. Dr. Leape's focus specifically surrounded physician behaviors and the widespread disrespect exhibited towards patients and other healthcare professionals. As a result, healthcare workers were noted to experience a diminished ability to clearly think, question care and make decisions which ultimately impacted patient care outcomes. Patients experienced longer wait times and less time

with their physician when such behaviors are exhibited. Dr. Leape recognized that the cause of this is primarily due to the stressful environment that healthcare workers are exposed to and makes several recommendations for organizations to follow to help alleviate the prevalence of workplace violence. Some suggested interventions include setting up a culture of respect as a precondition to working at the facility, conducting an awareness campaign, revising policies, establishing standards surrounding codes of conduct and learning environments and surveying front-line workers in what they perceive as stressors in their work environment (p. 3). Some of these recommendations such as policy making, learning environments and the involvement of front-line staff in research can be accomplished when an organization achieves Magnet status. These items compose some of the criteria enabling an organization to achieve this recognition. This connection then lends itself to the idea that perhaps as nursing environments change through the Magnet Certification process that in turn lower rates of HV will be experienced.

The Impact of Magnet Certification

With the recent advent of Magnet Certification recognizing nursing excellence at hospitals and the resulting change in hospital

cultures and environments, it leads this researcher to investigate whether the impact of the Magnet environment could decrease the incidence rates of horizontal violence. As of January 8, 2016, there are four hundred and twenty five (425) Magnet facilities, seven (7) of which are international facilities (Australia, 3; Canada, 1; Lebanon, 1; Saudi Arabia, 2). Twenty-three (23) Magnet hospitals are currently located in New Jersey. (http://www.nursecredentialing.org/Magnet/ProgramOverview/HistoryoftheMagnetProgram).

The history of the Magnet Program began thirty-three years ago. In 1983 the American Academy of Nursing (AAN) Task Force on Nursing Practice in hospitals studied the work environments of 163 facilities and their ability to recruit and retain nurses during the 1970's and 1980's nursing shortage . Forty-one of these facilities were identified as possessing these qualities and thus were identified as "Magnet" hospitals. Today these characteristics have been formulated into what is now referred to as the "Forces of Magnetism". (http://www.nursecredentialing.org/Magnet/ProgramOverview/HistoryoftheMagnetProgram & Table 1 *Fourteen Forces of Magnetism*).The AAN Task Force noted that the ability to recruit and retain nurses who were competent to work in their specialty field should translate into an

environment where positive patient outcomes were routinely experienced. In order to understand the work environment of Magnet certified facilities it is important to understand the basic structure of Magnet. Without this understanding it is difficult to envision how the outcomes are achieved and how the nurses work environment changes. Organizations awarded Magnet Status must exemplify the core elements contained in the Magnet Vision. The Magnet Vision states that "Magnet organizations will serve as the fount of knowledge and expertise for the delivery of nursing care globally. They will be solidly grounded in core Magnet principles, flexible, and constantly striving for the discovery of innovation. They will lead the reformation of healthcare; the discipline of nursing; and care of the patient, family and community" (American Nurses Credentialing Center, 2008, as cited in The Commission on Magnet Recognition, 2008). The Magnet Model contains five elements: structural empowerment; exemplary professional practice, new knowledge, innovations and improvements; transformational leadership; structural empowerment; and empirical outcomes. The 14 Forces of Magnet are embedded within the Magnet Model (American Nurses Credentialing Center, 2008, as cited in The Commission on Magnet Recognition, 2008). These fourteen Forces of Magnetism are used by organizations in redesigning their nursing

environments (American Nurses Credentialing Center, 2008, p. 71), (Table 1). These fourteen Forces of Magnetism are incorporated into each organization's nursing environment and must meet specific, stringent standards in order to become certified. All fourteen standards represent the core structure to the program and will ultimately change the environment that the nurse works in when fully implemented. According to Ulrich, Buerhaus, Donelan, Norman & Dittus (2007), *U.S. News and World Report* added Magnet as a measure for selecting best hospitals in 2005. Although not explained why this measure was chosen this researcher concludes that the impact of Magnet on the nurse's environment ultimately results in positive patient outcomes. Some of the challenges and barriers for organizations during the process include the extensive preparation time to meet the standards described in the Magnet process. This can take upwards of 3 ½ to 4 years (Russell, 2010). There is also a significant financial investment that needs to be made in order to apply, achieve and sustain Magnet Accreditation. Judith Russell (2010) surveyed seven executive nurse leaders at acute care facilities across America and reported that the Magnet journey costs ranged from $100,000 to $600,000 for one year, with varying ranges in between years. All of these factors need to be seriously considered when deciding to pursue this endeavor and quite often organizations

either fail to meet the standards or decide not to pursue the endeavor and remain non-Magnet hospitals. The inability to meet and adhere to the Magnet standards potentially results in nursing environments that are not recognized as containing the necessary elements to obtain and maintain successful outcomes for patients, organizations and nurses. This then translates into whether or not Magnet hospitals experience less HV than non-Magnet hospitals.

Studies Supporting Positive Magnet Outcomes

Eleven major research articles were found in the literature review that discussed the nurse's work environment and the outcomes achieved at the sample organizations. Most of these articles compared Magnet and non-Magnet hospitals. The first seven articles discussed the positive outcomes achieved (Aiken's, Clarke, Sloane, Sochalski & Silber, 2002; Kelly, McHugh & Aikens, 2011; Laschinger, Shamian & Thomson, 2001; Smokler Lewis & Malecha, 2011; Hickson, 2013; Buffington, Zwink & Fink, 2012; & Ulrich, Buerhaus, Donelan, Norman & Dittus, 2007) and the later four articles (Trinkoff, Johantgen, Storr, Han, Liang, Gurses & Hopkinson ,2010; Goode, Blegan& Park, 2011; Mills & Gillespie, 2012; Buffington, Zwink & Fink, 2012) discussed that either minimal differences or no differences were found. One article (Buffington, Zwink & Fink,

2012) was categorized to fit both sections because of the results obtained and is elaborated on in the later section.

Aiken's, Clarke, Sloane, Sochalski & Silber, (2002) examined "the association between the nurse to patient ratios, patient mortality, failure to rescue rates among surgical patients and factors related to nurse retention" (p. 1987). They conducted this study in response to the California legislation that mandated minimal staffing ratios for hospitals during the nursing shortage. Although Magnet facilities were not singled out in the sample, the results of this study can be applied and lend credence to the very foundation and vision that the Magnet Certification stands for – a positive nursing environment leads to positive patient outcomes and thus is worthy of an extensive review. Data was derived from the 1999 American Hospital Association (AHA) Annual Survey, the 1999 Pennsylvania Department of Health Hospital Survey, discharge data for specific Diagnosis Related Groups (DRG) and survey data of 10 or more nurses from each facility. One hundred and sixty eight (168) out of the two hundred and ten (210) acute care hospitals located in Pennsylvania were included in the sample. Hospitals that were excluded included Veterans Affair Hospitals, hospitals with missing variables in the data base and any hospital with less than ten (10) nurse surveys returned. "The nurse staffing measure was calculated as the

mean patient load across all staff registered nurses who reported responsibility for at least one (1) but no more than twenty (20) patients in the last shift they worked regardless of their specialty or shift (day, evening, night) worked" (p. 1988). Size, teaching status and technology were used as control variables. Hospital size was determined by grouping them into small (≤ 100 beds), medium (101-250 beds) and large (≥251 beds). Teaching status was determined by the ratio of residents and fellows to hospital beds and high technology organizations were defined as those that conducted open heart surgery and transplant surgery procedures. Nursing surveys were mailed to 50% of the nurses residing in Pennsylvania who were listed with the State Board of Nursing. A return rate of 52% was achieved and included ten thousand one hundred and eighty four (10,184) nurses responding to the survey who worked in hospitals. "Nurses were asked to pick their hospital from a list and answer questions surrounding demographics, work history, workload, job satisfaction and burnout" (p. 1989). The survey indicated that over fifty percent (50 %) of hospitals reported nurse to patient ratios of 1:5 and forty-three (43%) of nurses reported high burnout and job dissatisfaction associated with patient to nurse ratios with the intention to leave within the next 12 months. "An increase of 1 patient per nurse increased burnout and job satisfaction by 1.23

(95%CI, 1.13-1.34) and 1.15 (95% CI, 1.07-1.25) or by 23% and 15%" (p. 1991). Patient care outcomes were accounted for by obtaining the 1998-1999 discharge abstracts of all admissions to nonfederal hospitals and then merging them with the Pennsylvania vital statistics records to identify those patients that died within 30 days of hospital admission. The outcomes for 232,342 patients between 20-85 years old who underwent general surgery, orthopedic or vascular procedures were analyzed. Failure-to-rescue rates were also analyzed and were defined as "deaths within 30 days of admission amongst patients who experienced complications" (p. 1989). Of the two hundred and thirty-two thousand three hundred and forty-two (232,342) patients that were admitted, fifty three thousand eight hundred and thirteen (53, 813) or twenty-three point two percent (23.2%) experienced a major complication that was not present on admission and four thousand five hundred and thirty five (4,535) died within thirty (30) days of admission (2%). Orthopedic patients accounted for fifty-one point two percent (51.2%) of the patients and digestive and hepatobiliary patients accounted for thirty-six point four percent (36.4%) of the patients. Hypertension was the only chronic illness identified as being common amongst the patients. Patient and hospital characteristics were controlled for diminishing the odds ratio performed however the results

were still significant for mortality and failure to rescue rates (1.07; 95% CI, 1.03-1.12 and 1.07; 95% CI, 1.02-1.11) (p.1991). This translates into an increase of seven percent (7%) in patient mortality for every patient added to a nurse's assignment. For example, increasing an assignment from four (4) patients to six (6) patients will increase mortality by fourteen percent (14%). When the findings of this study are superimposed on the nurses work environment as outlined by the Magnet process, through the 14 Forces of Magnetism, the writer and reader can identify that Organizational Structure, Professional Models of Care, Quality of Care, and Quality Improvement are all negatively impacted (Table 1).

Kelly, McHugh & Aiken's (2011) also found differences in the work environments of Magnet hospitals compared to non-Magnet hospitals. Their research followed the research conducted by Aiken's et al. (2002) and was also conducted in response to the Trinkoff, Johantgen & Storr (2010) study which did not find differences in the work environments of Magnet hospitals compared to non-Magnet hospitals. The aim of this study was to determine whether work environments, staffing and nurse outcomes differ specifically between Magnet and non-Magnet hospitals. Their data was obtained from a prior study of hospitals located in New Jersey, Pennsylvania, Florida and California. The state

licensure lists from 2006 and 2007 were used to randomly mail surveys to the homes of RNs. Nurses employed at hospitals were asked the name of their hospital for comparison. The final sample included five hundred and sixty-seven (567) hospitals of which forty-six (46) were ANCC Magnet certified. The survey response rate was eighty-six percent (86%) with four thousand five hundred and sixty two (4,562) nurses working at Magnet hospitals and twenty-one thousand seven hundred and fourteen (21, 714) nurses working at non-Magnet hospitals. Six characteristics were measured and included: nurse characteristics, nurse staffing, work environment, education, hospital characteristics and outcomes. Nurse characteristics included age, years of experience, educational level, specialty certification, sex and whether their schooling occurred in the U.S.A. Nurse staffing was obtained directly from the nurses report of the number of patients cared for in their last worked shift. Work environment was measured using a tool validated by the National Quality Forum. It consisted of a thirty-one (31) item Practice Environment Scale of the Nursing Workforce Index. It measured the degree at which certain organizational features were present in the nurses work environment. Education information was derived from individual nurse reports. Hospital characteristics included the state the hospital was located, whether it was a teaching hospital

or not, whether it was defined as a high technology facility performing open heart and transplant surgery, number of hospital beds and staff levels and not-for-profit status. The outcome measurements included burnout and job satisfaction. Burnout was measured by the Maslach Burnout Inventory Human Services Survey and job satisfaction was measured through a single-item question "How satisfied are you with your current job?" This was scored based on a 4-point Likert scale ranging from "very dissatisfied" to "a little dissatisfied" to "very satisfied" to "satisfied". The intent to leave within one year was measured by the nurse answering yes. The results included a demographic population that was similar. Magnet hospitals tended to be teaching facilities (x^2 = 3.93, p =.05), have high technology (x^2 = 14.90, p<.001), have nonprofit status (x^2 = 11.11, p<.001) and have similar average beds (t = -5.04, p<.001). There was no difference in the mean years of experience (t= -1.06, p=.29) or the proportion of nurses educated in the U.S.A. (t=.29, p =.77) (p. 430). Specialty certified nurses were higher at Magnet hospitals (t= -2.80, p<.05). Magnet hospitals also had a higher number of bachelorette or higher degree nurses (t=- 2.27, p<.05) and the Magnet work environments were found to be significantly better than non-Magnet work environments (t= -5.29, p<.001). Staffing ratios were initially non-significant (t= 1.13, p<.26) between Magnet and non-Magnet

hospitals, but when California hospitals were excluded from the sample because of the mandated staffing ratios that were in place Magnet hospitals had staffing ratios slightly better than non-Magnet hospitals ($t= -5.29$, $p<.001$). Nurses in Magnet hospitals were eighteen percent (18%) less likely to be dissatisfied ($p<.05$), thirteen percent (13%) less likely to have high levels of burnout ($p<.05$) and were less likely to report to leave in the next year ($p<.05$). The results of this study showed significantly better work environments at Magnet hospitals along with better nurse outcomes. Kelly, McHugh & Aikens (2011) suggested that the Trinkoff, Johantgen & Storr's (2010) study may have been underpowered and therefore unable to detect the differences between Magnet and non-Magnet hospital characteristics. None the less opposing findings and conclusions exist.

Laschinger, Shamian & Thomson (2001) proposed a model for study that incorporated several of the Forces of Magnetism and hypothesized if nurses perceived their work environments as having a high degree of autonomy, control over practice environment, and strong collaborative nurse/physician relationships, that they would then have higher levels of trust in management and lower levels of burnout and high levels of job satisfaction (p. 212-213). Using a sample derived from a subset from Aiken et al. (2001) study, three tools were used to

capture the data. The Nurse Work Index Survey contained items derived from organizational traits reported by Magnet hospital staff nurses as characteristics if their work environments (Kramer & Hafner, 1989). The Interpersonal Trust at Work Scale was used to measure trust in the intentions of actions put forth by peers and managers. The Human Services Survey was used to measure burnout and job satisfaction was measured by asking nurses to rate their job satisfaction on a scale of 1-4 (1 = very dissatisfied, 4 = very satisfied). Surveys were mailed to nurses across the three Ontario providences yielding eight thousand two hundred and sixty-three (8,263) and of this sample three thousand and sixteen (3,016) were mailed an additional survey related to organizational trust. Based upon the results of this study the authors concluded that levels of autonomy, control over practice (extent to which an RN can make independent patient care decisions) and nurse physician collaboration were similar to those of non-Magnet hospitals found in the Aiken's (2001) research. Burnout, trust in management, and job satisfaction were also found to be average. The proposed model was tested and for job satisfaction revealed a reasonably good fit (x^2 = 18.1, GFI = .94, CFI = .92, IFI = .92). Higher levels of autonomy, control and collaboration were associated with higher levels of trust in management (.56) which in turn was associated with higher job

satisfaction (p. 215, 216). Positive work environments were associated with lower burnout levels (-.62) and higher job satisfaction (-.55). From this study the authors concluded that staff empowerment strongly relates to increased trust in management and subsequently to the organization. Environments lacking trust will result in decreased autonomy, control, and collaboration and an increase burnout rate. Generalization of these findings to nurses practicing in the United States is questionable because of the convenience sample of Ontario nurses utilized.

Workplace incivility has recently emerged as a new term in the literature when discussing HV. Smokler Lewis & Malecha (2011) studied whether the "impact of workplace incivility (WPI) on staff nurses was related to cost and productivity" (p. 41). Specifically the goals of the study were "to determine if there were differences between WPI between healthy and standard work environments; to determine if there was difference between academic medical centers, community medical centers and rural medical centers; to evaluate the cost and productivity of WPI in the hospital setting; to determine if a relationship exists between WPI and productivity subscales; to examine the relationship between manager skill and WPI; to determine if differences exist between type of unit and WPI scores; to determine if there exists

any organizational characteristics that predict WPI in the hospital setting" (p. 42-43). Healthy work environments included those containing the elements of performance embedded in Magnet (highest award for nursing excellence), Pathways to Excellence (essentially, stage 1 of the Magnet Recognition Process) and The Beacon Award (ICU Nursing Excellence Award). This study utilized a non-experimental, correlational, comparative and predictive model design. A random mailing was sent to two thousand one hundred and sixty (2,160) RNs currently employed in the state of Texas. Participants were given a choice as to whether they wanted to complete a hard copy of the survey or go on-line to a data base called Psyche/Data to enter their information. Three instruments were utilized. The first instrument was the NIS (abbreviation not explained) and was used to measure the source of the incivility. It contained forty-three (43) items and the internal consistency was noted to be .88 to .94 for each subscale. The subscales represented items such as inappropriate jokes, hostility and rudeness, free riding, gossip/rumors, inconsiderate and patient/visitor/physician and supervisor. A 5-point Likert scale was used but not further defined. The second instrument used was the WLQ (abbreviation not explained). It was designed by The Health Institute of Tufts Medical Center and consists of twenty-five (25) items to measure

productivity by the degree of interference an individual has in performing their job (p. 43). Elements such as time management, physical demands, mental-interpersonal demands and output demands were measured. "Difficult at all times" to "not difficult at all" were the response ranges used to indicate productivity. The Cronbach alpha ranges were .88 to .94 for this study. The third instrument used was the WLQ (abbreviation not elaborated upon) Productivity Loss Score. It measured the percent of reduction of work output to a work related limitation (incivility) compared to those who do not have this limitation (incivility). To calculate the cost of productivity loss the researchers used the process developed by Hutton and Gates (2008) and salary ranges noted by Keefe and O'Brien, 2009. In the end, the mean annual salary of the nurse was multiplied by the productivity loss. The salary was determined to be between $60,000 to $64.999 or $30.54/hr. The demographic results were typical of those found in other studies that represent the nursing profession: mean age = 46.4, female = 92%, baccalaureate = 48%, experience greater than 6 months = 86%, academic medical center = 38.6%, community medical center = 37%, 38% worked in Magnet facilities, 31% in Pathway to Excellence facilities (phase 1 Magnet Certification designation) and 6.4% in Beacon facilities (Critical Care Nurse Excellence designation). Of this sample

eighty-five percent (85%) of nurses experienced WPI during the last year and thirty seven percent (37%) reported administering WPI to another peer within the last year. Upon review of the data it was noted that nurses working in healthy environments were less likely to experience WPI ($p<.001$) in all subscales except for patient/visitor, no significant differences were found in hospital setting (academic, community or rural hospitals) and WPI scores, $11,581 per nurse per year of lost productivity was related to WPI. When comparing lost productivity between healthy work environments and standard work environments, no differences were noted. Higher incivility resulted in lower productivity. No correlation was found between nurse's perception of manager's awareness and WPI on their unit. The nurses negatively reported the manager's ability to handle WPI and the nurses had lower scores of WPI if their managers were perceived as being able to handle WPI. There was no significance between patient/visitor and WPI perceived by the RN. However, there was a difference between the type of unit and WPI with the ICU and Medical-Surgical units having lower incivility scores than the OR ($p<.001$). The ICU also had lower scores than the Emergency Department ($p<.002$). For the direct supervisor scale the Operating Room was significantly different than the ICU and Medical Surgical Units ($p<.001$ and $p<.003$) (p.45). For the

physician subscale, the Operating Room scored higher incivility scores and was significantly different than the ICU ($p<.001$), Med. Surg. ($p<.001$) and E.D. ($p<.002$). For the patient/family subscale the O.R. scored the lowest incivility scores compared to the ICU, Med. Surg. and E.D. ($p<.001$). The organizational factor that impacts WPI was found to be managers awareness of WPI which then impacts the ability of the manager to handle WPI ($z=23.896$, $p<.001$). Additionally the type of nursing unit was also found to be a predictor of WPI ($r^2= 34.51$, $p<.001$). This study found that the Operating Room was a better predictor than the ICU and Medical Surgical Units. This research supports that productivity is negatively impacted by WPI and that a supportive healthy work environment is associated with less WPI as previously determined by Laschinger et al., 2009.

Hickson (2013) conducted a descriptive correlation study to examine the perceptions of hostility and job satisfaction amongst new graduate nurses at Magnet vs. non-Magnet hospitals. New nursing graduates were defined as those nurses who passed the state licensure examine within the last 0 – 36 months. Four surveys were used to ascertain the results: the Negative Acts Questionnaire-Revised (NAQ-R), the McCloskey-Mueller Satisfaction Scale (MMSS), the Case-Fink Graduate Nurse Experience Scale (CFGNES) and a demographic

questionnaire. The NAQ-R consisted of twenty three (23) items of which the first twenty two (22) were scored on a 1-5 point Likert scale (1 = never, 2 = now and then, 3 = monthly, 4 = weekly and 5 = daily). These twenty two (22) items had an excellent internal consistency as represented by a Cronbach's alpha = .90. The last question asked the participants if they were victims from bullying after reading a definition that was provided within the tool. The MMSS consisted of thirty one (31) items used to measure hospital nurse's job satisfaction rates. There were four (4) dimensions of the questionnaire which included "rewards, social rewards and psychological rewards as well as eight types of satisfaction associated with extrinsic rewards, scheduling, family-work balance, coworkers, interaction, professional opportunities, raises and recognitions and control/responsibility" (p. 295). A 5-point Likert scale was used to score each item (1 = very dissatisfied, 2 = moderately dissatisfied, 3 = neither satisfied nor dissatisfied, 4 = moderately satisfied and 5 = very satisfied). These 31 items had an excellent internal consistency as represented by a coefficient alpha = .89. The CFGNES consisted of five items measuring the new nurse's experience which included support, patient safety, stress, communication/leadership and professional satisfaction. Section two of the full survey was utilized to obtain this information, thus the revision to the initial survey. A 4-point

Likert scale was used (1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree). These items had an excellent internal consistency as represented by a = .89.

Since an appropriate sample size was needed to show the potential differences that might exist between Magnet and non-Magnet hospitals a power analysis was conducted. The power analysis was based on the use of independent t-tests, small differences, and a Cohen's effect size of d= 0.2. The result was a sample of one thousand eighty four (1084) nurses to yield a power of 80%. This sample was further delineated when the researchers determined that, according to the American Hospital Association (2011) five thousand seven hundred and ninety-five (5795) hospitals had been registered in the U.S.A. of which three hundred and seventy-eight (378) were designated as Magnet. This resulted in a need to recruit 1 in every 15 nurses from a Magnet hospital. IRB approval was obtained from the Teachers College, Columbia University and advertised on Face-book. A link was provided that guided the respondent to a secure website and consent was implied if the survey was completed. The survey was available for fourteen (14) weeks and yielded a response of one thousand two hundred and seventy-one (1271) surveys of which one thousand one hundred and sixty-five (1165) were eligible for participation and one

hundred and six (106) were excluded. The sample size was just large enough as required during the power analysis and two hundred and twenty-six (226) Magnet nurses and nine hundred and thirty-nine (939) non-Magnet nurses were ultimately eligible for inclusion. The data analysis included "independent t tests to compare the perceptions of hostility, job satisfaction and job satisfaction through professional comfort, confidence and support among nurses of Magnet and non-Magnet hospitals. Testing was based on determining statistical significance at a 2-sided a of .05" (p. 295). "Correlational analysis was examined for the presence and strength of a relationship between perceptions of NH and job satisfaction of new graduate nurses by comparing Magnet and non-Magnet facilities" (p.295-296).

The demographic data results included nurses between the age of 18-24 (N= 418), who were mostly female (N=1050), possessed an Associate's Degree (N=736) and had 12 months or less experience as an RN (N=857). The nursing hostility results included two items: NH perceived and self-labeled victimization. NH as perceived by Magnet nurses was significantly different (M=64.72± 24.68; N=226) than non-Magnet nurses (M=60.83±26.13; N=939). After being presented with a definition of bullying the respondents were asked to answer whether they had been victims. Magnet nurses responded that 48.7% of the time

they were victims either "several times a week" (N=76) or "daily" (N=34) (p.297). Non-Magnet nurses responded similarly. Almost 49% responded that they were exposed "several times a week" or "daily" (p.297).

Overall job satisfaction results were rated higher by Magnet nurses (M=80.93± 22.48; N=226) than non-Magnet nurses (M=74.29±26.88; N=939). New graduates from Magnet hospitals (M=61.03±10.688; N=226) also rated professional comfort, confidence and support higher than non-Magnet nurses (M=59.17±9.90; N=939), t 324.60 =2.38, p=.018, 2-tailed, d=0.18) (p.297). Personal life stressors were evaluated by asking the participants to choose the items from a list that caused the highest incident of stress. They were allowed to choose more than one answer. Agreement between Magnet (51%, N = 115) and non-Magnet (68%, N = 639) nurses on job performance being the highest stress indicator was noted. Hickson (2013) concluded that "it is concerning that Magnet participants indicated only marginal differences in levels of job satisfaction when compared to non-Magnet nurses" (p.298).

Ulrich, Buerhaus, Donelan, Norman & Dittus (2007) expanded on their 2004 work by comparing the differences between hospitals with Magnet status, those in the process of achieving Magnet status and non-Magnet hospitals as it pertained to the nurse's views of their work

environment, professional relationships and the nursing shortage. In process of achieving Magnet was a new variable found in this study. Goode, Blegen & Park (2011) later concluded that this new variable could affect the results of studies that favored the outcomes achieved at non-Magnet hospitals. "A random sample of 3500 nurses was drawn from the database of licensed RNs in the U.S.A." (p. 213). The survey packet included an introductory letter and questionnaire as well as information for completing the questionnaire on-line if preferred. Two creative incentives were used to attract potential respondents: two free continuing education units and inclusion in a raffle to win a $1500 travel voucher. After further review, one hundred and eight (108) RNs were eliminated from the sample for reasons such as wrong addresses and being deceased. As a result three thousand three hundred and ninety-two (3,392) surveys were mailed and one thousand seven hundred and eighty three (1,783) surveys were completed which represented a fifty three percent (53%) response rate. For nurse's who answered that they worked in hospitals (N=735) one hundred and eighty five (185) reported working at Magnet facilities, two hundred and fifty-four (254) at facilities that were in the process and two hundred and ninety seven (297) responded that they worked at non-Magnet facilities. To further assist in enabling that the results be better generalized and representative of

nurse's across the U.S.A., age and region of the country were weighted according to 2000 National Sample Survey of the Population of Registered Nurses. The results showed that there were no statistical differences in demographics between Magnet, in process of Magnet and non-Magnet hospital nurses.

Overall Magnet hospitals had more positive responses than in process and non-Magnet hospitals. Magnet nurses viewed the nursing shortage as not being a major problem in regards to the early detection of patient complications however concerns regarding increased wait times particularly for the operating room were reported. The RNs perceived that improving the work environment would help the shortage. Overtime was described as voluntary. In-process nurses and non-Magnet RNs viewed that improving the work environment would also help the nursing shortage, but that the current shortage makes it difficult to allow for changes to occur. Overtime was described as "voluntary, but felt required" (p. 214). Non-Magnet RNs also reported concerns that the concept of patient-centeredness per the Institute of Medicine Report could be affected as a result of the shortage. Forty-five percent (45%) of Magnet and in-process RNs and twenty-six percent (26%) of non-Magnet RNs viewed the emphasis and commitment to patient care in the workplace environment as a priority

in their organization ($p<.05$). Surprisingly, opportunities for professional development and advancement were not scored by Magnet and non-Magnet nurses as excellent or good, however, in-process RNs were significantly more likely to rate professional development and advancement as excellent or very good. Twenty-three percent (23%) of in-process RNs, nineteen percent (19%) of Magnet RNs and fourteen percent (14%) of non-Magnet RNs rated opportunities to influence decisions as excellent ($p<.05$). Seventy nine percent (79%) of Magnet RNs and sixty eight percent of non-Magnet RNs reported that their relationships between peers was excellent or very good ($p<.05$). There was no data reported for in-process RNs. This result supports the hypothesis that Magnet environments should produce lower HV rates between peers. In regards to relationships between physicians fifty-six percent (56%) of Magnet RNs, forty-one percent (41%) of in-process RNs and thirty four percent (34%) of non-Magnet RNs reported increased efforts of teamwork between the two professions. In regards to recognition and support twenty-six percent (26%) of in-process RNs, twenty percent (20%) of Magnet RNs and sixteen percent (16%) of non-Magnet RNs rated recognition as excellent or very good at their hospitals, of which seventy-five percent (75%) of Magnet RNs, sixty-two percent (62%) of in-process RNs and forty-eight percent (48%) of non-

Magnet RNs reported observing increased efforts at their organizations to recognize RNs during the last year. Front-line management support was also significant ($p<.05$) at Magnet and non-Magnet hospitals particularly when it involved personal matters and family matters ($p<.05$). The Magnet environment is known for higher retention rates because of the positive work environments. Forty-five percent (45%) of Magnet RNs and fifty-six percent of non-Magnet RNs reported that their hospitals used sign on bonuses as a recruitment technique ($p<.05$). Forty-two percent (42%) of Magnet RNs, thirty-six percent (36%) of in-process RNs and twenty-four percent (24%) of non-Magnet RNs reported experiencing increased efforts made by their facilities regarding implementing retention strategies ($p<.05$). One strategy for hospitals to retain nurses is to pay for continuing education credits/units (CEU's). Fifty-three percent (53%) of Magnet RNs and forty-two percent (42%) of in-process and non-Magnet hospitals reported that their facilities pay for CEU's ($p<.05$).

Additionally as part of this study, three questions surrounding the career of nursing were asked: whether they were satisfied with nursing as a career and their current positions, their intent to stay or leave their position and whether they would recommend nursing as a career. There were no significant differences between facilities as to the level of

satisfaction of being a nurse. Magnet RNs reported higher levels of satisfaction with their present position (85%) compared to non-Magnet nurse's (75%), ($p<.05$). Those in the process of applying for Magnet certification were seventy-seven percent (77%) satisfied in their current positions. Plans to leave a position were defined as "a nurse's intent to leave within the next twelve months to three years" (p. 218). Non-Magnet RNs reported a forty-three percent (43%) rate of RNs intending to leave compared to a thirty-eight percent (38%) rate for Magnet RNs and a thirty-two percent (32%) rate for in-process RNs ($p<.05$). Even though these nurses were intending to leave, two thirds reported that they would be remaining in nursing and would obtain another nursing job. Magnet RNs also scored higher (80%) in recommending students with nursing as a choice of careers to pursue than in process RNs (70%) and non-Magnet RNs (67%), ($p<.05$).

In summary, generally the findings support that nurse's working at Magnet hospitals and in-Process hospitals, perceive better outcomes and have a more positive outlook regarding their work environments. Many of "The Forces of Magnetism" are adopted early in the process when preparing for Magnet Certification and therefore in-Process hospital nurses may benefit by experiencing the rewards of the Magnet Program without having been awarded the actual certification. Not all

in-Process hospitals will complete their journey. This may be due to financial reasons, a change in nursing leadership and/or philosophy as well as the inability to secure the necessary resources to get the required Magnet document written and submitted. Researchers need to be cautious when collecting Magnet data and non-Magnet data because of the potential influence of the in-Process hospitals. This could be considered a limitation for studies comparing Magnet and non-Magnet hospitals.

Non-significant Studies for Positive Magnet Outcomes

As referenced earlier, in 2010, research began to appear that challenged whether Magnet Certification accomplishes the goal of improving and changing the nurse's work environments resulting in positive outcomes. Trinkoff, Johantgen, Storr, Han, Liang, Gurses & Hopkinson (2010) compared the nurse's work schedules, job demands and practice environments between Magnet and non-Magnet hospitals by conducting a cross-sectional data analysis of the Nurses Work-life and Health Study (2004). Two thousand one hundred and fifty six (2,156) RNs formed the sample for this study which was restricted to RNs working in acute care hospitals. Exclusion criteria included retirees (N = 210), nonhospital RNs (N = 862) and RNs who failed to state the

name of their hospital (N = 233). Participating hospitals were either designated as Magnet (N = 14) or non-Magnet (N = 157) based on the criteria from the 2005 American Nurses Credentialing Center accreditation status. Hospitals pursuing their Magnet journey in 2004 may have already built in the new structures required for Magnet Certification thus their nursing environments and their outcomes may be quite similar to Magnet hospitals. Therefore, " a three level variable comparing nurses working in Magnet hospitals designated in 2004, to nurses working in hospitals designated in 2005 Magnet hospital nurses, verses nurses working in non-Magnet hospitals as of (2004-2005)" was conducted (Ulrich, Buerhaus, & Donelan, 2007). "The 2005 analysis showed minimal differences from the 2004 analysis; therefore, the results from the 2005 Magnet hospital designation were included" (p.311). The nurses were divided into two groups: Magnet (N = 162) and non-Magnet (N = 675) and work schedules, job demands and practice environment were compared. The Work Schedule Index provided the necessary variables for measuring work schedules. For example, nurses reported the last six months of a typical work schedule and actual hours worked. The Job Content Questionnaire was used to measure job demands that consisted of elements describing both psychological demands (working hard, working fast, excessive amounts of work,

intense concentration over long periods, enough time to get the job done and interrupted tasks, and waiting on others to get the work done) and physical demands (duration, frequency and exposure based on 12 items, ie: heavy lifting). Items from the Nursing Work Index-Revised (NWI-R), the Job Content Questionnaire support domain, The Patient Safety Center of Inquiry Culture Survey and Hospital Survey on Patient Safety Culture were used to measure the environment in which the nurse delivers care. Univariate, descriptive statistical analyses were performed. Demographic characteristics did not differ, however the proportion of nurses of color that worked at Magnet hospitals was significantly lower than non-Magnet hospitals (p. 312). Working conditions did not differ significantly either. Magnet hospital nurses did not report that mandatory overtime or on-call were used more frequently at Magnet hospitals nor were worked hours per day or per week higher. There were no differences in psychological demands noted, however, physical demands were lower at Magnet hospitals with a mean of 30.1 vs. 31.0 for non-Magnet hospitals ($t = 2.140$, $p = .034$). Nurse practice environments, patient safety cultures and overall job satisfaction produced no significant differences. The limitations of this study include that data was derived from self-reports, as well as the potential for errors regarding recall and biasness in responding to survey

questions and the potential of misclassifying 2004 – 2005 Magnet vs. non-Magnet facilities. There were no control variables identified and the sample size could be considered small and not representative of the larger population. Earlier in this literature review, Kelly, McHugh & Aiken's (2011) did state that this study may have been underpowered and perhaps if the sample size was larger the differences may have been more noticeable between the two.

Buffington, Zwink & Fink (2012) studied RN perceptions regarding nurse retention at the University of Colorado Hospital (UHC) which is an acute care, teaching, three time awarded Magnet hospital. Specifically, the purpose had four subcomponents: "To identify RN perceptions of the work environment, support and encouragement; to determine factors that influence RN job satisfaction; to understand RN perceptions of professional development, mentoring and recognition; to test an investigator-developed instrument to measure factors that influence nurse retention" (p. 274). A descriptive survey design was used to gather information from RNs who had one or more years of experience and had worked at the facility since the fall of 2009 on either the inpatient or ambulatory nursing units/departments. Appropriate IRB approvals were obtained and because all nurses had access to email the revised Casey-Fink Registered Nurse Survey (2009)

was sent through the Zoomerang application. Completion of the survey implied consent.

In 2008, the Casey-Fink Registered Nurse Survey was reviewed for content validity by nurse administrators and clinicians. It was also pilot tested on sixty (60) RNs working on the oncology/bone marrow nursing unit. The survey was revised by deleting redundant questions and adding new questions addressing scheduling, shift work, the economy, retention and manager support. Section one of the revised Casey-Fink Registered Nurse Survey (2009) ultimately achieved an overall Cronbach's α = .922. This was accomplished by assessing the nurse's work environment, support and encouragement through a thirty three item, 4-point Likert scale (1=strongly disagree; 4= strongly agree) in which six hundred and fourteen (614) of the six hundred and seventy seven (677) nurses completed. A factor analysis was conducted and after evaluating the nine (9) suggested criteria as per the Kaiser criteria, four (4) factors were selected because they were viewed as the easiest to understand and interpret. The four (4) subscales consisted of: recognition/rewards (Cronbach's α = .939), professional nursing role (Cronbach's α = .771), mentorship (Cronbach's α = .767), and flexible scheduling (Cronbach's α = .807). Each subscale contained 3-13 questions. These four subscales accounted for forty nine percent (49%)

of the variance. Section two of the survey included two (2) items involved in assessing nurse stressors and the third section assessed job satisfaction through a list of thirteen (13) items. This was done using a 5-point Likert scale (1=very dissatisfied, 5= very satisfied). The forth section assessed professional development, goal setting and mentoring while the fifth section assessed demographic information. The final section included four (4) open ended questions that assessed praise, recognition and retention.

The results were both quantitatively and qualitatively discussed. One thousand two hundred and fifty (1,250) surveys were sent and six hundred and ninety nine (699) nurses responded of which six hundred and seventy seven (677) met the inclusion criteria. Typical of most nursing research surrounding this topic the demographic information yielded a sample described as mostly female (N=657) who were 40 years old (SD, 11.21 years) having a B.S.N. degree (N=507, 76%). Inpatient RNs were slightly younger, 36.97 years old, compared to ambulatory RNs of 46.71 years old. The sample nurses had a mean of thirteen (13) years of hospital experience; seventy nine percent (79%) worked full time and sixty one percent (61 %) worked the day shift. The nurses were also asked to rate themselves as to where they fell on the Benner's novice to expert model. Level 1 = novice and level 4 = expert

and seventy nine percent (79%) graded themselves as Level 2, 19% as Level 3 and two percent (2%) as Level 4. There was no statistical significance between work environment, support encouragement and age, length of service and years of experience for Ambulatory and In-Patient nurse's combined. Upon further review, there were significant differences noted between ambulatory and inpatient nurse's surrounding recognition/rewards, professional nursing role, mentoring and scheduling flexibility. Inpatient RNs scored higher in recognition and rewards (N=445, *M*= 39.28, SD= 7.03, p<.032) than Ambulatory RNs (N= 164, *M*=37.84, SD= 8.07, p<.032). The professional nursing role of inpatient nurse's (N=454, *M*=27.14, SD= 3.50, p<.785) was similar to ambulatory nurse's (N=178, *M*= 27.7, SD =4.21, p<.785). Inpatient nurse's scored higher in the mentoring subscale (N= 435*M*=24.91, SD 3.27, p<.05) than ambulatory RNs (N=148, *M*=22.90, SD=1.58, p<.05). Scheduling flexibility in regards to working shorter shifts was more favorable scored by the ambulatory nurse's (n=176, *M*=5.30, SD = 1.33, p<.002) than the inpatient nurse's (N=471, *M*=4.91, SD = 1.58, p<.002). In regards to stressors and job satisfaction, 50% of the respondents reported stress and financial (N=181, 53%) and personal relationships (N=109, 32%) child care (N=72, 21% and student loans (N=56, 16%) were the highest. It is interesting to note that personal relationships were

mentioned to be the second highest stressor in the work environment as well as coworker (peer) relationships. This is important because peer relationships are the core issue surrounding HV. Age, years of experience and years worked were not significant for job satisfaction, however differences were again noted between inpatient and ambulatory RNs. Inpatient RNs were less satisfied with schedules, but more satisfied with scheduling flexibility than ambulatory RNs. Ambulatory RNs were not satisfied with orientation and career advancement opportunities.

The qualitative results revealed three themes: professional development, praise and recognition, and nurse retention. The question asked for professional development was "What are your professional goals for the next 1-5 years?" The answers ranged from achieving competence in the current job, certification to obtaining a Master's degree and becoming published. Praise and recognition results were analyzed based on the answer to the question "Describe ways in which you have received praise or recognition for a job well done" and "How would you like to receive recognition for a job well done?" The answers ranged from unit recognition, verbal praise from managers and educators, and thank you notes from patients/families. Suggestions were made by staff RNs to have managers give praise outside the

yearly performance evaluations and verbally thanking staff. In regards to nurse retention, most nurses stay in their current jobs because of the patients and their peers. The themes for nurses who were contemplating leaving their job included management, staffing levels, workload, pay packages, scheduling/shift work and retirement/family.

In conclusion, although this study did not compare their results to a non-Magnet facility and its results cannot be generalized beyond this one Magnet hospital, it did shed light on the fact that Magnet hospitals still struggle with these issues even though their environments have changed and they have become Magnet Certified. Furthermore, although the data may reveal that no overall differences exist at a facility, further analysis can reveal isolated nursing units that may have different nursing environments within a facility thus, have differing opinions between nurses on how their current environments impact their loyalty or retention to their organization. Nurse executives can glean valuable information from this type of analysis.

Mills & Gillespie (2012) sought out to compare whether differences existed between two nurse sensitive outcomes – pressure ulcer rates and failure to rescue rates – at Magnet and non-Magnet hospitals. They theorized that hospitals that were Magnet certified had met specific standards in order to be deemed nursing centers of

excellence and should be expected to provide better outcomes than non-Magnet hospitals. Their purpose was two-fold: to compare pressure ulcer rates between Magnet and non-Magnet hospitals and to compare hospital rates of failure to rescue between Magnet and non-Magnet hospitals. These two indicators are good predictors of patient safety and are preventable with good nursing care. According to Reed, May, Nicholas & Brown (2011), pressure ulcers contributed to 9.23% mortality amongst Medicare patients and cost an average of 2 billion dollars a year above the normal cost of hospitalizations. Failure-to-rescue events are complications not identified by staff containing a 100% mortality rate. Goode, Blegen, Park, Vaughn & Spetz (2011) is currently the only research study available that found no difference in failure to rescue rates between Magnet and non-Magnet hospitals. Mills & Gillespie (2012) hypothesized that Magnet hospitals would have lower failure to rescue and pressure ulcer rates than non-Magnet hospitals. A retrospective design was conducted using secondary data analysis to compare these two rates. "Data from 2011-2005 containing hospital level and patient level outcomes was obtained from five Healthcare Costs and Utilization Project (HCUP) Nationwide Inpatient Sample (NIS) databases of US hospitals, with all-payer patient data developed by the Agency for Health Research and Quality (AHRQ)" (p. 3). Data from

the American Hospital Association was also used in conjunction with the HCUP databases. HCUP/ NIS contain the largest US database of all-payer inpatient admissions in US hospitals. It represents a 20% sample of community hospitals as defined by the AHA. A stratified sampling technique was used and five years of data was pooled. Inclusion criteria consisted of adult inpatients in community hospitals and exclusion criteria consisted of children hospitals and federal hospitals as well as any state that reported data but did not identify the hospital. Pressure ulcers were defined as hospital acquired, on patients 18 years or older who had been hospitalized for five (5) or more days. Patients from long term care facilities were excluded as well as transfers from other acute care facilities. Construct validity was assessed by AHRQ through the use of experts and two (2) empirical studies and a high reliability to detect differences between hospitals was assessed from a signal to noise ratio per the AHRQ. Failure to rescue were defined as the deaths from complications related to pneumonia, deep vein thrombosis/pulmonary embolus, sepsis, acute renal failure, shock/cardiac arrest or gastrointestinal hemorrhage/acute ulcer (p.3). Patients between 18-75 years old were included and those transferred from another acute care facility or admitted from a long term facility were excluded. Construct validity was determined by the AHRQ

through literature reviews and empirical data. The signal to noise ratio was 66.6% which was determined to mean a moderately high reliability. Risk adjustments to the data needed to occur because it was obtained at discharge and the researchers also needed the data to reflect the patient's state on admission. Specific variables such as age and sex were controlled for with the goal of decreasing differences within the sample and eventually these risk adjusted processes produced a smooth rate which is considered reliable over time. Magnet hospitals from the ANCC Magnet Recognition Program Web site were cross-linked to the HCUP-NIS data bases. Magnet hospitals listed in the HCUP-NIS data bases that had achieved Magnet status within the four year designation period were included as well as those hospitals who had been on their Magnet journey for a period of two years with good outcomes but were not yet certified. The matching process used twelve organizational characteristics to control for organizational effects on outcomes (p.4). There were no statistical differences ($p<.05$) across these twelve hospital characteristics. Eighty (80) Magnet hospitals were included as well as eighty (80) non-Magnet hospitals across twenty two – twenty three (22-23) states respectively. There were no differences for expected, risk adjusted or smoothed rates between pressure ulcer and failure to rescue rates ($p>.05$). The limitations that I identified include the

composition of the Magnet sample. Having non-Magnet hospitals on their journey towards Magnet but not yet certified may have contributed to the outcomes. Also whenever data is submitted to national data base sources from hospitals, coding errors can be present.

The last research study to be discussed in this section is from Goode, Blegen & Park (2011) in which they compared eight patient outcomes and staffing in Magnet and non-Magnet hospitals. Subset data from the 2005 University Health Systems Consortium (UHC) was obtained. IRB approval for exempt status was received from the University of California Committee on Human Research. The sample consisted of 19 Magnet and 35 non-Magnet university hospitals and affiliates. Patient discharge data was used to assess patient care outcomes as outlined by the AHRQ. "A ratio of observed to expected (risk adjusted) adverse outcomes rates were calculated" (p. 519). The staffing data was obtained from the operational data base of staff working on adult nursing units which consisted of Intensive Care Units and general nursing units. Obstetrics, psychiatry, rehabilitation, and skilled nursing units were excluded. Observation and short stay data were included in the hours per patient day data in addition to the patient days counted in the midnight census (p. 519). RN staffing mix

and ICU staffing were calculated to compare patient outcomes for those areas. As previously mentioned, patient outcomes were measured from discharge data. The outcomes analyzed were: mortality rates for congestive heart failure (CHF), and myocardial infarction (MI), failure to rescue, hospital acquired pressure ulcers, infections, post-operative sepsis, and length of stay. The following scores were used to explain the data: 1= performance was as expected, <.9 = less than expected and >1 for better than expected.

The results of the study surrounded staffing and patient outcomes. The total hours of care per patient day at Magnet hospitals was 11.04 and non-Magnet was 11.18. The RN skill mix on general nursing units was 58% in Magnet hospitals and 61% at non-Magnet hospitals. These differences were statistically significant a = .05. For Intensive Care Units, the total hours per patient day were 21.08 for Magnet hospitals and 20.65 for non-Magnet hospitals. The RN skill mix was 75% Magnet ICUs and 77% for non-Magnet facilities. The RN skill mix difference was significant ($p<.05$).

In regards to patient outcomes, Magnet hospitals performed better than non-Magnet hospitals for pressure ulcers (a = .10). Non-Magnet hospitals performed statistically better than Magnet hospitals for hospital acquired infections ($p <.05$), postoperative sepsis ($p <.05$)

and postoperative metabolic derangement (p <.05). There were no differences noted between Magnet and non-Magnet hospital performances for failure to rescue, CHF mortality and MI mortality rates.

A multivariate analysis was conducted regarding these patient outcomes using variables known to affect outcomes: nurse staffing/hours per patient day/RN% and hospital case mix index. Higher rates of postoperative sepsis in ICU was evident in Magnet hospitals (p <.05) and general units (p <.10) as well as higher rates of post-operative metabolic derangement (p <.10). Nurse staffing levels did translate into better outcomes than expected by the researchers for failure to rescue, postoperative sepsis and length of stay.

These findings found that overall better outcomes existed at non-Magnet hospitals than at Magnet hospitals. Again, the researchers suggest that perhaps non-Magnet hospitals containing Magnet characteristics could indeed produce better outcomes. In conclusion, although the sample was small for Magnet hospitals and the generalizability is limited beyond the sample, these researchers concluded that "staffing matters" (p. 522). Staffing ratios were also found to be significant in the Aiken's, Clarke, Sloane, Sochalski and Silber (2002) research study.

In summary, most of the earlier research supports the Magnet Model and its impact on patient, nurse and organizational outcomes however recent literature has emerged challenging the consistency of these outcomes resulting in the need for further studies to be conducted.

Horizontal Violence and the New Graduate Nurse

The continued nursing shortage causes a staffing strain on the nursing profession. The stress surrounding poor staffing levels leads to poor patient outcomes (Aiken's et. al, 2002). The importance in understanding the nurse graduate's work environment will allow nurse leaders the ability to identify those characteristics important to graduate nurse's ultimately resulting in increased retention rates. Consequently, the literature contains evidence that new graduates experience HV at consistently alarming rates across all nursing units (McKenna, Smith, Poole & Coverdale, 2003; Smith, Andrusyszyn & Spence Laschinger, 2010; Weaver, 2013). The types of behaviors experienced and outcomes are similar to seasoned nurses. McKenna et al. (2003) studied first year registered nurses in New Zealand who were identified by the Nursing Council of New Zealand from their national register. Nurses who had registered for the state licensing exams in

November 1999, March 2000 and July 2000 were included in the sample. One thousand one hundred and sixty nine (1169) questionnaires were mailed and five hundred and eighty four (584) returned of which thirty three (33) were blank therefore yielding a forty-seven (47%) return rate. Over half the nurses reported being undervalued by other nurses, over one third had learning opportunities blocked, felt neglected, were distressed by the conflict and were thought to have been given too much responsibility without adequate support. Overt behaviors such as experiencing rude, abusive, humiliating and critical comments along with sexual harassment (5%), racial comments (4%), harassment through the formal complaint process (3%) and verbal threats (3%) were reported. However, no significance was noted between the any of the service areas worked in. Undervalued feelings were experienced by those under 30 years old as well as being given too much responsibility without appropriate support. Those above 30 years old were more often verbally abused. The most distressing incidents described included: rude, abusive or humiliating comments (41%) followed by being given too much responsibility without supervision (24%) and these were also graded as moderate to severe in regards to the level of distress by sixty six percent (66%) of the participants. Forty five (45) participants did mention that

these behaviors were experienced when engaging with someone that they reported to, however specific titles were never mentioned, but inferred. Seventy percent (70%) of the incidents occurred on the inpatient units from females (83%) between 30 - 49 years of age. Only forty nine percent (49%) reported these events and twelve percent (12%) received debriefing or counseling following an event. As a result of the consequence of experiencing HV, graduate RNs reported the following outcomes:

1. Reduced self-esteem (N=41)
2. Psychological (N= 33)
3. Physical (N=12)
4. Decreased patient safety (N=4)
5. Disappointment in the profession (N=4)

The data was collected using the Impact of Event Scale and an overall mean score of 12.1 was obtained of which twelve (12) incidents scored above thirty (30) which was representative of post-traumatic stress disorder. Fourteen percent (14%) of participants required days off from work and thirty four percent (34%) considered leaving the nursing profession. Other consequences included nurses relocating their area of work (N=17), intend to leave nursing (N= 14) or they had remained in the area (N=11). Forty one percent (41%) had received training which

they felt was adequate. Smith et al. (2010) found that the structure of a nurse's work environment played a vital role in molding the behaviors and attitudes of new nurses. Ninety point four percent (90.4%) of staff nurses reported that they had experienced some degree of incivility from their peers. Structural empowerment, psychological empowerment and workplace incivility were determined to be important predictors of commitment in newly graduated nurses towards their employer.

Weaver (2013) described both the outcomes of HV on new nurse retention rates as well as strategies to overcome and limit HV. She concluded that new nurses are at risk for higher rates of HV because they lack experience as a nurse as they transition into the profession and are often targeted by senior nurses. Negative physical and psychological are results of the stress experienced. Higher turnover rates are experienced as well as new graduates nurses ultimately leaving the profession. Rocker (2008) noted that new graduate nurses learn the behaviors of HV and often include them as part of their work behavior, thus making the cycle repetitive. She also reports that sixty percent (60%) of new graduate nurses leave their position within the first year. Cho et al. (2012) reported that almost eighteen percent (17.7%) of new graduate nurses leave their first position within the first year, thirty three

percent (33.4%) in their second year and forty six percent (46.3%) in their third year of employment. Interpersonal relationships were the primary reason for new graduate nurse turnover. Weaver, 2013 describes strategies to correct HV. These are recommended to start in nursing school. Sincox and Fitzpatrick (2008) noted that HV may begin during clinical nursing rotations. As nurses enter the profession, individual accountability and reporting of such incidences to management needs to be encouraged. Organizations can respond by having policies and procedures in place that are zero tolerance based and enforced. Mentor programs, whereby the senior nurse mentors the new graduate may prove to be beneficial in combating HV as these nurses foster their professional relationships. In conclusion, schools curricula, the individual, the organization and national nursing organizations all play a role in implementing strategies to reduce HV.

The Briles' Sabotage Savvy Questionnaire

The Briles' Sabotage Savvy Questionnaire (BSSQ) is the tool that will be used in this study to measure the frequency of Horizontal Violence in nursing. Dunn (2003) defined sabotage as "sabotage when directed at coworkers who are on the same level within an organization's hierarchy, it is called horizontal violence. The presence of

sabotage is an indicator that HV and oppression exist in the workplace" (p. 977). Dunn conducted a descriptive, correlational design study to measure perioperative nurses perceptions of Horizontal Violence in the workplace and levels of job satisfaction (p. 980). In regards to Horizontal Violence, the victim and saboteur roles were measured for frequency utilizing the BSSQ. Job satisfaction was measured utilizing the Index Work Satisfaction Questionnaire (IWS). Dunn reported that the BSSQ was composed of two-parts with 40 questions in each. The participant responses would include the choice of either "no," "not sure," or "yes." Frequencies were then totaled from this information. Each was given a numerical value to calculate the frequencies "no = 0," "not sure = 1," or "yes = 2." Higher scores indicated higher frequencies of being the victim or saboteur in the relationship. Seton Hall University, South Orange, NJ faculty reviewed the BSSQ and provided content validity. Before it was distributed, a Cronbach alpha score of .86 for the victim portion and a Cronbach alpha score of .72 for the saboteur portion were obtained and reported (p. 982). The IWS is also a two part questionnaire. Part one asked respondents to describe their current work environment with fifteen (15) paired comparisons to determine the top six (6) concerns in the workplace. Part two asked respondents to evaluate their satisfaction with their current job. Content validity was

determined after subscales were compared to the overall scale with a significance of p<.0001 (p. 982). The study was conducted in New Jersey. The Association of Operating Room Nurses (AORN) membership was accessed and provided a random sample of 500 RNs from which a 29% return rate was achieved (N = 145). RNs, meeting the inclusion criteria, were mailed a letter of introduction, questionnaires, and a self-addressed stamped envelope to their home. Respondents had 14 -21 days to complete and return the surveys.

The demographic results revealed an age range from 31- 68 years with a mean of 47.7 years (SD = 8.4) and a median age of 46 years. Ninety-eight percent (98%) were female, eighty-six percent (86.2%) were Caucasian, fifteen percent (15%) had a Master's Degree or higher and eighty three percent (83%) had achieved CNOR certification. Experience as a perioperative nurse ranged from 2 - 43 years (M = 21; SD = 8.2) and fifty five percent (55.6%) were staff nurses.

The BSSQ reported that the most frequent form of sabotage or HV was "being expected to do another's work" (M = 1.76; SD = .64). Saboteurs report that the most frequent method of victimizing someone was to "cease talking when others entered" (M = 1.32; SD = .91) and "complaining about another without speaking to them about it first" (M = 1.05; SD = .98) (p. 984).

The IWS reported that autonomy was the most important workplace concern followed next by professional status. The results of the BSSQ and the IWS were correlated. The IWS range for scores is between .9-37.1. The higher the score indicates higher work satisfaction. A mean IWS score of 11.91 (SD = 2.42) was obtained from the sample. A positive correlation was noted between being victimized and IWS scores ($r = 35$, $p<.01$). No significant correlation existed between IWS scores and reports of sabotaging others ($r = .08$), age ($r = -.02$), number of years in perioperative nursing ($r = -.001$). There was a positive correlation between those who reported to be victims of sabotage and those who reported to be saboteurs ($r = .46$, $p<.01$).

In conclusion this study showed the opposite of what was expected in regards to sabotage or HV and workplace satisfaction in that a positive correlation between the two was obtained. Dunn applied the Theory of Cognitive Dissonance as one reason as to why this happened. He described that nurses, in an attempt to be happy at work, could have minimized the proportion of sabotage in their workplace. The nurses may also feel that it is a natural part of their job and have become use to it or that it is too uncomfortable a topic to discuss at all. Dunn did acknowledge possible limitations surrounding the internal validity of the tool due to concerns surrounding

uncomfortable nature of the information being requested and the generalizability of this study beyond the NJ AORN membership.

Discussion

If nursing is considered a caring profession, then why do nurses continue to respond negatively towards their peers? The two ideas appear to contradict each other. According to Woelfle et al. (2007) "Vonfrolio, 2005 suggests that nurses are emotionally, spiritually and physically drained after administering patient care and have nothing left in reserve to maintain their peer relationships." Rowell (2005) suggests that as adults we carry with us lifelong unresolved issues which can result in HV behaviors towards others. Woelfle et al. (2007) gave merit to these two ideas, but states that "they do not justify a profession based on caring for others." The review of the literature supports that HV is prevalent throughout the nursing profession and contributes to negative physical and psychological outcomes for nurses as well as untoward patient care and organizational outcomes. Thomas (2003) and Rodwell et al. (2012) report increased depression and burnout rates among nurses. Woelfe & McCaffrey (2007) report increases in sick time and over-time among nurses and Rodwell et al. (2012) report an increase in patient complaints. The literature is clear in identifying that

this is a widespread international and national problem facing the nursing profession with prevalence rates ranging from 5% - 67% (Johnson, 2009; Simons, 2008; Spector, Zho & Xuan Che, 2013). The number of studies in the United States is limited, however they are steadily growing. Based upon the available literature the importance of this topic in our country is clear and conversations must begin so that we can determine what strategies should be implemented that could potentially lower the rates of HV. The literature discusses preventative techniques and suggests that HV is best addressed first by providing education and increasing awareness among nurses. The education should first focus on describing HV to nurses and then suggests strategies to decrease its prevalence. Recommended strategies to decrease the prevalence include: role modeling, personal self-reflection, zero-tolerance and teamwork (Egues and Leinung, 2013). Role modeling requires nurses to possess the positive behaviors that are the opposite of HV. A nurse who successfully confronts the aggressor in a professional manner would be labeled as a role model for those nurses who observed the negative encounter. Thus, the role model's behaviors would become what the observer learns to choose as their response in the future if HV presented itself. This type of learning through the modeling of behavior supports the tenets of Bandura's Social

Learning Theory. Managers also need to be role models in their daily interactions with staff. Nurse Managers who denounce HV behaviors and confront the aggressor will ultimately diminish the frequency on their nursing unit by acting as role models. Personal self-reflection is also a technique used to solve HV. Reflecting on one's own behavior can provide valuable information as to whether HV behaviors were experienced or whether HV behaviors were delivered to a peer. This can be an uncomfortable exercise to perform but could provide beneficial results and increase critical thinking during these encounters. Zero-tolerance of HV is another technique and is clearly supported by the leaders in the nursing profession. As mentioned previously, the Organization of Nurse Executives of New Jersey (2010) is an example of a nursing organization that has denounced HV and bullying in the workplace by endorsing a position statement supporting healthy work environments for nurses. The last technique described in the literature surrounds teamwork. Teamwork in nursing cannot be overemphasized. Caring for patients is complex and the decisions that accompany the care provided are critically important. Open and honest communication between team members is essential and unacceptable behavior needs to be denounced in order to sustain the team approach. As newer nurse's witness more experienced nurses

handle HV successfully they will follow in their footsteps and eventually HV will be minimized within the nursing profession.

Specific behaviors have been identified that limit the prevalence of HV between peers. Cleary, Hunt & Horsfall (2010) encourage colleagues to "accept their fair share of work; cooperate with others; give help when needed; ask for assistance and advice; do not question others about their private lives and don't criticize supervisors" (p. 334). Granstra (2015) notes that not only the nurse but "the entire Infrastructure within healthcare needs to be addressed so that all healthcare professionals are equally valued and respected" (p. 254). Nurse educators also need to teach students how to positively interact with each other; the culture needs to change whereby the nurse is able to express themselves and policies need to align with the goals and mission of the organization in order to support the nurse thus improving their work environment.

Federal organizations, the healthcare industry and professional nursing organizations recognize this disruptive behavior and have responded by formulating regulations, position statements, policies and preventative techniques to guide hospitals in decreasing their rates. With the recent advent of Magnet Certification and the resulting changes that occur to the structure of the nurse's work environment,

research has thus far focused on comparing specific patient, organizational and nurse variables between Magnet and non-Magnet hospitals, but has not sufficiently looked for differences in HV rates between each. This is important because if the negative behaviors exhibited by peers towards each other causes an intimidating work environment, then there may be a reluctance of the nurse to ask for help, which could inevitably cause delays in patient care resulting in poor outcomes. Through the Magnet Vision, the Magnet structure and the Fourteen Forces of Magnetism, the Magnet Organization defines those hospitals certified as having healthy nurse work environments therefore the rates of HV should be lower at Magnet hospitals because of these healthy work environments. The outcomes for patients, nurses and organizations should also be better than Magnet hospitals. New graduate nurses have also been identified as a subgroup of nurses who experience HV more frequently primarily because of their lack of experience (McKenna et al., 2003). However, additional studies also report that all nurses across the continuum have witnessed or experienced these disruptive behaviors at one time or another (Johnson, 2009; Simons, 2008).

The Briles' Sabotage Savvy Questionnaire (BSSQ) is the tool that will be used to measure the frequency of Horizontal Violence in nursing.

Dunn (2003) utilized this tool when measuring the frequency of HV in the peri-operative environment. Nurses were surveyed in respect to two roles: the victim and saboteur. The tool was validated with a Cronbach alpha score of .86 for the victim portion and a Cronbach alpha score of .72 for the saboteur portion (p. 982). The BSSQ reported that the most frequent form of sabotage was "being expected to do another's work" (M=1.76; SD = .64). Saboteurs reported that the most frequent method of victimizing someone was to "cease talking when others entered" (M= 1.32; SD = .91) and "complaining about another without speaking to them about it first" (M= 1.05; SD = .98) (p. 984).

With the continued focus of the healthcare industry on increased productivity, improved retention rates, decreasing turnover rates, increasing patient satisfaction and quality indicator scores, the need to study the impact of the nurses work environment as evidenced by the rates and outcomes of HV in nursing is important in order to impact each of these factors in a positive manner.

Therefore, the central purpose of this study was to determine whether Magnet Hospitals in New Jersey (N.J.) produce different prevalence rates of HV than non-Magnet Hospitals in N.J as measured by the Briles' Sabotage Savvy Questionnaire.

Chapter III

METHODOLOGY

Sample and Setting

The study was conducted in two phases. Phase one (1) included one (1) Magnet Hospital in Central New Jersey and one (1) non-Magnet Hospital in Central New Jersey (Appendix I). Phase one (1) was conducted from 1/5/15 – 2/4/15 for the Magnet Medical Center and 1/7/15 – 2/4/15 for the non-Magnet Medical Center. Phase one served to assess the study methods and informed Phase 2 if changes were required. Phase one data was merged with Phase two data for final data analysis as no methodological changes were required following Phase one.

Phase two (2) included one (1) Magnet Hospital System located in Southern New Jersey and one (1) non-Magnet Hospital located in Central New Jersey were included as part of a convenience sample. Phase two (2) was conducted from 9/23/15 – 10/23/15 for the non-Magnet Hospital and from 10/12/15 – 11/11/15 for the Magnet Hospitals. Direct care RNs employed at these two (2) organizations/systems were administered a demographic questionnaire and the Briles' Sabotage

Savvy Questionnaire in order to assess certain demographic information (ie: age, education, years of service); the frequencies of Horizontal Violence between staff nurses at Magnet and non-Magnet hospitals and the establishment of themes surrounding the experience of the bedside RN as it relates to HV.

In order to calculate the sample size required, G*Power (2011) software was utilized for a medium-effect size of .30, a power level of .80, DF = 5 and an alpha level of .05 (G*Power, 2011), (Figure 1). The sample size required was calculated to be 143 RNs. A convenience sample of direct care, bedside RNs were sampled from both facilities. The Magnet Hospital was part of a healthcare system and includes two acute care hospitals. Both campuses were not-for-profit, three time designees of Magnet Certification, comprised of 598 beds, and were teaching facilities. The non-Magnet Hospital was part of a larger healthcare system, was a not-for-profit, comprised of 527 beds, and had a Physician Residency Program consisting of eight medical-surgical specialties.

The inclusion criteria consist of Acute Care RNs licensed in New Jersey who were employed at the specified Magnet or non-Magnet Hospitals and report to either the medical, surgical, medical/surgical, telemetry, oncology, critical care, emergency department, short stay,

endoscopy, maternal child health services, outpatient infusion, operating room, post anesthesia care unit and psychiatric nursing units at the start of their shift for a patient care assignment in order to provide direct, patient care and are classified in the same job code.

The exclusion criteria consist of all other Registered Nurses who did not work on any of the previously listed nursing units as direct bedside nurses including agency and float pool nurses.

Instrumentation

The instrument used was titled "The Briles' Sabotage Savvy Questionnaire". It consists of two sections, victim and saboteur, and contains a total of 74 questions. The participants were asked to select "0= no", "1= not-sure", or "2= yes" after reading each question. Scores received indicated frequencies of Horizontal Violence. The higher the score indicated a higher perception of incidence regarding Horizontal Violence by the staff nurse. Included in the survey were two open ended questions that were used as part of the qualitative research. These questions were used to ascertain a more complete picture of what was occurring in the nurse's work environment as it pertains to HV. The central question was defined as "What does sabotaging behavior look like in the hospital setting and how do RNs react to it?"

The two sub-questions used from the BSSQ to answer the central question were:

1. "Is there sabotaging or abusive behavior in your current workplace?" Yes, No, Not Sure

"If Yes, in what form have you observed or experienced it: _____"

2."What do you do when it happens to you?

"Hope someone intervenes, confront it, ignore it, deny that it happened, other (please describe) _____"

Content validity of the questionnaire was conducted by Seton Hall University faculty. A Cronbach's alpha score of .86 for the Sabotage Savvy Victim portion of the questionnaire and .72 for the Sabotage Savvy Saboteur portion of the questionnaire was also obtained. This tool has been previously used in studies conducted by Dunn (2003), Sellers et al. (2005) and Vessey (2011).

In addition to the Briles' Sabotage Savvy Questionnaire, the respondents were asked to voluntarily complete a demographic questionnaire that included questions pertaining to age, years of experience, type of nursing unit employed, country where their education occurred, and educational level.

Procedure

Initially, the primary researcher contacted the Chief Nursing Officers at the Magnet and non-Magnet Hospitals to discuss the purpose of the study and to garnish support. Both Chief Nursing Officers supported the research being conducted at their facility and provided the contact information for the nurse researchers at their respective hospitals. The nurse researchers provided guidance on how to conduct the research at their facility, the necessary meetings to attend and appropriate forms to complete. After obtaining IRB approval from the Magnet Hospital, non-Magnet Hospital and Seton Hall University the following methodology was followed:

A. Magnet Hospital

The primary researcher attended the Nurse Manager Meeting which included the Nurse Managers from the units identified in the inclusion criteria in order to explain the research proposal. After approval had been received from the Magnet Health System's IRB and Seton Hall University's IRB, the study was conducted as follows:

Solicitation letters (Appendix B) were distributed to the Nurse Managers and placed in staff mailboxes (electronic or physical) at the Magnet Hospitals. A solicitation letter was also posted on the bulletin board in the nurse's lounge of each nursing unit. The solicitation letter

instructed the RNs to access the hospital intranet linking them to the Briles' Sabotage Savvy Questionnaire through a link to Survey Monkey, if they were interested in voluntarily participating in the study. The hospital intranet was accessible to staff at work and at home and participants were able to complete the survey in the location of their choice independently and quietly. On day 14, a flyer was posted in the nurse's lounge encouraging participation and alerting nurses to the approaching deadline (Appendix A). Participants were provided 31 days to complete the survey. It was estimated to take 7-10 minutes to complete.

B. Non-Magnet Hospital

The primary researcher attended the Nurse Manager Meeting which included the Nurse Manager of each nursing unit outlined in the inclusion criteria in order to explain the research proposal. After approval had been received from the non-Magnet's Medical Center's IRB and Seton Hall University's IRB, the study was conducted as follows:

Solicitation letters (Appendix B) were distributed to the Nurse Managers and placed in staff mailboxes (electronic or physical) at the non-Magnet Hospital. A solicitation letter was also posted on the bulletin board in the nurse's lounge of each nursing unit. The solicitation letter instructed the RNs to access the hospital intranet linking them to

the Briles' Sabotage Savvy Questionnaire through link to Survey Monkey, if they were interested in voluntarily participating in the study. The hospital intranet is accessible to staff at work and at home and participants were able to complete the survey in the location of their choice independently and quietly. On day 14, a flyer was posted in the nurse's lounge encouraging participation and alerting nurses to the approaching deadline (Appendix A). Participants were provided 31 days to complete the survey. It was estimated to take 7-10 minutes to complete.

No discomforts associated with this research study were anticipated nor reported. There were no risks associated with this study. Participants may or may not have experienced any direct benefits from participation however the organizations involved may proceed in developing educational programs focused on heightening awareness and preventing Horizontal Violence. Additionally, information collected in this study may benefit other RNs and acute care hospitals in the future by helping to heighten the awareness of Horizontal Violence in the nursing profession and potentially changing unhealthy nursing work environments that currently exist to healthy nursing work environments.

Confidentiality measures included that surveys were collected through a link to Survey Monkey and no identifiable information was

collected by the researcher. Survey Monkey "allowed authors to disable the storage of email addresses and disable IP address collection for all collection methods so that they could collect anonymous survey responses."

Data Analysis

A mixed method design was used to assess the prevalence rates of Horizontal Violence as well as to explore and explain HV in greater detail. A concurrent embedded approach was used to explore the quantitative and qualitative data in order to ascertain more information as to the experience of the nurse as it relates to HV. The quantitative data was examined using a Descriptive/Quasi Experimental Design because the researcher was examining what was naturally occurring in the environment and therefore there was no manipulation of it. Cause and effect were not being ascertained and survey methodology was utilized. The quantitative analysis for the descriptive design includes frequencies and percentages for the demographics of participants and the prevalence of HV between Magnet and non-Magnet Hospitals. Additionally the Chi Square Test of Difference was used to assess the differences between hospital type, education, less than 3 years of licensed experienced, specialty unit and the frequency of HV. The Explanatory and Textual Design were used for

the qualitative portion of the study. According to Creswell & Clark (2011), "the Explanatory Design uses qualitative comments in order to explain the initial quantitative results and to identify trends" (p. 82). Similarly McKee (2003) notes that when "textual analysis is performed on a text, we make an educated guess at some or most likely interpretations that might be made of that text. Additionally, qualitative analysis allows for a variety of ways to interpret reality" (p. 1). Content analysis was the approach utilized to conduct the textual analysis. Frey, Botan and Kreps (1999) note that "Researchers are more interested in the meanings associated with messages than with the number of times a message variable occurs." The text selected to be analyzed included the answers to the two open ended questions embedded within the Briles' Sabotage Savvy Questionnaire. The units of analysis applied are syntactical and thematic. Syntactical units allow for the use of words and sentences to be analyzed and thematic units identify the common topics embedded in the messages. Textual analysis was conducted utilizing SPSS. The most frequent words used by respondents to describe HV was reported and counted (Table 7). The central question was "What does sabotaging behavior look like in the hospital setting and how do RNs react to it?" The two sub-questions used from the BSSQ to answer the central question were:

1. "Is there sabotaging or abusive behavior in your current workplace?" Yes, No, Not Sure

   "If Yes, in what form have you observed or experienced it: ____"

2. "What do you do when it happens to you?

   "Hope someone intervenes, confront it, ignore it, deny that it happened, other (please describe) _____"

Triangulation was ascertained by analyzing the qualitative data further by using the following techniques:

1. The transcribing the data as reported across cases (surveys).
2. The coding or grouping the statements in order to assess the essence of HV.
3. The transformation of data was utilized when the PI used codes to develop themes by aggregating similar codes together.
4. Two researchers (PI and another) conducted inter-coder agreement by independently identifying the codes, compared their results codes to use.
5. Inter-relating themes were connected. The primary researcher sought agreement with the second rater to ensure validity.

6. The two data sets were merged to conduct concurrent data analysis and understand the complete picture (Creswell & Clark, 2011).

Integrating the qualitative and quantitative data met the intent of the Concurrent Embedded Design.

Chapter IV

Results

Demographic Sample Information

One thousand and seven (1007) RNs were distributed the Briles' Sabotage Savvy Questionnaire. The composition of this distribution included five hundred and eighty five (585) Magnet RNs and four hundred and twenty two (422) non-Magnet RNs. Surveys were accessed and completed utilizing Survey Monkey. Two hundred and seventy seven (277) surveys were returned (28%). Of these surveys eighty eight (88) were discarded (32%) which consisted of thirty eight (38) incomplete; twenty two (22) were exclusionary departments/units ie: maintenance; twenty eight (28) were exclusionary personnel type ie: management. These surveys were excluded and reduced the sample by thirty two percent (32%). The final sample included one hundred and ninety three (193) surveys or seventy percent (70%) of the surveys received and consisted of one hundred and forty four (144) Magnet surveys (75%) and forty nine (49) non-Magnet surveys (25%). The final response rate was nineteen percent (19%). More specifically, the

Magnet Hospitals had a twenty five (25%) response rate and the non-Magnet Hospital had a twelve percent (12%) response rate.

The final sample composed of both Magnet and non-Magnet hospitals consisted of one hundred and ninety three (193) nurse participants which included one hundred eighty three (96%) females and eight (4%) males. The age of the registered nurses ranged from nineteen to seventy six (19 - 76). Specifically, ages nineteen (19) to thirty one (31) represented twenty three percent (23%) of the sample; ages thirty two (32) to forty seven (47) represented thirty three percent (33%) of the sample, and ages forty eight (48) to seventy six (76) represented forty four percent (44%) of the sample. One respondent skipped this question. The majority of the sample was Caucasian (76%) followed by Asian/Pacific Islander (14%), would rather not say (4.66%), Black (4.15%), Multiracial (2.07%), Latino (1.04%) and Hispanic (.52%). The educational level of the registered nurses included: Bachelor Degrees in Nursing 58.6%, Associate Degree in Nursing 21%, Master's Degrees in Nursing 8.8%, Diploma nursing school certificate 7.8%, other 2%, some college credit 1.6%, vocational training .5% and 0% nurses with doctoral degrees. Total nursing experience ranged from less than 1 year to greater than 25 years and was composed of: less than 1 year 4.69%, two to three years 11.62%, four to seven 17.2 %, eight to twelve 14 %,

thirteen to seven 9.4 %, eighteen to twenty five 17.2 %, eighteen to twenty five 17.19 %, more than twenty five years 25.5 %. One respondent skipped this question. Most nurses were trained in the United States (89%) followed by the Philippines (10%), India (.01) and Poland (.005).

Quantitative Findings

Ha1: The prevalence rates of HV experienced by Registered Nurses in N.J. Magnet Hospitals *will be significantly less* than non-Magnet Hospitals.

The sampling of one hundred and ninety three (193) Registered Nurses evaluated the differences of HV prevalence rates between Magnet and non-Magnet Hospitals. This included (*f* = 52)) Magnet RNs that responded yes to HV and (*f* = 17) non-Magnet RNs that responded yes to HV. The data was analyzed using chi square test of differences. The null hypothesis was rejected, $X^2(1) = 17.75$, $p = .0001$ (Table 7). According to the cross-tabulation analysis and bar graph distribution 34.7% of RNs working at the Magnet facility experienced HV or 75% of the frequency compared to 33% of the RNs or 25% of the frequency at the non-Magnet facilities (Table 6) and (Figure 3). A post hoc analysis resulted in an effect size = .3, odds ratio o= 1.03 and a power of .98.

Table 6.
Cross-tabulation of the Prevalence of HV: Magnet vs non-Magnet

Magnet, non-Magnet * Frequency Crosstabulation

			Frequency			
			Yes	No	Not Sure	Total
Magnet, non-Magnet	Magnet	Count	52	74	24	150
		Expected Count	51.5	74.6	23.9	150.0
		% within Magnet, non-Magnet	34.7%	49.3%	16.0%	100.0%
		% within Frequency	75.4%	74.0%	75.0%	74.6%
	non-Magnet	Count	17	26	8	51
		Expected Count	17.5	25.4	8.1	51.0
		% within Magnet, non-Magnet	33.3%	51.0%	15.7%	100.0%
		% within Frequency	24.6%	26.0%	25.0%	25.4%
Total		Count	69	100	32	201
		Expected Count	69.0	100.0	32.0	201.0
		% within Magnet, non-Magnet	34.3%	49.8%	15.9%	100.0%
		% within Frequency	100.0%	100.0%	100.0%	100.0%

Figure 3.
Prevalence of HV between Magnet and non-Magnet Hospitals

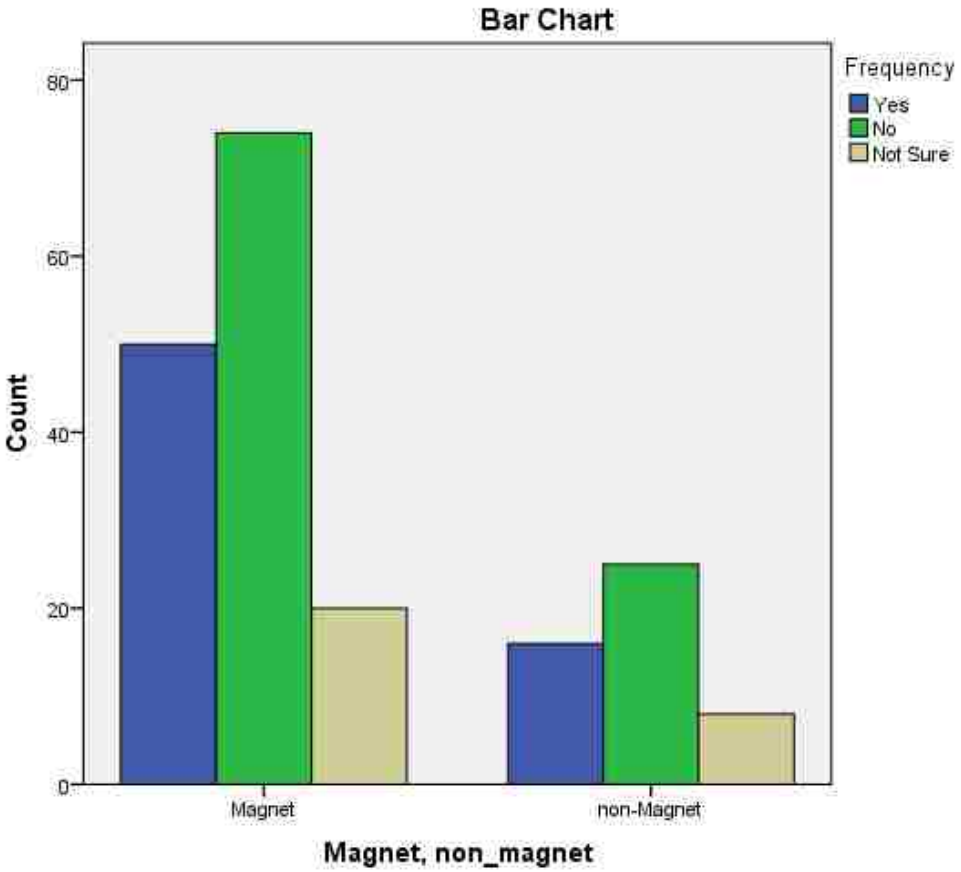


Table 7.
Chi square Test of Differences: Prevalence of HV Magnet vs non-Magnet Hospitals.

Test Statistics

	Magnet, non_magnet
Chi-Square	17.754[a]
Df	1
Asymp. Sig.	.000

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 34.5.

Ha2: The prevalence rates of HV experienced by Registered Nurses in N.J. Magnet Hospitals with ≤ 7 years of licensed experience *will be significantly less* than non-Magnet Hospitals.

The sampling of one hundred and ninety three (193) Registered Nurses evaluated the differences of HV prevalence rates between Magnet and non-Magnet Hospitals in which 65 RNs responded that they had ≤ 7 years of experience. This included (*f* = 14)) Magnet RNs that responded yes to HV and (*f* = 8) non-Magnet RNs that responded yes to HV. The data was analyzed using chi square test of differences. The null hypothesis was not rejected, $X^2(1) = 1.64$, $p = .201$ (Table 9). According to the cross-tabulation analysis 14 RNs working at the Magnet facility experienced HV compared to 8 of the RNs at the non-Magnet facilities (Table 8). There were no significant differences in HV experienced by nurses with ≤ 7 years of experience at Magnet and non-Magnet Hospitals.

Table 8.
Frequency of HV for RNs with ≤ 7 years' experience between Magnet and non-Magnet Hospitals - Crosstabulation.

Count

Frequency			Magnet, non_magnet		
			Magnet	non-Magnet	Total
Yes	Number	Skipped	0	1	1
		less than 1 yr	0	3	3
		2-3 yrs	3	2	5
		4-7 yrs	11	2	13
	Total		14	8	22
Total	Number	Skipped	0	1	1
		less than 1 yr	0	3	3
		2-3 yrs	3	2	5
		4-7 yrs	11	2	13
	Total		14	8	22

Figure 4.

Frequency of HV for RNs with ≤ 7years experience between Magnet and non-Magnet Hospitals.

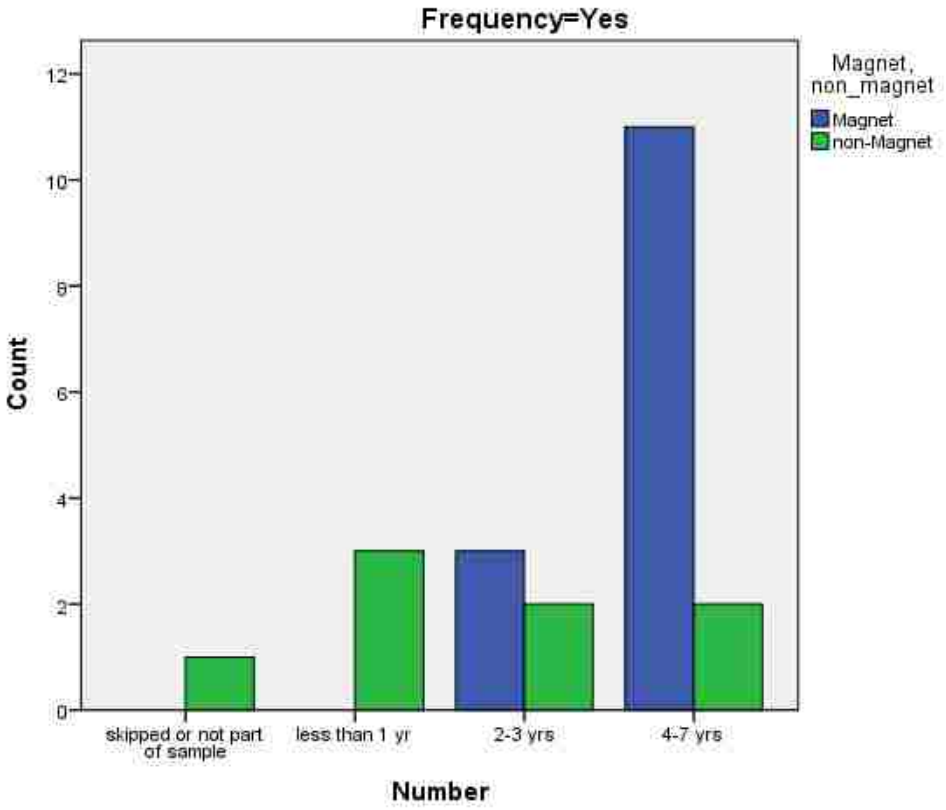


Table 9.

Chi square - frequency of HV for RNs with ≤ 7 years of experience between Magnet and non-Magnet Hospitals.

Test Statistics

	Magnet, non_magnet
Chi-Square	1.636[a]
Df	1
Asymp. Sig.	.201

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 11.0.

Ha3: The prevalence rates of HV experienced by RNs with B.S.N or higher academic degrees at NJ Magnet hospitals *will be significantly less* than those at non-Magnet Hospitals.

The total sampling of one hundred and ninety three (193) Registered Nurses evaluated the differences of HV prevalence rates with BSN or higher education levels between Magnet and non-Magnet Hospitals. The results included 116 Bachelor and 18 Master's prepared nurses. There were no PhD RNs that responded to the survey. Further breakdown included 82 Magnet RNs with a Bachelor's Degree and 15 Master's Degree prepared RNs. There were 34 non-Magnet Bachelor's Degree and 3 Master's Degree prepared RNs. This was further analyzed to include (*f* = 27)) or 69.2% BSN Magnet RNs that responded yes to HV and (*f* = 12) or 30.8% BSN non-Magnet RNs that responded yes to HV. This also included (f = 8) or 80% Master's prepared Magnet RNs that responded yes to HV and (f=2) or 20% Master's prepared non-Magnet RNs. The data was analyzed using chi square test of differences. The hypothesis was rejected, $X^2(1) = 9$, $p = .003$ (Table 10). Thirty five percent (35%) of Magnet nurses with BSN or higher degrees had higher prevalence rates of HV than non- Magnet RNs (14%), (Table 11) and (Figure 5). A post hoc analysis resulted in an effect size .3, odds ratio .93 and power = .93.

Table 10.
Chi-Square: Frequency of HV for BSN or higher academic degrees between Magnet and non-Magnet Hospitals.

Test Statistics

	Magnet, non_magnet
Chi-Square	9.000[a]
Df	1
Asymp. Sig.	.003

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 24.5.

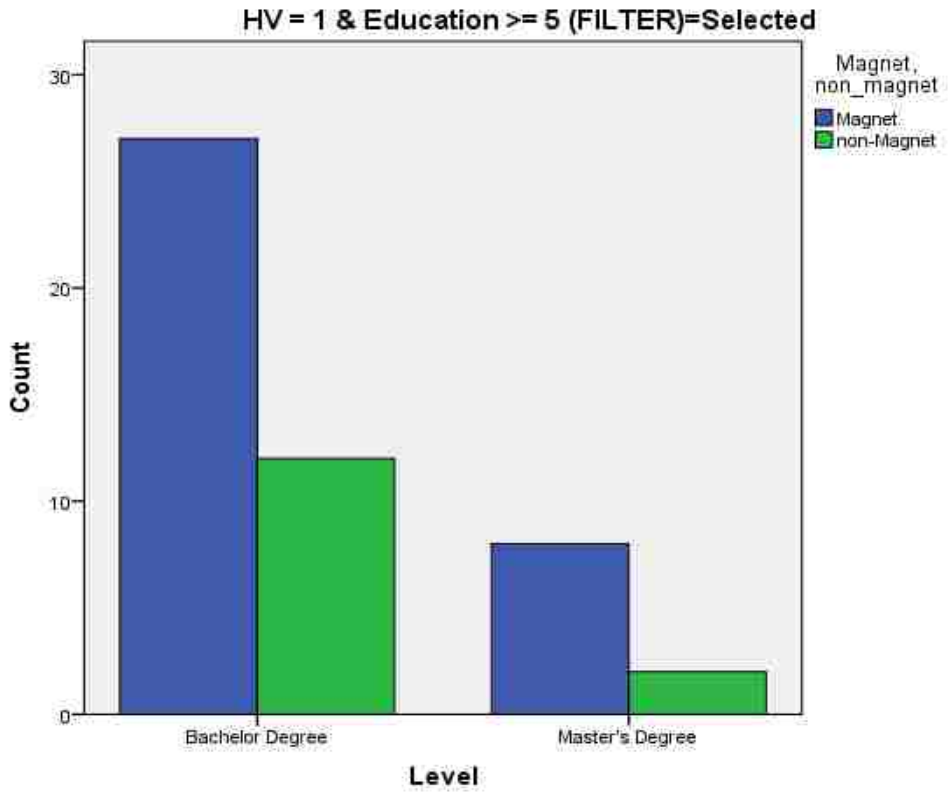
Table 11.
Crosstabulation – frequency of HV for BSN or higher academic degrees between Magnet and non-Magnet Hospitals.

Level * Magnet, non_magnet * HV = 1 & Education >= 5 (FILTER) Crosstabulation

HV = 1 & Education >= 5 (FILTER)				Magnet, non-Magnet		
				Magnet	non-Magnet	Total
Selected	Level	Bachelor Degree	Count	27	12	39
			Expected Count	27.9	11.1	39.0
			% within Level	69.2%	30.8%	100.0%
			% within Magnet, non-Magnet	77.1%	85.7%	79.6%
		Master's Degree	Count	8	2	10
			Expected Count	7.1	2.9	10.0
			% within Level	80.0%	20.0%	100.0%
			% within Magnet, non-Magnet	22.9%	14.3%	20.4%
	Total		Count	35	14	49
			Expected Count	35.0	14.0	49.0
			% within Level	71.4%	28.6%	100.0%
			% within Magnet, non-Magnet	100.0%	100.0%	100.0%
Total	Level	Bachelor Degree	Count	27	12	39
			Expected Count	27.9	11.1	39.0
			% within Level	69.2%	30.8%	100.0%
			% within Magnet, non-Magnet	77.1%	85.7%	79.6%
		Master's Degree	Count	8	2	10
			Expected Count	7.1	2.9	10.0
			% within Level	80.0%	20.0%	100.0%
			% within Magnet, non-Magnet	22.9%	14.3%	20.4%

Total	Count	35	14	49
	Expected Count	35.0	14.0	49.0
	% within Level	71.4%	28.6%	100.0%
	% within Magnet, non_magnet	100.0%	100.0%	100.0%

Figure 5.
Frequency of HV for BSN or higher academic degrees between Magnet and non-Magnet Hospitals.



Ha4: The prevalence rates of HV between like specialty divisions at Magnet Hospitals *will be significantly less* than non-Magnet Hospitals.

The total sampling of one hundred and ninety three (193) Registered Nurses evaluated the differences of HV prevalence rates and similar specialty units between Magnet and non-Magnet Hospitals. The data was analyzed using chi square test of differences. The Medical Surgical Division included the medical surgical, medical, oncology and surgical nursing units. The Critical Care Division included the Emergency Department, Telemetry and Critical Care nursing units. The Perioperative Division included the PACU, Short Stay and Operating nursing units. The Maternal Child Health Division included the Labor, Delivery, Recovery, Post Partum, and Special Care Nursery.

The Ho4 for the perioperative division was not accepted $x^2(1) = 9.14$, $p = .002$ (Table 12). Magnet perioperative RNs reported higher HV rates than non-Magnet hospital RNs (Figure 6). A post hoc analysis resulted in an effect size = .6, odds ratio = 1.44 and power = .85.

Table 12.

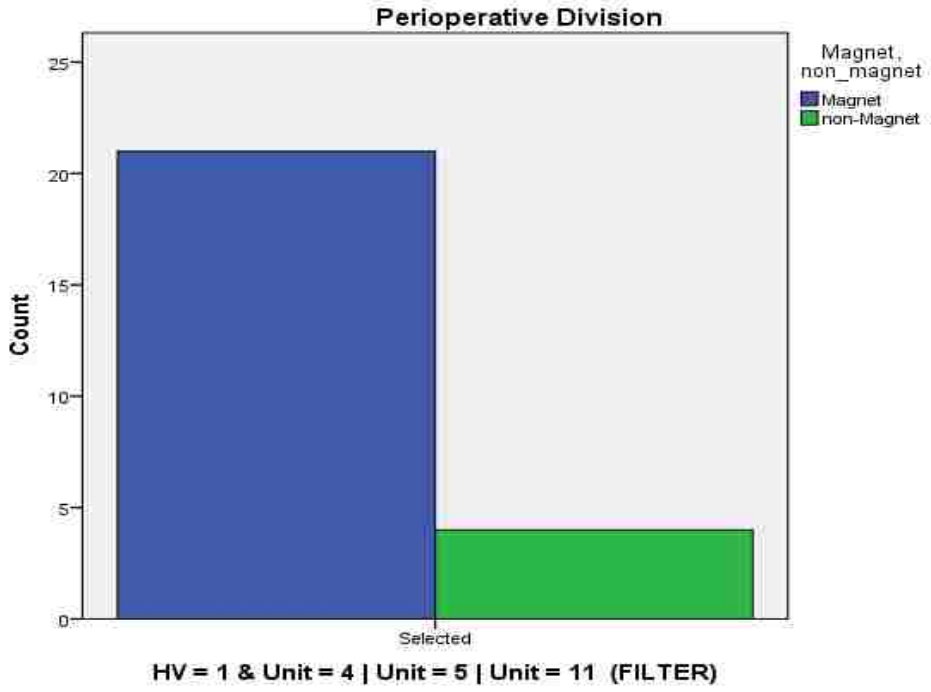
Frequency of HV by specialty division between Magnet and non-Magnet Hospitals - Perioperative.

Test Statistics

	Magnet, non_magnet
Chi-Square	9.143[a]
Df	1
Asymp. Sig.	.002

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 14.0.

Figure 6.
Frequency of HV by specialty division between Magnet and non-Magnet Hospitals - Perioperative.



The Ho4 for the Critical Care Division was rejected $x^2(1) = 35.28$, $p = .0001$ (Table 13). The Magnet Critical Care Division RNs reported higher HV rates (Figure 7). The post hoc analysis resulted in an effect size = .6, odds ratio = 0 and power = .61. The Magnet hospital = 46 RNs responding while the non-Magnet = 4 responses. Specifically 14 Magnet RNs responded yes to HV while 0 non-Magnet RNs responded yes. Although the results are significant, the small sample size of the non-Magnet hospital limits the generalizability of the results.

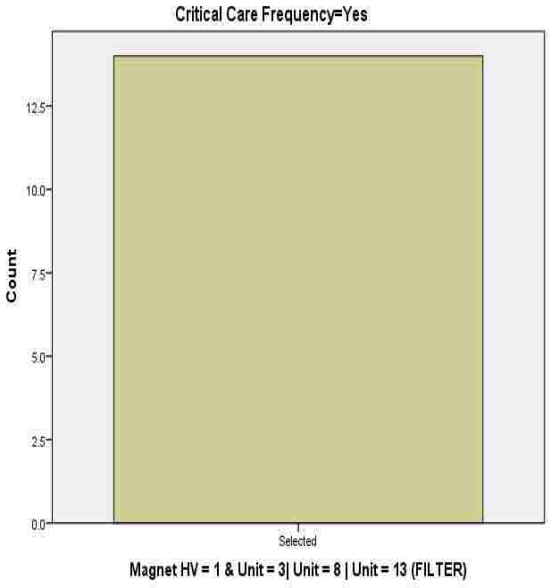
Table 13.
Frequency of HV by specialty division between Magnet and non-Magnet Hospitals – critical care.

Critical Care
Test Statistics

	Magnet, non_magnet
Chi-Square	35.280[a]
Df	1
Asymp. Sig.	.000

0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 25.0.

Figure 7.
Frequency of HV by specialty division between Magnet and non-Magnet Hospitals – Critical Care.



The Ho4 for the Maternal Child Health RNs was accepted x^2 (1) = 1.69, *p* = .194 (Table 14). There were no significant differences in HV between Magnet and non-Magnet Maternal Child Health Division RNs (Figure 8).

Table 14.

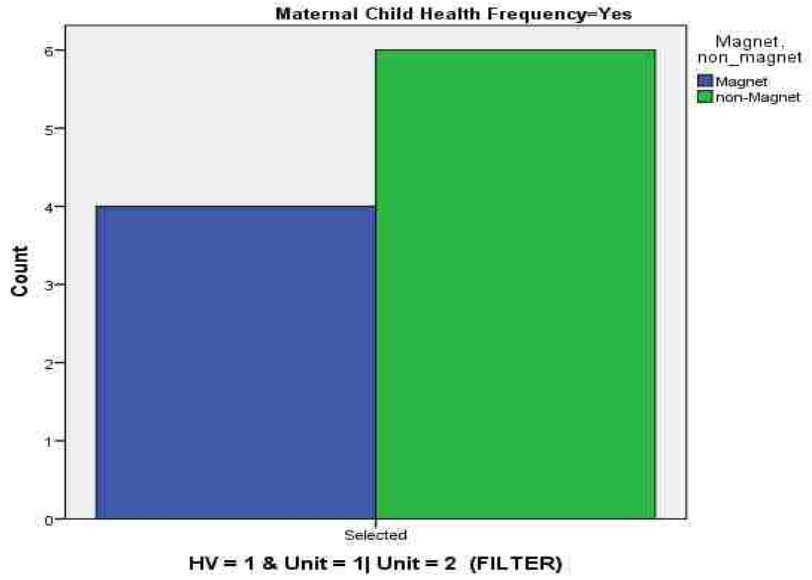
Frequency of HV by specialty divisions between Magnet and non-Magnet hospitals - MCH

Maternal Child Health
Test Statistics

	Magnet, non_magnet
Chi-Square	1.690[a]
Df	1
Asymp. Sig.	.194

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 14.5.

Figure 8.
Frequency of HV by specialty unit between Magnet and non-Magnet - MCH



The Ho4 for the Medical Surgical Divisional RNs was rejected $x^2(1) = 17.52$, $p = .0001$ (Table 15). Magnet Medical Surgical RNs had higher rates of HV than non-Magnet RNs (Figure 9). The post hoc analysis resulted in an effect = .34, odds ratio = .5 and power = .63. There were 23 Magnet RN and 10 non-Magnet RN responses. Of these 7 Magnet RNs answered yes to HV while 6 non-Magnet RNs responded yes. Although the results are significant, the small overall sample size of respondents limits the generalizability of the findings.

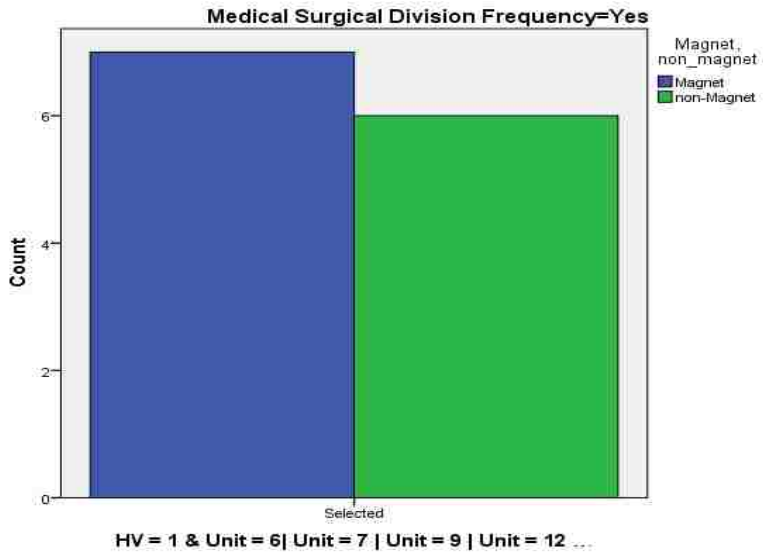
Table 15.
Chi-Square – Prevalence of HV for Medical Surgical Division RNs between Magnet and non-Magnet Hospitals

Medical Surgical
Test Statistics

	Magnet, non_magnet
Chi-Square	17.515[a]
Df	1
Asymp. Sig.	.000

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 33.0.

Figure 9.
Prevalence of HV for Medical Surgical Division RNs between Magnet and non-Magnet Hospitals



Qualitative Findings

As mentioned previously, the central question was "What does sabotaging behavior look like in the hospital setting and how do RNs react to it?" The two sub-questions used from the BSSQ to answer the central question were:

1. (Question 25) "Is there sabotaging or abusive behavior in your current workplace?" Yes, No, Not Sure

   "If Yes, in what form have you observed or experienced it: ____"

2. (Question 32) "What do you do when it happens to you?

"Hope someone intervenes, confront it, ignore it, deny that it happened, other (please describe) _____"

Five themes were ascertained for question 25:

1. *Senior nurses negative behaviors toward newer staff* (Table 16).
2. *Aggressive/Verbal communication as a dominant overt behavior* (Table 17).
3. *Gossip in pursuit of power as a dominant covert behavior* (Table 18).
4. *Manipulating the work environment* (Table 19).
5. *Speaking negatively about a healthcare professional* (Table 20).

Verbatim comments were transcribed from the survey and are included to elaborate on the individual themes and coding used to indicate inter-coder agreement. They are noted by either:

Rater 1 (R1) = Primary investigator selection only.

Rater 2 (R2) = Secondary rater selection only.

*Both raters selected the statement (Tables 16-20).

Table 16.
Theme 1

Theme 1: *Nurses eat their young (R1)*
Senior Nurse's Negative Behaviors Toward Newer Staff *(R1&R2)-* ***Final Theme***

Respondent #	Descriptor
175 *	Older nurse, wanting the easy assignment and refusing to take an assignment. Forcing other newer RNs to take the rough assignment.
113 *	The nurse's eat their young issue is alive and well here. We have middle nurses who were "raised" by older nurses and left to their own devices. Now the middle nurses do not help the younger nurses."
102 *	The more experienced nurses can tend to bully those that aren't as knowledgeable. I feel they do this to feel superior. They should instead teach their young. It creates resentment and animosity.
74 *	Passive aggressiveness; stirring up trouble with new staff.
62 *	Older nurses making newer nurses feel inadequate.
1 *	Staff RNs making nasty comments to newer nurses, making them feel as though they are not capable of doing the job.

Agreement = 6/6 = 1

Table 17.
Theme 2

Theme 2: Aggressive/Verbal communication as a dominant overt behavior (R1)- Final Theme
Aggressive Communication/Bullying (R2)

Respondent #	Descriptor
168 *	Verbal abuse, veiled threats, punitive punishment with scheduling.
162 (R1)	Threats, demeaning my character
159 (R1)	Verbal bullying
147*	Use of foul language from management level and coworkers.
142*	Nurse to Nurse belittling, judgement and passive aggression sometimes ending in a face to face verbal dispute.
124*	Abusive language from PCA's
118 (R2)	Physician bullying
113 (R2)	The nurses eat their young issue is alive and well here. We have middle nurses who were raised by older nurses and left on their own devices. Note the middle nurses do not help the younger ones
112 (R1)	Verbally face to face
105 (R2)	Manipulation; discreet bullying
102 (R2)	The more experienced nurses can tend to bully those that aren't as knowledgeable. I feel they do this to feel superior. They should instead teach their young. It creates resentment and animosity.
97(R1)	Staff members and how they speak to each other.
93*	Impatience and sarcasm.
92*	Another RN speaks very negatively to staff, demeans them in front of other nurses and gossips about them.
74 (R2)	Passive aggressiveness; stirring up trouble with new staff.
51 (R2)	Bullying setting co-workers up for failure; discrimination.
25*	She communicates with other staff abusively and tactlessly and degrades them.
20*	Speaking inappropriately to another co-worker.
19*	Verbal intimidation.
15 (R2)	Horizontal violence.
13*	Verbal abuse.
3*	I see some nurses talking to co-workers with no respect and yelling.
2*	Intimidating choice of words, screaming.

Agreement = 11 / 23 = .5

Table 18.
Theme 3

Theme 3: Gossip in pursuit of power as a dominant covert behavior
*(R1).**Final Theme***
Gossiping (R2).

Respondent #	Descriptor
177 (R1)	Frequent discussion about other nurses who are not present leading you to wonder, what do they say about me.
67*	Gossiping, spreading rumors about a situation they don't know all the details about.
66*	Gossiping, speaking poorly about other co-workers to each other.
63*	Gossiping.
43*	Gossiping, spreading rumors, lying to management, getting others to seek revenge.
14 (R1)	Talking behind your back; cold shoulder.

Agreement = 4/6 = .66 = .7

Table 19.
Theme 4

Theme 4: Manipulating the work environment *in order to exert control (R1).* ***Final Theme***
Manipulation of the Situation/Environment to One Person's Advantage (R2).

Respondent #	Descriptor
181*	Holding back information.
177 *	Cliques that are exclusionary to other staff making others more timid or unwilling to speak up.
173 *	Certain staff are able to skate through a shift without completing the basics and no retribution.
168 *	Verbal abuse, veiled threats, punative punishment with scheduling.
160 (R1)	Nurses treating employees who pump breastmilk poorly. For example, giving them the worst assignment to make it more difficult for them. Have seen management punishing nurses for certain things as sort of a payback. Have seen nurses like to see other nurses fail and not help them. Have seen and heard nurses making up nicknames for nurses they don't like.
141*	Nurse to nurse. Demanding that what they want done, not what is best for the patient or nurses.
132 (R1)	Giving harder assignments to certain staff members or not helping where you might help someone else.
128*	People getting their way by complaining excessively which causes others to cover for them.
98*	Chronic negativity, complaining, refusing to follow policy, bullying so others will do what they do not want to, always get their way because it's easier for staff to give in.
88*	Co-workers manipulate the work load to their advantage.
84*	Nurse aides towards nurses, attitude, avoiding doing things for a particular nurse.
78*	Special treatment.
71*	Punitive environment where opportunities to learn from mistakes are not as important as being written up.
70*	Unbalanced assignments, preferential treatment.
62*	Aids refusing to help nurses they don't like; gossiping, older nurses making newer nurses feel inadequate.
51 (R2)	Setting co-workers up for failure.
50*	Not giving pertinent information; taking equipment.
43 (R2)	Getting others to seek revenge.

Agreement = 14/18 = .8

Table 20.
Theme 5

Theme 5: Speaking negatively about a healthcare professional *(R1)-*
Final Theme
Speak Bad About Another Person (R2)

Respondent #	Descriptor
185*	Frequent discussion about other nurses who are not present leading you to wonder, what do they say about me.
121 (R2)	Nurses will say rude comments to other staff on occasion.
71 (R1)	Would not hesitate to obtain legal counsel if I felt it was warranted based on the situation
58*	Nurse chatter about other nurses.
57*	Being spoke down to, being spoken to in a condescending manner.
53*	Talking bad about someone.
47*	Doctors don't respect nurses and talk down to us. They don't treat us as professionals.
14*	Nasty comments. Talking behind your back.
1 (R2)	Staff RNs making nasty comments to newer nurses; making them feel as though they are not capable of doing the job.

Agreement = 6/9 = .75 = .7

One theme was ascertained for question 32: *Depends on the situation* (Table 21). Verbatim comments were also transcribed and are included to elaborate on the individual themes and coding used to indicate inter-coder agreement. They are noted by either:

Rater 1 (R1) = Primary investigator selection only.

Rater 2 (R2) = Secondary rater selection only.

*Both raters selected the statement (Table 21).

Table 21.
Theme 1

Theme 1: Depends on the situation *(R1 & R2)* - ***Final Theme***

Respondent #	Descriptor
114*	Depends on the situation.
71(R1)	Would not hesitate to obtain legal council if I felt it was warranted based on the situation.
53*	It depends on who is doing the bullying and how comfortable I am confronting them.
14*	At times I will confront but it has to be severe.
11*	Depends on the situation – ignore or speak up.

Agreement = 4/5 = 8

The sabotaging behaviors experienced by RNs in the hospital setting for this study were nonphysical in nature. RNs do not react to their peers consistently when they are confronted by HV behaviors. They react based on their assessment of the severity of the situation. This implies that HV behaviors are purposeful and repetitive in a nurses work

environment. Nurses consciously decide whether or not to react to HV behaviors unwillingly inflicted upon them. These behaviors are exhibited in two ways: overt and covert. Aggressive communication, senior nurse's negative behaviors towards newer nurses and manipulating the environment fall into the overt category. These behaviors are easy for the observer to identify. On the other hand, gossip and speaking negatively about another healthcare worker behind their back are covert behaviors. Observers may not identify these behaviors as easily as overt behaviors. The descriptors written by the RNs suggest that the nurse is responding to HV in an effort to retain or gain control of their environment. Control is an important element in the environment because nurses are providing direct patient care and patient outcomes are at risk if the environment becomes unsettled and chaotic as a result of HV.

Discussion/ Implications

Changing the nurses work environment in order to improve patient, nurse and organizational outcomes has been well documented in the literature (Aiken's, Clarke, Sloane, Sochalski & Silber, 2002; Kelly, McHugh & Aikens, 2011; Laschinger, Shamian & Thomson, 2001; Smokler Lewis & Malecha, 2011; Hickson, 2013; Buffington, Zwink &

Fink, 2012; & Ulrich, Buerhaus, Donelan, Norman & Dittus, 2007). Magnet Certification postulates that the changes to the nurses work environment which results from Magnet status produces healthy work environments and leads to positive outcomes, however, this notion has not been formally assessed. Assessing the nurses work environment is a critical first step in understanding the outcomes that are produced from both positive and negative work environments. Therefore the central question asked in this study was "Are there differences in the prevalence rates of HV between Magnet and non-Magnet hospitals?" The results indicated that differences do exist, $X^2(1) = 17.75$, $p = .0001$ (Table 7). Non-Magnet hospitals experienced HV less than Magnet hospitals. Horizontal violence has been established as prevalent internationally and nationally at rates ranging between 5% - 67% (Johnson, 2009; Simons, 2008; Spector, Zho & Xuan Che, 2013). The HV prevalence rate in this study was 34% and consistent with the literature. There was a 35 % rate of HV at the Magnet hospital and a 32 % rate of HV at the non-Magnet hospital. It is important to understand that when an organization undertakes the Magnet journey to become certified nurse administrators are under an enormous amount of pressure to have their bedside nurses consistently meet and exceed clinical benchmark performances. As observed in this study, HV can be a

byproduct of this highly productive environment as the bedside nurse attempts to control their environment in response to the demands placed upon them. Acknowledging the potential presence of HV as a byproduct of Magnet status presents the nursing profession with opportunities and challenges. HV resembles a black cloud that looms quietly over a hospital. Detecting it can be difficult to the onlooker because quite often the behaviors are covert in nature. As a result, hospital administrators are unaware that a problem exists and thus there are potential implications at the unit level for the patient, nurse and organization that follow. The ISMP Safety Alert (2012) reported that patients experience delays in receiving their care. This may result in poor quality outcomes for patient indicators such as pain control. The organization may experience an increase in sick time, turnover and a decrease in retention (Woelfe & McCaffrey, 2007; Rowell, 2005). The nurse can also experience depression and burnout (Thomas, 2003; Rodwell et al., 2012). Each of these clinical implications ultimately impacts the organizations financial performance. Aligning outcomes with organization financial performance is important because "in a new study, published in the May issue of *Medical Care*, it was noted that becoming a Magnet Hospital also increases revenue by an average of $1,229,770 to $1,263,926 annually."

and therefore makes it a highly aspired acquisition.

Alternately, acknowledging HV existence as a byproduct of the Magnet environment affords healthcare professionals and managers the opportunity to address HV head on. The literature recommends different approaches to addressing HV. Egues, A.L. & Leinung, E.Z. (2013); Briles, J. (1995) provide specific strategies for nurse administrators and staff to consider when formulating a plan to address this phenomena. Creating an awareness of the existence of HV in the nursing profession is the initial starting point. This awareness should occur in a number of arenas including the school setting and the professional environment. It is recommended that school curriculums include HV in order to prepare the new graduate nurse's entry into the work environment. Education should continue across the professional continuum regardless of the setting. Nurses at all levels of the organization should also be educated. Self-reflection of one's communication skills and behaviors as well as professional confrontation techniques are two items for the nurse to learn. Nurse leaders are responsible for developing and implementing zero tolerance policies. Perpetrators are to be held accountable for their actions. Zero tolerance policies and accountability will provide

additional tools for the nurses in the hopes of minimizing HV. Mandatory in-services at different intervals of a nurse's career are also recommended. This author would support HV education becoming part of the professional nurse's continuing education requirements for licensure renewal. Once HV is realized and techniques are implemented, the nurses work environment should have limited exposure to HV and positive patient, nurse and organizational outcomes will be sustained contributing to the overall solvency of the organization.

Chapter 5

Summary and Conclusions

If nursing is considered a caring profession, then why do nurses continue to respond negatively towards their peers? The two ideas appear to contradict each other. The literature review is clear in that the nurses work environment is of the utmost importance in producing positive outcomes. The findings from this study lead the investigator to believe that the additional stress in the nurses work environment at Magnet hospitals may be a contributing factor to higher rates of HV. As nurse administrators are directed to continually outperform clinical benchmarks in order to attain or retain Magnet status the creation of HV may have been an unanticipated byproduct of the pursuit of Magnet Certification. The nurses work environment is stressful and consistency is required within the environment to provide reliable patient care. In an attempt to control the environment and ensure consistency and reliability nurses begins to react negatively towards their peers and thus we believe the Theory of Oppression is operationalized. According to Bandura, as new nurses enter these environments and are exposed to nurses exhibiting HV behaviors they

are likely to repeat these behaviors because Bandura postulates that we learn to model behaviors. The environment and the cognitive abilities of the nurse are at play because we are social beings and want to belong to a group. As a result we choose either negative behaviors or positive behaviors to belong. If the nurse chooses negative behaviors, in this case HV behaviors, then the environment becomes cyclical and repeats itself. The literature is clear in identifying that HV is a widespread international and national problem facing the nursing profession with prevalence rates ranging from 5% - 67% (Johnson, 2009; Simons, 2008; Spector, Zho & Xuan Che, 2013). The results from this study clearly support that HV is present in nursing with rates ranging between 32% (non-Magnet) - 35% (Magnet) depending upon the Magnet status of the hospital. Much to our surprise while, nurses experience HV regardless of the environment, Magnet environments had higher rates of HV, $X^2(1) = 17.75$, $p = .0001$ (Table 7).

Additionally, new graduate nurses have also been identified as a subgroup of nurses who experience HV more frequently primarily because of their lack of experience (McKenna et al., 2003). However, additional studies also report that all nurses across the continuum have witnessed or experienced these disruptive behaviors at one time or another (Johnson, 2009; Simons, 2008). Interestingly this study showed

that nurses with less than or equal to 7 years of licensed experience showed no differences in HV between Magnet and non-Magnet hospitals, $X^2(1) = 1.64$, $p = .201$ (Table 9). Perhaps the recommendations from The Institute of Medicine's (IOM), (2010) report The Future of Nursing: Leading Change, Advancing Health,

(http://iom.nationalacademies.org/Reports/2015/Assessing-Progress-on-the-IOM-Report-The-Future-of-Nursing.aspx#sthash.e2RUhGCn.dpuf) influenced these results. "In 2008, The Robert Wood Johnson Foundation (RWJF) and the IOM launched a two-year initiative to respond to the need to assess and transform the nursing profession. The IOM appointed the Committee on the RWJF Initiative on the Future of Nursing, at the IOM, with the purpose of producing a report that would make recommendations for an action-oriented blueprint for the future of nursing. Through its deliberations, the committee developed four key messages: Nurses should practice to the full extent of their education and training. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression. Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the

United States. Effective workforce planning and policy making require better data collection and information infrastructure."

Specifically one such recommendation made by the IOM was for the nursing profession to develop residency programs addressing the needs of the new graduate by setting up peer mentoring relationships over a period of time. The intent was to assimilate the newer RN easier into the work environment by reducing some of the stressors experienced. The results of this study indicate that no differences existed for these nurses. It is noteworthy to mention that in years 4-7 of experience the rates of HV began to increase (Table 8). The residency programs may have addressed the new graduate however attention needs to continue to be paid on RNs across their professional continuum.

Another recommendation made by the IOM (2010) was to increase the number of RNs with a Bachelorette Degree from 50% to 80% by 2020 and to double the number of PhD nurses. There were no PhD respondents for this study however Bachler and Master's Degree bedside nurses at Magnet hospitals responded with higher rates of HV than non-Magnet hospitals , $X^2(1) = 9$, $p = .003$ (Table 10). The

application of Oppression Theory as it pertains to the nurses stressful work environment at Magnet hospitals remains a viable notion.

Since the nurses work environment is important in predicting outcomes then the setting or nursing unit that the RN delivers care in on a daily basis would also become important. Hospitals are large complex organizations and this researcher wanted to investigate whether pockets of HV existed within organizations and may be influencing the results. There is a trend in the literature which indicates that the higher the acuity level of the patient, the more potential for HV exists within that environment (Park, Cho & Hong, 2015 & Vessey et al., 2009). This study's results indicated that the Critical Care, Perioperative and Medical – Surgical Divisions yielded higher rates of HV at Magnet hospitals. There were no differences noted within the Maternal Child Health Division. A continued emphasis on investigating the differences between nursing units or divisions is recommended.

As ascertained by the qualitative analysis, prior to a nurse responding to horizontal violence an evaluation of the situation is completed. The nurse assesses whether the HV is severe enough and whether the environment is safe to respond. If so the nurse will confront the aggressor 78% of the time. This confrontation takes the form of

aggressive verbal language, gossip and speaking negatively about another healthcare worker. Overall the literature notes that nurses respond to HV in nonphysical ways. This study confirms what is noted in the current literature.

With the continued focus of the healthcare industry on increased productivity, improved retention rates, decreasing turnover rates, increasing patient satisfaction and quality indicator scores, the results of this study and the impact of the nurses work environment, specifically Magnet as evidenced by the rates of HV is important for nurse administrators to consider and factor in when pursuing Magnet Certification in order to reduce its prevalence in the bedside nurses work environment.

Limitations

Limitations exist in all research studies. The main limitation in this study originated from the disparity in the response rates between the Magnet and non-Magnet facilities. The number of returned surveys at the Magnet hospital was 144 surveys while the non-Magnet hospital had 49 surveys returned. The number of Magnet surveys returned comprised 75% of the returned surveys while the non-Magnet surveys

returned comprised 25% of the returned surveys. After the post hoc analysis was performed for all significant results by conducting the effect, odds ratio and power it became apparent that hypothesis 4 "The prevalence rates of HV between like specialty divisions at Magnet hospitals will be significantly less than non-Magnet hospitals" was affected because four specialty divisions were evaluated and the distribution of 49 non-Magnet surveys over these four specialty divisions reduced the number of nurses for a given specialty that would answer yes to HV. Specifically, the Critical Care Division and the Medical Surgical Division were impacted (p. 122, 123, 126, 127). This limitation cautions the primary investigator and the reader to exercise caution when interpreting and generalizing the findings.

A second limitation evolved from the aforementioned because when surveying two separate groups the risk that the investigator runs into is the disparity in the return rate between the two groups. As mentioned 75% of the survey returns were from Magnet hospitals and 25% were from non-Magnet hospitals. What might be some of the contributing factors that cause this to happen? Why did some nurses respond while others did not? Perhaps the nurses were too busy; did not trust the anonymity of the results; were poor work performers and now

felt that they had a venue to discuss their concerns; feared retaliation for providing input or were vulnerable nurses to the topic of HV.

The third limitation surrounds the use of a defined convenience sample. The Magnet hospital was sampled from southern New Jersey and the non-Magnet hospital was sampled from central New Jersey. Caution needs to be taken by the reader and the primary investigator when generalizing the findings beyond these two organizations.

The fourth limitation inherent in distributing surveys and having respondents complete them is the problem surrounding recall biasness. Self- reporting can be flawed because of this. As the time lengthens between the HV event and the survey completion, important details can be omitted as well as exaggerations occur surrounding the details of the event.

Tables

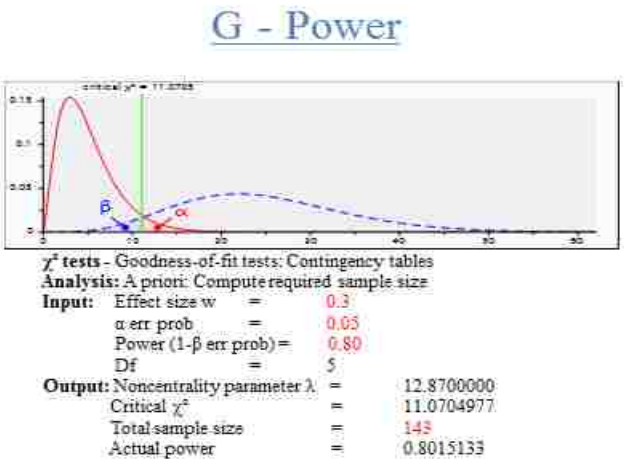
Table 1.
Fourteen Forces of Magnetism

Organizational Structure	Autonomy
Management Style	Community and the Hospital
Personnel Policies and Programs	Nurses as Teachers
Professional Models of Care	Image of Nursing
Quality of Care	Interdisciplinary Relationships
Quality Improvement	Professional Development

(The Commission on Magnet Recognition, 2008)

Figure 1.

G-Power Sample Size



(G*Power, 2011)

Table 2.

*Chi Square Test of Differences – **Phase 1***

Test Statistics

	Magnet or non-Magnet
Chi-Square	10.286[a]
df	1
Asymp. Sig.	.001

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 7.0.

Results: x^2 (1) = 10.29, P =.001 *Reject Ha1*.

Table 3.
Prevalence of HV in the PACU at the Magnet and non-Magnet Hospital ***– Phase 1.***

Table 4. Magnet or non-Magnet HV in Current Workplace

42

		HV in Current Workplace			
		Yes	No	Not Sure	Total
Magnet or non-Magnet:	**non-Magnet**				
	Count	1	7	1	9
	Expected Count	4.2	3.9	.9	9.0
	% within magnet or nonmagnet	11.1%	77.8%	11.1%	100.0%
	Magnet				
	Count	13	6	2	21
	Expected Count	9.8	9.1	2.1	21.0
	% within magnet or nonmagnet	61.9%	28.6%	9.5%	100.0%
Total	Count	14	13	3	30
	Expected Count	14.0	13.0	3.0	30.0
	% within magnet or nonmagnet	46.7%	43.3%	10.0%	100.0%

Figure 2.

Prevalence of HV in the PACU at the Magnet and non-Magnet Hospital **– Phase 1**.

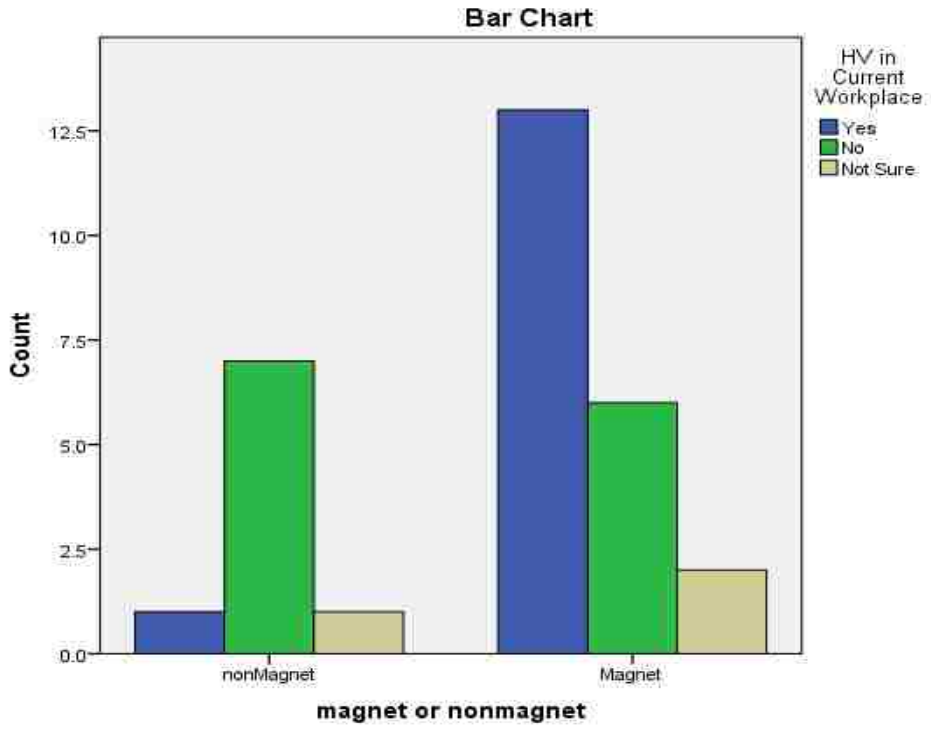


Table 4.

Frequency of HV for RNs with less than 3 yrs. of licensed experience – ***Phase 1.***

Total Licensed Years

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2-3	1	3.3	3.3	3.3
	4-7	2	6.7	6.7	10.0
	8-12	2	6.7	6.7	16.7
	13-17	2	6.7	6.7	23.3
	18-25	10	33.3	33.3	56.7
	more than 25	13	43.3	43.3	100.0
	Total	30	100.0	100.0	

Table 5.
Chi Square Test of Differences Academic Degrees ***– Phase 1.***

Test Statistics

	Magnet or non-Magnet
Chi-Square	8.333[a]
df	1
Asymp. Sig.	.004

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 6.0.

Table 5.
Prevalence of HV experienced by RNs with higher academic degrees at Magnet & non-Magnet Hospitals ***– Phase 1.***

HVCurrentWPlace = 1 & Education > 4 (FILTER) * Magnet or non-Magnet Crosstabulation

			Magnet or non-Magnet		
			nonMagnet	Magnet	Total
HVCurrentWPlace = 1 & Education > 4 (FILTER)	Not Selected	Count	8	10	18
		% within HVCurrentWPlace = 1 & Education > 4 (FILTER)	44.4%	55.6%	100.0%
		% within Magnet or non-Magnet	88.9%	47.6%	60.0%
	Selected	Count	1	11	12
		% within HVCurrentWPlace = 1 & Education > 4 (FILTER)	8.3%	91.7%	100.0%
		% within Magnet or non-Magnet	11.1%	52.4%	40.0%
Total		Count	9	21	30
		% within HVCurrentWPlace = 1 & Education > 4 (FILTER)	30.0%	70.0%	100.0%
		% within Magnet or non-Magnet	100.0%	100.0%	100.0%

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APPENDICES

Appendix A: Magnet Hospital Reminder Flyer

SETON HALL UNIVERSITY
1 8 5 6

REMINDER – TIME IS RUNNING OUT – 18 DAYS LEFT

REQUESTING ALL REGISTERED NURSES

To voluntarily participate in a research study

TITLED:

"EXPLORING THE PREVALENCE OF HORIZONTAL VIOLENCE IN NURSING BETWEEN MAGNET and non-MAGNET HOSPITALS."

WHY:

I am currently completing the degree requirements for a PhD at Seton Hall University, Department of Interprofessional Health Sciences & Health Administration. As part of my degree requirements I am conducting a research study looking at the prevalence of Horizontal Violence in Magnet and non-Magnet hospitals in NJ. This information may help hospitals address Horizontal Violence in the workplace.

HOW:

I will be using a valid and reliable tool called the Briles' Sabotage Questionnaire as a means to access the degree of Horizontal Violence. Participants wishing to participate in the study will be directed in the letter of solicitation to the survey access link which is located on the hospital Intranet Service. This link brings you directly to the tool that is housed on the Survey Monkey website which is a completely anonymous site.

Your participation is completely *Anonymous, Voluntary, & Confidential. All data in aggregate form will be stored for 3 years at the principal investigators home.*

The survey can be accessed until **(insert date)**

Thank you! Cathleen Janzekovich – Principal Investigator
cathyjanzekovich@gmail.com

Appendix A Continued: Non-Magnet Medical Center Reminder Flyer

SETON HALL UNIVERSITY
1 8 5 6

REMINDER: REQUESTING ALL REGISTERED NURSES

To voluntarily participate in a research study

TITLED:

"EXPLORING THE PREVALENCE OF HORIZONTAL VIOLENCE IN NURSING BETWEEN MAGNET and non-MAGNET HOSPITALS."

WHY:

I am currently completing the degree requirements for a PhD at Seton Hall University, Department of Interprofessional Health Sciences & Health Administration. As part of my degree requirements I am conducting a research study looking at the prevalence of Horizontal Violence in Magnet and non-Magnet hospitals in NJ. This information may help hospitals address Horizontal Violence in the workplace.

HOW:

I will be using a valid tool called the Briles' Sabotage Questionnaire as a means to access the degree of Horizontal Violence. Participants wishing to participate in the study will be directed in the letter of solicitation to an access link located on the MMC intranet which links directly to the survey.
The survey is housed on the Survey Monkey website which is a completely anonymous site.

Your participation is completely *Anonymous, Voluntary, & Confidential. All data in aggregate form will be stored for 3 years at the principal investigators home.*

The survey can be accessed until (insert date)

Thank you! Cathleen Janzekovich – Principal Investigator
cathyjanzekovich@gmail.com

Appendix B: Magnet Medical Center Solicitation/Consent Letter

SETON HALL UNIVERSITY
1 8 5 6

Affiliation

My name is Cathleen Janzekovich and I am a doctoral student in the Department of Interprofessional Health Sciences & Health Administration. I am conducting a research project that will culminate in my dissertation.

Purpose

You are being asked to take part in this study because you are a Registered Nurse licensed in the State of New Jersey, who provides direct patient care in an acute care hospital in the Post Anesthesia Care Unit. The hospital that you are employed at has been either identified as a Magnet Certified Hospital through the American Nurses Credentialing Center or non-Magnet Certified Hospital. Studies have reported that Horizontal Violence (HV) is prevalent in the nursing profession and causes negative patient, organizational and nurse outcomes. However, the frequency of HV has not been fully determined between Magnet and non-Magnet hospitals.

Procedure

You will be asked to complete the Briles' Sabotage Savvy Questionnaire and can access the survey through the hospital Intranet Service. A survey link will be provided for you and will connect you to the Briles' Sabotage Savvy Questionnaire on Survey Monkey. It consists of two sections, victim and saboteur, and contains a total of 74 questions. You will be asked to select "0 = no", "1= not-sure", or "2 = yes" after reading each question. Please only score the survey based on your experiences while working in your current position during the last five (5) years. It is important to complete the questionnaire in a quiet location such as the nurse's lounge or at home. The time required to complete the questionnaire is approximately 10 minutes.

Voluntary Participation

Your participation in the research study is entirely voluntary. You may decide not to participate at any time. If you decide not to participate, you will not be penalized or lose any benefits that you are otherwise entitled. Your consent to participate in this study is indicated by completing the questionnaire through Survey Monkey.

Anonymity

You will not be identified by name, employer or description in any reports or publications about this study. Survey Monkey "allows authors to disable the storage of email addresses and disable IP address collection for all collection methods so that they can collect anonymous survey responses."

Confidentiality

The information in this study will be kept strictly confidential. All data will be stored in a locked cabinet at the primary investigators home for a period of three years. There after the research data will be destroyed.

Risks

There are no foreseeable risk factors or discomforts associated with any part of this research study.

Benefits of Participation

Depending upon the results of this study, participants may or may not experience any direct benefits from participation. The organizations involved may develop educational programs to prevent Horizontal Violence. Additionally, information collected in this study may benefit other RNs and acute care hospitals in the future by helping to heighten the awareness of Horizontal Violence in the nursing profession and potentially changing unhealthy nursing work environments that currently exist to healthy nursing work environments.

Compensation

There will be no monetary or any kind of compensation for participation in this study.

Alternate Procedures

There are no alternate ways to participate in this study

Contact Information

You have the right to ask questions concerning this study at any time. If you have any questions concerning this study or your rights as a study participant, please contact the primary investigator Cathleen Janzekovich, through the office of Dr. Genevieve Pinto-Zipp, Dissertation Advisor and Chair, at Seton Hall University at 973-313-2076.

This project has been approved by the Seton Hall University Institutional Review Board (IRB) for Human Subjects Research. The IRB believes that the study procedures adequately

safeguard the study participants privacy, welfare, civil liberties, and rights. The Office of the IRB at Seton Hall University may be reached at 973-313-6314.

Informed Consent

I fully understand the purposes of this study and the lack of potential benefits of my participation. My consent to participate in this study is indicated by submitting the completed questionnaire.

Appendix B: Non-Magnet Solicitation/Consent Letter

SETON HALL UNIVERSITY
1 8 5 6

Affiliation

My name is Cathleen Janzekovich and I am a doctoral student in the Department of Interprofessional Health Sciences & Health Administration. I am conducting a research project that will culminate in my dissertation.

Purpose

You are being asked to take part in this study because you are a Registered Nurse licensed in the state of New Jersey, who provides direct patient care in an acute care hospital in the Post Anesthesia Care Unit. The hospital that you are employed at has been either identified as a Magnet Certified Hospital through the American Nurses Credentialing Center or non-Magnet Certified Hospital. Studies have reported that Horizontal Violence (HV) is prevalent in the nursing profession and causes negative patient, organizational and nurse outcomes. However, the frequency of HV has not been fully determined between Magnet and non-Magnet hospitals.

Procedure

You will be asked to complete the Briles' Sabotage Savvy Questionnaire and can access the survey through the Monmouth Medical Center intranet. A survey link will be provided for you and will connect you to the Briles' Sabotage Savvy Questionnaire on Survey Monkey. It consists of two sections, victim and saboteur, and contains a total of 74 questions. You will be asked to select "0= no", "1= not-sure", or "2= yes" after reading each question Please only score the survey based on your experiences while working in your current position during the last five (5) years. It is important to complete the questionnaire in a quiet location such as the nurse's lounge or your home. The time required to complete the questionnaire is approximately 10 minutes.

Voluntary Participation

Your participation in the research study is entirely voluntary. You may decide not to participate at any time. If you decide not to participate, you will not be penalized or lose any benefits that you are otherwise entitled. Your consent to participate in this study is indicated by completing the questionnaire through Survey Monkey.

Anonymity

You will not be identified by name, employer or description in any reports or publications about this study. Survey Monkey "allows authors to disable the storage of email addresses and disable IP address collection for all collection methods so that they can collect anonymous survey responses."

Confidentiality

The information in this study will be kept strictly confidential. All data will be stored in a locked cabinet at the primary investigators home for a period of three years. There after the research data will be destroyed.

Risks

There are no foreseeable risk factors or discomforts associated with any part of this research study.

Benefits of Participation

Depending upon the results of this study, participants may or may not experience any direct benefits from participation. The organizations involved may develop educational programs to prevent Horizontal Violence. Additionally, information collected in this study may benefit other RNs and acute care hospitals in the future by helping to heighten the awareness of Horizontal Violence in the nursing profession and potentially changing unhealthy nursing work environments that currently exist to healthy nursing work environments.

Compensation

There will be no monetary or any kind of compensation for participation in this study.

Alternate Procedures

There are no alternate ways to participate in this study

Contact Information

You have the right to ask questions concerning this study at any time. If you have any questions concerning this study or your rights as a study participant, please contact the primary investigator Cathleen Janzekovich, through the office of Dr. Genevieve Pinto-Zipp, Dissertation Advisor and Chair, at Seton Hall University at 973-313-2076.

This project has been approved by the Seton Hall University Institutional Review Board (IRB) for Human Subjects Research. The IRB believes that the study procedures adequately

safeguard the study participants privacy, welfare, civil liberties, and rights. The Office of the IRB at Seton Hall University may be reached at 973-313-6314.

Informed Consent

I fully understand the purposes of this study and the lack of potential benefits of my participation. My consent to participate in this study is indicated by submitting the completed questionnaire.

Appendix B Continued: Magnet Solicitation/Consent Letter

SETON HALL UNIVERSITY
1 8 5 6

Affiliation

My name is Cathleen Janzekovich and I am a doctoral student in the Department of Interprofessional Health Sciences & Health Administration. I am conducting a research project that will culminate in my dissertation.

Purpose

You are being asked to take part in this study because you are a Registered Nurse licensed in the State of New Jersey, who provides direct patient care in an acute care hospital. The hospital that you are employed at has been either identified as a Magnet Certified Hospital through the American Nurses Credentialing Center or non-Magnet Certified Hospital. Studies have reported that Horizontal Violence (HV) is prevalent in the nursing profession and causes negative patient, organizational and nurse outcomes. However, the frequency of HV has not been fully determined between Magnet and non-Magnet hospitals.

Procedure

You will be asked to complete the Briles' Sabotage Savvy Questionnaire and can access the survey through the hospital Intranet Service. A survey link will be provided for you and will connect you to the Briles' Sabotage Savvy Questionnaire on Survey Monkey. It consists of two sections, victim and saboteur, and contains a total of 74 questions. You will be asked to select "0 = no", "1= not-sure", or "2 = yes" after reading each question. Please only score the survey based on your experiences while working in your current position during the last five (5) years. It is important to complete the questionnaire in a quiet location such as the nurse's lounge or at home. The time required to complete the questionnaire is approximately 10 minutes.

Voluntary Participation

Your participation in the research study is entirely voluntary. You may decide not to participate at any time. If you decide not to participate, you will not be penalized or lose any benefits that you are otherwise entitled. Your consent to participate in this study is indicated by completing the questionnaire through Survey Monkey.

Anonymity

You will not be identified by name, employer or description in any reports or publications about this study. Survey Monkey "allows authors to disable the storage of email addresses and disable IP address collection for all collection methods so that they can collect anonymous survey responses."

Confidentiality

The information in this study will be kept strictly confidential. All data will be stored in a locked cabinet at the primary investigators home for a period of three years. There after the research data will be destroyed.

Risks

There are no foreseeable risk factors or discomforts associated with any part of this research study.

Benefits of Participation

Depending upon the results of this study, participants may or may not experience any direct benefits from participation. The organizations involved may develop educational programs to prevent Horizontal Violence. Additionally, information collected in this study may benefit other RNs and acute care hospitals in the future by helping to heighten the awareness of Horizontal Violence in the nursing profession and potentially changing unhealthy nursing work environments that currently exist to healthy nursing work environments.

Compensation

There will be no monetary or any kind of compensation for participation in this study.

Alternate Procedures

There are no alternate ways to participate in this study

Contact Information

You have the right to ask questions concerning this study at any time. If you have any questions concerning this study or your rights as a study participant, please contact the primary investigator Cathleen Janzekovich, through the office of Dr. Genevieve Pinto-Zipp, Dissertation Advisor and Chair, at Seton Hall University at 973-313-2076.

This project has been approved by the Seton Hall University Institutional Review Board (IRB) for Human Subjects Research. The IRB believes that the study procedures adequately safeguard the study participants privacy, welfare, civil liberties, and rights. The Office of the IRB at Seton Hall University may be reached at 973-313-6314.

Informed Consent

I fully understand the purposes of this study and the lack of potential benefits of my participation. My consent to participate in this study is indicated by submitting the completed questionnaire.

Appendix C: Definition of Terms

Covert Behavior is mainly psychological and examples of these behaviors include excessive criticism, the raising of eyebrows, innuendos, and passive aggression (Griffin, 2004; Baltimore, 2006).

Critical Care Division – telemetry, critical care and emergency department.

Horizontal Violence is the "interpersonal conflict amongst nurses" (p. 90) and the "destructive behavior of nurses against each other" (p. 123), (McKenna, Smith, Poole, & Coverdale (2003) & Woelfe & McCaffrey (2007).

Maternal Child Health Division – labor, delivery, post-partum, neonatal intensive care unit.

Medical Surgical Division – medical, surgical, medical surgical and oncology nursing units.

Overt Behavior is more visible in nature and examples include the scapegoating, antagonism, in-subordination, verbal and physical aggression (Griffin, 2004; Baltimore, 2006).

Perioperative Division – short stay, operating room, post anesthesia care unit.

Registered Nurse is a graduate trained nurse who has been licensed by a state authority after passing qualifying examinations for registration—called also *RN (*http://www.merriam-webster.com/dictionary/registered%20nurse).

Appendix D: SHU IRB Approvals

REQUEST FOR APPROVAL OF RESEARCH, DEMONSTRATION OR RELATED ACTIVITIES INVOLVING HUMAN SUBJECTS

All material must be typed.

PROJECT TITLE: *"Exploring the Prevalence of Horizontal Violence in Nursing Between Magnet and non-Magnet Hospitals*

CERTIFICATION STATEMENT:

In making **this application,** I(we) certify that I(we) have read and understand the University's policies and procedures governing research, development, and related activities involving human subjects. I (we) shall comply with the letter and spirit of those policies. I(we) further acknowledge my(our) obligation to (1) obtain written approval of significant deviations from the originally-approved protocol BEFORE making those deviations, and (2) report immediately all adverse effects of the study on the subjects to the Director of the Institutional Review Board, Seton Hall University, South Orange, NJ 07079.

Cathleen Janzekovich — September 30, 2014
RESEARCHER(S) OR PROJECT DIRECTOR(S) — DATE

Please print or type out names of all researchers below signature. Use separate sheet of paper, if necessary.

My signature indicates that I have reviewed the attached materials and consider them to meet IRB standards.

September 30, 2014
RESEARCHER'S ADVISOR OR DEPARTMENTAL SUPERVISOR — DATE

Please print or type out name below signature

The request for approval submitted by the above researcher(s) was considered by the IRB for Research Involving Human Subjects Research at the Oct 2014 meeting.

The application was approved ✓ not approved ___ by the Committee. Special conditions were _____ were not _____ set by the IRB. (Any special conditions are described on the reverse side.)

Mary F. Ruzicka, Ph.D. — 11/3/14
DIRECTOR, SETON HALL UNIVERSITY INSTITUTIONAL REVIEW BOARD FOR HUMAN SUBJECTS RESEARCH — DATE

SETON HALL UNIVERSITY
1 8 5 6

September 8, 2015

Cathleen Janzekovich
6 Julia Drive
Monroe Township, NJ 08831

Dear Ms. Janzekovich,

The IRB hereby approves the requested amendments to your research protocol, "Exploring the Prevalence Rates of Horizontal Violence in Nursing Between Magnet and non-Magnet Hospitals" to:

1. remove as a research site;
2. add as a research site and conduct the study at and ;
3. change the demographic questionnaire to reflect the additional nursing units.

Sincerely,

Mary F. Ruzicka, Ph.D.
Professor
Director, Institutional Review Board

cc: Dr. Genevieve Pinto Zipp

Please review Seton Hall University IRB's Policies and Procedures on website (http://www.provost.shu.edu/IRB) for more information. Please note the following requirements:
Adverse Reactions: If any untoward incidents or adverse reactions should develop as a result of this study, you are required to immediately notify in writing the Seton Hall University IRB Director, your sponsor and any federal regulatory institutions which may oversee this research, such as the OHRP or the FDA. If the problem is serious, approval may be withdrawn pending further review by the IRB.
Amendments: If you wish to change **any** aspect of this study, please communicate your request in writing (with revised copies of the protocol and/or informed consent where applicable and the Amendment Form) to the IRB Director. The new procedures cannot be initiated until you receive IRB approval.
Completion of Study: Please notify Seton Hall University's IRB Director in writing as soon as the research has been completed, along with any results obtained.
Non-Compliance: Any issue of non-compliance to regulations will be reported to Seton Hall University's IRB Director, your sponsor and any federal regulatory institutions which may oversee this research, such as the OHRP or the FDA. If the problem is serious, approval may be withdrawn pending further review by the IRB.
Renewal: It is the principal investigator's responsibility to maintain IRB approval. A Continuing Review Form will be mailed to you prior to your initial approval anniversary date. **Note:** No research may be conducted (except to prevent immediate hazards to subjects), no data collected, nor any subjects enrolled after the expiration date.

Appendix E: Phase 1 Study

The goal of phase one (1) was to examine whether Magnet Hospitals in New Jersey produce different prevalence rates of H.V. than non-Magnet Hospitals in N.J.; to gather demographic information; to develop further alternative hypotheses; to check the integrity of methodology designed.

Phase one (1) was conducted between 1/5/15 – 2/4/15 for the Magnet Medical Center and from1/7/15 – 2/4/15 for the non-Magnet Medical Center.

The research questions included:

1. Are the prevalence rates of Horizontal Violence experienced by RNs different between Magnet and non-Magnet hospitals?

2. Are the prevalence rates of Horizontal Violence experienced at Magnet hospitals less than non-Magnet hospitals?

3. Are the prevalence rates of Horizontal Violence higher in nurses with less than three years of experience?

4. Are the prevalence rates of Horizontal Violence experienced by Registered Nurses with less than three years of experience at N.J. Magnet Hospitals less than non-Magnet hospitals?

5. Are the prevalence rates of Horizontal Violence experienced by RNs with higher academic degrees different between Magnet and non-Magnet hospitals?

The purpose of this study was to explore what was currently known about HV in nursing in the literature as well as the impact that Magnet Certification had on changing the nurses work environment and whether these changes had an impact on the prevalence rates of HV.

The hypotheses were:

Ha1: The prevalence rates of HV experienced by PACU Registered Nurses in N.J. Magnet Hospitals *will be significantly less* than non-Magnet Hospitals.

Ha2: The prevalence rates of HV experienced by PACU Registered Nurses in N.J. Magnet Hospitals with less than 3 years of licensed experience *will be significantly less* than non-Magnet Hospitals.

Ha3: The prevalence rates of HV experienced by PACU RNs with higher academic degrees at NJ Magnet hospitals *will be significantly less* than those at non-Magnet hospitals.

Methodology

A. Magnet Hospital:

Initially, this researcher attended the Nursing Research Council. The Nursing Research Council membership included bedside RN representation from all patient care areas. For the Phase 1 study, five PACU registered nurses were present from both divisions. The facility's nurse researcher acted as the liaison between the two divisions or hospitals. After approval had been received from the Magnet Medical Center's IRB and Seton Hall University's IRB, the primary investigator attended the PACU staff meetings in order to explain the research proposal and the study was conducted as follows:

A solicitation letter (Appendix D) was placed in a presentation folder and distributed to the Post Anesthesia Care Unit Registered Nurses during the staff meetings. One hundred percent attendance was achieved. The solicitation letter was also posted on the bulletin board in the nurse's lounge. The solicitation letter instructed the RNs to access the hospital intranet linking them to the Briles' Sabotage Savvy

Questionnaire through a link to Survey Monkey, if they were interested in voluntarily participating in the study. The hospital intranet was accessible to staff at work and at home and participants were able to complete the survey in the location of their choice independently and quietly. On day 14, a flyer was posted in the PACU nurses lounge encouraging participation and alerting nurses to the approaching deadline (Appendix C). Participants were provided 31 days to complete the survey. It was estimated to take 7-10 minutes to complete.

B. Non-Magnet Hospital

For phase one (1) of the study, the principal investigator attended the PACU Staff Meeting during the month of December, 2014. Direct care providers from the PACU staff were present at this meeting. The primary investigator presented the study and distributed the solicitation letter to the PACU RNs. Those RNs who were unable to attend the staff meeting presentation were distributed the solicitation letter by placing the information in each PACU staff nurse's unit mailbox as well as being posted on the bulletin board in the PACU nurse's lounge. The Director of the PACU was provided the solicitation letter, by this Nurse Researcher, to ensure that the posting was located on the PACU bulletin board (Appendix D).

Data Analysis and Results

The data analysis was conducted using Chi Square of Differences.

Ha1: The prevalence rates of HV experienced by PACU Registered Nurses in N.J.

Magnet Hospitals *will be significantly less* than non-Magnet Hospitals (Table 3, 4, 5).

Results: x^2 (1) = 10.29, P =.001 Reject Ha1.

Ha2: The prevalence rates of HV experienced by PACU Registered Nurses in N.J. Magnet Hospitals with less than 3 years of licensed experience *will be significantly less* than non-Magnet Hospitals.

Results: Unable to be analyzed due to N= 0 at the non-Magnet hospital & N = 1 at the Magnet Hospital (Table 6).

Ha3: The prevalence rates of HV experienced by PACU RNs with higher academic degrees at NJ Magnet hospitals *will be significantly less* than those at non-Magnet hospitals.

Results: x^2 (1) = 8.33, p = .004 Reject Ha3 (Table 7).

The limitations of the study included:

1. Sample Size: the total sample size was small.

   N = 30

   N= 9 non-Magnet Hospital

   N= 21 Magnet Hospital

2. Defined Convenience Sample –

   The PACU RNs were sampled at two local medical centers therefore the generalizability was limited.

In conclusion of Phase 1, these findings suggest that HV is present in the nurses work environment at Magnet and non- Magnet hospitals, however the pilot data demonstrated that Magnet hospitals had higher prevalence rates of HV. In order to provide a potential practice framework for nursing to implement when designing work environments that could ultimately impact HV rates, as well as patient, organizational & nursing outcomes, we must continue to assess the frequency of HV between Magnet & non-Magnet Hospital environments across all practice specialties in order to better understand this phenomena.