

The Presence of Lateral Violence in the Operating Room Experienced by Certified Registered

Nurse Anesthetists: An Opportunity for Change

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### **Abstract**

Lateral violence (LV) is an unfortunate aspect of any workplace and can be referred to as incivility or bullying. Lateral violence is defined as a repetitive disruptive behavior among peers that is considered offensive, abusive or intimidating by the target. Incivility comes in many forms. It is considered any disruptive behavior between peers that would be identified as workplace incivility or bullying. The prevalence of incivility or bullying between healthcare providers is a rising concern. The stressful nature of surgery demands a calm, LV-free interaction between all parties in the operating room involved in patient care. The purpose of this project was threefold. First, to survey the presence of LV within the operating room among Certified Registered Nurse Anesthetists (CRNAs) who are active members of the Michigan Association of Nurse Anesthetists (MANA). Next, to educate these CRNAs on the scope and manifestations of LV and provide these learners with tools and coping mechanisms for appropriately dealing with lateral violence via a video platform. Lastly, to have the participants evaluate the effectiveness of the program on LV. The results obtained from this doctoral project met our primary objective of developing and evaluating a professional program that informs and educates CRNAs about lateral violence. All the pre- and post- test comparison items were statistically significant for improvement. Lateral violence education should be incorporated into CRNA workplace.

**Keywords:** CRNAs, lateral violence, incivility, bullying, operating room

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**Introduction to the Problem**

Lateral violence (LV) is an unfortunate aspect of any workplace and can be referred to as incivility or bullying. Lateral violence is defined as a repetitive disruptive behavior among peers that is considered offensive, abusive or intimidating by the target (Anusiewicz et al., 2019). Incivility comes in many forms. It is considered any disruptive behavior between peers that would be identified as workplace incivility or bullying. The prevalence of incivility or bullying between healthcare providers is a rising concern. In fact, in a study by Vessey et al. (2009), out of 303 registered nurses in a study, 57% were exposed to LV within 5 years or less of employment (In that same study, an overwhelming 97% of the nurses reported that no written policy or in-service education addressing lateral violence was conducted. In a survey of 299 CRNAs, it was found that 89.8% experienced or witnessed workplace incivility at least every year and more than 50% experienced it at least once a week (Kwak, 2020).

**Background**

Lateral violence is an ambiguous term. This phrase is utilized throughout the literature of various disciplines, however the meaning of the words itself can be subjective based on the context. Overall, it is portrayed as non-physical abuse in the workplace between co-workers (Anusiewicz et al., 2019). There are defining attributes of lateral violence which will be further discussed in this paper. For this study, lateral violence is defined as any behavior perceived as aggressive, abusive, intimidating, hostile, or offensive by the target (Anusiewicz et al., 2019).

Coursey, Rodriguez, Dieckmann, & Austin, (2013) define lateral violence as aggressive or hostile behavior in the professional environment between peers. Lateral violence may be exhibited in different forms and patterns. An example is an employee who uses rude, inconsiderate, or intimidating behavior against his or her peers (Coursey et al., 2013). Vessey, Demarco, Gaffney & Budin, (2009), believe that when an individual's efforts are mocked and belittled, they experience workplace frustration, and their self-esteem is diminished.

Lateral violence and hostile work environments have a negative impact on healthcare staff's performance including poor development of work abilities, missing orders in the chart, calling off, medication errors, poor documentation, and lack of timely interventions (Zhang et al., 2018). Therefore, it has been suggested that lateral violence education can provide a practical solution for these problems by strengthening coping skills and providing strategies for healthcare providers who are subjected to disruptive behavior (Kechi & Wahi, 2017). Educating healthcare staff about lateral violence can increase their job satisfaction and improve performance. Decreasing LV is even beneficial beyond increasing job satisfaction and performance. A lateral violence free environment can cause a domino effect that will improve multidisciplinary communication, promote optimal patient care, and help achieve higher Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores (Robinson & Dodd, 2014). This is not a cause-and-effect relationship but rather a cumulative effect (Robinson & Dodd, 2014).

The findings of Coursey et al. (2013) characterized a myriad of uncivil behaviors healthcare staff exhibited openly or secretly as lateral violence. They found that lateral

violence was directed most often towards healthcare professionals of equal or lower credentials within their organization (Coursey et al., 2013) such as CRNA to CRNA or CRNA to Registered Nurses (RN). Vessey et al. (2009) noted similar findings in their study of 303 hospital nurses and discovered that the highest percent of perpetrators of LV were from senior nurses, charge nurses, and nurse managers; the least infractions were from physicians toward nurses. Kvas and Seljak (2014) discovered that healthcare professionals with higher education and who were younger than their colleagues were more prone to be victims of lateral violence.

According to the critical appraisal by Coursey et al. (2013), implementation of policy addressing lateral violence has been ineffective. This ineffectiveness stems from the inadequacy of zero tolerance policies and passive dissemination of information.

Healthcare staff did not have guidance or direction when they became a victim of lateral violence. Coursey et al. (2013) discovered that policies set to address lateral violence ranged from zero tolerance to passive dissemination of information. Coursey et al., (2013) supports the idea that nurses would benefit from active education and awareness of lateral violence rather than implementation of a policy that is ineffective.

Researchers revealed a positive correlation that was statistically significant between the workplace stress manifested as lateral violence and the negative outcomes of patient care (Sakellaropoulos et al., 2011). If CRNAs are subject to lateral violence, this may negatively impact their ability to perform their job and provide appropriate care (Chipas and McKenna, 2011). If CRNAs do not give appropriate care due to the effects of LV, then this may have an impact on how the patients are being treated. This in turn may create poor outcomes for the patients involved (Elmblad et al., 2014). In a study

done by Sundler et al., (2018), the author discussed the negative impact of lateral violence prevalence in the work environment on the quality of patient care, the study reported that stressful environment and staffing issues created a fertile environment of errors and near miss incidents. Patientcare itself has seen an effect from incivility and disruptive behavior. Villafranca et al., (2018) discuss specifics of this deleterious effect, including undermining communication and teamwork amongst clinicians and decreasing clinical decision-making, as well as decreasing the technical performance of those involved.

### **Problem Statement**

There is currently little information on lateral violence in the workplace experienced by CRNAs. Educational sessions have the potential to positively impact this issue. Accordingly, the following problem statement was chosen: For CRNAs working in an operating room setting, how does lateral violence education affect recognition of lateral violence and coping mechanisms? The approach of this project was to develop a survey to identify how common lateral violence is, develop an educational training video program to enhance participants knowledge of LV, prevalence of the problem, triggers of LV, misconceptions, and strategies to address LV in the workplace, and finally have the CRNAs evaluate the effectiveness of this training program.

### **Organizational “Gap” Analysis of Project Site**

The intended population for this project was Certified Registered Nurse Anesthetists (CRNAs) currently working in the state of Michigan who are members of Michigan Association of Nurse Anesthetists (MANA). The platform was an online survey and video format. Email lists were utilized through the MANA database.



### **Review of Literature**

The aim of this literature review was to assess the impact of lateral violence on job satisfaction and intentions to leave the organization amongst nurses, specifically CRNAs. Accordingly, it was imperative to begin by classifying what constitutes lateral violence and identifying the target population for the review. Due to the subjective nature of LV, it became a complex task to identify LV. It is subjected to the personal interpretation of the victims and the perpetrators (Vessey, Demarco, Gaffney, & Budin, 2009). Based on the conducted literature search for this review, a broad definition for LV was formulated as follows: any behavior perceived as aggressive, abusive, intimidating, hostile, or offensive by the target (Anusiewicz et al., 2019). The target population of this review was CRNAs. Unfortunately, there is limited information for our target population. However, there is extensive research on lateral violence with registered nurses (RN). Thus, a literature review assessing the prevalence and effects of lateral violence amongst CRNAs as well as registered nurses is crucial.

### **Data Sources and Search Method**

After crafting the research question and identifying the topics to search, a list of search terms was compiled. These terms were included in the search methodology to ensure that there is no relevant data missed or overlooked. These words were used in the online search of four electronic databases conducted using Oakland University online library. The databases searched were CINAHL, Medline, Cochrane, and EMBase. In order to achieve optimal search results the search included Boolean operators' combinations of terms like "lateral violence", "workplace violence", "bullying", "incivility", "nurses", "Certified Registered Nurse Anesthetists", "CRNAs", "operating

room”, “OR nurses”, “acute care”, and “hospitals”. Additionally, the following was the inclusion criteria used for this search: peer-reviewed journal articles, publication within the last 15 years, and full article availability.

### **Lateral Violence Among Certified Registered Nurse Anesthetists**

The first section of the literature review investigates lateral violence for CRNAs. This search yielded 16 records. This number was reduced to 7 articles after applying the following exclusion criteria: articles published prior to 2008, authors who did not report original research, and articles not pertaining to the subject matter. The literature search revealed articles that showed CRNAs experience workplace lateral violence in the perioperative area. Behaviors considered uncivil happen more often in areas of high stress, especially in the operating room. This can be attributed to the small physical confinement of the area and the dynamic, fast-paced environment (Elmblad et al., 2014). If an atmosphere of incivility exists in the OR, stressful interdisciplinary altercations may occur. These stressful altercations may have a toll on the team dynamics, communications, and quality of healthcare given in the perioperative area (Elmblad et al., 2014). CRNAs serve healthcare systems and agencies by providing top-quality, affordable anesthesia. However, CRNAs often work in stressful and potentially uncivil environments. This incivility can lead to the development of psychological burnout and decreased job satisfaction (Del Grosso and Boyd, 2019). Therefore, it is necessary to recognize and mitigate lateral violence in the perioperative area by implementing interventions such as policy change, educational sessions, increased identification of incivility, and in-services or video platform CEs on handling lateral violence once acknowledged (Coursey et al., 2013; Elmblad et al., 2014; Griffin (2014; Kechi, I., &

Wahi, M., 2017; King, T., 2017).

Kwak (2020) conducted a national study to examine workplace incivility among CRNAs and the impact this incivility has on job satisfaction. The survey was completed by 299 CRNAs and showed that incivility occurs regularly among CRNAs and has a negative impact on job satisfaction. It was found that 89.8% CRNAs experienced or witnessed workplace incivility at least every year. More than 50% experienced it at least once a week and over 33% reported it at least once a day. Another study investigating workplace aggression among CRNAs by Sakellaropoulos et al., (2011), had 205 responses from the American Association of Nurse Anesthetists Research and Membership Service department with 90.2% of active CRNAs reported experiencing verbal aggression. An additional 58.4% of the perpetrators were supervisors and 36.6% were coworkers (peer CRNAs). 21% of the CRNAs believed that workplace aggression has a negative effect on patient safety.

Del Grosso et al., (2019) found that LV-generated stress is a contributing factor to the burnout experienced by CRNAs. The researchers explain that the psychological phenomenon of burnout originates from the prolonged response to chronic interpersonal job-related stressors manifested as LV; the researchers concluded that LV and its consequences manifested in burnout greatly hinders the accuracy of appropriate healthcare interventions.

Papp, (2019) found that the attrition rate for operating room personnel, at a metropolitan healthcare system based in Allentown, Pennsylvania was at 10% per year compared to the national attrition average of 9.7%. Papp, (2019) surveyed 373 operating room staff to assess for the prevalence of LV amongst operating room nurses and

CRNAs. The majority of respondents were RNs and CRNAs. The survey showed OR staff employees: raise their voice when they get frustrated (65.5%), blame others for their mistakes (59.8%), gossip about each other (87.6%), are verbally abused by physicians (68.8%), bad-mouth others at work (80.5%), experience irritated and impatient patients and families (65.4%). After implementing an educational intervention consisting of a PowerPoint presentation module with a pre- and post- test, the researcher found that 62% of the CRNAs reported a decrease in LV incidence after attending the educational session regarding LV. Papp, (2019) concluded that effective LV education enhanced coping mechanisms and reduced the incidents of LV.

The demanding environment of surgery and the stressful nature of operating rooms puts the CRNAs at a continuous risk of being subjected to LV (King 2017). Chipas and McKenna (2011) state that stressful interaction between OR healthcare personnel and CRNAs is a major source of burnout and job dissatisfaction; the psychological stress coupled with the physiological strain are reducing the retention rates of CRNAs significantly.

Elmblad et al. (2014) conducted a study of LV prevalence, severity, and consequences with a total sample size of 385 surveys from the Michigan Association of Nurse Anesthetists from October 8 to November 25, 2012. Elmblad et al. (2014) revealed that CRNAs practicing in Michigan experience LV from multiple sources that include OR nurses, non-OR personnel, and physicians. The statistical analysis conducted by Elmblad et al. (2014) showed a significant direct correlation between LV and burnout for CRNAs with a statistical significance of  $P < .0001$ . Therefore, the researchers concluded that when LV exists in operating rooms, it negatively affects CRNAs by increasing their

level of burnout.

### **Lateral Violence among Registered Nurses**

The second section to the literature review investigates lateral violence for RNs. This search yielded 871 records. This number was reduced to 31 articles after applying the following exclusion criteria: articles published prior to 2008, articles that did not report original research, and articles not pertaining to the subject matter. From the aforementioned 31 articles, 11 were selected for final inclusion based on the inclusion criteria outline previously.

The sample size for the quantitative studies ranged from 76 participants (O'Connell, Garbark, & Nader, 2019) to 1165 participants (Hickson, 2013). The samples in all the quantitative studies were randomized, based on the snow-ball effect and volunteering. Various standardized measuring instruments were used to assess the frequency of exposure to LV. The Negative Act Questionnaire-Revised (NAQ-R) was used by four studies (Chang & Cho, 2016; Simons, 2008; Hickson, 2013; Vogelpohl, Rice, Edwards, & Bork, 2013) and assessed participants frequency of exposure to negative behavior (Cronbach's  $\alpha > 0.90$ ). The rest of the quantitative studies used different scales to assess for the impact of exposure to LV. Hickson (2013) used the McCloskey-Mueller satisfaction scale (MMSS) and Graduate Nurse Experience Survey (CFGNES) to assess job satisfaction for registered nurses. Both of these scales had a Cronbach's  $\alpha$  of greater than 0.80. Hickson (2013) used the results from these scales as a reflection of the impact of LV. Embree et al., (2013) used the Nurse Workplace Behavior Scale (NWS) to assess the frequency of LV and the Silencing the Self -Work Scale to assess for the strategies that oppressed nurses used to cope with exposure to LV. Both

scales have a Cronbach's  $\alpha$  of 0.81 and 0.79 respectively.

The sample size in the qualitative studies ranged between 26 (Griffin, 2014) to 212 (Vessey et al., 2009), data were collected through interviews, focus groups (Griffin, 2014) and surveys (Vessey et al., 2009). Three of the qualitative studies were described as systematic reviews of descriptive studies (Anusiewicz et al. 2019; Crawford et al., 2019; Hawkins, Jeong, & Smith, 2019). The three systematic reviews used an extensive search approach and the number of research studies retrieved ranged between 16 (Anusiewicz et al. 2019) to 28 (Hawkins, Jeong, & Smith, 2019). Overall, the findings of the qualitative studies show that negative workplace behavior continues to be an international problem. The findings also validate the perceptions of frequency and patterns of bullying behavior experienced by nurses across the United States (Hawkins, Jeong, & Smith, 2019; Vessey et al., 2009). The researchers also report the impact of incivility on nurses' physical, emotional, and psychological wellbeing (Crawford et al., 2019).

Overall, there was no contradiction amongst the studies used for this review. Seven out of the eleven studies chosen for this review supported that education raised awareness of LV and enhanced coping mechanisms. This reflected on higher retention rates and better job satisfaction. The three systematic reviews in the selected studies concluded that knowledge and educational deficit about LV is the main perpetrator behind increased incivility in the workplace.

All the studies used in this review ( $n= 11$ ) supported that LV is one of the main factors for decreased job satisfaction and the main reason influencing a nurses' decision to voluntarily leave the organization. Only one study (O'Connell, Garbark, & Nader,

2019) stated that there was no difference in outcomes due to education about LV with active-duty military nurses. The frequency of occurrence of LV was reported as 1.3%, but the researchers questioned the validity of this number due to the hierarchical nature of military nurses and fear of retaliation.

### **Impact of Education on Lateral Violence**

Embree et al. (2013) conducted a pre-/post- interventional survey to measure the effects of education and cognitive rehearsal on the perceived levels of lateral violence over a period of three years for 143 nurses working at a full-service inpatient hospital. The researchers used the Nurse Workplace Behavior Scale (NWS), the Silencing the Self-Work Scale (STSS-W), NWS-Internal Sexism Scale, and the Minimization of Self Scale. Embree et al. (2013) found a downward trend in the NWS-Internal Sexism Scale, which indicated that nurses who had an increased awareness of LV and feelings of empowerment had higher self-esteem scores. The Minimization of Self score had a slight increase after educational training which meant a lower perception of oppression and movement toward liberation. The STSS-W scale showed a trend down in means which indicated that nurses after the educational sessions were starting to depend less on the outside judgment of others and were more empowered to speak up than to feel silenced. The researchers concluded that education and cognitive rehearsal increased awareness of LV and improved empowerment and self-esteem, factors that increased job satisfaction and retention rates.

Hickson (2013) found that registered nurses in Magnet hospitals reported less incidents of LV, due to presence of support and higher awareness of LV compared to their counterparts in non-magnet hospitals. In this study, the independent samples t-test

revealed that registered nurses in a Magnet status hospital reported lesser exposure to LV (mean 64.73, T 24.68; n = 226) than their counterparts in a non-Magnet status hospital (mean 60.83, T 26.13; n = 939) ( $t_{1,163} = 2.04$ ,  $P = .042$ , 2-tailed,  $d = 0.15$ ). Hickson (2013) concluded that healthcare organizations should incorporate an LV educational component in orientation programs to support their staff.

Intentions to leave the organization are one of the main consequences of LV. Vogelpohl et al. (2013) found that out of the surveyed sample of nurses (n=135) within the first year of employment, 21.1% of licensed registered nurses reported that they were overlooked and isolated, 15.5% reported that they were victims of negative rumors and gossip, 14% stated that offensive comments were made about them, and 12.6% reported that their duty was removed and replaced with minor tasks. According to Vogelpohl et al. (2013) 35.4% of the licensed registered nurses decided to quit their jobs as a consequence of negative workplace behavior and a toxic professional environment. Vogelpohl et al. (2013) stated that the presence of a mentor or a senior nurse to educate nurses about lateral violence helped to raise LV awareness, and that 62.7% of the nurses following a mentor reported feeling more confident to handle LV. Vogelpohl et al. (2013) reported that 98.9% of nurses supported the notion that healthcare organizations should launch an educational and mentoring approach to provide nurses with information about LV and disruptive behavior as recommended by Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Vessey et al. (2009) discussed that a new nurse will always be a target of LV, if this new nurse differs from the existing staff in any major attribute like gender, age, race and ethnicity, and level of education; all are probable instigators for LV. Vessey et al.



(2009) reported that out of 303 registered nurses in the study sample, 57% were exposed to LV within 5 years or less of employment. The researchers reported that 75% of the LV victims chose to talk about their experience with family members or colleagues. They did not refer to a human resource department or their upper management. Vessey et al.

(2009) acknowledges that employee assistance programs and written harassment policies were available to the nurses. However, an overwhelming 97% of the nurses reported that no written policy or in-service education addressing lateral violence was conducted.

Accordingly, 78.5% of the 97% decided to leave the organization due to LV.

Griffin (2014) assessed for witnessing LV and being a victim of lateral violence. The study found that in a sample of 26 registered nurses, 96.1% reported witnessing a form of LV, and 46% of those incidents were directed at them. In the interventional study performed by Griffins (2014), 85% of the sample reported more sense of empowerment after receiving one hour of education about LV. The researchers found that when the registered nurses confronted the perpetrators, 75% of the perpetrators were surprised that the nurses felt victimized by LV, 58% apologized, and 25% shunned the nurses for approximately two weeks. Griffins (2014) however, found that the disruptive behavior stopped. The study concluded that education about LV increased awareness, enhanced coping, and helped nurses confront the laterally violent nurse.

The integrative review conducted by Crawford et al. (2019) provided a set of recommendations for creating an environment of civility to address LV. The researchers stressed the necessity for educational programs and academic preparation for nurses about LV. They suggest that nursing schools should introduce civility and coping mechanisms as educational topics in the nursing curricula. Crawford et al. (2019)

recommends that instructors and academic leaders should instruct student nurses on how to recognize LV and understand its negative consequences. The review stresses on the continuing education after nursing school. It recommends that healthcare organizations should set in motion an extension to the nursing schools' education through residency programs that incorporate LV awareness training in its curricula.

Hawkins et al. (2019) conducted a systematic review and concluded that a nurse residency program that incorporates educational sessions about LV is imperative to raise awareness and improve coping mechanisms by nurses. Hawkins et al. (2019) found that nurses who attended study sessions and training classes about LV showed better communication skills and stress management when exposed to LV. The researchers found that new nurses who had the opportunity to participate in residency programs that incorporate education about LV showed better transition to professional settings than nurses who didn't have the same opportunity. This reflected positively on the scores of job satisfaction and retention rates. The study by Hawkins et al. (2019) concluded two strategies to reduce LV and its consequences. First, to improve coping mechanisms of the victims and second, to construct an organizational road map in healthcare organizations to reduce incivility and LV. Hawkins et al. (2019) stresses that these two strategies can be accomplished by incorporating LV education in the nurse residency transition programs.

### **Evidence Based Practice Project**

The chosen option for Evidence Based Practice (EBP) practice project was to implement a pre-and post-survey with an educational video in between the surveys. The goal was for the educational video to increase recognition of lateral violence and increase the ability of the CRNA to deal with lateral violence. If nursing personnel in the

operating room feel safe and well respected in the workplace then this may impact job satisfaction (Kwak, C., 2020). If a CRNA is highly satisfied, then they will potentially have less stress and less burn out (Chipas and McKenna, 2011). Experiencing minimal stress and burnout facilitates job productivity and engagement, which can further lead to improved patient care (Del Grosso et al., 2019).

### **Theoretical Framework or Evidence Based Practice Model**

The theoretical framework for this project is the Newman Model. This model outlines the impact and relationship of stressors on client system stability. Each client reacts to different types of stress. Incivility represents the concept of stressors. The Newman Model encompasses physiological, psychological, sociocultural, developmental, and spiritual effects from the stressors. It constitutes metaphorical lines of defense and lines of resistance for these stressors around a basic structure. Prevention interventions like education sessions can strengthen the lines of defense and resistance (DeMarco et. al, 2018). The Newman Model supports research advancing the understanding of this stability. It can be used to determine the benefit and utility of prevention interventions on various subjects including staff. This theory aligns with our education session as part of a prevention intervention to help prevent further harm from lateral violence. Our project is in alignment with the model diagram displayed in DeMarco et. al, 2018 (see Appendix A). This framework will be used to guide our DNP project by utilizing the CNRAs as the client system, lateral violence is the stressor, and the education program is a means to strengthen the lines of resistance and defense.

**Goals, Objectives and Expected Outcomes**

The primary DNP project objective is to develop a professional program that informs and educates the CRNAs about lateral violence and to evaluate the developed program for effectiveness through a post-educational survey. Secondary objectives include: 1) Assess how common it is for CRNAs to experience lateral violence in the workplace and 2) Explore how lateral violence impacts their professional role and personal well-being.

The overarching goals for this educational intervention are that participants will have increased confidence in confronting, reporting, and preventing lateral violence in the OR. The expected outcomes of the educational module and presentation included the participants have increased their knowledge of the following topics related to LV:

- Prevalence of lateral violence events in the operating room reported by CRNAs.
- Increased awareness about lateral violence, including being able to define lateral violence and the scope and manifestations of the issue.
- Identification of problematic behavior.
- How to appropriately deal with lateral violence
- Coping mechanisms involved with LV.

There were six specific objectives for the participants of this project to achieve. These objectives were developed utilizing Bloom's Taxonomy and include: 1) Define lateral violence. 2) Identify lateral violence behavior at your current workplace. 3) Give examples of lateral violence experienced directly or witnessed at your current workplace. 4) Differentiate between the following coping mechanisms: Box Breathing, Clench and

Release, and S.T.O.P. 5) Compose an appropriate response when confronted with a perpetrator of lateral violence. 6) Choose three effective ways to manage lateral violence.

Bloom's taxonomy of cognitive objectives describes learning in six levels including: knowledge, comprehension, application, analysis, synthesis and evaluation. See Appendix D for the taxonomy level that correlates with each objective. They are all observable and measurable through our pre- and post- survey questions for our project. These questions align with the objectives to measure if each was achieved after viewing the lateral violence presentation. The same question was asked in the pre-survey as well as the post-survey to be measurable. The objectives are realistic, and learner centered as they all integrate information presented in the lateral violence presentation.

### **Project Design**

This project is an educational intervention which included pre-educational survey (see Appendix L), video educational session (see Appendix M), and post-educational survey (see Appendix N). Approval for this project was obtained from Oakland University Institutional Review Board (IRB). On November 4, 2021 the IRB gave the decision for this project to be exempt (see Appendix I). After IRB exemption was obtained, the survey link was submitted via email to the Michigan Association of Nurse Anesthetists (MANA) (see Appendix O). The one survey link included the pre-survey, educational video, and post-survey.

### **Project Site and Population**

The population for this study is Certified Registered Nurse Anesthetists that are currently working in the state of Michigan who are members of Michigan Association of

Nurse Anesthetists (MANA). A mass electronic email from the MANA organization database was used for the target CRNA population.

## **Methods**

### **Measurement Instruments**

Measurements for this project included a pre- and post- intervention survey. These surveys had multiple sections. For the pre-test, there were 22 questions total. These included general demographics (n=11), multiple choice (n=11), an optional fill in the blank (n = 1), and knowledge-based questions (n = 6). For the post-test, there were 16 questions total. These consisted of multiple choice (n=16), an optional fill in the blank (n = 1), knowledge-based questions (n=6), and select all that apply (n=2). In order to measure the outcome of the educational module, the pre-test and the post-test included 5 of the same questions to test participants knowledge. There were also two more questions added to evaluate information taught in the presentation. These two questions were about the coping mechanisms, "Clench and Release" and "S.T.O.P." that were taught to the participant in the educational video. The questions were selected based on the information in the education module.

### **Data Collection Procedures**

The data were collected by sending the pre-educational survey, video educational session, and post-educational survey in one combined link. The link was sent out to the MANA database of emails on three separate occasions. The surveys and videos are embedded through Qualtrics. One link was used in order to evaluate the same participant and compare that same participant's answers of their pre-survey to their post-survey. This allowed the data to remain anonymous, yet still allow a comparison of the pre-survey to

the post-survey to assess the prevalence of LV in the target population. Confirmation of the survey being sent out three times was received through e-mail correspondence. The educational module target was to reduce incidence of LV and the enhancement of job satisfaction and coping mechanisms when one is confronted with LV.

### **Data Analysis**

The data collected from the Qualtrics surveys were processed for frequencies and central tendencies using SPSS IBM statistics software version 28.

All data were organized and labeled with codes and all participants were anonymous. Anonymity was established and maintained because the pre-test survey, the educational intervention, and the post-test survey were all embedded into one Qualtrics link. Therefore, participants completed the pre-test, watched the voice-over PowerPoint presentation, and then completed the post-test survey which were recorded into Qualtrics for each participant.

Additional screening and cleaning of the data included the following process. The initial analysis consisted of 110 participants in the dataset. These candidates were screened for eligibility. There were five participants who indicated they are not currently practicing in Michigan with no additional data provided. These five participants were eliminated from further analysis. Upon further screening, 11 participants were eliminated from analysis due to only answering the first question, "Are you a current CRNA practicing in Michigan?" This brought the final number of pre-test participants to n=94. Upon further examination of the dataset, 41 out of the 94 participants did not complete a post-test. So, the final sample size of both pre- and post- test came to n=53 for this

dataset. Separate analysis of the n=94 pre-test is discussed in the section titled “Pre-Test Specific Results.”

## Results

Demographic data collected for the n=53 included age, gender, years practiced as a CRNA, employment setting, and anesthesia model of work. Participants were divided into six age groups. The highest frequency of participants were ages 50-59 (n=16; 30.2%). The next highest frequencies were both ages 30-39 and 40-49 (n=12; 22.6% for both groups). The smallest frequency age group was >69 (n=2; 3.8%), (see Appendix P).

The majority of participants were female (n=29; 54.7%) with 39.1% (n=21) identifying as male. The years practiced as a CRNA were divided into five groups. The sample size had a wide range of practice years. The highest percentage was 20+ years of experience (n=18; 34%). The next largest group was the newest CRNAs with 0-5 years of practice (n=12; 22.6%), (see Appendix P).

The majority of participants worked at a hospital with 100 - 499 beds (n=22; 41.5%) and a hospital with 500 or greater beds (n=19; 35.8%). There were three participants who answered the open-ended statement, “I do not work in a hospital setting, I work in a (an) \_\_\_\_\_.” The three responses were as follows: “Ambulatory Surgery Center”, “I have two practices; one in a hospital 100 - 499 beds and another at a free-standing endoscopy center”, and “private practice.” The majority of respondents work in an urban/suburban location (n=39; 73.6%). One participant answered the open-ended statement “Other (please describe): \_\_\_\_\_” with “Primary employment is in the University setting.” The majority of participants (69.8%; n=37) worked in an Anesthesia Care Team (ACT) model with MDA direction/ supervision for their primary place of



employment. The other models of work included MD + CRNA model (20.8%; n=11) and all CRNA model (9.4%; n=5).

Further survey questions we analyzed sought to investigate the current experiences of CRNAs pertaining to lateral violence. These questions involved witnessing lateral violence, awareness of a bullying policy, previous incivility education or training, ability to define lateral violence, and LV factoring into job dissatisfaction. There were 67.9% (n=36 of 52) of participants who reported “yes” to having witnessed lateral violence/ incivility/ bullying at their current department. Another 11.2% of the 52 participants were unsure if they had witnessed LV. Responses to the question stating: “Are you aware of a policy against lateral violence/ incivility/ bullying at your facility?” included the majority of respondents either unaware or unsure of a policy. There were 41.5% unaware (n=22), 30.2% unsure (n=16), and the remaining 28.3% of participants were aware of a policy. The largest percentage of respondents (43.4%) had not received previous education or training about incivility at their facility with another 12 participants (22.6%) who were unsure if they had received previous education or training. When asked if the participant was able to define lateral violence, 47.2% said yes, 35.8% said they were unsure, and 17.0% said no. A Likert-scale response was used to explore what degree workplace lateral violence factored into job dissatisfaction. The highest frequency response was “to a moderate degree” with 28.3% (n=15) answers, (see Appendix P).

There were five questions that had a Likert-scale response (1=strongly disagree to 5=strongly agree) to analyze examples of lateral violence participants experienced from operating room (OR) staff. The staff could include OR nurses, surgical technicians, surgeons, students, anesthesiologists and CRNAs. The questions asked if 1) some OR

staff raise their voices when they get frustrated (79.2% agreed or strongly agreed), 2) yell at me or others about matters that are not important (52.8% agreed or strongly agreed), 3) take their feelings out on me or others (e.g. stress, anger) (62.3% agreed or strongly agreed), 4) blame me or others for their mistakes or offenses (62.3% agreed or strongly agreed), and 5) have basic disagreements that turn into personal verbal attacks on other employees (64.2% agreed or strongly agreed) (see Appendix P).

There were five questions that were asked in both the pretest and the posttest. The material in these questions was taught in the educational module. For the discussion of these results, each full question was shortened to an abbreviated question. Here are the five questions with the abbreviations following.

- What is the definition of lateral violence? → “definition of LV”
- Approximately what percent of people gossip about each other in the perioperative area? → “percent gossip”
- Approximately what percent of CRNA’s experienced incivility at least once a week? → “experienced incivility”
- When confronted with a perpetrator of lateral violence, the best response is: → “when confronted”
- During your shift a coworker started yelling at you because of some delays. What would be an appropriate response? → “started yelling”

For “definition of LV” in the pre-test, 67.9% had the answer correct and, in the post-test, 94.3% correctly answered the item. The correct answer was “any repetitive disruptive behavior among peers that is considered offensive, abusive or intimidating by the target.” For “percent gossip” in the pre-test, 20.8% had the answer correct and, in the

post-test, 61.5% correctly answered the item. The correct answer was “88%.” For “experienced incivility” in the pre-test, 32.1% had the answer correct and, in the post-test, 51.9% correctly answered the item. The correct answer was “> 50%”. For “when confronted” in the pre-test, 73.6% had the answer correct and, in the post-test, 84.9% correctly answered the item. The correct answer was “Address the statement or actions, not the individual.” For “started yelling” in the pre-test, 60.4% had the answer correct and, in the post-test, 90.6% correctly answered the item. The correct answer was “I will not discuss this further until you lower your voice.” All of the items were statistically significant for improvement. The post-test “definition of LV” reported significantly higher correct answers ( $M = 1.96$ ,  $SD = 1.414$ ),  $t(1) = 4.174$ ,  $p < .001$ . The post-test “percent gossip” reported significantly higher correct answers ( $M = 3.37$ ,  $SD = 0.929$ ),  $t(1) = -5.346$ ,  $p < .001$ . The post-test “experienced incivility” reported significantly higher correct answers ( $M = 3.23$ ,  $SD = 0.783$ ),  $t(1) = -3.538$ ,  $p < .001$ . The post-test “when confronted” reported significantly higher correct answers ( $M = 3.09$ ,  $SD = 0.450$ ),  $t(1) = -3.274$ ,  $p < .001$ . The post-test “started yelling” reported significantly higher correct answers ( $M = 3.79$ ,  $SD = 0.661$ ),  $t(1) = -4.136$ ,  $p < .001$ .

In the pretest, for the Question “Most of the lateral violence/incivility and bullying seen in the operating room comes from which of the following source?”, the highest frequency was for surgeons at 45, followed by anesthesiologists at 26, OR nurses at 20, CRNAs at 11, and surgical technicians at 10. No answers stated witnessing LV from students. These frequencies changed after the educational module, and new categories were picked by the participants after they developed a better understanding for LV. The frequencies to sources of LV in the post test were as follows: 20 for patients, 24 for

visitors, 34 for OR nurses, 32 for preop and postop nurses, 42 for anesthesiologists and 50 for surgeons.

In the pretest, when the participants were asked if they were able to define LV, 47.2% answered yes, 17% answered no, while 35.8% answered unsure. When the same question was asked to the participants after the educational module, 100% answered yes. A Wilcoxon Signed Rank Test revealed a statically significant increase in identifying LV after the program intervention,  $z = -2.67$ ,  $p = .008$ .

In the posttest, for the question “Now that you have additional information about the definition of lateral violence, do you believe that you have witnessed lateral violence at your current workplace?”, 94.3% of the participants answered yes. This is an increase of 26.4% compared to 67.9% in the pretest. There were 32.1% of the participants that admitted to being more able to define LV better after the educational module and they were unable to define it before.

### **Discussion**

Currently, there are more than 57,000 CRNAs in the United States. CRNAs practice in every U.S. state and provide anesthesia in every practice setting requiring anesthesia. The demographic dataset obtained from this doctoral project closely resembles the demographic dataset obtained from the AANA (American Association of Nurse Anesthesiology). MANA is a statewide organization representing over 2,600 CRNAs and students. It has been established for over 75 years in Michigan. The following statistics are obtained from the AANA Member Survey Data for 2021, which includes data from 2020 ( $n=4,251$ ). About 46% of the nurse anesthetists are male and 54% are female. The current average age is 48.6 years old. The AANA divided its ages into nine groups. The

most frequent age ranges are ages 35 - 39, 40 - 44, and 45 - 49, with each group at 14%. The smallest percentage age range is ages 20 - 29 at 2%. The most common ethnicity is White or Caucasian (88%), then Asian or Pacific Islander (4%), and Hispanic or Latino (4%). Their experience as a CRNA was broken down into six groups. The highest percentage of CRNAs fell into the 11-20 years of experience group (31%). The largest percent of CRNAs are employees of a hospital (41%). The AANA did not subcategorize employment settings or anesthesia work models. The demographic dataset obtained from this doctoral project closely mirrors that obtained from the AANA.

The results obtained from this survey evaluation allowed us to meet our objective: Create and evaluate an educational program for effectiveness through a pre- and post-educational survey. The five questions utilized to compare pre- and post- test answers showed this through an increase in correct responses for all five questions. Based on the results obtained, the proper effectiveness of this program was demonstrated. All of the items were statistically significant for improvement.

Aligning with our objective to increase awareness about lateral violence, 100% of participants said “yes” to being able to define LV in the post-test with statistical significance. Also, there was mostly positive agreement with the ability of the educational module to allow the participant to better identify lateral violence. The majority strongly agreed (50.9%) and somewhat agreed (26.4%). Our educational program objective of participants being able to effectively manage lateral violence was met. When asked if the participant was able to describe at least three effective ways to manage lateral violence after the educational module, 79.3% either agreed or strongly agreed (20.8% somewhat agreed, 58.5% strongly agreed).

The secondary objective includes to assess how common it is for CRNAs to experience lateral violence in the workplace. Pre-test values for witnessing LV include the majority of participants saying yes (67.9%) and this value increasing to 94.3% in the post-test. Also, all five of the questions that analyzed examples of LV from OR staff had “somewhat agree” for the highest response. Another secondary objective to see how LV impacts participants’ professional role and personal well-being. The highest frequency of participants responded, “to a moderate degree” (28.3%, n=15) when asked if workplace lateral violence factored into job dissatisfaction.

All specific goals for this educational intervention were met. These goals were discussed in the “Objectives” section. Results obtained from the five comparison questions show an increase in knowledge pertaining to each area of interest. For “definition of LV”, the pre- to post-test increase in correct answer was 26.4%. For “percent gossip” 40.7% more answered the question correctly in the post-test. For “experienced incivility”, there was a 19.8% improvement in the post-test response. For “when confronted” there was an 11.3% increase. For “started yelling”, 30.2% more participants answered the question correctly in the post-test. Overall, there was an average increase of 25.68%.

Further objectives were met through increased confidence in identifying and managing lateral violence in the OR. Most participants agreed the educational module was effective. This was displayed through the positive answers to the post-test questions regarding effective ways to manage and identify LV. In these questions, the majority strongly agreed (50.9%) and somewhat agreed (26.4%). Our objective of being able to effectively manage lateral violence was met. When asked if the participant was able to

describe at least three effective ways to manage lateral violence after the educational module, 58.5% strongly agreed and 20.8% somewhat agreed (79.3% of positive agreements).

Limitations of this project include a small sample size of the overall total CRNA population. Also, there were two questions to evaluate management strategies in the post-test that were not asked in the pre-test. For true comparison of these questions, these questions could have been added to the pre-test. So, it is unclear if this educational module effectively increases participant's ability to perform these stress reduction strategies. Therefore, the objective to "differentiate between the following coping mechanisms: Box Breathing, Clench and Release, and S.T.O.P" was not met.

Our results would have been strengthened if all 94 initial participants that completed the pre-test would have completed the post-test. Possible explanations include time constraints, lack of motivation, or technological issues.

Overall, the majority of our objectives were met. The five questions utilized to compare pre- and post- test answers showed this through an increase in correct responses for all five questions. Aligning with our objective to increase awareness about lateral violence, 100% of participants said "yes" to being able to define LV in the post-test. Also, there was mostly positive agreement with the ability of the educational module to allow the participant to better identify lateral violence.

The information obtained in this doctoral project supports the current information in the literature review. LV is prevalent in the operating rooms today, especially in lieu of the aftermath of the Covid-19 pandemic. An educational intervention about LV

identification, management, and coping mechanisms should be incorporated into healthcare organizations.

### **Timeline**

The tentative timeline for this project was as follows. Original proposal approval for this project was obtained in July of 2020. Further approval with design and details was obtained in November 2020. MANA approval for sending the survey out was obtained in August 2021. Designing and recording the educational video occurred through the fall and winter of 2021. Oakland University IRB exemption was obtained in November of 2021. The combined link with the pre-educational survey, video educational session, and post-educational survey in one combined link was sent out on three separate occasions from February through March of 2022. Analysis and assembly of the final project occurred in Spring of 2022.

### **Ethical Considerations/Protection of Human Subjects**

The Oakland University of Internal Review Board (IRB) approval was obtained prior to initiating the DNP Project (see Appendix I). The participants were anonymous, and their confidentiality was assured by coding every participant name using numerical identifiers and filing the returned surveys in an electronically secured location. This location was through the Qualtrics survey system. There was no patient information or identifiers discussed in either surveys or the educational video.

### **Conclusion**

The review of literature showed the efficacy of education in reducing the incidence of lateral violence and increasing job satisfaction and performance. An environment with less lateral violence will create less stressful work conditions that will



help increase productivity and job satisfaction in the perioperative arena. Certified Registered Nurse Anesthetists experience lateral violence in hospital settings; however, the magnitude of this issue needs further research. The results obtained from this doctoral project met our primary objective of developing and evaluating a professional program that informs and educates CRNAs about lateral violence. A professionally developed program that informs CRNAs about lateral violence will enhance opportunities to change patterns of its existence and ultimately promote job satisfaction and personal wellbeing.

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**Appendix A****DNP PROJECT AREA OF INTEREST AND DNP  
PROJECT TEAM APPROVAL FORM**

Date: \_\_\_\_\_

Student name: \_\_\_\_\_

The signature of the DNP Project Team indicates approval of the DNP Final Project idea/concept and agreement to serve on the team.

Student (print):

Name: (print)

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

DNP Project Chair:

Name: (print)

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

DNP Project Team Member:

Name: (print)

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Additional Team Members (Optional):

Name: (print)

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

DNP Program Coordinator/Director:

Name: (print)

\_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPENDIX B****DNP PROPOSAL RUBRIC**

Score each area using the following Likert scale: 1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree

		Score
Background and Significance	Describes the phenomena, its importance to healthcare and affected stakeholders.	
Purpose Statement	Clearly and concisely states the goal of the project.	
Review of the Literature	Provides an organized, integrated summary of the state of the science (with level of evidence provided).	
Theoretical Framework	Provides appropriate theoretical framework to guide project.	
Methods and Procedures	Clearly and concisely summarizes (where applicable): <ul style="list-style-type: none"> <li>• Evidence-based practice model or research design</li> <li>• Participants/population</li> <li>• Sample/setting</li> <li>• Recruitment</li> <li>• Instruments</li> <li>• Procedures</li> <li>• Key personnel</li> <li>• Stakeholders</li> <li>• Barriers to implementation and sustainability</li> <li>• Data collection plan</li> <li>• Data analysis plan</li> <li>• Ethical considerations</li> </ul>	
Resources	Identifies all anticipated resources and potential costs.	
Approvals for Implementation	Identifies required approvals needed for implementation (cooperating agencies, IRB, etc)	
Evaluation Plan	Clearly and concisely summarizes evaluation plan (where applicable): <ul style="list-style-type: none"> <li>• Objectives or research questions.</li> <li>• Plan for monitoring objective accomplishment.</li> </ul>	

	• Plan if problems encountered during implementation.	
References	Current references	
Clarity of Writing and Writing Technique	Writing is clear and succinct. The writer incorporates the active voice when appropriate. Appropriate grammar	
APA	Follows current APA format guidelines	

DNP Project

Chair\_\_\_\_\_Date\_\_\_\_\_

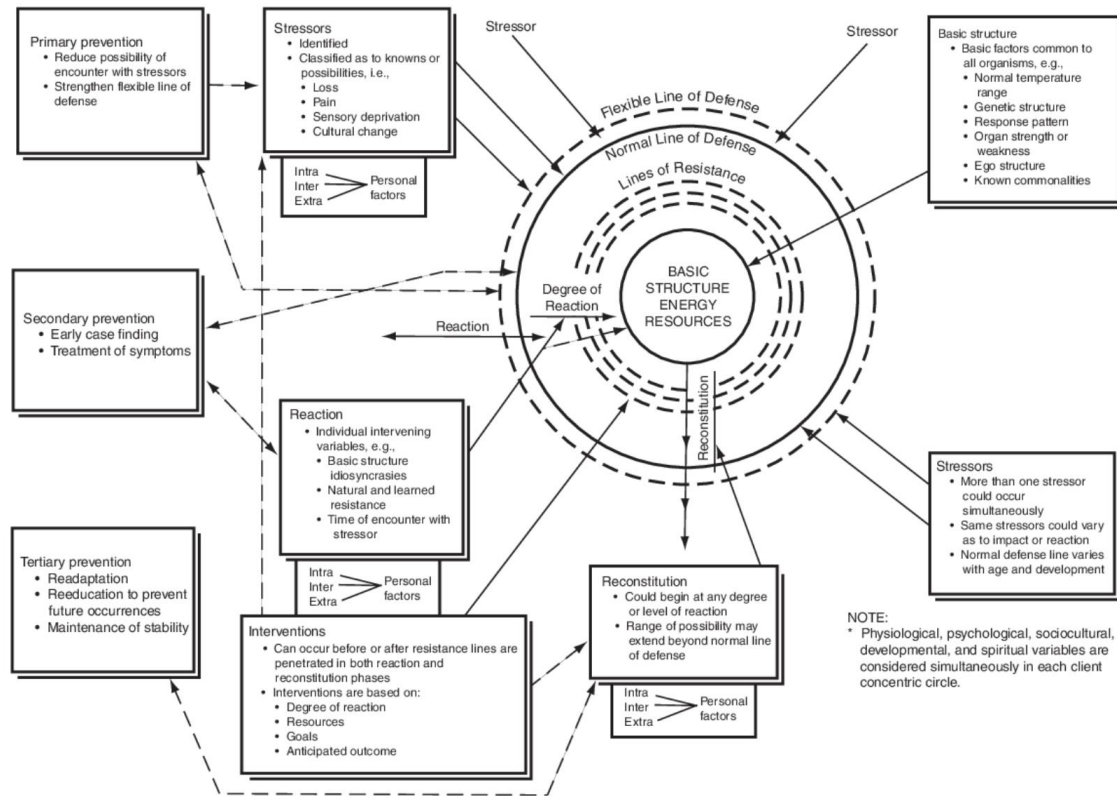
\_\_\_\_\_

DNP Team

member\_\_\_\_\_Date\_\_\_\_\_



## Appendix C



### Appendix D

#### APPENDIX D: FINAL PROJECT RUBRIC/APPROVAL FORM

Score each area using the following Likert scale:

1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree

		Score
Background & Significance	Describes the phenomena, its importance to healthcare and affected stakeholders	
Purpose Statement	Clearly and concisely states the goal of the project.	
Review of the Literature	Provides an organized, integrated summary of the state of the science (with level of evidence provided).	
Theoretical Framework	Provides appropriate theoretical framework to guide project.	
Methods and Procedures	Clearly and concisely summarizes (where applicable): <ul style="list-style-type: none"> <li>• Evidence-based Practice model or Research design</li> <li>• Participants/population</li> <li>• Sample/setting</li> <li>• Recruitment</li> <li>• Instruments</li> <li>• Procedures</li> <li>• Key personnel</li> <li>• Stakeholders</li> <li>• Barriers to implementation and sustainability</li> <li>• Data collection plan</li> <li>• Data analysis plan</li> <li>• Ethical considerations</li> </ul>	
Resources	Identifies all required resources and costs	
Approvals for Implementation	Provides all required letters of support from cooperating agencies (as appendices).	
Results	Clearly and concisely summarizes (if appropriate): <ul style="list-style-type: none"> <li>• How each goal/research question was objectively evaluated.</li> <li>• Statistical analyses for each goal/question.</li> </ul>	
Discussion	Addresses each objective: <ul style="list-style-type: none"> <li>• Provides facilitators and barriers encountered.</li> <li>• Identifies unintended consequences (both positive and negative, if appropriate) and how handled.</li> <li>• Thorough analysis of findings with comparison to literature.</li> </ul>	
Recommendations and Limitations	Provides future recommendations for project/research and possible application of this project in other settings. Identifies all limitations of project	

Implications for practice and career development	Discusses impact of project and residency on personal growth and development.	
References	Current state of the science references (with matrix).	
Clarity of Writing and Writing Technique	Writing is clear and succinct. The writer incorporates the active voice when appropriate. Grammar appropriate	
APA	Follows APA.	

**Appendix E**

## DNP FINAL PROJECT COMPLETION APPROVAL FORM

This is to certify that \_\_\_\_\_, a  
DNP student in the School of Nursing, has successfully presented and received approval  
for completion of his/her DNP Project entitled

\_\_\_\_\_ and it has been approved as meeting the requirement for the Degree of Doctor of  
Nursing Practice.

Oral presentation approved Date: \_\_\_\_\_

Manuscript approved Date: \_\_\_\_\_

\_\_\_\_\_ DNP Project Chair Date

\_\_\_\_\_ Faculty Team Member Date

\_\_\_\_\_ Clinical Expert Mentor  
Date

\_\_\_\_\_ Graduate Program Director Date

**APPENDIX F****DNP PROJECT TIME LOGS****DNP Project Hours Tracking Form**

Date	Hours	DNP Project Task Completed	AACN Essential Met	Mentor Signature
5/9/2020	4	Brainstorming	Essential I & II	
5/16/2020	4	Brainstorming	Essential I & II	
5/23/2020	5	Task examples	Essential I & II	
5/30/2020	8	Research	Essential II, III, IV	
6/6/2020	6	Research	Essential II, III, IV	
6/13/2020	7	Research	Essential II, III, IV	
6/27/2020	8	Research	Essential II, III, IV	
7/4/2020	6	Proposal creation	Essential V	
7/11/2020	5	Proposal creation	Essential V	
7/18/2020	7	Proposal creation	Essential V	
7/25/2020	6	Proposal creation	Essential V	
8/1/2020	4	Proposal presentation	Essential V	
8/8/2020	4	Proposal presentation	Essential V	
8/15/2020	7	Proposal presentation	Essential V	
8/22/2020	8	Proposal presentation	Essential V	
8/29/2020	8	Research	Essential II, III, IV	
9/5/2020	6	Research	Essential II, III, IV	
9/12/2020	4	Research	Essential II, III, IV	
9/19/2020	7	Research	Essential II, III, IV	
9/26/2020	3	Research	Essential II, III, IV	
10/3/2020	6	Literature Review	Essential III	
10/17/2020	8	Literature Review	Essential III	
10/24/2020	5	Literature Review	Essential III	
10/31/2020	7	Literature Review	Essential III	
11/7/2020	6	Design approval	Essential VI	
11/21/2020	2	Design approval	Essential VI	
11/28/2020	6	Design approval	Essential VI	
12/12/2020	4	Literature Review	Essential III	
12/19/2020	6	Literature Review	Essential III	
12/26/2020	2	Literature Review	Essential III	
1/2/2021	7	Literature Review	Essential III	
1/9/2021	5	Literature Review	Essential III	
1/16/2021	6	Literature Review	Essential III	
1/23/2021	5	Project design	Essential VI, VII	
1/30/2021	5	Project design	Essential VI, VII	

2/13/2021	6	Project design	Essential VI, VII	
3/6/2021	8	Project design	Essential VI, VII	
3/20/2021	6	Project design	Essential VI, VII	
3/27/2021	9	Project design	Essential VI, VII	
4/3/2021	6	Survey research	Essential II, III, VIII	
4/10/2021	8	Survey research	Essential II, III, VIII	
4/24/2021	8	Survey research	Essential II, III, VIII	
5/1/2021	4	Survey research	Essential II, III, VIII	
5/8/2021	2	Survey Creation	Essential II, III, VIII	
5/15/2021	8	Survey Creation	Essential II, III, VIII	
5/29/2021	5	Survey Creation	Essential II, III, VIII	
6/12/2021	4	Survey Creation	Essential II, III, VIII	
6/26/2021	6	Survey Creation	Essential II, III, VIII	
7/3/2021	4	MANA Information	Essential III	
7/10/2021	8	MANA Information	Essential III	
7/24/2021	4	MANA Information	Essential III	
7/31/2021	6	MANA Information	Essential III	
8/7/2021	9	Educational Module Research	Essential VII, VIII	
8/14/2021	6	Educational Module Research	Essential VII, VIII	
8/28/2021	5	Educational Module Research	Essential VII, VIII	
9/4/2021	8	Educational video Construction	Essential VII, VIII	
9/25/2021	6	Educational video Construction	Essential VII, VIII	
10/2/2021	6	IRB Process	Essential III, VIII	
10/9/2021	8	IRB Process	Essential III, VIII	
10/30/2021	4	IRB Process	Essential III, VIII	
11/6/2021	2	IRB Process	Essential III, VIII	
11/20/2021	7	IRB Process	Essential III, VIII	
11/27/2021	5	IRB Process	Essential III, VIII	
12/4/2021	9	Qualtrics	Essential III, VIII	
12/11/2021	4	Qualtrics	Essential III, VIII	
12/18/2021	3	Qualtrics	Essential III, VIII	
12/25/2021	6	Editing Educational Video	Essential VII, VIII	
1/1/2022	4	Editing Educational Video	Essential VII, VIII	
1/8/2022	8	Editing Educational Video	Essential VII, VIII	
1/15/2022	6	Qualtrics	Essential III, VIII	
1/22/2022	8	Editing Educational Video	Essential VII, VIII	
1/29/2022	5	Editing Educational Video	Essential VII, VIII	
2/5/2022	8	Email MANA	Essential III	
2/12/2022	4	Literature Review Research	Essential III	
2/26/2022	8	Literature Review Research	Essential III	
3/5/2022	7	Literature Review Research	Essential III	
3/12/2022	5	Literature Review Editing	Essential III	
3/19/2022	9	Literature Review Editing	Essential III	

3/26/2022	4	Literature Review Editing	Essential III	
4/2/2022	3	Project editing	Essential II, III, VIII	
4/9/2022	6	Project editing	Essential II, III, VIII	
4/16/2022	4	Project editing	Essential II, III, VIII	
4/23/2022	8	Statistical results analysis	Essential II, III, VIII	
4/30/2022	8	Statistical results analysis	Essential II, III, VIII	
5/7/2022	6	Editing Results & discussion	Essential II, III, VIII	
5/21/2022	8	Editing Results & discussion	Essential II, III, VIII	
5/28/2022	8	Editing Results & discussion	Essential II, III, VIII	
6/4/2022	4	Dissemination presentation work	Essential V, VII, VIII	
6/6/2022	3	Dissemination presentation work	Essential II, III, VIII	
6/11/2022	7	Editing PPT, Results & discussion	Essential II, III, VIII	
6/14/2022	4	Editing PPT, Results & discussion	Essential II, III, VIII	
6/20/2022	6	Editing PPT, Results & discussion	Essential II, III, VIII	
6/23/2022	2	Editing PPT, Paper	Essential II, III, VIII	
6/26/2022	3	Editing PPT, Paper	Essential II, III, VIII	
6/29/2022	2	DNP Dissemination Practice	Essential II, III, VIII	
6/30/2022	1	DNP Dissemination	Essential II, III, VIII	

**APPENDIX G****GROUP DNP PROJECT PLANNING FORM**

Students who are completing a Group DNP Project are required to submit this form to the DNP Project Chair for approval at the beginning of the DNP Planning Process. As outlined in the DNP Project Requirements, only 2 students may work together, students must be individually evaluated, and the Project must comply with the AACN (2015) requirements.

<b>Requirements</b>	<b>Student A Ahmed Alyabdellatif</b>	<b>Student B Victoria Tripp</b>
Describe the contributions to overall DNP Project Planning.	Shared Responsibility in: Planning, implementing and data collection	Shared Responsibility in: Planning, implementing and data collection
Describe the Aim/Objectives of which student is taking a leadership role.	Speaking to Students and anesthesia providers regarding the chosen topic	Speaking to faculty regarding topic ideas and presenting topics to faculty
Describe contributions to: - Writing DNP Project Proposal - Proposal Presentation - IRB submission - Developing plan for Experience Hours	Shared Responsibility in: Writing and editing the project proposal  Participated in the PowerPoint presentation  Completing the IRB form  Create slides 2, 5, 7, 8, 11, 12  Present half of slides to faculty during project proposal presentation	Shared Responsibility in: Writing and editing the project proposal  Participated in the PowerPoint presentation  Completing the IRB form  Create slides 1, 3, 4, 6, 9, 10  Present half of slides to faculty during project proposal presentation
Describe the contributions to: - Project Planning - Project Implementation	Shared Responsibility in:	Shared Responsibility in:



- Project Analysis/Synthesis - Project Dissemination-	Develop educational module curriculum  Write video script Create video  Develop assessment tools (pre- and post-tests and Likert items)  Upload video on YouTube.com  Obtain pre- and post-intervention tests and surveys  Analyze pre- and post-test and survey results  Write finding analysis and conclusions, draft final DNP paper	Develop educational module curriculum  Write video script Create video  Develop assessment tools (pre- and post-tests and Likert items)  Upload video on YouTube.com  Obtain pre- and post-intervention tests and surveys  Analyze pre- and post-test and survey results  Write finding analysis and conclusions, draft final DNP paper
Describe the contributions to: -DNP Project Final Report -Mechanism for dissemination	Create DNP project PowerPoint presentation  Present project to DNP committee, submit final DNP paper	Create DNP project PowerPoint presentation  Present project to DNP committee, submit final DNP paper
Student Signatures:		

**Approved by DNP Project Chair:**

**Name**

**Date**

**APPENDIX H****AUTHORSHIP AGREEMENT**

The student(s) and the DNP Project Team agree to the following in regards to authorship of any published material, posters, and or presentations based on this project. (Check one only).

\_\_\_The team does not wish to be included in the authorship of any published material, posters or presentations.

\_\_\_The team must be included in the authorship of the first published article only.

\_\_\_The team must be included in the authorship of ALL published materials, posters, and presentations based on this project.

Student signature \_\_\_\_\_Date\_\_\_\_\_

Student signature \_\_\_\_\_Date\_\_\_\_\_

DNP Project Chair signature\_\_\_\_\_Date\_\_\_\_\_

Team member signature \_\_\_\_\_Date\_\_\_\_\_

## Appendix I



Ahmed Alyabdelatif &lt;alyabdelatif@oakland.edu&gt;

## IRB-FY2022-39 - Initial: Exempt Decision

1 message

do-not-reply@cayuse.com &lt;do-not-reply@cayuse.com&gt;

Thu, Nov 4, 2021 at 11:39 AM

To: alyabdelatif@oakland.edu, biting2@oakland.edu, vtripp@oakland.edu



Institutional Review Board

Date: November 4, 2021

Study #: IRB-FY2022-39

Study Title: The Presence of Lateral Violence in the Operating Room Experienced by Certified Registered Nurse Anesthetists and Registered Nurses: An Opportunity for Change

Submission Type: Initial

IRB Decision: Exempt

## Research Team:

Ahmed Alyabdelatif  
Victoria Tripp, Andrea Bittinger  
Julie Kruse, Andrea Bittinger

Based on applicable federal regulations, the above referenced study has been determined to be Exempt, with the following categories:

Category 3.(j)(A). Research involving benign behavioral interventions in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection.

The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects.

Category 3.(s). For the purpose of this provision, benign behavioral interventions are brief in duration, harmless, painless, not physically invasive, not likely to have a significant adverse lasting impact on the subjects, and the investigator has no reason to think the subjects will find the interventions offensive or embarrassing. Provided all such criteria are met, examples of such benign behavioral interventions would include having the subjects play an online game, having them solve puzzles under various noise conditions, or having them decide how to allocate a nominal amount of received cash between themselves and someone else.

## Notes for Researcher(s):

This submission includes the following approved documents:

- Recruitment message
- IRB Date-Stamped Consent Form V 11-4-2021 (uploaded under Attachments in the Submission Details page in Cayuse)
- Pre- and Post- Surveys

## Letter and Consent Document:

This letter along with the IRB approved (date-stamped) consent document can be found in Cayuse in the [Submission Details](#) page under [Letters](#) and [Attachments](#), respectively. The IRB date stamped consent document must be downloaded and used in consenting participants.

## Permission from Research Site(s):

Please note the following:

- This IRB exemption determination letter means that this research has met one or more of the federal criteria for exemption per 45 CFR 46.104- Exempt Research.
- Before the research is initiated, permission to conduct research at a given site must be obtained from all research locations listed in the IRB submission. You must keep copies of all such permission letters for your files.
- It is the responsibility of each researcher to follow all applicable policies and procedures of any outside institution where the research will be conducted.

## Modifications:

Any changes to this exempt project must be reviewed by the IRB prior to initiation by submitting a MODIFICATION request. Do not collect data while the changes are being reviewed. Data collected during this time cannot be used in research.

## Record Retention:

Exempt projects will be retained by the IRB office for three years after the last action on the project.

You are approved to start the research. Please retain a copy of this notification for your records.

If you have any questions, please contact the IRB office.

Thank you.

The Oakland University IRB

**Appendix J**

From: **Olivia Hagerman** <[ohagerman@managedbyamr.com](mailto:ohagerman@managedbyamr.com)>  
Date: Mon, Aug 16, 2021 at 10:33 AM  
Subject: RE: MANA Listserv for OU DNP Project  
To: Victoria Tripp <[vtripp@oakland.edu](mailto:vtripp@oakland.edu)>, <[jennifer@miana.org](mailto:jennifer@miana.org)>

Hi Victoria,

I can schedule your survey to be sent out to the membership. I will need the following information from you:

- Survey Link
- Email language
- When to be sent
- Is it CRNA only?

Thanks,  
Liv Hagerman

**Appendix K**

Knowledge/ Remembering	Define lateral violence.
Comprehension/ Understanding	Identify lateral violence behavior at your current workplace.
Application/ Applying	Give examples of lateral violence experienced directly or witnessed at your current workplace.
Analysis/ Analyzing	Differentiate between the following coping mechanisms: Box Breathing, Clench and Release, and S.T.O.P.
Synthesis/ Creating	Compose an appropriate response when confronted with a perpetrator of lateral violence.
Evaluation/ Evaluating	Choose three effective ways to manage lateral violence.

**Appendix L****Pre-Educational Survey****Demographics:**

1. Age:
  - ☐ <30
  - ☐ 30 – 39
  - ☐ 40 – 49
  - ☐ 50 – 59
  - ☐ 60 – 69
  - ☐ >69
2. Gender:
  - ☐ Male
  - ☐ Female
  - ☐ Other
3. Years practiced as a CRNA:
  - ☐ 0 – 5
  - ☐ 6 – 10
  - ☐ 11 – 15
  - ☐ 16 – 20
  - ☐ 20 +
4. Which of the following best describes your employment setting?
  - ☐ Hospital with less than 100 beds
  - ☐ Hospital with 100 to 499 beds
  - ☐ Hospital with 500 beds or greater
  - ☐ I do not work in a hospital setting, I work in a (an) \_\_\_\_\_ (Ex: ambulatory surgery center)
5. Which of the following best describes your PRIMARY place of employment?
  - ☐ Rural/remote location
  - ☐ Urban/suburban location
  - ☐ Other (please describe): \_\_\_\_\_
6. Have you witnessed lateral violence/incivility/bullying at your current department?
  - 1) Yes
  - 2) No
  - 3) Unsure
7. Are you aware of a policy against lateral violence/incivility/bullying at your facility?

- 1) Yes
  - 2) No
  - 3) Unsure
8. Have you received previous education or training about lateral violence/incivility/bullying at your facility?
- 1) Yes
  - 2) No
  - 3) Unsure
9. Are you able to define lateral violence?
- 1) Yes
  - 2) No
  - 3) Unsure
10. If you have any dissatisfaction with your current job, to what degree does workplace lateral violence/incivility/bullying factor into this dissatisfaction?
- 1) To a very high degree
  - 2) To a high degree
  - 3) To a moderate degree
  - 4) To a low degree
  - 5) To a very low degree
  - 6) None
11. Which of the following best describes the model of work at your primary place of employment?
- Anesthesia Care Team (ACT) model - with MDA direction
  - Anesthesia Care Team (ACT) model - with MDA supervision
  - MD + CRNA model
  - All CRNA model

Please rate the following on a scale of 1 – 5 (1 is Strongly Disagree; 5 is Strongly Agree)  
Please note: OR staff include “OR nurses, Surgical technicians, Surgeons, Students, Anesthesiologists and CRNAs”

1. Some OR staff raise their voices when they get frustrated.
  - 1) Strongly Disagree
  - 2) Disagree
  - 3) Neutral
  - 4) Agree
  - 5) Strongly Agree
2. Some OR staff yell at me or others about matters that are not important.
  - 1) Strongly Disagree
  - 2) Disagree

- 3) Neutral
  - 4) Agree
  - 5) Strongly Agree
3. Some OR staff take their feelings out on me or others (e.g. stress, anger).
  - 1) Strongly Disagree
  - 2) Disagree
  - 3) Neutral
  - 4) Agree
  - 5) Strongly Agree
4. Some OR staff blame me or others for their mistakes or offenses.
  - 1) Strongly Disagree
  - 2) Disagree
  - 3) Neutral
  - 4) Agree
  - 5) Strongly Agree
5. Some OR staff have basic disagreements turn into personal verbal attacks on other employees.
  - 1) Strongly Disagree
  - 2) Disagree
  - 3) Neutral
  - 4) Agree
  - 5) Strongly Agree
6. Most of the lateral violence/incivility seen in the operating room comes from which of the following source?
  - OR Nurses
  - Surgical Technicians
  - Surgeons
  - Students
  - Anesthesiologists
  - CRNAs
  - More than one source equally. Name sources: \_\_\_\_\_
7. What is the definition of lateral violence?
  - Any repetitive disruptive behavior among peers that is considered offensive, abusive or intimidating by the target.
  - Bringing guns and weapons to the workplace.
  - Being reprimanded from superiors for shortcomings at work.
  - All the above.

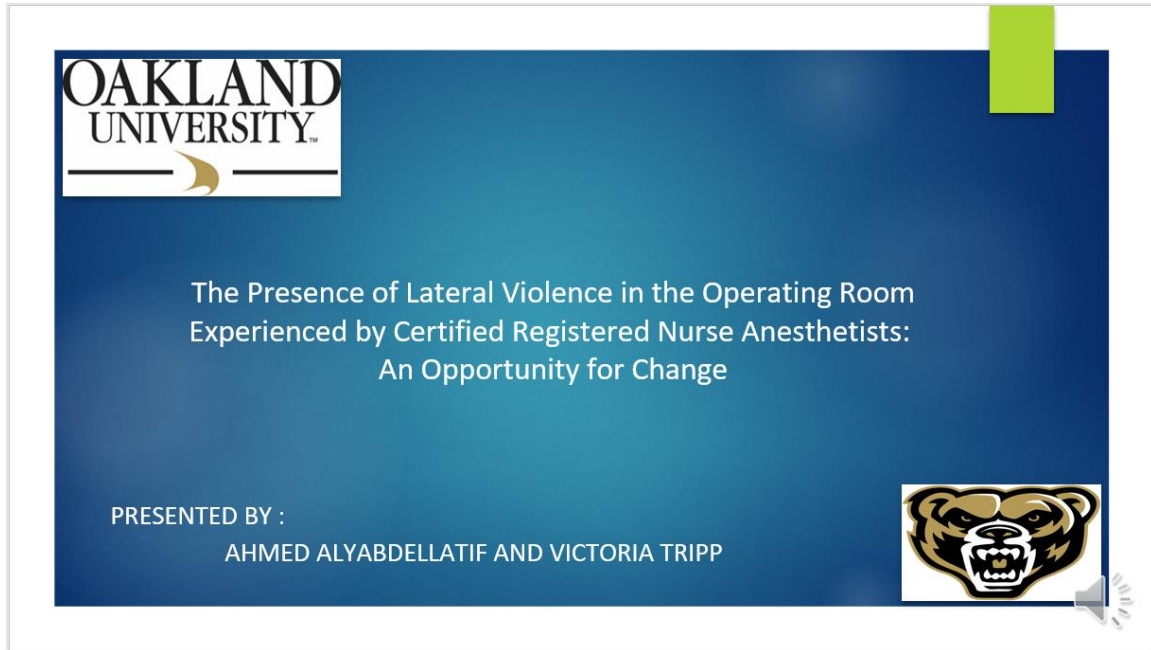


- 8 Approximately what percent of people gossip about each other in the perioperative area?
- 10%
  - 40%
  - 70%
  - 90%
- 9 Approximately what percent of CRNA's experienced incivility at least once a day?
- 5%
  - 10%
  - 30%
  - 70%
- 10 When confronted with a perpetrator of lateral violence, the best response is:
- Say nothing.
  - Always use "you" instead of "I" to describe your feelings
  - Effective communication and conflict management.
  - Immediately confront the abuser in a public area
- 11 During your shift a coworker started yelling at you because of some delays. What would be an appropriate response?
- 1 Start yelling back to explain that the delay was not because of you.
  - 2 Stop what you are doing and leave the escalating situation.
  - 3 Use sarcastic humor to calm your coworker down.
  - 4 State "I will not discuss this further until you lower your voice."

## Appendix M

**Link to the educational module on YouTube:**

<https://www.youtube.com/watch?v=H6s4iDeavJc>



## Appendix N

### Post-Educational Survey

1. Are you able to define lateral violence?
  - ☐ (1) Yes
  - ☐ (2) No
2. Is this a different answer than your pre-test?
  - ☐ Yes
  - ☐ No
3. Now that you have additional information about the definition of *lateral violence*, do you believe that you have witnessed lateral violence at your current workplace?
  - ☐ (1) Yes
  - ☐ (2) No
  - ☐ (3) Unsure
4. Is this a different answer than your pre-test?
  - ☐ Yes
  - ☐ No
5. What source/s of lateral violence have **you experienced directly** at your workplace? (Please select all sources that apply):
  - ☐ Patients
  - ☐ Visitors of patients
  - ☐ Operating Room Nurses
  - ☐ Pre-op / Post-op Nurses
  - ☐ Surgeons
  - ☐ Other surgical staff (OR technicians, physician assistants)
  - ☐ Unsure
  - ☐ Comment if additional sources:
6. What source/s of lateral violence have **you witnessed** in the healthcare facility where you work? (Please select all sources that apply):
  - ☐ Patients
  - ☐ Visitors of patients
  - ☐ Operating Room Nurses
  - ☐ Pre-op / Post-op Nurses
  - ☐ Surgeons
  - ☐ Other surgical staff (OR technicians, physician assistants)
  - ☐ Unsure
  - ☐ Comment if additional sources:-----

7. What is the definition of lateral violence?
  - Any repetitive disruptive behavior among peers that is considered offensive, abusive or intimidating by the target.
  - Bringing guns and weapons to the workplace.
  - Being reprimanded from superiors for shortcomings at work.
  - All the above.
8. Approximately what percent of people gossip about each other in the perioperative area?
  - 10%
  - 40%
  - 70%
  - 90%
9. Approximately what percent of CRNA's experienced incivility at least once a day?
  - 5%
  - 10%
  - 30%
  - 70%
10. When confronted with a perpetrator of lateral violence, the best response is:
  - Say nothing.
  - Always use "you" instead of "I" to describe your feelings
  - Effective communication and conflict management.
  - Immediately confront the abuser in a public area
11. During your shift a coworker started yelling at you because of some delays. What would be an appropriate response?
  - Start yelling back to explain that the delay was not because of you.
  - Stop what you are doing and leave the escalating situation.
  - Use sarcastic humor to calm your coworker down.
  - I will not discuss this further until you lower your voice.
12. Which of the following coping mechanisms includes squeezing your hands together tightly for a few seconds, thinking of a stressful topic, and then relaxing your hands?
  - Box Breathing
  - Clench and Release
  - S.T.O.P.
  - All the above
13. What does the stress relief acronym "S.T.O.P." stand for?

- a. Secure, Transport, Offer Help, Preparation
- b. Squeeze, Target, Overhead, Pull Pin
- c. Sarcasm, Trickery, Overzealous, Pass the Blame
- d. Stop, Take a Deep Breath, Observe, Proceed

14 I can describe at least 3 effective ways to manage lateral violence

- a. (1) Strongly Disagree
- b. (2) Disagree
- c. (3) Neutral
- d. (4) Agree
- e. (5) Strongly Agree

15 I can better identify lateral violence after this educational module

- a. (1) Strongly Disagree
- b. (2) Disagree
- c. (3) Neutral
- d. (4) Agree
- e. (5) Strongly Agree

16 The information that I gained from this learning activity will assist me in my practice.

- a. (1) Strongly Disagree
- b. (2) Disagree
- c. (3) Neutral
- d. (4) Agree
- e. (5) Strongly Agree

## Appendix O

Dear MANA Members,

We are graduate students from Oakland University and are pursuing a Doctorate in Nursing Practice degree in Nurse Anesthesia; Ahmed Alyabdellatif, RN, SRNA, PI and Victoria Tripp, RN, SRNA, Co-PI, under the direction of Julie Kruse, PhD, RN and Andrea Bittinger, DNP, CRNA from the Oakland University, School of Nursing. We are conducting a research study to determine if lateral violence training will improve lateral violence knowledge and coping mechanisms.

It is our hope to recruit individuals who are currently practicing CRNAs to complete a short survey including demographics and your background knowledge of lateral violence (pre-test). We will then provide you with a lateral violence educational module to help you learn more about this topic. Finally, you will complete a brief post-test. It will take approximately 30 minutes for you to complete the whole process.

Your participation in this study is voluntary.

The research will take place in a virtual setting of your choice on the Qualtrics website.

If you'd like to participate, we would be very appreciative – the link to begin can be found at:

[https://oakland.az1.qualtrics.com/jfe/form/SV\\_3O6Iw6a8ip23yd0](https://oakland.az1.qualtrics.com/jfe/form/SV_3O6Iw6a8ip23yd0)

If you have any issues accessing the video through the Qualtrics survey, here is a link to the video:

<https://www.youtube.com/watch?v=H6s4iDeavJc>

Should you have any questions concerning the research study, please contact

[alyabdellatif@oakland.edu](mailto:alyabdellatif@oakland.edu) or [vtripp@oakland.edu](mailto:vtripp@oakland.edu).

Sincerely,

Ahmed Alyabdellatif, RN, SRNA

Victoria Tripp, RN, SRNA

**Appendix P**