Team-Building Handbook
Improving Nurse-To-Nurse Relationships

Kathleen Bartholomew, RN, MN
Author of *Ending Nurse-To-Nurse Hostility* and *Speak Your Truth*
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About the Author

Kathleen Bartholomew, RN, MN

Before turning to healthcare as a career in 1994, Kathleen Bartholomew held positions in marketing, business, communications, and teaching. It was these experiences that allowed her to look at the culture of healthcare from a unique perspective and speak poignantly to the issues affecting providers and the challenges facing organizations today.

Bartholomew has been a national speaker for the past 12 years. As the manager of a large surgical unit in Seattle, she quickly recognized that creating a culture where staff felt a sense of belonging was critical to retention. During her tenure as manager, staff, physician, and patient satisfaction reached the top 10% as she implemented her down-to-earth strategies. Despite the nursing shortage, she could always depend on a waiting list of nurses wanting to work in her units.

For her master’s thesis, Bartholomew authored *Speak Your Truth: Proven Strategies for Effective Nurse-Physician*
Communication, a book that broke new ground in addressing physician-nurse issues. In December 2005, she resigned her position as manager to write the first edition of Ending Nurse-to-Nurse Hostility, her second book on horizontal violence in nursing. The expression “nurses eat their young” has existed for many years in the nursing profession (and has troubled many).

Now published in an expanded second edition, Ending Nurse-to-Nurse Hostility’s comprehensive and compassionate look at the etiology, impact, and solutions to horizontal violence forms the basis of the handbook you are holding.

Bartholomew won the best media depiction of nursing for her op-ed in the Seattle Post Intelligencer, and in 2010 she was nominated by HealthLeaders Media as one of the top 20 people changing healthcare in America.

Her passion for creating healthy work environments is infectious. She is an expert on hospital culture and speaks internationally to hospital boards, the military, leadership, and staff about safety, communication, cultural change, and power. With her husband, John J. Nance, she coauthored Charting the Course: Launching Patient-Centric Healthcare in 2012, which is the sequel to Why Hospitals Should Fly (2008).

From the bedside to the boardroom, Kathleen Bartholomew applies research to practice with humor. Her call to excellence ignites and inspires health caregivers and leaders to unprecedented levels of excellence.
Understanding horizontal hostility allows us to have compassion not only for ourselves but also for all the players stuck in the same drama, regardless of their role. Nurses blame each other and their managers, who blame their directors, who blame the chief nursing officer (CNO), who can’t even find whom to blame for the scarcity of resources and the dysfunctional system. “They” are all hiding in the shadows of the corporate culture. To paraphrase Pogo (from the comic strip), “We’ve met the enemy, and ‘they’ is us.”

About This Book

The real tragedy is that when nurses suffer, patients suffer. And when decisions about the future of healthcare are made without the knowledge and wisdom of nurses, quality of care will deteriorate. If we don’t stop the infighting, rally around this incredible profession, and form a powerful governing body representing a single workforce of three million strong, we will have failed to rescue ourselves.

The purpose of this handbook is to serve as a tool we can use to build our strength and that of our peers.
Genesis

In Ending Nurse-to-Nurse Hostility, the book that inspired this handbook, I started with my own story, collected the stories of others, and discovered that an imbalance of power frequently drives human social dynamics. But then I found an even bigger story: culture.

I began to understand how culture created and drove the daily beliefs and actions of leaders. Culture is the lens through which leaders perceive and respond to reality. We get so accustomed to wearing these glasses (which we unconsciously accepted in our youth) that we forget we have them on at all. What are the latest frames today to view reality? How would wearing these lenses change how we lead, live, and love?

This handbook, while not as comprehensive as Ending Nurse-to-Nurse Hostility, provides a set of tools based on the science of and research on horizontal hostility. You can use this little book as an individual, or in a group setting.

For the nursing profession to flourish, we all need to accept that hostility exists and understand why. Then we can stamp out our self-inflicted pain.

For the Love of Nursing

What we need is what the ancient Israelites called hochma … the capacity to see, to feel, and then to act as if the future depended on you. Believe me, it does. —Bill Moyer
In the end, it comes down to respect. According to the *American Heritage Dictionary*, the etymology of the word *respect* is from Middle English, mixing *regard*, from Old French, and *respectus*, from the Latin past participle of “*respicere: to look back at, regard, consider.*”

We’re not looking. If we could only take the time to be with and listen to each other, horizontal hostility couldn’t exist. If we looked with intention into each other’s eyes, we would see the two things we so desperately need to heal: each other’s pain, and our own reflection.

We need each other. Nursing is difficult work. Building a new culture starts with rebuilding our relationships—one at a time. At this very moment, each of us knows the name of the person who “doesn’t respect me/doesn’t like me/won’t sit next to me/is putting me down.” And we know who we feel the same way about. Any hesitance to hold the crucial conversations necessary to heal these relationships must be immediately addressed, whether the relationships are with superiors, peers, or subordinates. Our voice—your voice—is the power that will liberate nursing from fear and oppression. And when that happens, all of humanity will reap the reward. The nursing revolution we so desperately need to eliminate horizontal hostility will come from the deep and profound respect, compassion, and admiration we have for ourselves and each other. We just need to stop being afraid.

For fear to transform into safety, every nurse must become a leader.
The Supporting Science

Recent research by led by Diane Ceravolo, director of nursing practice at Kaleida Health, supports the effectiveness of using a workplace curriculum designed to reduce lateral violence by strengthening assertive communication skills.

After implementing the curriculum, the percentage of nurses who reported experiencing verbal abuse fell from 90% to 76%, and turnover and vacancy rates dropped. In addition, the proportion of nurses who believed that verbal abuse would influence their overall delivery of nursing care increased from 42% to 63%.

Early interventions, counseling, and formal education programs to catch the behavior before it escalates (Anderson and Stamper, 2001) are highly recommended. Committed nurse leaders who use effective process and team-building skills can have a positive impact on a hospital’s nursing culture (Wagner, 2006).

*Fostering an environment of lateral violence awareness, assertive communication, and collaboration can have a positive impact on organizational outcomes.*

—Diane Ceravolo et al. (2012)

The impact of implementing these programs is essential, but ongoing reinforcement and practice of the skills is the only way to effect true and lasting change. In fact, the most common
pitfall of organizations is believing that because they’ve taken a class, people are using the skills. Sadly, this is often not the case.

**How to Use This Handbook**

We know that staff must have opportunities to practice in order to build muscle memory, and that leaders must measure communication competency as they would any other vital skill.

Learning new communication and confrontation skills, de-personalizing hostility, and understanding human behavior will all build self-esteem. As we individually tackle these challenges, our units, organizations, and profession will reap tremendous rewards. But most of all, we will create a safe environment for our patients.

You can read and reflect independently on the thoughts and questions shared in this handbook, or you can use this tool within the context of an in-service or group exercise. Regardless of the circumstances, I’ve designed this handbook to support you in creating a better workplace for yourself, your peers, and your patients.
“You’ll know it when you see it” is the easiest way to describe the multilayered issue of horizontal hostility, but for the purpose of creating a common language, let’s look at one often used description.

**What Is Horizontal Hostility?**

Very simply, *horizontal violence* and *horizontal hostility* describe aggressive behavior between people on the same power level, such as nurse-to-nurse and manager-to-manager. Anger, aggression, bullying, and verbal abuse are all ways that hostility bubbles to the surface. For an official definition, here’s the way it’s defined by Gerald Farrell, RN, PhD, a highly respected researcher on the subject:

*Horizontal hostility is a consistent pattern of behavior designed to control, diminish, or devalue a peer (or group) that creates a risk to health and/or safety.*
Subtle and Not-So-Subtle Hostility

Horizontal hostility can be subtle, or it can be hard to miss, as in physical or verbal aggression. It can also include any kind of mistreatment, spoken or unspoken, that leaves a person feeling personally or professionally attacked, devalued, or humiliated. In other words, it can be either overt or covert.

Because most of our communication is nonverbal and stress increases in ambiguous situations, covert behaviors have the biggest impact. See if any of these forms of horizontal hostility seem familiar to you:

**Overt:** name-calling, bickering, fault-finding, backstabbing, criticism, intimidation, gossip, shouting, blaming, using put-downs, raising eyebrows, etc.

**Covert:** unfair assignments, sarcasm, eye-rolling, ignoring, making faces behind someone’s back, refusing to help, sighing, whining, refusing to work with someone, sabotage, isolation, exclusion, fabrication, etc.

The following is an example of overt hostility experienced by a fellow nurse:

_I am used to being in a charge nurse position and am now working with recovering patients from the cath lab. The hostility here is thinly veiled. I come into work and say something like, “Nice day today,” and the charge replies, “What’s that supposed to mean?”_
We have really sick patients just fresh out of the cath lab. When the charge nurse told me she was going to take a break, I asked her a few questions so I would have the information I needed to cover. I asked, “Does 212 have a sheath in?” and the charge nurse said, “What do you want to know for?” I tried to ignore her and just did my job.

When she came back from break I told her all that had happened in her absence—for example, that I taped down the IV in 214. Coldly, she responded, “That could’ve waited until I returned.” It’s a constant, negative, put-you-down undercurrent that never ends.

And this offers a brief look at one person’s experience with covert hostility:

It was the looks [the preceptor] gave me, like I was stupid. In my whole three months of orientation, I can’t think of a single time anyone ever complimented me.

Is Horizontal Hostility Intentional?

For more than an hour, Bethany has been recounting examples of horizontal hostility over a 14-year career, which brought her to three different states and through major depression. At the end of the interview, I ask her, “Do you think the nurses knew what they were doing? Were their actions intentional?”

She bristles and responds almost indignantly, “Their actions were very intentional. They knew exactly what they were doing!”
I press further. “But were their actions conscious? Do you think those nurses were aware of the pain they were causing you?”

Bethany pauses and her face softens. “No, they were clueless to the effect of their actions. They never looked past [their actions] to see how another person would feel. What got me was how a person could hate someone they didn’t even know.”

The above scenario has occurred with dozens of nurses I’ve counseled. Backstabbing, intimidation, fault-finding, etc., is designed to alienate, attack, or punish a coworker. In every case I’ve handled, the perpetrators didn’t realize the effects of their actions. Many believed that they were justified because they were upholding a standard of quality patient care. Only through education, which began by confronting the behavior, did nurses begin to comprehend the full extent of their actions. And when a nurse got it, the behavior stopped immediately.

It’s difficult to even admit that we could be hurting each other in a profession that has its roots in caring. Uncovering and discussing horizontal hostility is about as easy as a family acknowledging how damaging it is to live with alcoholism. It is embarrassing and so remotely removed from our idea of the perfect nurse that we shudder to think that this hostility could be true. In addition, there is an unspoken fear, warranted or not, that admitting the problem will make it worse. However, if nursing is to survive, we need an immediate intervention. This intervention starts with listening to the voices in the room: the researchers who have uncovered this behavior, and the nurses who are experiencing the hostility.
Tales From the Front Line

Nothing is quite as powerful as a personal story. Stories put the truth out into the world, and once shared, you cannot call it back. Stories are a means of truth-telling. If we have had a similar experience, a story resonates with us at the deepest level, and there is comfort and validation as we realize that others share our experience.

Several years ago, at a Horizontal Violence in the Workplace conference held by the Oregon chapter of the American Psychiatric Nurses Association, I asked participants whether they would be willing to share their stories about hostility in the workplace. I collected a list of names and phone numbers of interested nurses and arranged convenient times to speak to each one by phone.

As I listened to the first story, I was shocked at the intensity of the aggression the nurse had experienced and by the fact that the continuous verbal abuse had resulted in a suicide attempt. From hospitals and academia to outpatient clinic settings, nurses shared with me their poignant experiences with horizontal hostility. I’ve incorporated many of their stories, and numerous others, in this handbook to illustrate the behaviors and emotions they generate. For example:

*The smallest thing would trigger retaliation. [The charge nurse’s] refusal to speak was the worst. Once she went 27 days without speaking.*
The orientation nurse was ultimately fired. She started drinking and felt attacked all the time. Everything was her fault, all the time.

As nurses shared their experiences with me, two common themes emerged. First, every single participant was gravely concerned about maintaining anonymity. Even if the violence happened 10 years ago and was resolved by the abuser leaving the workplace, all feared retaliation. The workplace was still viewed as dangerous, and nurses continued to feel vulnerable. Second, no matter what the situation, the stories clearly brought up a lot of emotional pain that was difficult to acknowledge.

Like soldiers suffering from post-traumatic stress disorder (PTSD), participants appeared to relive their pain all over again. The air was thick with feelings of loss and betrayal. As I coaxed stories from each nurse, the courage required to speak became obvious.

As a frontline manager, I witnessed horizontal hostility on many occasions. One nurse constantly wrote up other nurses, rather than speaking to those particular nurses directly. It wasn’t unusual for me to come into the office in the morning and find three incident reports in my box written on the same person.

Problems also arose because new hires and resident nurses found it difficult to fit into a clique. Comments like “I hate to follow her” were common. The longer the nurses had worked
together, the harder it was for others to join their group. Nurses put down each other by making snide comments, and new nurses struggled to be perfect, knowing that every mistake would be seen as a direct reflection of their competence. Much to my chagrin, the practice of horizontal hostility was common on my unit.

Intrapersonal conflicts—nurse-to-nurse hostility—rob us of our energy, deflect our interests from patient care, and prevent us from unifying to obtain the resources we need to do our jobs. The consequences of horizontal hostility can be felt on all levels: individual, professional, and organizational.

How Does Horizontal Hostility Manifest?

In the nursing profession, every day brings incremental pressures that weren’t there the day before: escalating acuity, physically heavier patients, shorter lengths of stay, new technology and treatments, and higher staff ratios. Advances in technology and pharmacology have resulted in an increase in pills and information that challenges even experienced nurses. From a clinical standpoint, new resident nurses aren’t walking into the same scenario as their mentors.

One would think that experienced nurses would welcome new grads in a nursing shortage. One year, I decided to put a new resident nurse into the hands of one of our younger nurses who had been with us for five years. Her lack of patience and harsh expectations took me by surprise. After speaking to the nurse, I learned her underlying belief system: “If I did it, she can too.”
If I had to do orientation in 12 weeks, so should she.” This could be considered a hazing or induction phase, which is also commonly practiced among physicians. In every comment, the nurse was comparing the new resident nurse to herself and to her own experience.

The stresses on new and experienced nurses alike function as a catalyst for horizontal hostility, also referred to as lateral violence. The 10 most frequent forms experienced in nursing, ordered from most to least frequently encountered, are:

1. Nonverbal innuendo (raising of eyebrows, face-making)
2. Verbal affront (covert or overt, snide remarks, lack of openness, abrupt responses)
3. Undermining activities (turning away, not available)
4. Withholding information (practice or patient)
5. Sabotage (deliberately setting up a negative situation)
6. Infighting (bickering with peers)
7. Scapegoating (attributing all that goes wrong to one individual)
8. Backstabbing (complaining to others about an individual and not speaking directly to that individual)
9. Failure to respect privacy
10. Broken confidences

Adapted from Duffy, 1995; Farrell, 1997; McCall, 1996; McKenna, Smith, Poole, & Coverdale, 2003. SLACK Incorporated and The Journal of Continuing Education in Nursing. Reprinted with permission.
How Does Horizontal Hostility Affect You?

A more accurate question would be: Is there any way that horizontal hostility doesn’t have an impact on your work, health, and happiness?

Victims suffering from the stress of horizontal hostility experience a range of emotional, social, psychological, and physical consequences. Verbal abuse takes a heavy toll on the work environment—it decreases morale, increases job dissatisfaction, and creates hostility. Bullied staff lose their sense of well-being at work, along with the ability to relax or to concentrate.
Well-documented studies show that workplace verbal abuse increases mistrust, lowers self-esteem, and undermines support from both staff and superiors.

The medical community recognizes several physical ailments as being triggered or aggravated by stress, including irritable bowel syndrome, migraines, hypertension, allergies and asthma, arthritis, and fibromyalgia. Emotional-psychological damage can be less obvious, but common effects include poor concentration and forgetfulness, fatigue or loss of sleep, indecisiveness, anxiety and nightmares, and obsessive thinking about a bully. The following figure lists the well-known effects of horizontal hostility, as defined by Gerald Farrell, RN, PhD, the researcher whose definition of horizontal hostility opens this chapter.

Figure 1.2 | The effects of horizontal hostility
What Is the Impact on Our Patients and on Our Group?

The invisible thread that weaves the human race together is the quality of our relationships. High-quality relationships enjoy a sense of cohesiveness or solidarity; in the work environment, it produces employees who are “all on the same page” and who function with a clear vision of the organization’s goals. A study in 2005 (Amos et al.) also noted a direct link between high rates of group cohesion and work satisfaction, which resulted in a lower turnover rate in acute care settings.

Clearly, the hallway conversations that result from such cohesion often give us the critical information and support we need as we do our jobs. Now more than ever, streamlining processes and procedures in hospitals is critical to patient safety and financial efficiency.

On the flip side, horizontal hostility creates a toxic workplace by producing feelings of inferiority, anger, powerlessness, and frustration, all of which are counterproductive when working in a group. Emotional issues incapacitate even the greatest of initiatives and, as you’ll hear in this example, can have a serious effect on our patients:

*A root-cause analysis performed after an episode of oversedation revealed that the nurse was upset about an interaction with a coworker. Tearfully she stammered to the charge nurse, “I know I shouldn’t have let [my coworker] get to me, but he did, and I just wasn’t thinking clearly. I felt so humiliated, so belittled.”*
The nurse had inadvertently programmed the PCA to deliver 10 times the ordered dose of morphine. The patient was found unresponsive, with an oxygen saturation of 50%, and was transferred to the ICU. Two days later, a brain scan still showed areas of hypoxia, and the patient still could not put thoughts together clearly.

The nurse transferred to another department within the month. In her department exit interview, the nurse told the manager that she “had always wanted to work on the other unit and wanted to take advantage of the opportunity to transfer.”
For decades, horizontal hostility has been known to play a pivotal role in increasing nursing attrition rates. Team-Building Handbook: Improving Nurse-to-Nurse Relationships offers healthcare organizations a proactive approach to creating a healthy workplace for nursing staff. This small guide provides the core tools they need to build strong teams and avoid the unnecessary expense of finding, hiring, and training new nurses to replace burned-out staff.

Compact and practical, this handbook can be used as part of healthcare orientation and precepting programs, as well as for in-services and self-study. From Team-Building Handbook: Improving Nurse-to-Nurse Relationships, nurses will gain the skills they need to build cohesive teams and combat negativity if it arises in the workplace.

Other books by Kathleen Bartholomew:

 Ending Nurse-To-Nurse Hostility
 Speak Your Truth
 Team-Building Handbook: Improving Nurse-Physician Communications