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Lessons Learned From a Lateral Violence and Team-Building Intervention

Ann Barrett, MBA, RN, NE-BC; Carolyn Piatek, MA, RN; Susan Korber, MS, RN, OCN, NE-BC; Cynthia Padula, PhD, RN

Background: Lateral violence is likely to exist in settings characterized by poor leadership and lack of clearly articulated roles, expectations, and processes that guide behavior. **Objectives:** The purposes of this process improvement project were to (1) identify and improve baseline levels of nurse satisfaction and group cohesion through planned unit-based interventions, (2) determine the effect of a team-building intervention on factors that impact cohesive team functioning, and (3) determine the effect of lateral violence training and communication style differences in improving team cohesion. **Methods:** The sample consisted of registered nurses (RNs) from 4 diverse patient care areas, chosen on the basis of low scores on the *National Database of Nursing Quality Indicators* (NDNQI) RN-RN interaction subscale. A quasi-experimental pre–post intervention design without a control group was employed. The intervention focused on lateral violence and team building. A qualitative component focused on the impact of the intervention on overall group dynamics and processes. **Results:** RN scores on the Group Cohesion Scale ($P = .037$) and the RN-RN interaction scores improved postintervention. Group sessions focused on building trust, identifying and clarifying roles, engaging staff in decision making, role-modeling positive interactions, and holding each other accountable. **Conclusions:** Key to a cohesive environment is an effective nurse manager able to drive and sustain change. **Key words:** *group cohesion*, *horizontal violence*, *lateral violence*, *team building*

ESTABLISHING a culture that fosters a sense of cohesiveness among staff is a critical link in improving nurse satisfaction. Strategies have been developed to promote group cohesion and improve the relationship among nurses. This project expands upon the work of DiMeglio et al,[1] which linked group cohesion and nurse satisfaction by utilizing team-building interventions. DiMeglio et al used a team-building approach to improve group cohesion, turnover, and nurse satisfaction. Issues regarding ineffective communication and the assumption that experience and competence equate to a cohesive, high-performing team were discovered.

Ineffective communication, disruptive behavior, and a chaotic work environment are likely to exist in settings characterized by poor leadership and a lack of clearly articulated roles, professional practice expectations, and processes that guide behavior. Improving cohesion among nurses by identifying and addressing these issues through unit-based

Author Affiliations: *The Miriam Hospital (Mss Barrett and Korber and Dr Padula) and Human Resources, Lifespan (Ms Piatek), Providence, Rhode Island.*

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Corresponding Author: *Ann Barrett, MBA, RN, NE-BC, Nursing Resource Management, The Miriam Hospital, 164 Summit Ave, Providence, RI 02906 (abarrett@lifespan.org).*

team-building sessions was the idea behind this project. An opportunity was identified to improve the practice environments in specific areas throughout the hospital and to participate in further work that examined group cohesion. The decision was made to replicate and expand the successful team-building approach used in the study of DiMeglio et al and to explore the effects of disruptive nurse behaviors, especially lateral violence, on team cohesion.

BACKGROUND

The Miriam Hospital (TMH) is a private, 247-bed, not-for-profit, acute care teaching hospital in Providence, Rhode Island. This hospital is one of 4 healthcare affiliates of the Lifespan system and is a Brown Medical School teaching facility. The hospital provides a broad range of clinical services with nationally recognized research and teaching programs. In 1998, TMH became the first in Rhode Island and ninth in the country to be awarded Magnet status by the American Nurses Credentialing Center[2] and has since been redesignated twice. Magnet hospitals have consistently demonstrated higher nurse satisfaction and lower turnover and vacancy rates.[3,4] Creating a Magnet culture necessitates building magnetism into organizations.[5] To sustain that culture, TMH nursing leadership continually evaluates satisfaction and retention of clinically competent nurses by monitoring the professional practice environment.

LITERATURE REVIEW

Group cohesion has become increasingly recognized in the literature as important to nurse satisfaction, retention, and quality of patient outcomes and has been defined in varying ways. Some focus on the quality of the nurse-coworker relationship are as follows: the degree of attraction that a nurse feels toward the work group,[6] the degree to which group members are socially attracted to each other,[7] or employees have friends in the work environment.[8] More complex definitions have also been identified, including staff members' perception of integration into the organizational and collegial environment[9] and as "the way that a workgroup functions and rests on the ability of the members to communicate, share responsibility in getting the work done, and feel as if they belong to the group."[10(P173)]

Group cohesion has been consistently identified as a strong, positive predictor of nurse retention[11–13] and work satisfaction.[14–17] Group cohesion positively relates to work group performance.[18] Chang et al[19] demonstrated that group cohesion predicted higher levels of patient satisfaction and higher levels of met expectations for symptom management. Unhealthy work environments not only contribute to conflict and stress among healthcare providers but also negatively impact the quality of patient care.[20] The American Association of Critical-Care Nurses (AACN) identified 6 standards for establishing and sustaining a healthy work environment[20]: skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition for, and authentic leadership. More than 90% of AACN members identified effective leaders as key to a healthy work environment.

Nurse managers are critically important in creating an environment that supports job satisfaction and retention through promotion of a cohesive environment.[21,22] Those who are people-oriented, visible, and empowering are more likely to create a supportive, collaborative environment.[23] Satisfaction with nursing leadership is positively correlated with group cohesion.[24] Transformational leadership provides a framework developing and sustaining a supportive[25] and growth-producing culture. The number 1 quality that a good nurse manager must possess is respect for staff as professionals.[26] Nurse managers who create a healthy work environment promote group cohesion, teamwork, and constructive conflict resolution.[22]

The opposite environment is one in which conflict, aggression, and lateral violence may flourish. Lateral violence occurs when nurses covertly or overtly direct their dissatisfaction inward toward each other, themselves, and those who are less powerful.[27] Lateral violence in nursing has been linked to behaviors of oppressed groups,[28] and some forms have simply been tolerated. This destructive phenomenon is linked to nurse satisfaction and retention[29] and is believed to contribute negatively to nursing and patient outcomes.

PRELIMINARY STUDIES

A nurse leader who had participated in the earlier cohesion work[1] assumed leadership of the outpatient oncology unit and recognized a group of fractured professionals. The unit had been cited during a recent accreditation visit for outdated practices and documentation; morale was low and employee engagement scores were among the worst in the hospital. Communication among leadership, professionals, and administrative staff was marked by triangulation and innuendo. Multiple areas of concern were apparent to the new manager: lack of leadership visibility and communication (particularly listening), splitting, gossip, judgment, negative attitudes, scapegoating, personality walls, and cliques. Classic symptoms of an oppressed group surfaced, including expressed isolation, low self-esteem, and newer nurses identifying themselves as targets. The leader asked a professional facilitator to assist. Team-building interventions were planned by using organizational development tools in a structured format. It was hoped that nurses would begin to identify and explore the real issues behind the destructive behavior they were experiencing.

The group sessions were a combination of process improvement and interpersonal behavior skill building as well as the leader articulating a vision of a primary model of care. Transforming a chaotic work environment into a collaborative unit with a unified mission became the objective. As the sessions progressed, all staff members engaged in presenting concrete ideas for change. This process of working together and hearing each other's perspectives promoted ownership of each individual's role in creating a positive work and patient care environment. Creating a forum for communication became the key to change. The leadership strategy became one of encouragement, facilitation of problem resolution, and obtaining resources for the implementation of the staff's ideas. The design of the primary care model with process flow changes, involving nurses and other disciplines, took 3 months to complete.

One conclusion drawn from the preliminary study was that when a chaotic work environment is allowed, patient care and nurse cohesion suffer. Measured results showed significant improvement in employee engagement scores measured pre and postintervention, registered nurse (RN) certification rate, RN satisfaction scores, and patient satisfaction scores. Outcomes demonstrated the success of a nurse leader and facilitator partnership using focused group interventions involving the entire staff.

PROCESS IMPROVEMENT PROJECT: GROUP COHESION AND BUILDING COHESIVE TEAMS

Purpose

The purposes of this process improvement project were to (1) identify and improve nurse satisfaction and group cohesion among RNs on selected nursing units through planned unit-based interventions, (2) determine the effect of a team-building intervention on cohesive team functioning, and (3) determine the effect of lateral violence training and communication style differences on improving team cohesion.

Sample

The overall sample consisted of RNs employed in an inpatient surgical unit, a critical care unit, the emergency department and the inpatient operating room. As a Magnet-accredited facility, TMH nurses participate yearly in the *National Database of*

Nursing Quality Indicators (NDNQI) Nurse Satisfaction Survey (see Instruments section); these units were chosen because they were the lowest-scoring units on the RN-RN interaction subscale.

The nurse manager of each unit was asked to identify a subsample of approximately 20% of the nursing staff to participate in a team-building intervention. Managers selected a mix of nurses who represented informal leaders as well as "bulliers" and potential "victims"; volunteers were also solicited. These nurses participated in the focused intervention, expecting that they would bring back to their units and "champion" team-building strategies that they learned during the intervention. Nurses who completed both sessions received contact hours and a $100.00 stipend supported by outside funding.

Design

This project included both quantitative and qualitative components. A pre–post design was employed, with a targeted intervention that focused on team building. The qualitative component focused on the impact of the intervention on overall group dynamics and processes on the units.

Intervention

The intervention was conducted separately on each unit, with similarities in terms of structure but tailored to meet individual unit needs and issues. Six to 8 RNs from each unit participated in the sessions. They comprised two 2-hour group sessions, conducted by a trained group facilitator and nurse manager at a neutral site off the unit. The agenda and activities were uniform in session 1. The interactive sessions began with the group describing the unit atmosphere, patient makeup, and how they believed staff was perceived. A description of the ideal high-performing team for the specialty, as well as a list of issues faced, was generated. Information on lateral violence, as well as a discussion on their personal experiences with it, was presented. The Myers-Briggs Type Indicator (MBTI) was presented; members identified preferences and discussion ensued when each member viewed the information and recognized some stark differences in type preference among themselves and their colleagues.

Session 2 began with insights on MBTI results and more exercises and stories to demonstrate how differences play out in work situations. Skill-building sessions on giving and receiving feedbacks and managing conflict by using an adapted version of the Thomas-Kilmann Conflict Mode Instrument were conducted. These helped members focus on some of the issues identified. In addition, process improvement tools were recommended for follow-up sessions to assist in developing structures and processes to overcome other issues recognized. Nurses were encouraged to bring information back to their unit staffs and to function as "champions" related to creating cohesive work environments.

Procedures

This project took place more than 6 months and was approved by the Lifespan Institutional Review Board. Information was placed in the mailbox of all RNs employed on the individual units 2 weeks prior to and 3 months after the unit champions completed the scheduled intervention on the unit. The information included an informational letter explaining the purpose and procedures, a demographic profile, "How Well Are We Working Together?" and the "Group Cohesion Scale" (GCS; see Instruments). Staff was informed that participation was voluntary, responses were anonymous, and no identifying information would be recorded. A sealed dropbox was placed on the units for completed materials.

Instruments

Registered nurses completed a demographic data form. Information about group dynamics and functioning were gathered using the "How Well Are We Working Together?" measure, developed by the facilitators' colleagues in Human Resource Development at Rhode Island Hospital, circa 1992. It is a 10-item scale with a 5-point Likert-type response

Table 1. Pre- and postintervention RN-RN interaction scores[a]

	Preintervention	Postintervention
Critical care unit	60.56	71.30
Surgical unit	63.79	64.20
Operating room	62.13	65.57
Emergency department	62.39	67.18

[a] <40, low satisfaction; 40–60, moderate satisfaction; >60, high satisfaction.

of "strongly agree" to "strongly disagree." This instrument was used in the prior DiMeglio research and provided invaluable information to direct and tailor sessions in this project.

Cohesion of the group was measured with the GCS.[30] Developed by Price and Mueller in 1986 as an "integrated scale," this instrument was later modified for use with nurses. It is a unidimensional, 6-item instrument with a 7-point Likert-type response scale that takes approximately 2 minutes to complete. Cronbach α reliability scores range from .82 to .89.[30,31]

One subscale each from the NDNQI Adapted Index of Work Satisfaction[32] and the NDNQI Adapted Index of Job Enjoyment[33] were used to measure nurse satisfaction pre- and postintervention. TMH is an ongoing participant in NDNQI,[34] sponsored by the American Nurses Association[35] through a contract to the National Center for Nursing Quality. Nurse satisfaction is a quality indicator and RNs are surveyed annually. The Index of Work Satisfaction is a global measure of nurse satisfaction and consists of 7 subscales[32]; the Job Enjoyment measure is a single scale.[33] Both have extensive psychometric evaluation, and both demonstrated reliability and validity. Cronbach α scores were between .78 and .91 ($n = 1385$).[36]

RESULTS

Quantitative

Surveys were provided to 145 RNs; 59 (41%) were returned preintervention and 45 (31%) postintervention. The mean age was 40.8 years with a range of 25 to 60 years. The average number of years as an RN was 13.5 years; the mean years employed at TMH was 11 years, with a range of 0.3 to 35.0 years.

Pre- and post–mean scores on the "How Well Are We Working Together" measure were not statistically significant. Using SigmaStat, the Mann-Whitney rank sum test was used to examine the difference in the values of the GCS scores. The median prescore (540) was significantly lower than the postscore (612; $P = .037$). Scores on the RN-RN interaction subscale of the NDNQI Adapted Index of Work Satisfaction[32] are illustrated in Table 1 and improved on all units postintervention.

Qualitative

Although units received the same information and techniques during the team-building sessions, all had unique dynamics and issues to be addressed, which were pertinent to their environment and culture. Overall, RNs had a difficult time determining what their needs were, but they knew that they were in chaos.

The operating room was the only area to have had a consistent manager in place. RNs could clearly articulate that they needed more structure and process in daily operations. Although the environment was described as fun, it was said to be disorganized and frustrating because of a lack of communication among staff and the presence of "too many controlling individuals." The most difficult issue identified centered on the daily flow of the front desk and management of the nurses' schedule. Scheduling had become a "free for all," with certain individuals getting the

preferred days per hours and others too intimidated to bring their concern forward. There was not a consistent expert nurse assigned to perform the charge role. Having different individuals, some not skilled in daily flow, caused confusion and chaos. The manager resigned between the second team-building session and the resurveying of the staff. Her replacement followed through on some of the initiatives that were identified in the sessions. Acknowledging what the key issues were that created tension and disruption, the new nurse manager designated a consistent charge nurse and it became the responsibility of the clinical coordinator on the unit to prepare the schedule.

The emergency department struggled from the beginning with engaging those who were identified as participants. Attendance at the sessions was low, and it was difficult to engage the nurse manager because there were vacant management support positions within the department and multiple competing priorities. The staff and manager felt like victims, identifying most issues as another department's responsibility to correct. They did not feel that administration and the rest of the hospital understood the nature of their role as individuals and as a team. Staff themselves described their unit as isolated from the rest of the hospital and their work viewed by others as a "mystery." There were nurse-physician and nurse-nurse conflicts evident.

The critical care unit, which had the greatest improvement in the RN-RN interaction scores, had a new nurse manager who was also new to leadership. The staff members had worked with 3 nurse managers in as many years and were troubled but interested in working together to improve the climate and change unhealthy behaviors. Data from a hospitalwide employee engagement survey conducted during this time reflected a perceived lack of communication and reward and recognition for staff contribution. At the beginning, the group was interactive but was hesitant to engage in difficult conversations. By the end of the second session, staff members were very open, freely discussing preferences and "pet peeves." The entire staff experienced what the manager described as a collective epiphany when staff realized how personality preferences may affect their approach and style of communication and how this is perceived by and impacts others. Manager and staff were extremely engaged in the project and worked to role model appropriate behaviors and improve communication and cohesion among the nurses. The manager was clear about expectations of participating staff and their role in changing behavior. The main theme identified was how the staff dealt with conflict. When a nurse brought issues regarding staff conflict to the manager's attention, she would refer back to what was discussed in the sessions and guide the individual to have a productive conversation to resolve the conflict.

The inpatient surgical unit was quick to identify their work environment as chaotic. They had also experienced leadership turnover, and patient satisfaction scores and RN-RN interaction scores were low. Staff turnover and vacancy rates were high, and staff felt victimized and unsupported. Anxiety about moving into a new patient care unit that would significantly transform their work routine was identified. What should have been an exciting opportunity to move into a state-of-the-art area had become an overwhelming threat. The session's focus was working together to make decisions about the daily operations in the new unit. Nurses were able to identify their strengths and uniqueness as individuals and as teams and were empowered to take control over their work environment. Shortly after, the nurses were instrumental in interviewing nurse manager candidates and having significant input into the selection. The nurses now describe a very different culture: one that is supported by leadership, fosters relationships with all disciplines, and holds everyone accountable. Most remarkable is the new approach taken with new nurses, rather than the sink or swim method of teaching; experienced staff are providing them with more support and mentoring.

DISCUSSION

Despite differences in the issues brought forth and discussed, all sessions focused on building trust, identifying and clarifying roles, engaging staff in decision making, role-modeling positive interactions, and holding each other accountable. Commonalities in some but not all included tense physician-nurse relationships, chaotic work environments that lacked structure and consistency, communication style differences, lack of support and recognition from administration, and conflicts between experienced and novice nurses.

The lack of cohesive work environments was confirmed as present on every unit and next steps were discussed to implement changes and work toward improving group cohesion. Each unit also identified processes that needed to be refined or changed, processes that were integral to workflow and helped define roles and expectations. Although results showed improvement in the RN-RN interaction and the GCS scores, there were varying degrees of leadership engagement to act on what was discovered. The unit with the manager who was most engaged in the process and clearly articulated expectations had the greatest improvement. This result underscored the importance of the leader in ensuring appropriate processes are implemented, setting and articulating role expectations and role-modeling collaborative communication. In contrast, the 3 other units, where the managers were less engaged, appeared fearful of conflict, and identified with the staff as victims, were marked by chaotic work environments and noncohesive behaviors.

Valuable lessons applicable to strategic planning of team-building interventions and the work environment necessary for successful change management were learned. A positive personality trait of the leader and a focus on the relationship between leadership behaviors and successful intervention drive the first lesson. Prior studies clearly defined leadership behaviors that are essential to healthy and productive work environments. Kramer et al[22] cited 9 supportive role behaviors identified by staff nurses as essential, including promotion of group cohesion and teamwork and resolving conflicts constructively. Thompson[26] listed the number 1 quality of a nurse manager as respect for staff as professionals followed by being a great communicator, available and accessible. In TeamSTEPPS,[37] behavioral examples supporting effective team leadership include facilitating team problem solving and providing performance expectations and acceptable interaction patterns. Force[21] identified themes with implications for nursing leadership and promotion of job retention as follows: dominant transformational leadership style and strong communication skills; positive personality traits; perceived support for leadership; institution-specific interpersonal and technical expertise; and encouraging staff autonomy, shared governance, group cohesion, and empowerment.

This project validated the literature related to characteristics of effective nurse managers and the leadership role in group cohesion initiatives. The common denominator in units experiencing successful cultural change was the intentional presence of the nurse manager. Managers' ability to clearly articulate trust and belief in the potential for improvement in unit cohesion was critical. Unit leaders with a reputation for high expectations and consistent follow-through proved to be able to guide units to increased awareness of lateral violence and its negative impact. Units with weaker leadership, identified by frequent turnover in managers or staff description of absence of defined structure and accountability, also had chaotic work environments. Staff spoke to disorganized processes in patient flow, work schedules, patient assignments, and role definitions. Chaos required nurses to use valuable work time and energy to maintain a safe practice environment and a sense of order and structure to their day. Interpersonal relationships on chaotic units mirrored the pilot study with splitting, personality walls, cliques, and scapegoating. The resulting frustration and

acting out was characterized by negative communication patterns and examples of lateral violence.

The second lesson learned is applicable to all nurse leaders when planning group cohesion work. Nurse managers selected nurses to participate in the intervention; the variability and quality of the selection process was a significant limitation and lesson learned. In retrospect, the less engaged nurse managers may have handpicked participants based on limited personal perceptions or preconceived agendas. This process may have allowed the manager to avoid difficult conversations and messages. DiMeglio et al[1] demonstrated that making significant, sustained change required consistent membership and attendance at group sessions and focused engagement of informal leaders. Varying results in the current work validated the impact of the participant selection process and having the right people in the room. The leaders' initial honest and critical analysis of the situation, the staff members, and the goals of the group work should drive the selection process. The inability of the leader to do this may seriously limit the scope, impact, and success of the project.

An additional lesson emerged from the use of a monetary stipend, in lieu of paid work time, for participation. The number of participants was necessarily limited by the stipend sum available, which was divided equally among the units and offered to participants to encourage consistent attendance. The stipend may have been perceived by unsolicited staff as validating a less than honest selection process and suspected favoritism. Without staff input in the process, and the time away from the unit being compensated, the potential for tension and discord among staff members was recognized. Using a representative sample of staff members in cohesion work heightens the requirement of integrity in the participant selection and remuneration process.

The final lesson looks at the analysis of the targeted units. Four units were chosen on the basis of lowest scores in the NDNQI results. The assumption was made that those units would benefit most from the intervention, and no analysis was made of readiness for change or ability of the manager to lead and sustain the change. Units that were not the highest performers but had solid leadership and a base of staff engagement might have provided a better opportunity for change. As a Magnet facility focused on nurse and patient satisfaction, the philosophy of good to great is prevalent in the culture. This philosophy assumes a good foundation, or at least a unit with leadership stability that can support the change process. Crucial to the success of group cohesion work is the ability of executive leadership to identify a troubled unit, help an engaged unit manager stabilize the unit, and then mentor the manager through the work required to lead a successful group cohesion effort.

CONCLUSION

The ultimate measure of leadership success is the sustaining of process changes that drive the metrics. Cultivating a critically thinking, articulate, honest, and engaged group of nurse leaders is key to an organization looking at group cohesion and lateral violence. The nursing leadership group must be able to analyze units in crisis and admit that process improvement and group cohesion work are difficult to simultaneously address. This work demonstrated that the chaotic work environment, often seen as allowing lateral violence and lacking group cohesion, requires an effective nurse manager to drive and sustain substantial change.

The team-building approach continues to be utilized throughout the nursing department on many patient care units and with the nursing leadership team. One particular unit involved a professionally young staff and nurse manager and provided a measure of success. The manager clearly articulated willingness to engage in leading change. Feelings of openness, acceptance, and learning together were expressed. Group cohesions sessions were successfully tailored to address role definitions and development of a shared vision.

The opportunity for further research exists. Lessons learned have heightened awareness of the critical role that leadership plays in this work, but validation in multiple Magnet and non-Magnet hospitals is possible. The next phase might examine strategies to assist nurse managers in developing skills necessary to identify chaotic work environments, address lateral violence, and build successful team interventions.

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