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No longer eating their young, but eating their own: Developing capacity to decrease lateral aggression among nurses and leaders

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Abstract

Nursing is generally known as a profession of caring. The public identifies these professionals as one of the most trusted roles in a healthcare setting. Despite this, many behaviours contradict this paradigm. These uncivil behaviours may be overt or subtle, but they are contributing to a psychologically unsafe environment where nursing instability and increased turnover threaten the ability to provide competent care for current and future patients. The nursing literature often refers to the term, *eating their young*, to summarize a harmful concept where experienced nurses neglect, betray, or belittle junior nurses who are in need of support from their more experienced peers. Many stressors at micro, meso, and macro levels have led to the resurgence of lateral aggression in the nursing profession. These actions have permeated to novice nurses, who now act as perpetrators engaging in this cannibalistic behaviour. This creates psychologically unsafe environments and acts as a deterrent for nurses staying in a specialty area. In view of its costly health-related repercussions, the prevention of lateral aggression is crucial to conserve nurse well-being and safeguard the provision of competent nursing care into the future. A blended learning pathway is proposed for nurses and leaders to recognize, respond, and address lateral aggression in action on adult surgical units. Kotter's 8-step change model, combined with CQI methodology, is used to guide a change implementation plan. Workforce metrics such as turnover rates, overtime usage, absenteeism, sick time, and safety occurrence reporting will serve as indicators of success.

Keywords: Lateral aggression, psychological safety, nurses, leaders, ethical, relational, blended

Executive Summary

The problem of practice (PoP) is the lack of formal training opportunities for nurses and leaders to address lateral aggression (LA) in the nursing workforce at a large healthcare organization (HcO) in southern Ontario. This dissertation-in-practice (DiP) explores organizational readiness for change in adult surgical units by using two readiness tools. The Organizational Change Recipients' Beliefs Scale (OCRBS) assesses individual readiness for change within smaller teams to assess organizational conditions (Armenakis et al., 2007). Additionally, the organizational readiness for change assessment (ORCA) tool is used to examine stakeholder perceptions (Helfrich et al., 2009) and assists with developing solutions based on organizational needs and conditions. Complex relational leadership theory (CRLT) and ethical leadership theory (ELT) addresses different components of the PoP. These leadership approaches are essential in supporting individuals and teams in addressing LA because they increase collaboration and relations within a complex adaptive system (CAS).

As a first step, continuous quality improvement (CQI) methodology is used to explain the process by which the PoP is analyzed. The use of CQI is an important component of the change plan as these principles are embedded into the organizational fabric. Kotter's eight-step change model and dual operating system assists in understanding the sequential processes needed to undergo change at this HcO. The DiP considers change drivers such as the HcO's strategic plan, national guidelines to ensure psychological health and safety, recommendations to retain a knowledgeable nursing workforce, practice standards from the regulatory body and guidelines stemming from professional associations. To inform the selection of the preferred solution, three foundational theories were used: adult learning theory (ALT), social learning theory (SLT), and social cognitive learning theory (SCLT). This change plan provides goals, sequencing, and timelines for the development of a training program targeting nurses and their leaders through one of three role-specific blended learning pathways. Three other solutions were explored but were ultimately rejected based on financial feasibility, curriculum design,

accessibility, and adaptability. The blended learning approach was selected as it combined the flexibility of e-learning, with the interactivity of face-to-face learning (Du et al., 2022) to support knowledge acquisition and cognitive rehearsal. The literature recommended skills-based training focused on interpersonal communication, conflict resolution, reporting, emotional self-management, stress management, and bystander intervention (Pfeifer & Vessey, 2018; Gardner & Cooper-Thomas, 2021).

To guide the communication process, the KMb Planning P model was used to inform the structure and process for the knowledge mobilization plan. Various CQI tools assist with the monitoring and evaluation phases to improve data collection to understand the success of the change plan. The Kirkpatrick training evaluation model will be used to evaluate the effectiveness of the training in the recognition and response to LA. If success can be demonstrated within the model cell units, the training will expand to other units and roles using a spread and scale approach. Finally, the Phillips ROI evaluation process and V model will act as a long-term strategy to determine a financial return on investment for training. This will help to anchor change to prevent and minimize the harmful effects of lateral aggression for nurses at this HcO.

Acknowledgements

The topic has been near and dear to me since I started as a student. I was a fresh-faced nineteen year old, excited to be in the hospital learning how to be a nurse. On my very first day in the clinical placement, I didn't know how to take the brakes off of the stretcher. Two nurses watched me struggle and very pointedly said, "So you'll have a degree and make more money than us, but you can't even do this?" I remember the shame and embarrassment I felt, which quickly turned to anger when others started joining in on the laughter. I've had other experiences over the years but this seemingly innocent first encounter is somehow ingrained in my memory. As I progressed throughout my career, I've seen the effects of this bullying behaviour present in various ways and settings. I knew there wasn't always malicious intent behind misguided words or actions, but the interpretation on the recipient's end – shaped by their own experiences or trauma- would be vastly different.

In the height of a global pandemic, I landed in the role of a clinical manager during the most stressful time of my career. Plagued by chronic and crippling staffing shortages, I was haunted by the clinical decisions that would be morally distressing if active stewardship of resources was needed. The pandemic fatigue had set in for many. Nurses, who had already been burdened with so much, started leaving in droves. The stories they shared were heartbreaking. Those who remained were committed to change and their openness and vulnerability inspired the work for this dissertation-in-practice. First and foremost, to the nurses on the surgical units who championed and role-modelled the ethical and relational practices that inspired my own leadership, thank you. My hope is that the team continues to build on the great work that had been started to create the psychologically safe environment we've always envisioned.

I also wanted to extend my sincere thanks and appreciation to colleagues and leaders who checked in frequently during stressful times. Our shared experiences from the pandemic have shaped me both as a leader and as a healthcare professional in so many ways and have left an indelible mark. I

am tremendously fortunate to have had inspiring nurse mentors who served as professional guides throughout all stages of my career. I know that I stand on the shoulders of the countless leaders before me and hope to lift up others in the same way. To my community cohort: thank you for the encouragement, support, and friendship over the past few years. The late-night consultations at the eleventh hour before an assignment was due always provided clarity and served to preserve my sanity.

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To my friends and family for your love and support: thank you for understanding how important this academic journey has been for me and for letting me off the hook when I needed time, space, or sleep. I'm pretty sure that you still don't know the intricacies of this topic, but I appreciate you nodding politely and listening wholeheartedly whenever I needed to talk things through. As someone who birthed four children, this was undeniably the longest labour of love. It really does take a village. Thank you for being my village. To my children, Sophie, Ari, Audrey, and Alistair: thank you for being perfectly imperfect. Your beautiful souls and unwavering belief in me as a supermom inspire me to put forward my best effort every day.

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Table of Contents

Abstract i

Executive Summary ii

Acknowledgements iv

Table of Contents vi

List of Tables xi

List of Figures xii

Acronyms xiii

Definitions xiv

Chapter 1: Problem Posing 1

Positionality and Lens Statement 1

- Personal Leadership Position 2
  - Beliefs and Understanding 3
- Alignment to Equity, Diversity, and Inclusion 4
  - Cultural Hegemony 5

Organizational Context 5

- Governance Structure 6

Leadership Problem of Practice 9

- Lateral Aggression 11

Framing the Problem of Practice 12

- Power Imbalances 13
- PEST Analysis 15
  - Political Impact 15
  - Economic Impact 17

Sociocultural Impact 18

Technological Impact 21

Relevance to the Organization 22

Guiding Questions Emerging from the Problem of Practice 24

Leadership-Focused Vision for Change 26

Vision for Change 26

The Current State 26

The Preferred State 28

Optimize Data Collection & Adherence to Processes 29

Dedicated Training 30

Professional Socialization 30

Mentorship for Leaders 31

Indicators of Success 31

Chapter 1 Summary 32

Chapter 2: Planning and Development 33

Leadership Approaches for Change 33

Ethical Leadership Theory 33

Complex Relational Leadership Theory 34

Relationship to Organizational Context 35

Agency to Impact Change 36

Framework for Leading the Change Process 37

CQI Methodology & A3 Problem-Solving 37

Kotter's Change Model 40

Connections Between Change Frameworks 42

Lewinian Field Theory 43
Second & Third Order of Change 43
Alignment to Leadership Approaches 44
Organizational Change Readiness 45
History with Change 46
Barriers to Change 47
Responsibility of Organizational Actors 47
Responsibility of the Organization 48
Readiness Tool for Microenvironment: OCRBS 48
Readiness Tool for Mesoenvironment: ORCA 51
Overall Readiness 54
Leadership Ethics in Organizational Change 54
Ethical Considerations and Challenges 55
Addressing Ethical Responsibilities of the Organization 56
Use of ELT and CRLT 57
Solutions to Address the Problem of Practice 58
Change Drivers 58
Theories Informing Solutions 60
Potential Solutions 62
First Potential Method: External Resources 63
Second Potential Method: e-Learning Only 64
Third Potential Method: Face-to-Face Sessions 65
Most Appropriate Solution: A Blended Approach 65
Application of Foundational Theories to Solution 67

Chapter 2 Summary 67

Chapter 3: Implementation, Evaluation, and Communication 69

Change Implementation Plan 69

Alignment to Organizational Strategy 69

Change Implementation Alignment and Plan 71

Step One: Create Urgency 73

Step Two: Build Guiding Coalition 74

Step Three: Form Strategy 75

Step Four: Enlist Volunteer Army 76

Step Five: Enable Action for Change 78

Step Six: Generate Wins 79

Step Seven: Sustain Gains for Bigger Results 79

Step Eight: institute Change 80

Considerations for Equity-Deserving Groups 81

Communicating the Change Plan and the Change Process 81

Knowledge Mobilization Plan 82

Phase One: The Main Idea 82

Phase Two: The Target Audience 84

Phase Three: The Credible Messenger 85

Phase Four: The KMb Processes & Communication Structure 85

Phase Five: The Evaluation 88

Change Process Monitoring and Evaluation 89

CQI Tools & Processes 89

CQI: Standard Work & Process Observations 89

CQI: Balanced Scorecard 91
CQI: PDSA Cycles 92
Kirkpatrick's Training Evaluation Model 92
Level One: Reaction 93
Level Two: Learning 94
Level Three: Behaviour 94
Level Four: Results 94
Future Considerations of the Plan for Organizational Improvement 95
Expansion Through Spread & Scale 95
Return on Investment (ROI) Framework 95
Chapter 3 Summary 96
Dissertation-in-Practice Summary 97
Epilogue 98
References 99
Appendix A: Completed A3 Tool 121
Appendix B: Organizational Change Recipients' Belief Scale (OCRBS) 122
Appendix C: Organizational Readiness for Change Assessment (ORCA) 123
Appendix D: Change Implementation Alignment and Plan 127
Appendix E: Knowledge Mobilization (KMb) Planning P Model 132
Appendix F: Standard Work Example 133
Appendix G: Expanded CQI Scorecard with Examples Populated 134
Appendix H: ROI Evaluation Planning and the V Model 135

List of Tables

Table 1: Connections Between CQI & Kotter……42

Table 2: OCRBS Questions and Five Beliefs Influencing Individual Readiness……49

Table 3: Potential Solutions to Consider for Problem of Practice……61

List of Figures

Figure 1: Organizational Governance Structure with Chief Nursing Officer Role ……6

Figure 2: Expanded Governance Chart for VP Oncology Portfolio……8

Figure 3: CQI Methodology……38

Figure 4: A3 Problem Solving Tool Template……39

Figure 5: Kotter's Change Model and Dual Operating System……41

Figure 6: Learning Pathways for Staff……66

Figure 7: HcO's Strategic Plan……70

Figure 8: Change Implementation Timelines and Goals……72

Figure 9: KMb Planning P Model……83

Figure 10: Communicating Using Kotter's Change Model ……86

Figure 11: Standard Work Template and Process Observation Tracking……90

Figure 12: Simplified CQI Scorecard……91

Figure 13: Four Levels of Evaluation Using Kirkpatrick's Model……93

Figure 14: Phillips ROI Evaluation Planning and V Model……95

Acronyms

ALT	Adult Learning Theory
CAS	Complex Adaptive Systems
CNO	College of Nurses of Ontario
CQI	Continuous Quality Improvement
CRLT	Complex Relational Leadership Theory
CQI	Continuous Quality Improvement
DiP	Dissertation-in-Practice
EDI	Equity, Diversity, and Inclusion
ELT	Ethical Leadership Theory
HcO	Healthcare Organization (a pseudonym)
IEN	Internationally Educated Nurses
IPP	Interprofessional Practice
LA	Lateral Aggression
KMb	Knowledge Mobilization
OCRBS	Organizational Change Recipients' Beliefs Scale
ORCA	Organizational Readiness for Change Assessment
NQC	Nursing Quality Council
NSI	Nurse Sensitive Indicators
PDSA	Plan, Do, Study, Act
PoP	Problem of Practice
PS	Psychological Safety
QIP	Quality Improvement Plan
RN	Registered Nurse
RNAO	Registered Nurses' Association of Ontario
ROI	Return on Investment
RPN	Registered Practical Nurse
SCLT	Social Cognitive Learning Theory
SLT	Social Learning Theory

Definitions

A3-Thinking: The practice of analyzing root causes to create countermeasures for an implementation plan rather than jumping directly to a solution (Lee & Kuo, 2009).

Balanced Scorecard: A visual tracking tool used to monitor progress using pre-determined metrics (Canaud et al., 2013).

Countermeasures: A term used frequently in Lean methodology, a countermeasure is an action taken to counteract a weakness or a threat (Lean Enterprise Institute, 2024).

Critical Allyship: A practice for those who are in positions of privilege to guide action to address a particular system of inequality (Nixon, 2019).

Cultural Hegemony: A dominate cultural perspective that benefits one social group through the tacit control and oppression of another in a society (Kneipp et al., 2014).

E-Learning: This approach to learning is based on the use of electronic media as tools for improving access to training, communication, and interaction (Sangrà et al., 2012). In this document, it refers to electronic learning modules.

Ethical Disengagement: The normalization of apathy may cause disengagement to the point of being unkind or even cruel to others (Canadian Nurses Association, 2017).

Experience-Based Co-Design: The practice of involving stakeholders, with purposeful inclusion of vulnerable groups, to improve systems by translating the experiences of those groups into service redesign (Mulvale et al., 2016).

Flipped Classroom: This method involves a reversal of traditional teaching where learners gain exposure to new material outside of class, usually by reading or lecture videos, and then class time is used to do the harder work of assimilating that knowledge through strategies such as problem-solving, discussion or debates (Brame, 2013).

Hegemony: A concept rooted in power relations with the idea of one group dominating over a subordinate group (Racine, 2021).

Lateral Aggression: Repeated, unwelcome, and destructive actions intended to humiliate and upset a peer through verbal and non-verbal actions (Vessey & Williams, 2020). Many names exist for this term such as workplace bullying, emotional abuse, interpersonal mistreatment, harassment, social undermining, emotional tyranny, horizontal violence, mobbing, and incivility (Daly et al., 2020).

Leader: A person who leads or oversees individuals, groups, or teams. In this document, it refers to formal and informal leaders, such as clinical managers, clinical leaders, supervisors, and charge nurses.

Model Cell: A unit or department to model a proof concept for the rest of the system to learn from (Johnson, 2017).

PDSA Cycles: These cyclical processes involve a planning phase, a doing phase, a studying phase, and an acting phase. They assist in evaluating and assessing the effectiveness of change, allowing for course corrections to occur through an evolutionary process in response to situations (Chakravorty, 2009).

Process Observations: An auditing practice that allows for compliance tracking (HcO, n.d.).

Psychological Safety: The absence of harm and/or threat of harm to mental well-being that a worker might experience (Canadian Standards Association Group, 2022).

Self-Determination Theory: A socio-cognitive motivational theory that examine how social contexts affect human functioning based on the social environments' ability to satisfy three basic psychological needs: autonomy, competence, and relatedness (Manninen et al., 2022).

Standard Work: These documents create procedural predictability and reduce unnecessary variations (Lavelle et al., 2015).

Chapter 1: Problem Posing

Without question, there is a need to maintain a knowledgeable and competent nursing workforce. However, the need to create psychologically safe environments is required to allow for the retention of existing nurses in Ontario. The term, *eating their young*, has been prevalent in the nursing literature for decades and has historically referred to the harmful rite of passage that occurs when experienced nurses bully novice nurses (Aebersold & Schoville, 2020). However, this wrongdoing no longer lies with experienced nurses as the perpetuators: novices are now engaging in uncivil behaviours as well. Throughout this Dissertation-in-Practice (DiP), these uncivil behaviours will be collectively coined as lateral aggression (LA). In a time where healthcare workers are facing constant stressors and challenges, it is not surprising that LA is occurring.

This DiP will suggest a new phrase to describe this cannibalistic behaviour: *nurses are eating their own*. This chapter will discuss contributing factors to LA and provide the theoretical underpinnings that will address the problem of practice (PoP) while summarizing my positionality and agency as a nursing leader. This chapter will outline the problem and frame it within the healthcare sector, as well as delineate the current state and preferred state, with the intention for nursing leaders to create psychological safety (PS) in the workplace. This is central to the employee's mental well-being as PS will allow them to feel safe to bring forward ideas, participate in feedback loops, collaborate, take risks, and experiment with new ideas (Newman et al., 2017). Addressing LA will bolster PS and prevent a catastrophic exodus from the nursing profession in a large healthcare organization (HcO) in Ontario.

Positionality and Lens Statement

I am a cisgendered Taiwanese woman, born and raised in Ontario, in my forties. I have spent the entirety of my career in healthcare and education as a Registered Nurse (RN). I hold a Bachelor of Science degree in Nursing, a Master in Education, and many specialized nursing certifications to support my practice. I bring a passion for education and professional development to my work and strive to be

aware of how personal biases can shape my research. I acknowledge my privilege in being able to access certain resources because of my role as a senior leader in the healthcare system. My ethnicity may be perceived as a privileged minority by some, so my experiences of being privileged-adjacent has caused me to feel unseen at times. This has fueled a desire to be a voice for the voiceless.

Personal Leadership Position

I have held various nursing roles throughout my career, ranging from bedside care as an oncology nurse, to clinical practice and education, to academia as a nursing faculty member, to management, and now to my current role as the Chief Nursing Officer. This senior role utilizes an enterprise approach to develop, implement, and evaluate quality outcomes. In this role, I develop the organization's vision of nursing practice excellence and align work to strengthen the corporate presence, value, impact, and recognition of nurses at this HcO. I initiate organization-wide, nursing-focused strategies to optimize work environments to enhance professional practice. This includes strategies to improve communication and team functioning in the care of patients, the development of people, and the experiences of new hires and students. My role fosters links with external partners such as professional associations, regulatory bodies, academic organizations, hospitals, and service providers in the region and provincially. While I no longer have operational or fiscal responsibilities, I provide professional practice oversight to all nurses and lead corporate projects and change. My role requires meeting the strategic goals and addressing key performance indicators identified by the Vice President (VP) of the nursing, practice, education, and community health portfolio. Key performance indicators (KPIs) for me include nursing staff metrics (turnover, attrition, and new hires), worked hours per patient day (WHPPD) (including regular worked hours, overtime, sick rates, and nurse-to-patient ratios), and nurse-sensitive indicators (NSIs). Considering I no longer have staff reporting to me (nor a budget to enact change), I influence operational leaders by providing key workforce metrics and identify trends and areas of concern. I enable quality improvement opportunities and recommend the deployment of

organizational resources if there is strategic alignment to the quality improvement plan. However, there are limitations to the changes I can make. For example, I can advocate for increased compensation within operating budgets for clinical units but am unable to directly apply those increases. I can suggest strategies to decrease workload strain but not if it means turning away patients. As a leader, I am also required to follow human resource (HR) protocols within a unionized and non-unionized environment.

Prior to starting in this role, I managed approximately 200 interprofessional staff on two adult inpatient surgical oncology units and an outpatient surgical ambulatory clinic. The surgical inpatient units consisted of 73 surgical beds with a complex postoperative population. Nurses represented 83 percent of the employees on these units.

Beliefs & Understanding

Ashford and DeRue (2012) describe experiential learning as a process involving approach, action, and reflection. Since I lacked the formal training needed to go into management from a frontline role, I have always used an experiential approach when presented with unfamiliar situations and tasks. This involves identifying goals, going through trial and error, seeking feedback, and evaluating through self reflection. Ashford and DeRue (2012) state that experience-based leadership occurs when the lessons learned through cause-and-effect are applied to future scenarios.

As a leader, I believe in leading by example and serving those under my charge which broadly includes staff, patients and families, and learners. This is reflective of the servant leadership approach. Fahlberg and Toomey (2016) explain how this follower-centric approach involves cultivating relationships through empathy and awareness while fostering collaboration and community building. Further, the servant approach allows for follower needs and interests to be prioritized which positively impact staff engagement and organizational identification, allowing for psychological empowerment during times of uncertainty (Jimenez et al., 2021). Role-modeling behaviours and values that I want to see in others is important to me. Musbahi et al. (2022) state that leaders should set the moral tone for

their followers by role-modeling civil behaviours, prioritizing staff well-being, and addressing workplace inequality and diversity.

The positions I have held have contributed to a leadership philosophy supportive of mentorship and professional development. With a decade working as a nursing educator, education holds a prominent mantle in my leadership beliefs. As a result, I purposefully endorse and encourage the redirection of operational dollars towards orientation, training, and professional development for nurses. It is also important for me to meet with staff regularly. These meetings can happen organically or formally, and often occur with nurses in all roles, at all levels, and at all sites. The intention of these connections is to review barriers to their work, identify new opportunities, and review KPIs, nursing needs and trends, sustainability plans, and research capacity. I also visit clinical units to attend morning huddles to hear updates, opportunities, and celebrations at the unit level.

Alignment to Equity, Diversity, & Inclusion

My leadership stances stem from lived experience as a female visible minority leading a female-dominated workforce within a patriarchal healthcare system. Three quarters of my career was spent as a unionized nurse, so my values are inclined towards social justice and equality with a fundamental belief in the collective power of people. Johnston (2017) states that hospitals represent a hegemonic medical space where the nursing voice is commonly dismissed in favour of the reverent physician view by staff and patients alike. Since hegemony exists in tension with counter-hegemony, this gives agency for oppressed groups to challenge the status quo and oppose dominating ideas (Johnston, 2017). Knowing this, I chose to focus my graduate work on hegemony, hierarchy, and oppression. It is no surprise that Freire's seminal work have influenced my beliefs as a leader substantially. As a nurse, I am conscious of oppressed populations, cultural and gender disparities, and power differentials that exist and how it impacts healthcare decisions. The desire for action through emancipatory knowledge counters the cultural hegemony present and form the ontological basis of this DiP.

Cultural Hegemony

In many healthcare settings, there are hegemonic systems preventing frontline staff from fully participating in decision-making. Since healthcare has traditionally been paternalistic with strong hierarchal influences favouring physicians (Israilov & Cho, 2017), its structure naturally puts nurses at a disadvantage, which contributes to an imbalance of power. Although nurses comprise the largest percentage of the workforce and thus should be pivotal in influencing clinical decisions, their voices are often missing, excluded, or lost in the din of more dominant voices. In these hegemonic settings, Tosh (2007) states that the "sheer force of numbers does not ensure equal distribution of power" (p. 75). Medical dominance continues to persist because of deeply rooted ideologies of altruistic nursing service and the continuous undervaluing of the nursing profession. The perpetuation of subordinate and subservient relationships of doctors and nurses in hospitals occurs because "the gendered nature of nurses' work gives way to upholding patriarchal ideology as hospital hegemony" (Urban, 2014, p. 72). According to Coombs and Ersser (2004), the existence of this hegemony continues to render nurses powerless to influence the decision-making process because nurses and physicians value different types of knowledge. Cultural hegemony prevents full autonomy in influencing certain practices and furthers the oppressive narrative for nurses by highlighting inequalities at this HcO.

Organizational Context

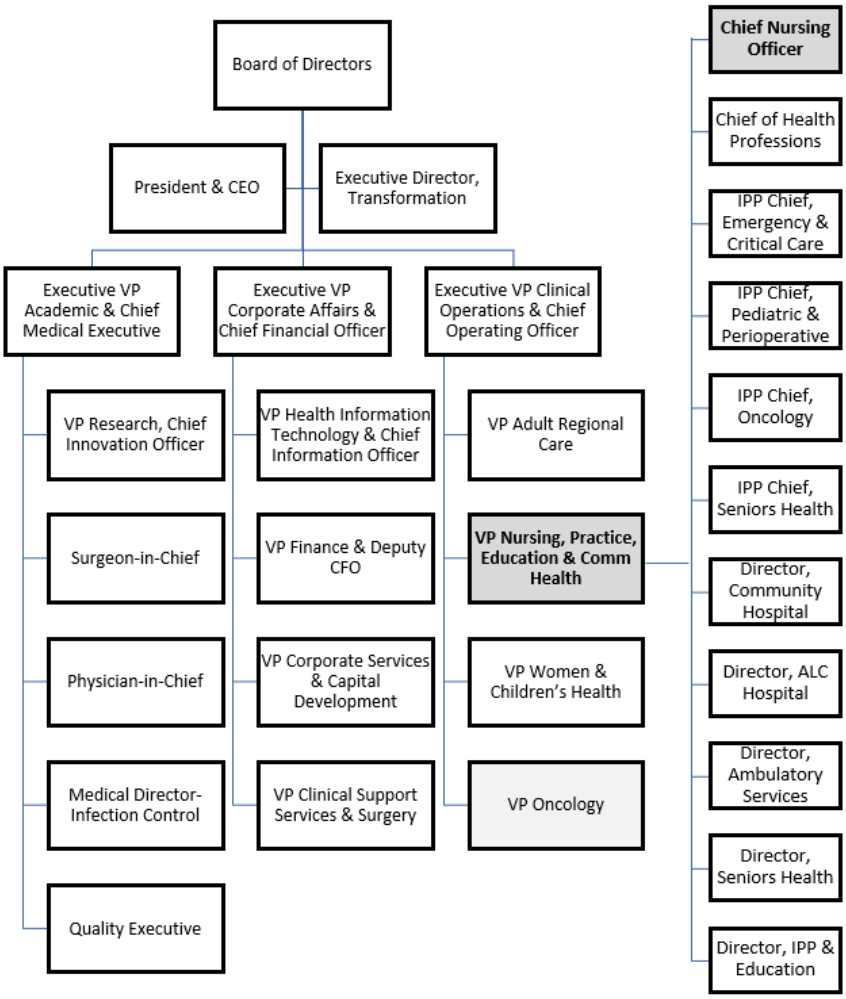
This HcO is a prominent academic teaching organization, consisting of four acute care hospitals, one sub-acute care hospital and several satellite locations, employing over 15,000 people in a large urban city in southern Ontario. Combined, these hospitals consist of over 1,400 inpatient beds. This HcO consistently ranks among the top five research hospitals in Canada. Nurses comprise the largest percentage of the workforce and represent over a quarter of employees in this HcO, with their numbers exceeding 4,400. This includes RNs, Registered Practical Nurses (RPNs), and Advanced Practice Nurses (APNs), which includes Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs).

Governance Structure

In this HcO, the governance structure is hierarchical, functional, and multi-divisional, with clinical and non-clinical branches within a centralized, social structure where power moves up the chain of authority, with each division functioning semi-autonomously. The Board of Directors and the President/Chief Executive Officer (CEO) set strategic priorities for the Executive Vice-Presidents (EVPs) who report to them. Each EVP oversee several VPs. Each division is substantial enough to warrant its own activities and are separated based on the specialization of labour or service delivery. Since the activity within divisions can vary widely, Ahmady et al. (2016) state that hierarchical reporting relationships to a suitable leader must occur. These clinical and non-clinical branches may range from surgery, oncology, or regional care, to finance, research, capital development, or technology. Each divisional leader is responsible for the operations, activities, and strategic decisions to maximize advancements within their area. Figure 1 demonstrates the complex governance structure of this HcO, with my role highlighted under the VP portfolio to which I report to.

Figure 1

Organizational Governance Structure with the Chief Nursing Officer Role



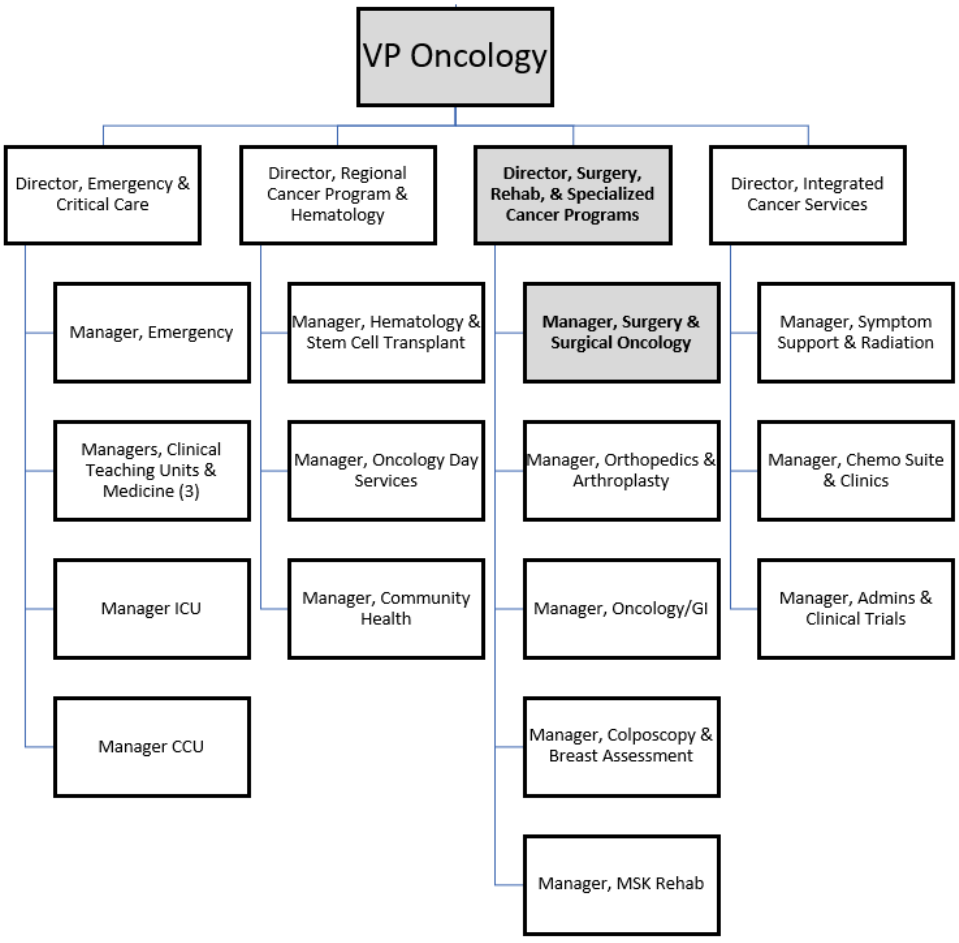
Note. Roles most relevant to the DiP are represented by the shaded boxes.

I am focusing on stakeholders within the EVP for Clinical Operations/ Chief Operating Officer (COO)'s portfolio because there are two VPs to which this DiP applies. The involvement of the VP of nursing, practice, education & community health's portfolio is important because the collaboration of the interprofessional practice (IPP) chiefs are needed for the success of this DiP. The VP of oncology is another important stakeholder as the focus of the change plan will be centered upon the surgical units within his portfolio. This VP uses a distributed leadership approach by which he sets the plan and communicates the strategic goals for his portfolio. The directors reporting to him act as mobilizers and oversee clinical operations within their units. According to Leach et al. (2021), distributed leadership

rallies expertise and creates shared opportunities for change while building capacity for improvement. The director for the surgical units has five clinical managers reporting to her within the program. Lastly, the manager of the surgical units will need to be engaged for change to be implemented on her units since the day-to-day unit-based functioning occurs at this level. These roles would all have tremendous influence on organizational change to reach the preferred state. Figure 2 outlines the reporting structure within the VP of oncology's portfolio.

Figure 2

Expanded Governance Chart for VP Oncology Portfolio



Note. The VP Oncology's portfolio depicts roles that would be relevant to the DiP.

Since replication is needed to maintain operational standardization between units in a clinical portfolio, these important stakeholders would need to understand the impact of LA on patient care and safety. By promoting PS, this will allow for overall well-being for nurses and leaders within this portfolio.

Leadership Problem of Practice

With a recognized nursing shortfall of more than 24,000 RNs, Ontario has one of the highest nurse-to-patient ratios compared to the rest of Canada (Canadian Institute for Health Information [CIHI], 2023). Although the overall number of RNs licensed to practise in Canada grew at a rate of 1% in 2022 (College of Nurses of Ontario [CNO], 2023a), this net gain still does not address the widening gap between the increasingly complex needs of an aging population and the number of practising nurses needed to care for sick patients. Simply put, the number of new nurses coming into the system does not directly replace the number of experienced nurses leaving. Despite a recent infusion of 35 million dollars into increasing enrollment for Ontario colleges and universities, this has only translated to 1,130 new RPN prospects, and 870 new RN prospects (Alberga, 2021). Applications for enrollment have increased but the demand continues to surpass the number of program seats available. Overcapacity and under-resourced, hospitals are unable to enact safe staffing ratios needed for the optimal provision of patient care. The recognized shortage results in higher workload, burnout, and physical and psychological burden. This serves as the impetus for creating antagonistic environments at this HcO where bullying situations and hostile interactions between nursing colleagues happen.

The resulting hostility sets the stage for bullying situations to occur. Graf et al. (2019) suggest that novice nurses will struggle the most from bullying, with attrition rates reaching an astounding 60 percent within the first year of practice. Additionally, up to 39 percent of novice nurses reported experiencing bullying behaviour by their peers in Canadian healthcare settings (Rush et al., 2014). This is significant because there are high numbers of novice nurses present on these acute surgical units. LA appears to be propagated through continued exposure to unprofessional behaviours resulting from the

prolonged challenges and associated staffing pressures in the clinical environment. Nurses who have been the recipients of bullying behaviour at work are more likely to leave (The Vector Poll, 2017), with conversations about the toxicity they encountered on their former units serving as a cautionary tale to others, thereby perpetuating staffing shortages. The downstream effect on recruitment and retention are the by-products of LA. Clearly, workplace climate and safe working conditions are factors worth exploring. Despite the many challenges that exist in the healthcare environment, nurses need to develop awareness of LA in action and feel empowered to address and strengthen the safety culture to improve working conditions. This requires a responsive approach to prepare nurses at all levels, from frontline to nursing leaders. This will support a psychologically safe environment, where there is intentional effort from all to create space for ideas, productive conflict, and establish normative behaviour for open communication and support (Center for Creative Leadership, 2024). In this HcO, RNs outnumber RPNs in a ratio of 2:1. Despite this, RPNs bully RNs as much as RNs bully RPNs. RNs care for unstable, acute care patients and this often means they have fewer patients as a result. In contrast, RPNs care for predictable, stable patients and this often means their patient assignments are greater in number. RPNs automatically belong to the union representing clerical staff and trades upon hire, while RNs will be aligned with a nursing union. These unions coexist in disharmony and unrest. The workplace harassment and anti-bullying policies are enforced differently depending on which union is present, which leads to inconsistent practices and results in eroded trust in the leader's ability to address uncivil behaviours. This requires purposeful adherence from nurses and leaders to follow the under-utilized processes already developed in order to support victims of LA. Thus, a change strategy supporting a psychologically safe culture by decreasing LA at this HcO could prevent intensifying the effects of the existing nursing shortage by developing capacity for those entering or remaining in the profession. However, there are no formalized training opportunities for nurses or leaders to learn the skills to identify, communicate, and intervene in response to LA. Therefore, the problem of practice is: What

training is needed to ensure nurses and leaders can identify and respond appropriately to lateral aggression to enhance psychological safety at this HcO?

In this HcO, turnover and attrition are high in many clinical units. In particular, the adult surgical units had consistently demonstrated high nursing turnover and sick time usage in the last few years, indicating that these units were in dire need of interventions to address these deficits. However, with so many hospital sites spread across a large urban city with nearly 4400 nurses, it would not be feasible to deploy finite resources to target the entire organization simultaneously. Therefore, a unit can serve as a model cell to demonstrate proof-of-concept to show tangible change and measurable results to leaders, demonstrating success for the rest of the system to learn from (Johnson, 2017). It can organically generate excitement if successful, but also mitigate risk by containing potential failures to a specific area rather than to the entire organization.

Thus, it is prudent to utilize a model cell approach to this change plan first. This approach will be used to align nurses and leaders to the goal of addressing LA to improve PS in specific areas. Using this approach allows time for people to learn tools and principles, as well as behaviours, to achieve transformation (Johnson, 2017). By starting the learning pathways in this high-need area first, the adult surgical units can act as a model cell which can set the groundwork for the rest of the HcO to learn from and adopt in other areas. Considering these units were under my management prior to entering the chief nursing officer role, I will be focusing on these inpatient areas for the DiP.

Lateral Aggression

Vessey and Williams (2020) define lateral aggression as repeated, unwelcome, and destructive actions intended to humiliate and upset a peer through verbal and non-verbal actions. Falletta (2017) states that dissatisfaction is often directed towards each other and towards those perceived to be less powerful than themselves. Although this typically occurs when experienced nurses direct their displeasure towards those new to the profession or new to the setting, nurses with the same job title

and responsibilities also commit LA against their peers (Vaughn & Snively, 2023). Verbal abuse may include using escalated tones or volume to indicate hostility, involve threatening language, scolding or criticism, insults, humiliation, sarcasm, or blatant disrespect (Shoorideh et al., 2021). In contrast, nonverbal abuse may involve more subtle, seemingly harmless actions such as raising eyebrows, scrunching up the eyes, scowling, creating physical distance, purposeful exclusion from activities and conversations, or invading one's privacy (Shoorideh et al., 2021). While instances may occur singularly, LA strikes when a harmful activity, interaction, or process occurs repeatedly to a person or group over a length of time (Giorgi et al., 2016; Jönsson & Muhonen, 2021). In the accumulated literature, diverse terminology exists for LA. It is known by many names such as workplace bullying, emotional abuse, interpersonal mistreatment, harassment, social undermining, emotional tyranny, horizontal violence, mobbing, and incivility (Daly et al., 2020). The multiplicity of terminology makes this behaviour difficult to recognize and report so the term lateral aggression will be used to describe these unprofessional behaviours throughout the DiP. The impact of nurses eating their own reaches far beyond the affected individuals and their aggressors. It also extends to those entering the profession because this abusive behaviour is often directed towards students (Thomas & Burk, 2009). These acts reinforce feelings of disempowerment and heighten tension in already stressful environments, furthering these cyclical uncivil behaviours.

Framing the Problem of Practice

The normalization of bullying behaviours can be attributed to many factors such as a lack of power, structural constraints, workload intensification, and hierarchical structures, but definitive causes remain unclear (Roberts, 2015). The nursing workforce is changing in Canada. The coronavirus pandemic increased the anxiety level of nurses, but especially for those who were already struggling with their mental health and this has contributed to the mass exodus out of the nursing profession (Byrd-Poller et al., 2021). Pandemic fatigue has heavily affected nurses, prompting the need to address improved

resiliency for an already stressed population. According to Byrd-Poller et al. (2021), individuals who have experienced organizational trauma from the COVID-19 pandemic will suffer emotional, psychological, and physical effects. The pandemic also influenced decisions for early retirements, further threatening an already vulnerable and short-staffed profession. Nurses face unique stressors such as prolonged exposure to human suffering, which ultimately create stressful environments and takes a psychological toll (Roberts, 2015). This in turn, increases frustration, making nurses more prone to interpersonal conflict and LA. According to Vaughn and Snively (2023), 80 percent of nurses frequently miss their breaks and 75 percent believed that inadequate compensation compounded their stress. Combined with the stress of working in a high-pressure environment, nurses are prone to interpersonal conflict and LA (Vaughn & Snively, 2023).

Power Imbalance

Many theorize that power imbalance is a main reason for why LA occurs. A common explanation found in the accumulating body of evidence for why this occurs is based on Freire's oppressed group behavior theory (1971), which speculates that powerless members turn on each other because they feel devalued when power resides with a more dominant group (Roberts, 2015). Nurses are an oppressed group because they lack the autonomy and control of the work environment leading to feelings of low self-esteem and powerlessness in nurses (Sellers et al., 2012). Nurses often do not feel valued by hospital administrators, other healthcare providers, and the public, with nursing knowledge viewed as inferior to physician knowledge (Vaughn & Snively, 2023). This powerlessness and lack of recognition leads to internal frustration that is inappropriately directed towards others. Daldal (2014) offers insight into power imbalance using Foucault's three modes of objectification. This includes the objectification of man into dividing practices. This divide separates the physicians from nurses, the nurses from allied health disciplines, nurses from each other and so on, down to the separation of the healthcare teams to patients and families. These divisions reinforce power imbalances and highlight hierarchical structures.

Cultural hegemony places nurses and allied health staff in subservient roles and awards physicians a higher status based on the possession of their educational credentials. This aligns with Weber's idea of legitimate domination and monopolization, which infer that educational certifications are used to restrict entry to privileged social positions (Porter, 1999). By having societal acceptance that the attainment of certain educational credentialing equates to mastery of care, it gives physicians authority and control over other healthcare disciplines (Porter, 1999).

The professional segregation of nurses into registration classes (RNs, RPNs, and extended class nurses) adds to this narrative. Each class has separate educational requirements but function synergistically with similar scopes of practice. In Ontario, RNs are recognized and compensated more generously than RPNs for the same work. Healthcare organizations also award pay incentives, opportunities for career advancement, and recognition for one nursing group over another. Separate nursing unions for these roles also obstruct solidarity efforts since contrasting practices for scheduling, recognition, and compensation fuels tension and hostility. Additionally, the financial compensation of RPNs is only marginally higher than personal support workers (PSWs), despite having higher educational requirements and increased responsibilities. This professional segregation, along with the rewards and recognition most organizations place on class, can exacerbate feelings of frustration and powerlessness. Despite common values of altruism and public service, these nursing roles represent different ways of achieving the shared goals and a widening chasm exists, highlighting a clear power disparity.

Finally, there are unconscious biases with implied hierarchies and preferences regarding international nursing education and practice, based on race and ethnicity. Allan (2022) recognized the presence of historical institutional racist practices in a system of discrimination, oppression, and white privilege through micro-aggressions and systemic injustices. Iheduru-Anderson (2020) suggests that a complicity with silence and a collective denial of racism work as racializing processes in clinical practice. In this HcO, there are some who believe that white nurses have unequal, advantageous access to

interpersonal and structural resources. As a result, racialized nurses may struggle to fit in because their differences go unrecognized, and whiteness persists. These power imbalances and challenges of working within an interprofessional team can affect the ability to initiate and sustain collegial relationships needed to prevent LA because hierarchical structures and cultural hegemony contribute to power imbalances and work against the idea that all are equal.

PEST Analysis

While power imbalances provide an underlying explanation for why LA occurs in nursing, there are other factors to consider. To understand further, an analysis of trends in areas that commonly affect operations and performance can be useful for ensuring successful organizational change (Siddiqui, 2021). A PEST (political, economic, sociocultural, and technological) analysis can examine the impact of these forces on LA in this HcO. Workload intensification due to staffing shortages, decreased nursing experience and knowledge due to attrition, communication barriers, compensation inequities, and changes in the nursing workforce demographics all contribute to nurses eating their own and will be explored further through this analysis.

Political Impact

Historical underinvestment into nursing and healthcare by the provincial government has resulted in inadequate compensation, continued unfavourable working conditions, and funding inequities, heightening tension in healthcare settings. In 2020, wage suppression legislation limited pay increases to a maximum of one percent for three years and this heavily impacted nursing, a predominately female profession (Ontario Nurses' Association [ONA], 2021). Although the legislation was ultimately overturned, the decision to appeal the court's decision sparked ire (Artuso, 2022) and divided public opinion. This furthered contentious discussions about what constituted as fair compensation, especially among nurses in different registration classes working in the same setting.

Healthcare in Ontario has been historically underfunded and under-resourced. The pay disparity dispute coincided with the detrimental working conditions that worsened from the aftermath of the COVID-19 pandemic. Vidal-Alves et al. (2021) stated that physical exhaustion became more pronounced as reports of more emotionally taxing and ethically-charged situations increased. Further, the lack of personal protective equipment and subsequent improvisation of protective gear, combined with fears of contracting COVID-19 were often reported by nurses (Vidal-Alves et al., 2021). These occupational hazards continued to place strain on an already-stressed population.

The lack of provincial support to retain sought-after nurses in Ontario is another political consideration. According to Canadian Institute for Health Information [CIHI] (2023), internationally educated nurses (IENs) made up 64 percent of the net increase in RN supply in Canada in 2022, compared to 19 percent in the previous year. In Ontario, a recent report showed that 53 percent of newly regulated nurses in Ontario were internationally educated (CNO, 2022a). IENs are needed to fill the existing nursing gaps. However, in order to obtain a nursing license, IENs often need to complete a clinical placement to demonstrate nursing knowledge and language proficiency skills in a Canadian setting. Nurses are already continuously precepting new hires in response to the high turnover rate, so preceptor fatigue is commonly cited. Precepting can be emotionally and physically taxing, particularly if the learner is struggling. The reality is, with a finite number of preceptors available, the same nurses are often asked to take on preceptorship responsibilities. Smith and Sweet (2019) summarize accounts of nurses falling behind in their nursing duties because of teaching responsibilities, which drastically increased their stress levels and affected overall well-being at work. The regulatory college also state that all nurses (including inexperienced ones) are accountable to support, mentor, and teach learners. Therefore, nurses can not refuse a preceptor assignment (CNO, 2023b) and when nurses are told to precept a colleague, they are not compensated for the additional workload stemming from orienting their peers. Moreover, if the learner is perceived to be unmotivated or has a seemingly lack of work

ethic, it can result in further conflict (Smith & Sweet, 2019). The added perceptor burden may be contributing to nurses eating their own. Another political consideration contributing to LA involves acquiring permanent residency status through the economic immigration program. Ontario hospitals are unable to assist IENs with the time-sensitive requirements of the application due to resource limitations within HR departments. As a result, other provinces willingly aid IENs in completing the immigration process, thereby inciting these nurses to leave Ontario in search of permanent residency status. This has resulted in frustration and resentment from many who have dedicated countless hours precepting nurses to develop skills and competency so it is often seen as a wasted effort when resignations occur abruptly and frequently.

Lastly, there are funding inequities that represent opportunity for some, but not all nurses, so these have proven to be divisive. These provincial incentives are subject to yearly approval. For example, the Nursing Graduate Guarantee (NGG) supports the transition of a novice nurse into clinical practice by providing funds to lengthen orientation in acute care settings while guaranteeing full time employment upon completion (Ministry of Health, 2023). Since not all novices are granted this opportunity for longer orientation time and guaranteed full time employment, it furthers hostility by offering unfair advantages for one to attain clinical proficiency. This is problematic when many nurses assimilated to the unit through a 'sink or swim' orientation and see this as a rite of passage. Another example of a funding inequity is the Community Commitment Program for Nurses (CCPN), by which eligible nurses are given a $25,000 grant in exchange for a two-year commitment to work (Health Force Ontario [HFO], 2023). The stringent eligibility criteria ensures that most nurses will not receive this generous incentive, which further incites bitterness among nurses.

Economic Impact

Orientation is a costly endeavor. In 2023, the estimated cost of orienting a nurse in this HcO ranged from $9,970 to $12,165 in a three-month period. The costs of frequent onboarding due to high

attrition has implications to the unit's compensation budget. A 2017 national membership poll conducted by the Canadian Federation of Nurses Unions (CFNU) showed that four in ten nurses cited a poor working environment as the primary reason for leaving their jobs. These funds cannot be recuperated if a nurse leaves prematurely due to LA. This also represents a significant preceptorship challenge since upwards of 320 hours is needed to sufficiently onboard a nurse in this HcO. The economic impact of LA is costly because not only is there a direct correlation with intention to leave and staff turnover, but it also requires repeated human resource support, deflects time away from regular duties, and increases absenteeism (Giorgi et al., 2016). Additionally, the costs associated with orienting a new nurse means that the unit is paying twice as much since both the new nurse and the preceptor are caring for the same patients in their assignment.

There has also been a growing reliance on private, for-profit nursing agencies to fill nursing gaps. The promise of lucrative wages and flexible scheduling have lured some nurses away from their permanent positions and into agency nursing. This cyclical problem exacerbates the shortage, increases workload for those who remain, and has obvious economic implications to compensation budgets since agency nurses are paid more than double the staff nurse's hourly rate. Staff nurses are bound by the regulatory college to train cost-prohibitive agency nurses and share their knowledge and expertise for free. This understandably fuels resentment. The final straw is when higher-paid agency nurses are given easier assignments with lower acuity patients to ensure safety. This negatively impacts the morale of nurses employed by the hospital when they receive sicker patients (Hassmiller & Cozine, 2006).

Sociocultural Impact

The demographics of the nursing workforce (age, generational cohort, gender, and level of experience), work-related factors (shift, type of work, and setting) as well as unit culture contribute to incidences of LA. A hostile unit culture may also hinder effective communication needed for minimizing the occurrence of LA. Shoorideh et al. (2021) concluded through a systematic review and meta-analysis

examining incivility that poor communication skills, inadequate allotment of time to one's duties, and delay in information-sharing may lead to higher incidences of verbal incivility.

Nursing Workforce. Multigenerational workforces can prove to be challenging since up to four generations of nurses could be working together with each generational cohort having contrasting attributes, characteristics, education, and goals, especially towards learning and working (Hisel, 2020). Each generational cohort has a distinct set of attributes, characteristics, education, and goals (Hisel, 2020). For example, Millennial and Gen Z cohorts prioritize work-life balances that favour social interaction compared to traditionalists. These intergenerational differences offer contrasting worldviews and varied perceptions of goals and risks (Coventry & Hayes, 2020). This can fuel conflict and incivility, which can result in performance issues, absenteeism, and increased turnover (Coventry & Hayes, 2020). Complaints of LA from all levels of nursing reflects greater professional disengagement, absenteeism, and turnover rates, so this can lead to an unhealthy work climate. Additionally, nurses targeted by their peers have often report damaging psychological and physical consequences to their health, impairing their functional ability in both their personal and professional lives. This results in depersonalization, emotional exhaustion, sleep disturbances, concentration difficulties and negative emotions (anger, frustration, helplessness, depression, anxiety), which may lead to harmful counteractions of wrongdoing, self-harm, or suicide (Galanis et al., 2021; Giorgi et al., 2016). Age is another vulnerable factor to LA since younger professionals are often more harassed (Vidal-Alves et al., 2021). Generational attitudes and age are other contributing factors to LA, especially when the preceptor is younger than the new hire or if the new hire is more experienced than their preceptor. Dissatisfaction with the preceptor is often reported in these cases, resulting in complex communication challenges. This, coupled with the preceptor's inability to provide individualized and skilled guidance to the preceptee due to workload, are often cited as reasons for increased frustration (Kawakami et al., 2022). Labrague and McEnroe-Petitte (2018) also report that many novice nurses lack assertive

communication skills when dealing with difficult situations compared to more experienced nurses. Novices often fail to take appropriate actions because of poorer communication skills and a lack of support from their colleagues, leaders, and the organization (Shoorideh et al., 2021).

Gender is another important sociocultural consideration for LA, as the nursing profession has historically been associated with female gender roles shaped by social perceptions dividing the sexes. Male nurses struggle with misinterpretations of their actions and intentions by their colleagues, battle distrust in their professional capabilities for caregiving, and report their masculinity and sexuality are often questioned by colleagues and patients alike (Baker et al., 2021).

Work-Related Factors. Since nursing shortages persist in many units, leaders may reassign junior nurses to understaffed and unfamiliar areas without the proper training to care for the population (Maunder et al., 2021). Many nurses will report higher stress levels as a result and harbor resentment towards unfamiliar colleagues or even towards their own colleagues. Data examining LA has been manually collected and began when I was the manager for the surgical units. This includes the collation of relevant metrics based on the number of informal and formal complaints of bullying, as well as escalations to HR and the unions. In a five-month period, an internal report showed that nurses were reassigned 64 percent of the time when fully staffed to a lesser staffed unit, with more reassignments occurring on a night shift or on a weekend (HcO, 2023a). Walker et al. (2017) state that a lack of leader support in these unfamiliar areas, exposure to unprofessional workplace behaviours, combined with responsibilities beyond their expertise, increased the likelihood of LA. Additionally, Vidal-Alves et al. (2021) state that LA appears to be higher among shift workers than among those with fixed schedules. This is relevant because up to 36 percent of nurses hold casual or temporary positions (CIHI, 2023) and it would be an important consideration as the inconsistency with schedules may create breeding grounds for LA to occur.

Unit Culture. Low staff morale, decreased teamwork, lack of professional identity and little sense of community are often associated with LA (Crawford et al., 2019). Nurses will develop within a social context shaped by stereotypes that influence perceptions and affect the advancement of the profession (Teresa-Morales et al., 2022). Clearly, the implications of professional socialization are great because the level of organizational commitment and willingness to trust each other is based on the employee's observations of situations in the workplace (Schein, 2010). These negative perceptions can cause stress, job dissatisfaction, and decreased work performance, while affecting care and the overall work climate (Rubbi et al., 2017). Many studies cite a correlation between increased levels of stress and reduced self-esteem in nurses (Serafin et al., 2022). This fatigue is often blamed on the nurse's inability to cope with stressors due to deficits in their own lifestyle or mindset. Vidal-Alves et al. (2021) note that nurses can be at higher risk of LA if they are new to the job, are promoted, have relational difficulties among the team, receive special attention from physicians, or work in understaffed conditions. Additionally, nurses who wish to enhance their role or progress in their career are often held back by damaging attitudes. They may be vilified by colleagues as being a sell-out or not a real nurse if they express the desire to advance beyond direct care responsibilities (Tosh, 2007). Nurse-sabotage thwarts solidarity efforts, while decreased levels of teamwork or diminished team function can also fuel the occurrence of LA. Vessey and Williams (2020) highlight that nurses are less likely to ask for help if they expect ridicule from their colleagues or leaders for asking, so there are increased risks for impaired decision making or inappropriate nursing interventions to occur. A unit culture normalizing team dysfunction can produce more errors. Ultimately, when communication and teamwork are jeopardized, this results in poor outcomes with life-threatening or life-limiting consequences for patients.

Technological Impact

This HcO underwent the largest clinical transformation in their history by moving to a new electronic health information platform to manage patient care data. By doing so, this digital

transformation meant that experienced practitioners needed to un-learn old ways of working and knowing. They needed to lean on the expertise of others to re-learn how to review data and health information in real time while fulfilling their professional requirements to document in a timely and efficient manner. For some, this represented major challenges if they were not already technologically proficient. According to Borycki and Kushniruk (2023), digitized health information systems lead to new healthcare processes but can introduce new types of technology errors. Human error combined with poor human-computer interactions may result in diagnostic errors, the wrong tests taking place, and the wrong treatment provided (Borycki & Kushniruk, 2023). Despite its launch over two years ago, nurses on these surgical units continue to struggle with changes in workflow processes and may shift the blame for missed tasks to others. This major technological change contributed to feelings of powerlessness for some, which further increased LA in the setting.

The pandemic changed the way most students learned in post-secondary environments as it shifted the learning space from a physical environment to a virtual one. Clinical nursing education has historically provided tactile learning opportunities, so this changed with the shift to e-learning in a digital age. Many hypothesize that nurses entering the profession are ill prepared for the physical and emotional demands of the clinical environment. Novices may have strong theoretical understanding but will not have experiential learning from real-life scenarios in order to progress to safer levels of practice so this has created internal sources of conflict.

Relevance to the Organization

An analysis done in the United States by Wilson et al. (2011) found that 85 percent of nurses had seen or experienced bullying, 90 percent had difficulty confronting the perpetrator and 40 percent considered leaving their job because of the behaviour. Similar statistics can be seen in Canada, where a 2019 study done by Small et al. (2019) found that 87 percent felt incivility in nursing was a problem while 89 percent of surveyed nursing students reported experiencing bullying behaviours themselves

(Clarke et al., 2012). Goh et al. (2022) examined 12 systematic reviews to understand the pervasiveness of LA in the nursing profession and found the prevalence rates ranged from 40 to 77 percent. This is further reinforced by findings from a longitudinal study completed by Holm et al. (2023), where the authors concluded that witnessed bullying and certain bystander roles (such as assistant, defender, and outsider) could have detrimental consequences by influencing a perceived quality of care, engagement with work, and intention to leave.

This HcO saw 369 nursing resignations in 2021, with novice nurses comprising 35 percent within two years after graduation (HcO, 2021). In a two-year period, nursing resignations had increased by 42 percent (HcO, 2021). In the surgical units, high turnover with resignations was seen, accounting for 79 percent of voluntary exits that year. This HcO continues to suffer the detrimental effects of a prolonged nursing shortage. Recent data provided by this HcO's HR department has shown that many nurses are novices. As of October 2023, 67 percent of the nursing workforce in the surgical units had less than three years of overall nursing experience. Of that, 42 percent had less than 1 year of nursing experience. These surgical units have historically attracted novices and is considered by many to be entry-level in nature. Based on internal reports from 2022 to 2023, 86 new nurses were hired on these units. This also demonstrated that turnover was high, with 54 nurses electing to transfer to another unit or department and 29 nurses leaving the HcO entirely. Sick time and absenteeism rates are unusually high on these units, averaging a two-to-three-fold increase compared to other inpatient units (HcO, 2023b). Through exit interviews, many staff had expressed anxiety due to the larger workloads related to the nursing shortages, challenging interactions, and exposure to unprofessional behaviours. According to HcO (2023a), 32 percent stated being the recipient of harmful actions by a colleague, while 67 percent recounted witnessing unpleasant interactions between peers. Over a two-year period, more than 30 complaints of bullying were escalated to the management team. Most were resolved at a preliminary stage as defined by this HcO's workplace harassment policy while an additional six incidences were

escalated to HR investigation. The harassment protocol provides a procedural process for leaders to address complaints and ensure conflict resolution occurs, applied to any conduct described as harassment, sexual harassment, discrimination, and/or a poisoned work environment (HcO, 2023c). This protocol encourages self-directed resolution efforts by supporting the need for conversations between the affected individuals at the first stage, supported by the manager if needed. Another three incidences required coaching support and a code of conduct review; two incidences required environmental separation and schedule changes of the affected nurses; and one incidence resulted in formal discipline without termination. Managers within the same program also reported incidences of LA in their units and HR business partners reported these numbers appeared to have risen since the corporate policy was revised in 2022. While the number of harassment claims were expected to increase with heightened awareness of corporate processes, these anecdotal reports are troubling, nonetheless.

Guiding Questions Emerging from the Problem of Practice

There are many factors that contribute to this PoP. Considering the DiP centers upon the nurse and their leader, there are still numerous considerations that add to the complexity of this problem. Damaging perceptions can also impact decisions to enter or stay in nursing. Considering LA isn't a new issue in the nursing profession, how do we objectively measure the prevalence and compare it to historical data? Leaders at this HcO have noted an increase in uncivil behaviours among their nursing staff but may not have data to support these claims through safety occurrence reporting. Many leaders also speculate that LA has increased in recent years as a predicted by-product of the challenges prevalent in the nursing profession. Secondly, while there is undoubtedly a need to focus training efforts on frontline nurses to address the PoP, how would training for leaders be different? For example, if a leader believes themselves to lack the emotional stamina needed to have an effective conversation with the perpetuator, what role do leaders inadvertently play in contributing to the LA in the workplace?

Would it be beneficial for leaders and nurses to learn alongside each other to understand their collective role in stopping LA in nursing teams?

Thirdly, how can leaders change organizational culture to decrease this long-standing LA? Vaughn and Snively (2023) assert that if LA has been ingrained or normalized as part of the culture, the collective group may not view it as immoral, but rather, a rite of passage that builds character. The theory of ethical relativism provides an explanation, where it asserts that the perceived morality of an abhorrent act is influenced by the culture in which it occurs (Vaughn & Snively, 2023). In the end, people want to feel as if they belong. According to Schein (2016), social validation means that certain beliefs and values are affirmed by the shared social experience of a group. Members who fail to accept those beliefs run the risk of exclusion or expulsion from the group. Schein (2016) elaborates by stating that the test of whether validation occurs is how comfortable members are when they abide by them. Social cohesion is vital because it steers the commitment of its members and impacts one's desire to work and remain within the group to contribute to attaining its goals (Paunova & Li-Yung, 2023). Li et al. (2014) outlines that this cohesion is beneficial for job performance and satisfaction, as well as intention to stay within the organization. Strong group cohesion was found to have positive impacts on patient satisfaction and reduced the number of safety occurrences (Bae et al., 2010). Therefore, it is important to assess self-concept for nurses within the model cell, as well as the social context within which they are embedded. Those with differing concepts of self will interpret their contexts differently, which results in incongruent perceptions of group cohesion (Paunova & Li-Ying, 2023).

Lastly, vertical aggression needs to be considered. This differs from lateral aggression because followers may direct bullying behaviours towards their leaders rather than towards their peers. As a former manager, I have been on the receiving end of this aggression. With so many nurses leaving because of LA among their peers, how many nursing leaders are leaving due to the same issues? How do we support the people who support our people? According to Cathcart et al. (2010), nursing managers

engage in demanding relational work, see what is at stake in acute situations and intervene in ways to ensure good outcomes while simultaneously supporting the ongoing development of their staff. This involves upholding high standards for patient care and safety, so managers have a vested interest in ensuring stability and job satisfaction in their nursing workforce. Self-concept has similarities to self-efficacy but Bong and Skaalvik (2003) state that self-concept is formed through experiences and can be influenced through social comparisons to peers. Therefore, do leaders have self-efficacy navigating interpersonal conflicts and does self-concept influence self-efficacy behaviours?

Leadership-Focused Vision for Change

Considering the critical nursing shortage exists on all levels (municipal, provincial, national, and global), it would be important to retain nurses at this HcO by creating a culture of PS to address the occurrence of LA on clinical units. Therefore, strategies must be developed to address LA to prevent or minimize its damaging effects. There is an urgent need to create an environment where precautions are taken to avert injury or harm to the psychological health of staff.

Vision for Change

The HcO's strategic plan highlights the need to create a safe work environment with highly engaged staff and a desire to be a top-ranking hospital for high quality of care (HcO, 2023d). The focus and goal of the DiP to have a psychologically safe environment aligns with the HcO's vision and strategic plan. There is a public vow to change culture and integrate inclusive practices at every level where equity, diversity, and inclusion (EDI) encompasses every role, team, event, and patient care (HcO, 2023e) and the change plan will support the HcO's ongoing commitment to ensure the socially-just allocation of resources. My goal to address LA in nurses align with the organization's mission statement. It also utilizes existing CQI methodology to create a solution; thus, embodying the HcO's vision of creating a workforce where everyone is a problem-solver (HcO, n.d.).

The Current State

The guiding questions that have emerged from the PoP have driven the analysis of this HcO's current state. There are limitations to how this HcO objectively measures the prevalence of LA and compare incidences to historical data. At the organizational level, safety specialists monitor the number of safety occurrence reports (SORs) related to harassment and bullying while leaders may manually track these incidences. Training for nurses and leaders would have similarities but there may be nuances to consider to support nurses in different roles. The environmental scan revealed that there are no formal training opportunities for staff to recognize LA in the workplace. There are two voluntary courses employees can take that may align with this PoP. One is entitled Crucial Conversations, which allows staff to address difficult conversations and engage in healthy dialogue. A barrier to this is that it is cost-prohibitive, requiring staff to pay out of pocket to attend the course. It is only available every four months on a first-come, first-serve basis. The second course is entitled Unconscious Biases and Micro-aggressions, where the focus is on identifying micro-aggressions within an EDI context. This is more accessible to staff since it does not require payment but it too, is also only available every four months with limited seats. Finally, there are provincial safety requirements that necessitate completion of a mandatory annual e-learning module for workplace violence prevention that focuses on vertical aggression between leaders and followers, as well as horizontal aggression among members of the inter-professional team. However, it does not address behaviours within a specific profession. It broadly covers general de-escalation of violent behaviours for patients and visitors, recognition of domestic violence, and staff responsibilities for reporting.

Organizational culture can be difficult to change and everyone has a responsibility to contribute and commit to positive change. This can prove to be challenging in a hegemonic environment where members may feel disempowered to enact improvements. Freire (1971) suggests that these behaviours are detrimental because it prevents the development of group cohesion necessary to collectively support peers and gain power in the setting. Not only does this contribute to lower self-esteem and

heighten anxiety, but powerlessness also encourages passive-aggressive behaviours when confronted by the dominant group because the belief in inferiority makes them unable to express anger (Roberts, 2015). The utilization of the organizational development (OD) department may prove to be beneficial when supporting change in this HcO. Finally, the current state of support for our leaders reveals similar themes of powerlessness. Hampton et al. (2019) state that nurse managers often utilize three action-oriented responses, including taking charge, supporting staff, or doing nothing. Witnessing nurse-to-nurse bullying and experiencing personal bullying was found to contribute significantly to the manager's ability to recognize bullying and to take action to address it. According to Hampton et al. (2019), over 58 percent of leaders acknowledged being a victim of bullying. I experienced vertical aggression during my two-year tenure as a clinical manager but have fortunately not experienced this in my new role. However, Prestia et al. (2017) state that the Chief Nursing Officer is another vulnerable nursing leader, as their study showed that this role often suffered a loss of self-confidence, experienced powerlessness and reported moral distress and trauma from these behaviours when supporting nurses and their leaders. Although HR can support procedural adherence by providing guidance, there are staffing constraints within the department which limits the amount of mentorship available for leaders.

The Preferred State

PS is important for high-performing teams because when individuals voice concerns without fear of reprisal, wellbeing and job satisfaction improve and overall stress is decreased in the workplace (Murray et al., 2022). The preferred state needs to consider the impact of organizational culture in developing PS at this HcO since LA is a learned behaviour in the workplace. According to Schein (2010), newcomers are typically socialized into the dominant culture by how they are expected to think and act, so allowing negative behaviours to continue unchecked would hinder successful longitudinal and impactful change. These behaviours may potentially worsen through cultural and professional normalization, undermining nursing standards and safe practices (Sellers et al., 2012). Considering the

guiding questions emerging from the PoP, the preferred state can be achieved through co-design processes with important stakeholders. This includes optimizing data collection and adhering to processes, dedicated training efforts, professional socialization, and mentorship to support leaders.

Optimize Data Collection and Adherence to Processes

In order to measure the prevalence of LA and compare its impact, there needs to be formal tracking and utilization of already established protocols. It is essential to have measurements of success through appropriate data collection at various points throughout the change plan. Considering the time and workload needed for leaders to manually collect data, the preferred state should include ways to optimize data collection, identify relevant metrics and standardize reporting templates. This would involve engaging with other departments to automate processes using existing electronic systems to reduce the administrative burden on leaders. The preferred state would also utilize CQI methodology that is prevalent at this HcO to streamline workflow processes related to data collection. This will offset the time required to collect data manually by having information flow to one place and improve leader capacity to address incidences in a timely manner.

The workplace harassment and violence prevention protocol outlines steps for employees to take to address the behaviour themselves but relies on individuals to identify colleagues whose actions do not align with the values-based code of conduct policy. This places the onus on the individual to take the first step in addressing LA. There should be improved awareness of these processes in the preferred state, as well as the proper utilization of resources to support addressing LA. Risk mitigation processes for reporting and escalation need to be followed in order to more accurately capture the prevalence of LA and determine whether the change plan resulted in improvement. Thus, the preferred state would need a plan to address this deficit to increase awareness of these processes. These protocols and subsequent resources should be revised routinely by health, safety and wellness (HS&W) and HR to best support staff in addressing LA. There should also be a shared understanding between nurses and their

leaders on the expectations for professional conduct, as well as the consequential actions that will occur as a result of uncivil or bullying behaviours. Having increased awareness of existing processes will strengthen adherences for all parties.

Dedicated Training

The guiding question of determining training requirements requires coordinated efforts across departments at this HcO to formalize training pathways for staff to recognize and respond to LA. The preferred state for training and mentorship requires thoughtful consideration on which methods, format, and delivery approaches would prove most helpful based on the audience. Considering this HcO has an OD department, a HS&W department, and a clinical practice and education (CP&E) department, these members would be essential stakeholders in developing and delivering training programs for staff. As stated, there are significant gaps at this HcO in recognizing and understanding LA, as well as knowledge of ways to overcome it in the workplace. If nurses fail to recognize LA in action and are unable to name it, both the lack of recognition and the inability to name it are barriers to accurate measurement and to effective intervention (Sellers et al., 2012). This training is essential to equip staff with methods and tools to effectively address LA and minimize its harmful effects. The preferred state would consider existing training material and courses, combined with collaboration with internal experts, to efficiently utilize and refine resources to meet the needs of the audience. It would be important to define who should participate in this training and when it should be mandated, as well as ensure protected time, be readily accessible, and support the needs of those in attendance.

Professional Socialization

To address how nurses and leaders can change organizational culture, it is essential to learn the skills, attitudes, and behaviour necessary to fulfil the role, as well as to build trust in a team (MacIntosh, 2003; as cited in Thrysoe et al., 2012). Collegial relationships can influence a sense of belonging and job satisfaction, as well as allow for successful transition into a professional role (Thrysoe et al., 2012).

Familiarity boosts the willingness of colleagues to answer questions and to help with practical tasks, which would impact culture. Thrysoe et al. (2012) stated that professional and social interactions combined with the opportunity to contribute knowledge increased the likelihood of feeling like a valued member of a community. Hover and Williams (2022) state that understanding why oppressed groups behave in the way they do will help to empower nurses to regain the power needed to affect change. Therefore, the change plan will need to consider relationship building, education, and networking opportunities to help nurses and leaders change culture.

Mentorship for Leaders

Nurse managers need dedicated support and would benefit from additional higher level leadership competencies and from mentorship, as well as a formalized way to successfully transition nurses into the manager role (Roth & Whitehead, 2019). Evidence has shown that nurse managers often lack formal role orientation to become a successful leader (Keys, 2014; Roth & Whitehead, 2019). The preferred state would consider what resources are available for leaders and ensure the timeliness of the support. Therefore, adequate mentorship opportunities should be tailored to the leader's needs so that they feel confident in their ability to address incivility and PS would be positively affected to allow for prompt recognition of LA.

Indicators of Success

To track data, it would be pertinent to create a dashboard for leaders to see how frequently this information is reported to HR and to senior leaders through the SOR reporting system. The creation of this dashboard will allow LA to be at the forefront, with harassment and bullying landing seamlessly into the KPIs for nursing. This will allow leaders to review the impact of LA as an important indicator when reviewing trends and metrics such as turnover, churn, overtime, and absenteeism. In the preferred state, it would also be necessary to gather the qualitative experiences of nurses and managers from exit interviews to conduct a thematic analysis at specific intervals for comparison. Objective measures could

include the number of people trained, incidences of LA in areas with high turnover, number of nurses retained at the HcO, and reports of self-efficacy in recognizing and addressing LA in the workplace. A return-on-investment (ROI) model could also determine whether the financial investments into a specialized orientation for nursing managers to include training for LA would result in retention of mid-level leaders as well.

Chapter 1 Summary

As Bolman and Deal (2017) purport, it is imperative that organizations invest in their employees. Undertrained workers harm organizations by providing poor quality and service, resulting in higher costs and costly mistakes. In this case, nurses and leaders who are ill-equipped to recognize and treat the symptoms of LA in the workforce will perpetuate the continuous cycle of nurses eating their own. Ultimately, the goal of achieving a psychologically safe environment would allow for job satisfaction, retention, and organizational identity to flourish by decreasing LA since it often occurs as a response to situations outside of one's control (Sellers et al., 2012). According to Murray et al. (2022), all frontline care providers need to feel psychologically safe to be empowered to ask questions, raise concerns, identify occurrences to decrease safety risks, and offer opportunities for improvement. Lateral aggression cannot be allowed to continue, nor be widely accepted as a rite of passage in the nursing profession. Chapter two will focus on outlining a plan to address this, in order to retain a knowledgeable and competent nursing workforce into the future.

Chapter 2: Planning and Development

This chapter will discuss how ethical and relational leadership approaches can address the problem of practice (PoP). These approaches are central in analyzing and driving the changes needed to decrease the harmful effects of lateral aggression (LA) in the nursing profession at this healthcare organization (HcO). In this dissertation-in-practice (DiP), two processual frameworks will help to lead the change process. Kotter's change model will provide a foundational understanding of how to change, while the continuous quality improvement (CQI) framework will help to inform the development of a comprehensive training program for nurses and leaders at this HcO. Lewinian field theory will supplement this understanding to explain individual resistance to change. Organizational change is inevitable so supporting a workforce undergoing constant change can be challenging for leaders. Thus, assessing organizational readiness for change will be required and this will be explored on the micro (unit) level and meso (organization) level. Leadership ethics will be used to guide decision-making processes in the selection of appropriate solutions to address LA, which will allow for positive steps towards a healthy work environment for nurses.

Leadership Approaches for Change

The nursing profession has been synonymous with an ethos of caring, with the mentality of putting people first. This has influenced my leadership beliefs and has prompted an inclination towards ethical and relational leadership approaches. Both approaches align with supporting change within a complex adaptive system (CAS).

Ethical Leadership Theory

Since ethics provides standards for decision-making, behaviour in situations and provides rationale for the choices (Trevino & Brown, 2014), the logical course is to utilize ethical leadership theory (ELT) for this DiP. According to Brown and Trevino (2006), an ethical leadership approach demonstrates normatively appropriate conduct through actions and interpersonal relationships, thus

promoting these behaviours to followers through two-way communication, reinforcement, and decision-making. Den Hartog (2015) underpins ethical behaviours as being central to the leader's credibility and trustworthiness, which can influence followers at all levels. Leaders set the ethical and moral tone for the workplace by actively promoting staff well-being and by promptly addressing workplace inequality (Musbahi et al., 2022). I would do this by integrating and role-modeling inclusive and empathetic practices. Utilizing ELT would have a positive impact in the workforce because it encourages open dialogue and self-care (Mushahi et al., 2022) and may also heighten sense of duty, moral obligation, conscientious behaviour, and responsibility (Den Hartog, 2015). This value-driven leadership approach enables trusting relationships with followers. This makes them more willing to engage in voicing concerns and taking initiative (Den Hartog, 2015). Additionally, utilizing an ELT approach to leadership will strive for outcomes that produce the greatest good for the largest amount of people. My leadership roles within this HcO have greatly influenced my understanding of the importance of organizational safety and supporting work that will benefit the greatest number of people, so this approach aligns well with the change plan. As an ethical leader, I will send clear messages about ethical values and hold others accountable. These actions mirror strategies to address LA and ensure psychological safety (PS).

Complex Relational Leadership Theory

Person-centredness is a core value of effective workplace culture and is grounded on the establishment of healthy relationships based on the humanistic values of mutual respect and understanding, and the individual right to self-determination (Cardiff et al., 2018). Fulop and Mark (2013) state that leaders need to consider "roles, relationships and practices that are made within contexts and through social interactions, while learning with people who share these contexts" (p. 257). The relational perspective views leadership as a process of social construction to produce a person-centered culture that can support nursing values (Cardiff et al., 2018).

Using complex relational leadership theory (CRLT), nurses can be empowered to identify potential solutions to problems in the practice environment. Feistritzer et al. (2022) state that having engaged, accountable nurses are as important as having effective leaders for organizational vision alignment. Relationship-focused leaders improve work and care environments, productivity, and patient outcomes (Cardiff et al., 2018). Thus, strong relationships are required to co-create the preferred nursing practice environment. CRLT can assist in navigating the complex systems in which nurses at all levels function and is based on three principles: professional governance, equitable and inclusive relationships, and clinical practice (Feistritzer et al., 2022). Since CRLT views leaders as collaborators with frontline nurses, this partnership enhances the overall adaptability and efficiency of the system (Feistritzer et al., 2022). There are parallels to my experiential leadership worldview, as both are grounded in lived experiences. The collective insights gained from nurses and leaders through the CRLT approach can be applied to future learning. Using this approach will allow for a clearer understanding of how hostile situations arise and increase the development of collaborative approaches to improve responses within a nursing team to decrease LA within a complex adaptive system.

Relationship to Organizational Context

With increasing numbers of internationally educated nurses (IENs) in this HcO, it is important to acknowledge the reality of discrimination or this potential form of LA on others because of race, gender, sexual orientation, or religion. In times of uncertainty, leaders should set the ethical and moral tone through the promotion of staff well-being and addressing workplace inequality and diversity (Musbahi et al., 2022). According to Petrovic et al. (2023), the Canadian nursing workforce is disproportionately representative of heteronormative, white, non-disabled women. This is problematic because hegemonic workplaces prevent the ability to decrease inequities within diverse populations. Feistritzer et al. (2022) underscores the importance of creating an environment where diversity and inclusivity are normalized to mitigate the effects of discrimination since there is a strong correlation between work environment

and employee engagement, which negatively impacts the perception of patient safety. Followers perceiving credible behaviour demonstrated by ethical leaders will emulate their leaders, while leaders who demonstrate concern and treat others with fairness increase credibility in their leadership ability because they practice what they preach (Brown & Trevino, 2006). Barkhordari-Sharifabad et al. (2017) state that leaders should integrate ethics into daily activities while simultaneously supporting the ethical competence of nurses. These conditions must be created for the implementation of good care (Brown & Trevino, 2006). Nurses who feel safe to voice their concerns, feel heard, and contribute to developing solutions report more engagement and having more control over their work (Feistritzer et al., 2022). Thus, the ability to utilize ethical and relational leadership approaches will allow for the creation of a psychologically safe environment where nurses feel valued and supported to contribute their insights and experiences is important for this HcO.

Agency to Impact Change

According to Feistritzer et al. (2022), hospitals are complex adaptive systems (CAS) which have dynamic operating needs with multiple processes and teams. There are inter-professional processes requiring adaptation, coordination, collaboration, and cooperation at all levels. According to the Registered Nurses' Association of Ontario [RNAO] (2013), chief nursing officers are involved in significant decisions dealing with the day-to-day operational management of the organization. As demonstrated in chapter one, nurses are a high-risk population for exposure to workplace incivility. LA within the nursing profession has a tremendous impact on general health and job satisfaction and contributes to early burnout (Vidal-Alves et al., 2021). In this role, my agency to impact change extends to all programs with nurses working within this HcO. This general oversight on nursing practice means that I can impact change in my role. I do this through regular engagement with inter-professional practice (IPP) chiefs and directors, departments, leaders, and frontline staff to initiate and support change management. As the chief nursing officer, I must rely on my powers of influence to guide decision-making and corporate

directions. Legitimate power, and therefore formal authority over others does not reside within my role. Lunenberg (2012) states that expert power is one of five powers that exert influence, and this type occurs because the leader has recognized knowledge, skills, and abilities, and others perceive the power holder to be credible, trustworthy, and relevant. Additionally, referent power is also heavily dependent on the relationships I've built with stakeholders. Lunenberg (2012) states that referent power refers to the leader's ability to influence others' behaviour because there are positive relationships built on admiration and respect for the leader. This further supports the need to utilize CRLT and ELT in my leadership approach to influence change at this HcO. Considering the need to involve multiple groups and levels of stakeholders within a CAS, I have the agency and power in my role to engage, influence, and initiate change on a micro (unit) level to a meso (organization-wide) level.

Frameworks for Leading the Change Process

The frameworks guiding this comprehensive plan will offer practical processes to lead successful change. Firstly, CQI and A3 methodology will describe how to systematically navigate through a problem, the solution, and relevant revision cycles. Next, Kotter's change model will offer a structured change approach for this organizational change. Finally, Lewinian field theory will augment understanding by addressing driving and resisting forces to successful change. Although the initial focus is on the surgical units, the entire organization may be affected by LA. These theoretical foundations will support the development of a comprehensive training plan to decrease LA in nursing.

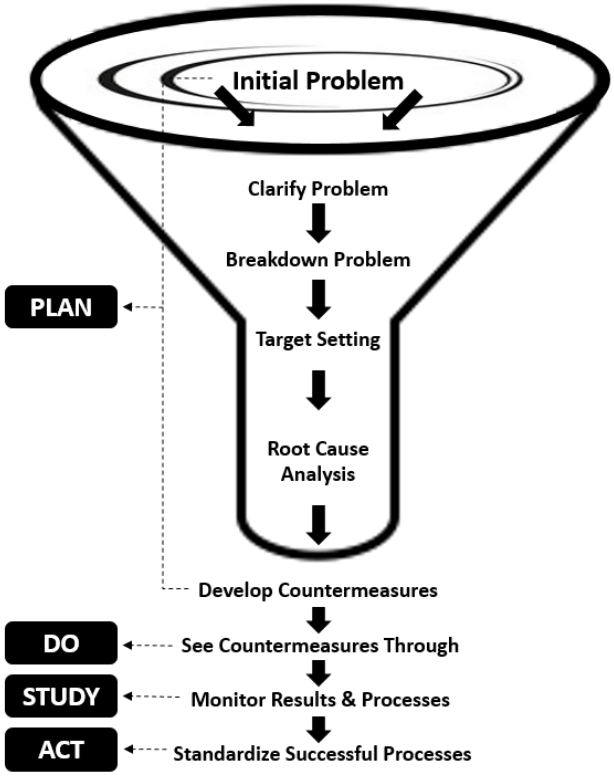
CQI Methodology & A3 Problem-Solving

This HcO has established CQI processes for staff to identify change opportunities. This methodology encourages grassroots action and involvement from frontline staff. This methodology offers processes and tools to ensure those closest to the work are empowered to improve it as they are the ones best able to identify suitable solutions to address their needs (HcO, n.d.). Staff can work with their leaders to improve capability and understanding to respond to challenges in their environment

(HcO, n.d.). This quality improvement framework allows staff to methodically work through the problem, identify targets to indicate improvement, and discover the root causes of a problem through a standardized approach. This systematic process is seen in Figure 3. While this methodology offers leaders and staff ample opportunities for empowerment and collaboration, individuals must be intrinsically motivated and willing to improve performance to achieve the targeted outcomes.

Figure 3

CQI Methodology

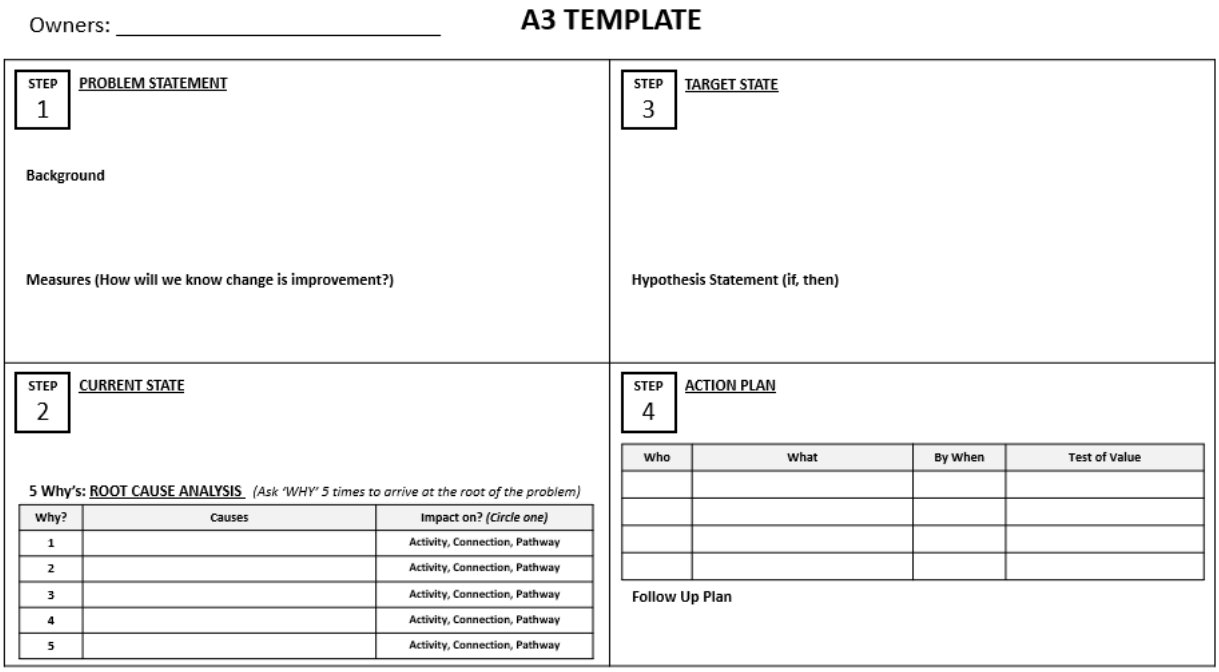


Plan-Do-Study-Act (PDSA) cycles are a part of the CQI process and can assist in the evaluation of change effectiveness, which allows for corrections to occur through evolutionary processes. This methodology uses what the Toyota management system has coined as the A3 tool, which simply represents a way to identify the problem, conduct an analysis, and create an action plan on a single sheet of A3-sized paper (Lean Enterprise Institute, 2024). This approach recognizes the value of solving a problem by confronting

the root causes (HcO, n.d.). This can generate countermeasures to counteract weaknesses or threats in an implementation plan (Lee & Kuo, 2009). The A3 tool can depict both text and visuals (such as diagrams and charts), which can enrich and clarify the data (Chakravorty, 2009). This tool can serve multiple purposes and can be used throughout the planning, implementation, monitoring, and evaluation phase. Since it acts as a storyboard with the facts about the problem centralized in one place, the information can be logically presented and corrective actions can occur through revision cycles. Figure 4 demonstrates the systematic approach that is employed when using an A3 tool to guide discussions and analysis, as well as report progress and actions.

Figure 4

A3 Problem Solving Tool Template



Note. This figure serves as a template only. The completed A3 tool can be seen in Appendix A.

The A3 tool is continually revisited and revised by group members throughout all phases of the change process. The CRLT approach encourages ongoing collaboration between leaders and frontline nurses to

solve complex practice problems within a CAS. The tool is intended to increase collective efforts and to gain various perspectives from all roles (HcO, n.d.). The root cause analysis depicted in Appendix A identifies the failure to recognize LA in action, combined with the inability for nurses and leaders to effectively address occurrences without assistance. These contributing factors point to why nurses are eating their own.

Kotter's Change Model

In 1996, Kotter introduced an eight-step change model to provide operational oversight in a sequential fashion to implement strategies by encouraging employee inclusion and organizational buy-in to increase the likelihood for success (Burke, 2018). The eight steps included: 1) creating urgency; 2) building a coalition; 3) forming a vision and strategy; 4) enlisting others; 5) enabling action by removing barriers; 6) generating short-term wins; 7) sustaining improvements; and 8) instituting changes into long-term corporate culture. This system provided reliability and efficiency for change management within a traditional hierarchical system to respond to episodic change in sequential ways. Kotter (2012) notes that there are two primary reasons – political and cultural - why hierarchies are slow to respond to change. Managers are reluctant to take chances without permission from their superiors, while people cling to older practices and fear loss of power (Kotter, 2012).

Considering the rapid rate of changes that occur in organizations, Kotter's change model evolved to integrate a complementary system. Kotter (2014a) stated that while large companies required established organizational structures for governance, the rigidity of these constructs prevented members from managing rapid changes. Kotter (2012) stated that the second system was network-like in nature to complement the organizational hierarchy, while continually seeking opportunities for agile responses and timely completion. Kotter (2014a) clarifies further by stating:

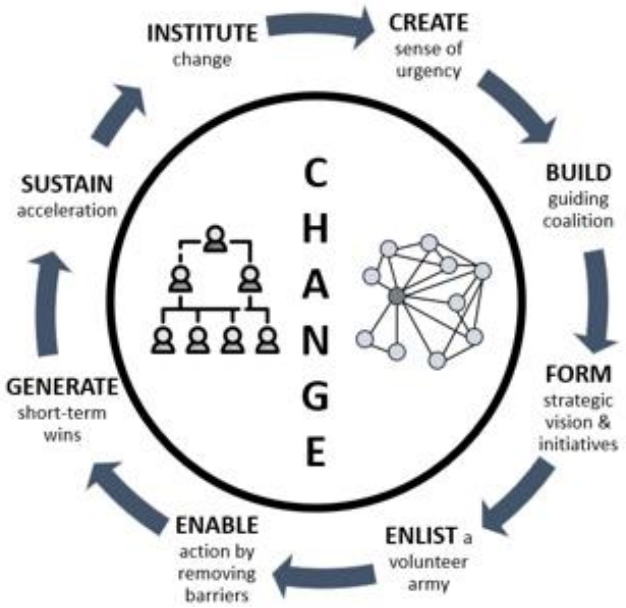
> The basic structure is self-explanatory: hierarchy on one side and network on the other. The network side mimics successful enterprises in their entrepreneurial phase, before there were

> organization charts showing reporting relationships, before there were formal job descriptions and status levels. (p. 20)

Due to the size and hierarchal nature of this HcO, the use of this change model will offer the processual structure needed for predictable tasks such as seeking endorsement, engaging relevant parties, and communicating milestones within a large organization. To complement the organizational hierarchy, a network would comprise a motivated volunteer army of nurses and leaders from all levels, committed to providing knowledge and skills, lend credibility, and offer influence. The use of the CRLT approach would combine effective leadership and engage nurses in this network to co-design the practice environment ahead (Feistritzer et al., 2022). This network can be achieved by leveraging the HcO's Nursing Quality Council (NQC), which I oversee in my role as a nursing leader. Considering the diversity of nursing members present, the NQC can offer development, implementation, and communication support throughout the change process. These complementary systems create a dual operating system needed for organizational change and can be seen in Figure 5.

Figure 5

Kotter's Change Model & Dual Operating System



Note. The hierarchy at this HcO can partner with a motivated network within Kotter's 8 steps for change.

As a CAS, hospitals need to adapt and process information quickly to evolve through dynamic changes (Feistritzer et al., 2022). Therefore, the CRLT approach is embedded within this change model because it relies on relationships to co-design the practice environment to respond to the complex needs of the HcO. Kotter's change model will inform the change plan by offering a sequential way to structure and action goals. It will also offer a way to assess, implement, monitor, evaluate, and adapt to the challenges that arise during the change process.

Connections Between Change Frameworks

Stakeholder involvement is essential in both CQI methodology and in Kotter's change model. Collaboration should occur frequently throughout each stage but most importantly during the second to fourth stages of Kotter's change model. Their perspectives are needed to help break down the issue, set targets, and undergo a root cause analysis. Arguably, stakeholders should be involved in other stages as well. For example, the A3 tool may be commonly used throughout stages six through eight of Kotter's change model, but can be used at any point during the change process. This will prove to be especially helpful when PDSA cycles are used to drive incremental improvements through corrective actions to sustain or anchor change (HcO, n.d.). Table 1 outlines the connections between these frameworks.

Table 1

Connections Between CQI & Kotter

KOTTER		1. Create Urgency		2. Build Coalition; 3. Form Vision; 4. Enlist Others			5. Enable Action; 6. Generate Wins		7. Sustain Improvements	8. Institute Change
CQI	Overall	Initial Problem	Clarify	Break Down	Target Setting	Root Cause Analysis	Counter-measures	Action	Monitor & Evaluate	Standardize Processes
	PDSA	PLAN						DO	STUDY	ACT *Repeat PDSA*
	A3	Problem Statement	Background		Measures	Current State	Target State	Action Plan	Follow Up	Standard Work

The diverse perspectives expressed by stakeholders will be important throughout this change plan to address both internal and external factors that may influence or hinder progress. This will be explored further when discussing organizational readiness.

Lewinian Field Theory

This theory offers a means to view the HcO as a social system comprising of many groups as the focus for change (Burke, 2018). Lewinian field theory addresses gaps in Kotter's model and in CQI methodology, because it tackles why individuals may be hesitant to change. Any driving or restraining forces affecting the group structure would also affect behaviour and capacity for change. Depending on how an individual perceives a force, it will directly impact their needs during the change process. Burke (2018) states that if a force is perceived to be imposed, it is usually resisted; whereas forces that are perceived to be of one's own volition are embraced. Driving forces will push an individual towards new behaviour while restraining forces will inhibit new behaviour (Burke, 2018). For example, a driving force towards better teamwork may involve the creation of shared tasks, while a restraining force may be a cultural norm that expects nurses work independently. According to Hussain et al. (2018), resistance is an expected response to major organizational change because future states are uncertain and may impact one's competency. Therefore, application of Lewin's field theory would allow the change process to focus on 1) changing group norms; 2) increasing driving forces to overcome resisting ones; and 3) increasing forces perceived as autonomously adopted while decreasing externally imposed forces.

Second & Third Order of Change

The change strategies centre upon creating opportunities for nurses and leaders to learn the skills to identify, communicate, and intervene in response to LA to enhance PS. In order to ensure success, an awareness of interpretive schematas can offer a way to understand events to help guide organizational interventions, as well as limit redundant information (Bartunek & Moch, 1987). The organizational schemata of this HcO's nursing culture is one of unhappiness: nurses often complain of

oppressive conditions and dissatisfaction while looking to leaders to solve these problems. Consequently, the change strategies will need to address the nurses' schemata of oppression while addressing the leaders' saviour schemata. The internalized oppressive perceptions by nurses are damaging and are echoed across multiple units. An understanding of self-determination theory may be beneficial to address the nurses' schemata and motivation for change. Manninen et al. (2022) describe this theory as understanding how social contexts may impact human functioning based on the environments' ability to satisfy three basic psychological needs: autonomy, competence, and relatedness. Since psychological well-being is entwined, altering the social and situational contexts will facilitate the attainment of these psychological needs so a nurse will be more likely to engage in intrinsically motivated behaviours (Flannery, 2017). In doing so, change strategies should allow nurses to engage in voluntary behaviours, develop mastery and efficacy, and feel meaningfully connected to others. To address the saviour schemata, Nixon (2019) states that leaders can practice critical allyship as "it can guide action for people who find themselves in positions of privilege in relation to a particular system of inequality" (p. 2). This requires leaders to reorient themselves from the schemata of saving the marginalized group to working in solidarity with staff nurses to take action on solutions to address systems of inequality (Nixon, 2019). These strategies represent second-order change, where there is a conscious modification of present schemata to be phased out as another is phased in through the change process (Bartunek & Moch, 1987). Finally, the strategies also represent third-order change, where the direct training will increase awareness of the schemata and enable changes where appropriate (Bartunek & Moch, 1987). The implementation of a training program to recognize LA will aid in the prevention of these occurrences while reinforcing a professional code of conduct to encourage PS.

Alignment to Leadership Approaches

Implementing second-order and third-order changes may involve utilizing an ethics of critique approach as to whose interests (and manner) ought to best be served. By practicing critical allyship, it

encourages a relational mindset, as the importance is shifted away from the intent (simply doing for the sake of doing), to the impact (why action must be taken to address the needs of the people). The implementation of training strategies may not offer immediate change through natural means; rather, it may give way to incremental improvements, which are congruent with CQI processes. These change strategies align with third-order change, occurring as members improve their capacity to create and sustain ongoing change and the CRLT approach enables support in creating change where members see fit. In doing so, the application of both ELT and CRLT as leadership approaches can target oppressive conceptions because they are person-centred in nature, focused on relationships and doing what feels ethically right according to the circumstances. If staff feel psychologically safe, these approaches will increase the likelihood of engaging in open and honest dialogue with their leaders (Cardiff et al., 2018). Not only would this allow for inclusive practices, but it creates opportunities for both parties build upon existing work related to LA. Using a collaborative, co-design process will also diminish the leader as the savior schema. Further, utilizing a team-centred approach would strengthen cooperative partnerships between leaders and frontline nurses by placing everyone on more equal footings, which may allow for a redistribution of power and combat the oppressive schemata that persists in the nursing profession.

Organizational Change Readiness

Assessing an organization's readiness for change is a complex process with readiness framed by psychological and structural factors. Both are crucial for successful organizational change. Weiner et al. (2008) state that psychological readiness encompasses attitudes, beliefs, and intentions. In contrast, structural readiness refers to the capabilities and resources in an organization (Weiner et al., 2008). Nurses in this HcO may demonstrate psychological readiness by acknowledging the need for change but organizational barriers may represent structural obstructions that prevent the adoption of change. Holt et al. (2010) states that "success is contingent on the coordinated actions of interdependent individuals, each of whom contributes to the change effort" (p. 51). Therefore, since nurses are heavily reliant on

each other, there must be shared recognition that a problem exists, a desire to see change, and a collective confidence in the group's capabilities to enact change. These psychological factors experienced by a group may prove to be stronger indicators of readiness for change than an individual's confidence in their own abilities (Holt et al., 2010).

History with Change

The HcO has undergone significant changes within the past few years. During the multi-million-dollar digital transformation of the HcO's electronic health information system, many staff perceived the dedication of already-scarce hospital resources as misguided priorities by the leadership. Another noteworthy change required widespread preparation for hospital accreditation, which dominated workloads and trumped pre-existing priorities. This immediately followed months after the digital transformation and represented never-ending changes as updates to workflows and procedures were accelerated to align with the new electronic system. Despite the onslaught of rapid changes, staff did not protest the inevitable accreditation cycle. Occurring every four years without fail, staff appeared to be accustomed to the familiarly rigorous processes. As a result, the HcO received exemplary standing for a fourth consecutive time. This may signal the staff's ongoing willingness to improve organizational performance and may suggest receptiveness to organizational change.

Since cultural hegemony may be contributing to a culture of nurses feeling devalued at this HcO, they may be reticent in sharing their experiences (Urban, 2014). Suddaby and Foster (2017) assert:

> Those who see the past as an objective reality might see the future as highly influenced, if not fatalistically determined by history. Conversely, those who see the past as highly subjective might see the future as much more malleable and be open to alternatives based on creative interpretations of the past. Our explicit theories of change and our ability to change, thus, vary by our implicit models of history. (p. 20)

The use of experience-based co-design is one way to combat this reticence and give voice to previously silenced groups. Mulvale et al. (2016) describe experience-based co-design as a methodology used in healthcare to purposefully include the experiences of vulnerable groups. Historically, this approach has targeted patients and families to incorporate their lived experiences to improve systems and service redesign. However, the principles of inclusion and participatory action may help to shift this paradigm, bolster empowerment, and lessen the power imbalance (Mulvale et al., 2016). Historical circumstances can influence organizational conditions and limit the agency of those who wish to change the organization (Suddaby & Foster, 2017). The inclusion of a co-design approach would allow nurses to feel they are an active part of the change, rather than being a passive recipient, and can be used as a driving force to influence change.

Barriers to Change

It would be crucial to consider perspectives focused on the nursing team working within the hospital as a CAS. According to Pype et al. (2018), viewing the unit in this way can provide insight into team behaviour by focusing on interactions rather than on the characteristics of individual team members. This will help to inform appropriate solutions.

Responsibility of Organizational Actors

An individual's psychological readiness can contribute to personal adoption of the changes and to overall organizational readiness. Burke (2018) states, "some organizational members fight the change to the death; constantly denying that the change is necessary while others embrace the change readily and move with it" (p. 110). Knowing this, leaders have a responsibility to understand individuals' reactions will differ and need to proactively address and respond to the feelings of their followers.

Formulating a vision with stakeholder buy-in is paramount in organizational readiness, as is identifying and gathering the right change agents and collaborating with change recipients to participate. According to Burke (2018), having diverse stakeholders on various levels will help to offer

different perspectives to drive successful change. Nurses (new and experienced), IENs, students, charge nurses, formal leaders, educators, inter-professional teams, union representatives, HR partners, and academic institutions all offer valuable perspectives and levels of influence, so the perspectives of these organizational actors are important in determining organizational readiness.

Responsibility of the Organization

The HcO needs to be cognizant of the demographics of their nursing workforce when considering appropriate change strategies to address LA. Internal politics or bureaucratic processes may contribute to change inertia. This includes a lack of dedicated operational funds to support training purposes, unprotected education time, or the presence of discriminatory coalitions. By addressing these domains, leaders can demonstrate commitment to improvement for their staff. Similarly, organizations should be supportive of their leaders to prepare for and enact changes when a path to execution is blocked (Ford et al., 2020). This flexibility will enable leaders to co-design a plan that is likely to succeed based on reflections on shortcomings from plans that did not work. This strategy aligns with the CQI methodology outlined previously, where those closest to the work are best positioned to suggest solutions and alternatives. Finally, change fatigue may occur due to unrelenting, competing organizational pressures. As Ead (2015) asks, “How do busy health care organizations determine the optimal number of change initiatives to enact each quarterly season?” (p. 505). Organizations have a responsibility to consider the number of concurrent changes while respecting the workload of the staff and be mindful when proposing solutions to address frequent change (Ead, 2015). I am cognizant of these factors and will use my influence to adjust timelines where needed.

Readiness Tool for Microenvironment: OCRBS

The Organizational Change Recipients’ Beliefs Scale (OCRBS) can assess individual readiness for change within smaller teams and if used in combination with other tools, can provide valuable information in assessing organizational conditions (Armenakis et al., 2007). This 24-item self-assessment

tool is applicable at any stage to estimate progress and can be helpful to inspect themes as it examines individual attitudes towards change as well as perceptions of change. This scale examines five essential beliefs that are the most likely to affect readiness for change and can affect the success of organizational change: discrepancy, appropriateness, principle support, valence, and efficacy (Oreg et al., 2011). These five beliefs signal an individual's perceptions of the implications of organizational change and these beliefs are summarized in Table 2. The OCRBS tool can determine the level of buy-in among change recipients, identify barriers affecting successful change, assess progress, and provide a plan to increase stakeholder support by focusing on troublesome factors (Armenakis et al., 2007).

Table 2

OCRBS Questions and Five Beliefs Influencing Individual Readiness for Change

Questions	Factor
We need to change the way we do things.	Discrepancy
We need to improve the way we operate in this organization.	
We need to improve our effectiveness by changing our operations.	
A change is needed to improve our operations.	
The proposed organizational change will have a favourable effect.	Appropriateness
The change will improve the performance of our organization.	
The change that we are implementing is right for our situation.	
When I think about this change, it is appropriate for our organization.	
This organizational change will prove to be best for our situation.	
Most of my respected peers embrace the proposed organizational change.	Principle Support
The top leaders in this organization are 'walking the talk'	
The top leaders in our organization support this change	
The majority of my respected peers are dedicated to making this work.	
My leader is in favour of this change.	
My leader encourages me to support the change.	
This change will benefit me.	Valence
With this change, I will experience more self-fulfillment.	
I will earn higher pay from my job after this change.	
The change in my job assignments will increase my feelings of accomplishment.	
I have the capability to implement the change.	Efficacy
I can implement this change in my job.	
I am capable of performing my job duties with the proposed change.	
I believe we can successfully implement this change.	
We have the capability to successfully implement this change.	

Note. The questions have been rearranged by factor and the grading scale is included in Appendix B.

In completing this tool from the lens of the former manager of these units, I scored higher in the beliefs of discrepancy, appropriateness, principle support, and efficacy. This did not yield any surprises to me. The proposed change plan addresses the discrepancy, where there is a gap between where the HcO is and where it needs to be in order to address LA. The change plan is appropriate because the proposed changes are suitable and addresses the discrepancy. I perceived principle support to be high for this change plan as there would be support for the change plan at supervisory levels. I also believe that the HcO has the efficacy and capacity to implement this change because fundamental LA processes are already in place and stakeholders are poised to support organization change. Conversely, the OCRBS showed valence as a belief that scored lower for individual readiness for change. According to Torppa and Smith (2011), valence relates to change resulting in tangible benefits to the individual in some manner. The questions measuring valence could have been perceived differently and would have yielded different outcomes if the questions were phrased to measure intangible benefits. Valence may have scored higher for me if the questions were worded differently. I suspect my perspectives for readiness would be congruent with or similar to the outlook of the current manager.

This tool can also be used to capture the readiness of the nursing staff at the unit level. Staffing has stabilized in recent months, so the focus has shifted towards nurse retention efforts. I expect staff would similarly score higher on their perspectives of discrepancy, appropriateness, and principle support and would also score lower on valence for the same reasons listed above. In contrast to the leader perspective, efficacy for staff would likely yield a lower score. While all five beliefs are equally important, efficacy may be one of the hardest to influence given the intrinsic nature of this belief. Torppa and Smith (2011) describe efficacy as the capacity to implement change. Frontline staff may lack awareness of existing processes to address LA, feel powerless to report occurrences, or feel their actions would lead to inaction by their leaders (Hampton et al., 2019). Mulvale et al. (2016) describe the

inability of traditionally oppressed and discriminated against groups to speak up or initiate action. It is important to note that implementing a training program may not translate to individuals taking action. This may be related to self-efficacy. Bong and Skaalvik (2003) describe the role confidence plays in self-efficacy to achieve success as importance is placed more heavily on what individuals perceive they are capable of doing with the skills and abilities they already have. Somani et al. (2022) state that while training can increase the confidence and self-efficacy of nurses to manage conflict in the short-term, further research is needed to determine whether nurses can recall their LA training to respond to occurrences in the work environment. A longitudinal study done by Sanner-Stiehr (2018) examined the impact of cognitive rehearsal for LA and found that there was a decrease in self-efficacy and confidence in nurses to respond to bullying behaviours at three months post-training compared to the end of the training program. This is congruent with the literature on individual beliefs of efficacy and readiness to change (Rafferty et al., 2013). Therefore, there must be concentrated effort to target pessimistic beliefs to encourage movement from the current state to the desired state (Torppa & Smith, 2011). Based on this tool and from my experience working with the nurses on the surgical units over a two-year period, I believe the change recipients (nurses and leaders alike) are ready for change to occur and more focus will be required to improve self-efficacy to ensure successful adoption of change.

Readiness Tool for Mesoenvironment: ORCA

To assess readiness for change on a meso level, the organizational readiness for change assessment (ORCA) tool can examine stakeholder perceptions in the organization (Helfrich et al., 2009) and is used in tandem with the OCRBS tool for this DiP. The ORCA tool was designed as an instrument to assess organizational readiness to change according to the promoting action on research implementation in health services (PARIHS) framework since it frequently supports the implementation of evidence-informed clinical practices in healthcare (Helfrich et al., 2009). ORCA is a helpful heuristic tool to assess a healthcare organization's readiness to change (Hagedorn & Heideman, 2010). It wields a

dual benefit, where it provides diagnostic and prognostic indicators. This tool can assist with developing solutions based on organizational needs and conditions, where success can be predicted at the organizational level. The seventy-seven item tool considers three domains: evidence, context, and facilitation. Scores can be added and then divided by the number of items in each section and can be further divided based on the number of respondents to show congruence (Hagedorn & Heideman, 2010). Its simplicity and relevance to healthcare settings, combined with the ability to analyze quantitative data, can yield valuable insights.

The first domain, evidence, seeks to understand stakeholder perception of the strength of supporting evidence as the foundational basis of the intervention. There are four sub-scales in this category: level of concordance between stakeholders on the strength of the overall evidence, as well as impressions of research and clinical evidence, and patient preferences. The second domain, context, examines the circumstances of the HcO or environment in which the intervention is being implemented. The sub-scales under context explore perceptions of organizational culture, leadership practices of formal leaders, the attitudes of opinion leaders, evaluation of goals and communication processes, and resources needed to support organizational changes (Hagedorn & Heideman, 2010). The last domain, facilitation, examines the internal capacity for solutions. Leadership versus champion characteristics, roles of formal leaders and opinion leaders, as well as project team roles, implementation plan, communication, progress updates, implementation resources, and evaluation of findings, are necessary in determining readiness.

Appendix C depicts the completed ORCA tool, done from the imagined perspective of a senior stakeholder, by which I would need to seek endorsement from in the initial phases. Using this lens, the ORCA tool yielded some interesting aspects to consider. Firstly, under the evidence domain, the proposed change scored lower, weakened by the lack of scientific evidence and findings through randomized controlled trials in the healthcare system and by the fact that this change solution had not

been attempted in the surgical units previously. Additionally, the paucity of research on the long-term impact of training on LA action may undermine the implementation of a proposed training program. I do not believe these to be deterrents; rather, they can act as powerful motivators for innovative practices or provide opportunities for future research. Regardless, there is substantial evidence for LA training and its impact on decreased turnover intention, increased awareness of bullying behaviour, and the strengthening of collegial working relationships cannot be refuted (Fehr & Seibel, 2021). The context domain scored highly because the change addresses culture, leadership, and measurement of success. Infrastructure and staffing factors scored lower in the resource support of the context domain. At this HcO, the environmental constraints in the physical environment limit the availability of space dedicated for classroom training. Additionally, persistent staffing shortages will hinder the ability for nurses to attend training during a scheduled work day without compromising patient care needs. Finally, I anticipate responses from senior leaders will vary widely in the facilitation domain of this tool. On any given day, the stability of resources and the role of stakeholders will fluctuate in response to clinical activity, operational pressures, and HR limitations.

The ORCA tool has a few notable limitations. For instance, the analysis or interpretation of the scores can be subjective, which would influence the application of the findings. Additionally, respondents may not have enough information in the beginning phases of the change implementation if the vision is improperly communicated. This can be used as a potential strategy to maintain the engagement of a volunteer army in the beginning phases. The evidence and context domains can provide updated information throughout each phase of the implementation. If all patient-related factors are excluded from the tool, I suspect senior leaders will score more favourably towards agree or strongly agree in most of the sub-scales of the three domains. I believe these stakeholders would feel confident knowing that an enterprise approach will be used in the implementation of the change plan, where alignment to the HcO's strategy, mission, and vision, can be easily seen through this tool.

Overall Readiness

The exercise of completing the OCRBS tool from the perspective of the manager of the model cell units and the ORCA tool from the perspective of a senior leader yielded meaningful information and offered specific domains to focus on to improve the likelihood of a successful change outcome for this HcO. The belief, valence, is one example where there can be concentrated effort to highlight how the change will benefit the individual's practice, increase self-fulfillment and feelings of accomplishment, and equip the individual with the leadership skills needed to address LA behaviour, thus positioning them for career advancement. This aligns with conclusions made by Rafferty et al. (2013) where the intangible aspects for the change recipient can facilitate the implementation of change. Armenakis et al. (2007) state that expected variations for readiness will occur within units at various times. This signals the need to assess for readiness at various intervals. To further optimize readiness, I will need to place additional attention on the positive outcomes of LA training research to improve stakeholder buy-in and directly support resource allocation for these units. The completion of both tools revealed encouraging results, heavily favouring the inclination for change readiness based on individual and organizational factors. My knowledge of the HcO, intermixed with the presence of compelling evidence which outline the antecedents as well as the devastating consequences of LA on retention and well-being makes one thing abundantly clear: organizational inertia is not an option. The results from these tools firmly dispute inaction and imply readiness is present on meso and micro levels. The HcO and staff are set for changes to occur to address lateral aggression in the nursing profession.

Leadership Ethics in Organizational Change

Ethics plays an important role in addressing challenges and developing solutions to decrease and minimize harm from lateral aggression in this HcO. According to Starratt (1991), three primary paradigms of ethics can address moral quandaries: care, justice, and critique. Nursing is a regulated profession; thus, the ethics of profession (Shapiro & Stefkovich, 2016) is another important paradigm to

consider when developing solutions for organizational change. Wood and Hilton (2012) expand further by imploring leaders to consider a final paradigm: the ethic of local community, grounded in serving the needs, interests, and public good. Considering the implied positive effects on the well-being of patients, families, and staff, this ethic paradigm is not explored but others will be elaborated further.

Ethical Considerations and Challenges

Firstly, the ethics of care paradigm is compassion-oriented and considers how circumstances may hurt others. The tenet belief with care ethics is that caring is fundamental: when you experience caring behaviour, you can extend that care to others (van Dijke et al., 2019). It has reciprocal and mutually beneficial effects for leaders, staff, patients, and their families. This paradigm is also focused on supporting individual growth and development through mentoring and community building (Sullivan, 2001; as cited in Woods & Hilton, 2012). The conundrum is that while nurses are generally known as carers, they are notoriously known as uncaring when it comes to supporting their peers. The well-known phenomenon of nurses eating their young represents a destructive rite of passage for many nurses with up to 39 percent experiencing bullying rather than support in their new roles (Aebersold & Schoville, 2020). Utilizing ethics of care allows for actions to be guided by insights and through active self-reflection, so if we perceive the other's reality as our own and respond to their needs accordingly, a connection between the carer and the cared-for can be formed or strengthened (van Dijke et al., 2019). Secondly, the ethic of justice perspective guides decision-making through pre-determined rules, policies, codes, and procedures. This mindset strives for a balance between competing notions of maximum benefit and equal respect (Gorman & Pauken, 2003). The change plan would need to consider outcomes that will produce the greatest good for the most amount of people in the environment and this approach would ensure fairness when responding to negative actions across a large organization. Next, an ethic of critique lens analyzes who is in control, who defines a problem, and what legitimizes a solution (Starratt, 1991; as cited in Gorman & Pauken, 2003). The juxtaposition of critique and justice is

an interesting challenge because the ethic of critique frame may provide advantage to certain individuals over others. This approach would be important to utilize in the development of ethical sensitivity, which would allow for the development of more ethical leaders to support a psychologically safe environment (Langlois et al., 2014). Shapiro and Stefkovich (2016) also underpin the importance of the ethic of the profession paradigm, whereby professional codes of ethics provide guiding values and is an obligatory duty of the working professional. A question then, is if nurses continue to engage in uncivil behaviours, are the actions serious enough for the regulatory body to intervene rather than shifting onus to the employer?

Addressing Ethical Responsibilities of the Organization

The ethic of justice paradigm frames the other approaches to allow for fair and equitable practices within the unionized environment at this HcO. Although it may offer rigidity in response to specific circumstances, this approach will allow nurses and managers to address LA in a standardized way across a large organization. Nurses may be eating their own because of long-standing power imbalances created by situational and contextual characteristics such as gender, seniority level, and minority status (Salin, 2003). Critical pedagogy would allow for equitable training practices to be developed through leader and follower collaboration (Petrovic et al., 2023). This co-design will allow followers to question and challenge dominating beliefs and practices to uncover oppressive structures and practices. According to Petrovic et al. (2023), critical pedagogy supports an ethics of justice paradigm by protecting human rights and dignity, while ensuring equity and fairness in interventions. Its use will enable the application of a social justice lens to analyze structures and practices that disadvantage nurses at individual, unit, and organizational levels. Optimistically, if collaborative partnerships are built on less hierarchal footings, it would allow for power to be redistributed in nurses.

Use of ELT and CRLT

Ethical leadership theory (ELT) and complex relational leadership theory (CRLT) approaches are essential to simultaneously support a person-centred and a team-centred approach to address LA at this HcO. These relational practices allow meaningful connections to scaffold onto existing ways of knowing (Petrovic et al., 2023). By utilizing these approaches, it will allow for an understanding of how hostile situations arise and increase collaborative approaches to improve responses within high-risk units. Musbahi et al. (2022) encourages leaders to integrate ELT into practice knowing that inclusive, empathetic, and ethical approaches will have a positive impact on the entire workforce.

At times, there may be incongruence, especially when the follower's perception of leadership does not align with a leader's intentions. Nursing managers often experience internal conflict between individual and organizational ethics, especially when quality care or education cannot take precedence due to clinical pressures, or when market-oriented values such as efficiency, productivity, and patient and family satisfaction are prioritized over nurse well-being (Barkhordari-Sharifabad et al., 2017). These represent different ethical challenges, particularly if it contradicts a leader's own values. Frontline nurses often plea for leaders to 'put yourself in our shoes', especially when larger caseloads are experienced because of ongoing nursing shortages and when expectations are relentless. This is why ELT and CRLT approaches must be used to address these emotions and to consider the unique perspectives of staff. Since Feistritzer et al. (2022) tote the importance of leader/follower collaboration, the CRLT approach will align with the dual operating systems aspect of Kotter's change theory where hierarchical structure coexists synergistically with a motivated group. For my role, ELT aligns with the expectations of how the chief nursing officer role functions within the HcO and combines other leadership principles when working with other key stakeholder groups. According to RNAO (n.d.), the chief nursing officer should role-model vigilance in ensuring high quality care, provide mentorship, create a supportive environment, and establish metrics to determine success in all deliverables. Further, CRLT moves away

from the leader-subordinate paradigm and focuses instead on leadership through relations occurring between people and throughout organizations (Feistrizer et al., 2022).

Solutions to Address the Problem of Practice

The PoP leads to questions on which methodology is appropriate to allow nurses and leaders to identify and respond appropriately to LA. Potential solutions should involve more than simply awareness-building or punitive measures; it requires purposeful culture change through a system-wide approach. A literature review by Papies (2017) demonstrated that many interventions involving behaviour change have good intentions but do not easily translate into desired behaviour outcomes. For example, nurses may intend to show caring behaviours and collegiality towards their peers, but these good intentions vanish when stressful challenges arise in a complex environment. Papies (2017) state that the intention-behaviour gap occurs when situational cues trigger habits, impulses, or stereotypical associations, which can then influence negative behaviour. Further, implicit stereotypes, prejudice, and aggressive impulses can influence our behaviour despite being inclined towards egalitarian beliefs (Papies, 2017). Since behaviour change strategies can influence responses to situational cues, solutions involving professional socialization behaviours with reminders of social norms are required. These are significant considerations when formulating potential solutions.

Change Drivers

There are six change drivers for this DiP: the HcO's strategic plan with provincial requirements, national guidelines for workplace psychological health and safety, national recommendations to retain nurses in healthcare settings, regulatory practice obligations, and guidelines from professional associations to guide policy development and nursing excellence.

The first change driver is the HcO's Quality Improvement Plan (QIP), which identified staff retention and workplace violence prevention as high organizational priorities (HcO, 2023f). The importance of providing a safe work environment free from violence and harassment aligns with

provincial requirements outlined in Bill 168 and Bill 132. According to the Workplace Safety and Insurance Board [WSIB] (2023), these policies must be in place to allow employers to enact timely follow up and investigation, as well as to mandate annual training completion for employees.

The second change driver comes from the Canadian Standards Association [CSA] Group's psychological health and safety in the workplace standard, which encourages safety, sustainability, and social good (CSA Group, 2022). This document outlines harm reduction strategies and offers solutions to resolve incidents or concerns. While it acknowledges external forces that affect safety, it focuses on internal aspects within the control, responsibility, or influence of the workplace (CSA Group, 2022).

The third change driver was the recently published toolkit from Health Canada. In this document, it provides pan-Canada recommendations for healthcare systems to support nursing retention by improving the working lives of nurses. Through this work, eight central themes were identified and relevant themes for the DiP included: inspired leadership, organizational mental health and wellness supports, professional development and mentorship, strong management and communication, and clinical governance and infrastructure. Tangible initiatives and actions are proposed to address these themes and include recommendations for healthcare leaders to implement leadership competencies, zero-tolerance for bullying, moral distress and injury care, and mentorship programs (Health Canada, 2024). Many of these strategies inform the curriculum design for the learning pathways. Nurses and leaders can be empowered to handle incidents with consequences, support victimized individuals, and prevent future occurrences of bullying behaviour (Health Canada, 2024).

The fourth change driver comes from the regulating body for nurses in Ontario. The College of Nurses of Ontario (CNO) Code of Conduct practice standard states that all nurses are accountable to uphold professional behaviour and ethical conduct. According to CNO (2023), the code helps to promote safe nursing practice by maintaining public trust and confidence in the profession's integrity and care. This practice standard promotes accountability to build and maintain respectful relationships within the

team and explicitly state that nurses should not “physically, verbally, emotionally, financially, or sexually harass or abuse team members” (CNO, 2023, p. 11).

The Canadian Nurses’ Association [CNA]’s Code of Ethics document is the fifth change driver and is intended to be used dually as an aspirational document and a regulatory tool (CNA, 2017). It states, “nurses are bound to a code of ethics as part of a regulatory process that serves and protects the public” (CNA, 2017, p. 2). Additionally, it unequivocally states that it is as an ethical responsibility to “refrain from any form of workplace bullying” (CNA, 2017, p. 15).

Finally, the last change driver is the undeniable need to retain nursing staff at this HcO. According to an internal report, more than sixty percent of nursing turnover in 2023 were nurses with less than three years’ of experience in the profession. This high turnover rate underscores the need to address contributing factors that lead to a nurse’s decision to leave the HcO.

Theories Informing Solutions

Three foundational theories form the basis of the solutions to support the nurse, the team, and the leader: Knowles’ (1984) adult learning theory, Bandura’s (1977) social learning theory and (1999) social cognitive theory. These solutions should also consider equity, diversity, and inclusion (EDI) practices. First, Knowles’ (1984) adult learning theory (ALT) states: 1) previous experiences will inform learning; 2) adults need to participate to be motivated to learn; 3) readiness occurs when relevancy to personal or social roles are seen; and 4) knowledge is purpose-driven, and learning is problem-centered (Clapper, 2010). Therefore, andragogic principles will support the development of a plan so that nurses and leaders can identify and respond appropriately to uncivil behaviours.

Secondly, Bandura’s (1977) social learning theory (SLT) encourages peer mentorship and solidifies a team-based mindset for learning (Stanley et al., 2020). It also emphasizes the significance of observing, modeling, and imitating the behaviour and attitudes of others through social interactions (Nabavi & Bijandi, 2012). SLT also aligns with ethical leadership because there is a social learning aspect

to being an ethical leader where followers will behave similarly to their leader through observational learning (Hartog, 2015). Bandura's theory maintains that assimilation occurs when people adopt similar behaviour after observing and imitating others (Nabavi & Bijandi, 2012).

Next, Bandura's (1999) social cognitive learning theory (SCLT) supports the learning for the leader. In contrast to SLT, this theory emphasizes observing, understanding, predicting, and changing human behaviour (Nabavi & Bijandi, 2012) since individuals will learn cognitive strategies through observing others. Since cognition affects internal processes such as information processing, it will improve competence of the leader to respond accordingly. Similar to ELT, this would allow for continued modeling of effective behaviours, thus reinforcing the behaviour they wish to see in others. Both SLT and SCLT align with self-efficacy behaviours. For example, successful training efforts will strengthen self-efficacy as the confidence to endure setbacks is built on the basis of past successes (Bandura, 1977; as cited in Bong & Skaalvik, 2003). Additionally, modeling serves as another useful efficacy input since self-efficacy beliefs are established based on observations of peer performance (Bong & Skaalvik, 2003). The use of SCLT will support the individual's readiness for change by addressing efficacy. The linkages between the foundational theories, change drivers, ethical considerations, and potential solutions are demonstrated in Table 3.

Table 3

Potential Solutions to Consider for PoP

Potential Solutions	Evidence / Change Driver	Ethic of Profession	Ethic of Care	Ethic of Critique	Ethic of Justice	ALT	SLT	SCLT
Nurse Training: education & skills	RNAO, CNO, Health Canada, CAN	X	X	X	X	X	X	
Manager Training: education & skills	RNAO, CNO, Health Canada	X	X	X	X	X		X
Lateral surveillance & reporting	HcO, literature review, CSA, CNO	X	X	X	X		X	X

Potential Solutions

Covey (1988) describes two circles: a circle of concern and a circle of influence. There are many root causes of LA in the nursing profession that it would prove impossible to address them simultaneously. Themes such as a global nursing shortage, provincial wage suppression, and funding inequities may evoke a mental or emotional reaction, but reside within the broader circle of concern. These problems add to the context of LA, but represent issues beyond the reach of my role. The circle of influence is smaller and is situated within the circle of concern. Organizational culture, mentorship, organizational processes, and resource allocation are positioned within this circle and represent issues I can directly influence as the change leader. Finally, the third innermost circle, the circle of control, represents issues I can directly control. Root causes such as the failure to recognize LA in action, the lack of awareness and full utilization of existing reporting processes, and sub-optimal education can be situated within this circle. Therefore, the potential solutions posed mainly target issues at the individual and unit levels as they are positioned within the inner two circles of influence and control.

Olsen et al. (2020) summarized interventional research on lateral aggression to support providing nurses with training and education about bullying behaviours to improve recognition and increase confidence in responding effectively. This includes education and skills-based training to promote dialogue within the team (Pfeifer & Vessey, 2018) as well as provide opportunity to learn about root causes of LA in nursing. According to Gardner and Cooper-Thomas (2021), this should also include definitions of bullying, professional behaviours, and training for reporting bullying using established policies, as well as interpersonal communication, emotional self-management, conflict resolution and stress management. This training should focus on perpetrator-focused strategies to respond based on role, as well as how to intervene as a bystander. Leaders will benefit from attending the same training as frontline nurses. This will help to balance power differentials when learning takes place together. However, leaders have an added responsibility to utilize organizational processes for resolving issues

and role modeling behaviours, so this will require additional training (Gardner & Cooper-Thomas, 2021). The literature supports using cognitive rehearsal and conflict management skills as effective methods to learn about LA (Dahlby & Herrick, 2014). Leaders would benefit from the addition of a second training pathway to improve their knowledge on conflict management, communication, and team building. Leaders need to engage in debriefing as an important reflective learning activity, but it may prove challenging to protect the privacy of their team members (CSA Group, 2022). The HR department would be positioned as experts to support in this knowledge acquisition and highlight how inaction to LA breeds mistrust in leaders. This second pathway should also include focused training on the escalation requirements for leaders so timely follow up can occur. Surveillance should be included in this pathway and include tiered and non-confrontational intervention strategies for leaders to use when addressing discovered issues (Pfeifer & Vessey, 2018). To support improvements to surveillance and reporting, an organization-wide change is required because it extends beyond the model cell units and necessitates the revision of harassment protocols to coincide with the training pathway for leaders. Three potential solutions will be posed as ways to deliver the training before concluding with the most feasible format for these learning pathways.

First Potential Method: External Resources

There are several options available across Canada to consider. Pre-built e-learning modules and in-person training opportunities exist and are worth considering. The learning objectives of these offerings vary widely, as do the topics discussed within the field of LA. While some modules are free, many options are cost-prohibitive, and leaders would not be able to reimburse staff for training completed outside the HcO. There is no budget available to hire external consultants to teach or design curriculum so internal experts must be utilized. The inconsistency with knowledge and topics, as well as the infrequency of educational offerings, would make it difficult for leaders to track training so this solution would not be feasible.

Second Potential Method: e-Learning Only

Online learning can provide a learner-centric approach to facilitate learning opportunities for the adult learner to allow for the balance of personal and work commitments. Sinclair et al. (2016) states that its flexibility and accessibility contribute to the cost-effectiveness of this modality compared to traditional in-person formats. In an organization this large, it allows for an accessible means for instruction where staff can learn at their own pace, revisit topics, and complete educational requirements at a time and location that is convenient for them. Another advantage for education design using this method would be an assurance that customization could occur to account for the HcO's workplace harassment protocol and ensure compliance to the Accessibility for Ontarians Disabilities Act (AODA). An existing e-learning module covering workplace violence prevention is already a mandatory yearly educational requirement of Bill 168 but does not explore LA in a particular profession. The time allotment for this mandatory education is fifteen to thirty minutes. Based on this knowledge, there is an opportunity to either expand this module to include the harmful effects of LA or create a separate e-learning module focused on this topic. Outcome metrics will capture completion rates (separated by role, team, and date) with automatic reminders to the learner and to their leader for compliance on a yearly basis. There are a few limitations to consider in this modality. Learners would not benefit from group interaction and discussion using this approach. Financial impacts to unit operational budgets will grow if the module time increases from 15 minutes to 60-120 minutes since staff will need to be compensated for completing this education. While this HcO has the technological infrastructure in place to support virtual training and e-learning completion, not all staff have access to dedicated devices or the technological savviness to complete educational requirements at home so this solution may result in inequities in accessing this training. A major disadvantage is the lack of human resources since there are only two e-learning specialists who have access to the software needed to

create these modules, ensuring compatibility with the learning management system. This has an impact on curriculum creation and timely updates if processes change.

Third Potential Method: Face-to-Face Sessions

Du et al. (2022) summarized the traditional method of learning where instructors deliver knowledge face-to-face, and students more passively accept this information but lack active learning. Protected education time can prove to be challenging in a setting where hospital operations require nurses to work twelve-hour shifts around the clock. Lean resources limit the number of nurses who can attend training at a given time, especially for longer periods, because of nursing shortages and already higher caseloads. The unit operational budgets must also consider overtime costs to allow nurses to attend training sessions during off-duty hours. Nurses living in areas distant from where courses are offered, night shift workers, and those with family commitments, often find it difficult to attend scheduled class times (Reavley et al., 2018). Leaders working business hours (traditionally Monday to Friday and eight-hour days), would be more likely to attend face-to-face sessions given the nature of their work and ability to have protected time to engage in this approach to learning. Additionally, content experts require time to develop course curriculum for the recognition of LA in action and skilled facilitators must guide in-person learning on a regular basis. Dedicated space is also required for learning and may be difficult to coordinate given physical constraints in this HcO's footprint.

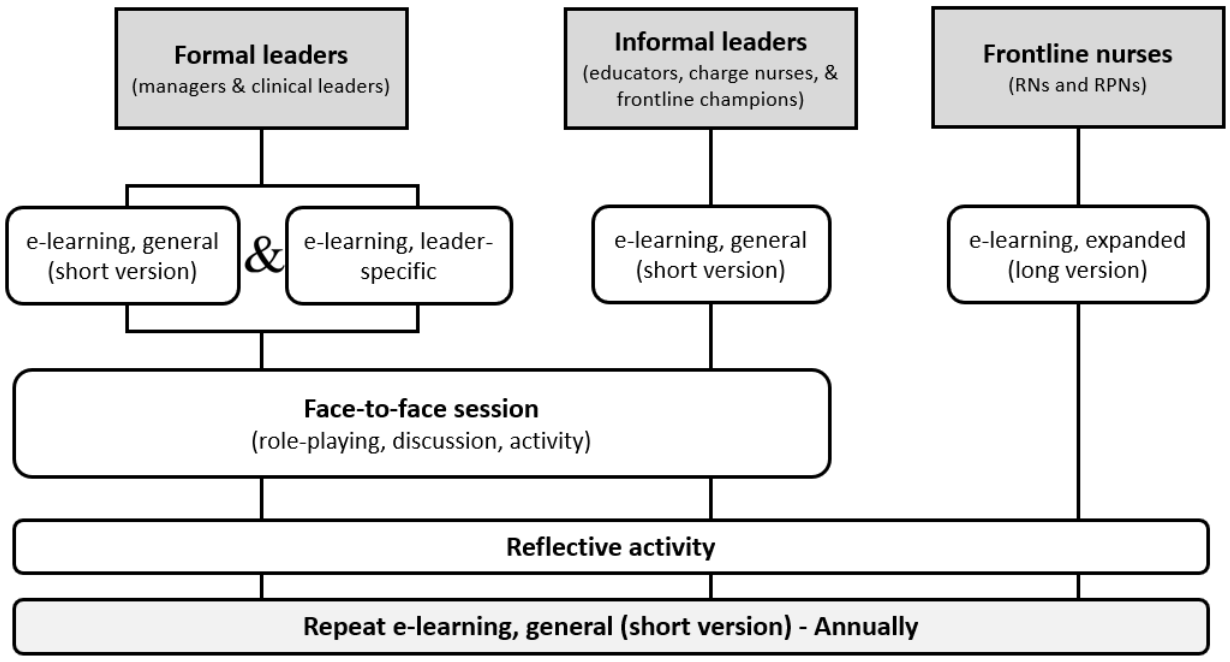
Most Appropriate Solution: A Blended Approach

Effective training is imperative to address LA in nurses to promote PS. This training process combines the proposed solutions in a blended or mixed modality approach, targeted towards nurses and leaders, and requires a systematic approach to training. Reavley et al. (2018) state that health professional education commonly employs a blended approach to learning: one that leverages the convenience and flexibility of e-learning with the interactivity of traditional face-to-face learning to create a learner-centric focus (Du et al., 2022). Blended learning has been shown to be more effective

than (or at least as effective) as non-blended instruction for knowledge acquisition (Liu et al., 2016). This approach will also address multigenerational and individual learning styles while allowing for didactic transmission of information and experiential learning for adult learners to role-play responses to scenarios. It also requires clarification and refinement of organizational protocols to maintain leader credibility and assist in clear communication. This approach would be the most feasible to implement to support knowledge acquisition and cognitive rehearsal. Based on their role, learners can choose between three pathways depicted in Figure 6.

Figure 6

Learning Pathways for Staff



Note. All roles would complete a reflective activity and have annual e-learning requirements.

Frontline nurses can opt for the longer e-learning as a sole option or combine the shorter module with the in-person training if they are motivated to champion change. This is also applicable for nurses in informal leadership roles such as educators and charge nurses. Formal leaders such as managers or

clinical leaders would complete two shorter e-learning modules, combined with in-person training. All staff would be required to complete a reflective activity as a professional obligation to practice, as well as a review of the shorter e-learning module as a mandatory requirement of Bill 168 on an annual basis.

To implement this solution, a flipped classroom approach will be used where some learners will be exposed to new material through the e-learning module(s), before attending the in-person session for cognitive rehearsal and role-playing. According to Betihavas et al. (2016), this allows focused time for knowledge assimilation through problem-solving, discussion, or debates. Using this blended approach will allow for an understanding of education design and deployment costs to inform whether a positive return on investment for education can be achieved in the evaluation stage as well.

Application of Foundational Theories to Solution

Bandura's SCLT theory addresses behaviour through cognitive, environmental, and behavioural factors. Holloway and Watson (2002) contend that these factors overlap, and behaviour is informed by learning through conditions with individuals shaping their environment. SLT also addresses self-efficacy to improve confidence in their own abilities to initiate actions. Bandura (1994) states that those who view difficult situations as challenges to be mastered rather than as threats to be avoided achieve performance accomplishments, which improve self-efficacy (Holloway & Watson, 2002). Thus, having a mixed modality approach to training would address the intention-behaviour gap as well.

Chapter 2 Summary

Evidence from multiple sources speak to the importance for leaders to role model ethical behaviour and focus on relationship development for a psychologically safe environment to be cultivated. By doing so, it ensures that ethical conversations and behaviour continue well after nurses enter professional practice. Additionally, leaders have an ethical obligation to ensure their followers are equipped with the tools and resources they need while providing the time and space to do so to ensure a healthy workplace culture. This means establishing the contextual, cultural, and professional

prerequisites that make good care possible. It is especially important to utilize ELT and CRLT approaches for LA to be addressed in the nursing profession, thereby improving retention and sustaining an experienced nursing workforce into the future. Navigating organizational change requires knowledge of organizational readiness for change enablers and barriers. The likelihood of success will depend on buy-in from senior leaders to dedicate funds to support a mixed methods training approach to improve PS. Through the creation of concurrent training pathways for nurses and leaders in select units to identify and respond appropriate to LA in action, there is opportunity to transfer these learnings to other units at this HcO to enable psychologically safe environments to create cohesive nursing teams. Chapter three will focus on implementation efforts, as well as the importance of communication throughout each phase of the change plan. If change can be successfully demonstrated within the surgical units at this HcO, a spread-and-scale strategy will allow information transfer to replicate outcomes in other high-risk departments for LA. This strategy would extend to students, senior leaders, union representatives, and other healthcare providers at this HcO. This will, in turn, benefit patient care outcomes and contribute to overall organizational success.

Chapter 3: Implementation, Evaluation, and Communication

In the first chapter, the prevalence and devastating impact of lateral aggression (LA) in the nursing workforce was described as a problem of practice (PoP), contributing to a culture of psychological hostility and nursing staff instability at a large healthcare organization (HcO). The second chapter provided an organizational analysis focused on the role of frontline nurses and leaders to inform readiness for change to improve psychological safety (PS) by addressing uncivil behaviours through one of three role-specific learning pathways. These pathways supported a standardized approach for nurses and leaders to recognize, respond to, and prevent LA from happening in the workplace. This final chapter will outline the knowledge mobilization (KMb) plan using an adapted framework, borrowed from emergency planning, along with a communication plan using Kotter's change model to implement these pathways. The tools used in continuous quality improvement (CQI) methodology will describe how they can be used to monitor progress and evaluate outcomes to determine success at various stages of this plan. While success of the change strategy can be measured using pre-determined metrics, the fundamental goal is to change behaviour. This will address and minimize the harmful effects of LA and improve PS within the adult surgical units at this HcO.

Change Implementation Plan

Bryson and Alston (2011) state that strong implementation plans embody an agreement about where, when, and why change needs to occur, what needs to be done, how to achieve the goals, and identify key responsibilities for individuals, groups, or departments. Strategic planning is often seen as good professional practice to help people think, act, and learn (Bryson & Alston, 2011). This implementation plan will offer clarity using these principles to ensure accountability to meet objectives.

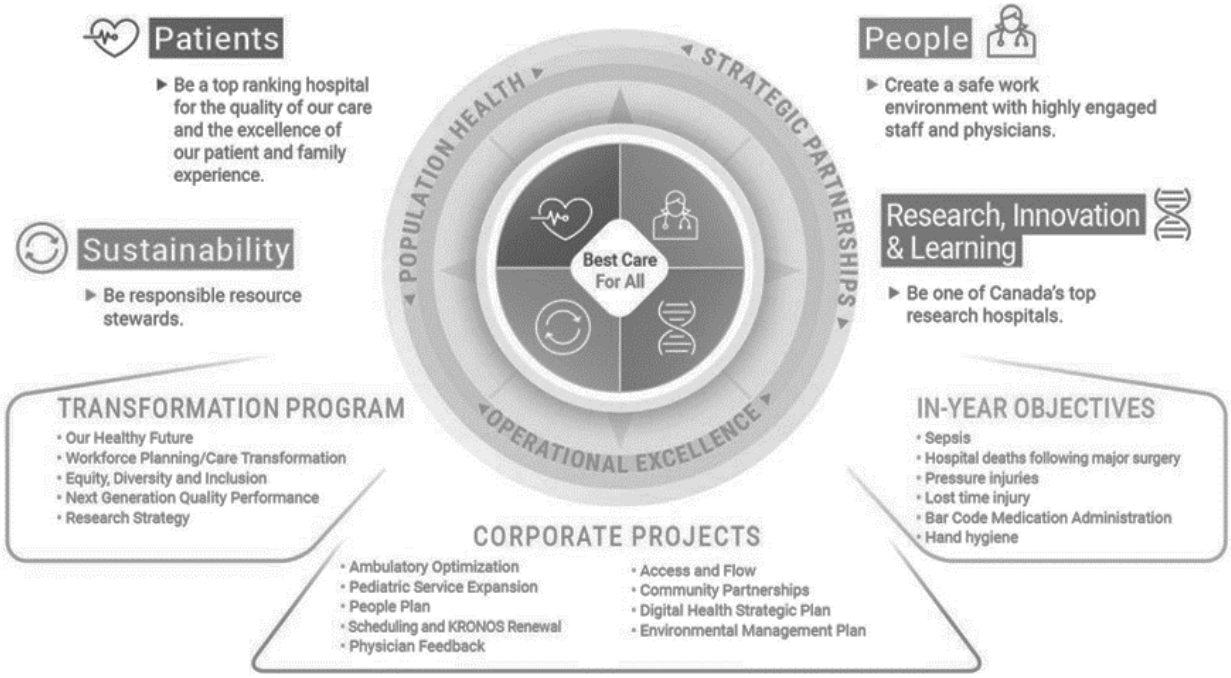
Alignment to Organizational Strategy

To obtain buy-in with executive sponsors, there must be a demonstrated alignment to organizational objectives. The four main pillars of the HcO's strategic plan include people, patients,

sustainability, and research and learning, and are represented in Figure 7. According to HcO (2023d), the people pillar indicates that the creation of safe work environments will allow for staff engagement, while the sustainability pillar supports resource stewardship to retain capable nurses. This parallels the patient pillar as a skilled nursing workforce is needed to drive quality clinical outcomes. Finally, the research and learning pillar indicate the desire to lead innovation in the country and learnings from this change plan can be applied to other hospital settings in Canada.

Figure 7

HcO's Strategic Plan



Note. These strategic priorities are updated every few years and was last revised in September 2023.

This PoP intuitively aligns with organizational initiatives such as workforce planning, quality performance, and the people plan. The key performance indicators (KPIs) are synonymous with nurse-sensitive indicators (NSIs) and align with the in-year objectives of this strategic plan. These NSIs can impact clinical outcomes through direct nursing actions (Burston et al., 2014). Since Coventry and Hayes

(2020) state that conflict and incivility can hinder optimal teamwork, this can delay timely communication of clinical deterioration to other members of the team and can result in poor clinical outcomes such as sepsis, pressure injuries, and death.

The focus of the EDI strategic plan is on the creation of an inclusive, safe, and respectful environment (HcO, 2023e). Policies and protocols are routinely reviewed to ensure sensitivity to the needs of racialized minorities and vulnerable populations. Additionally, KPIs connected with staff well-being can be seen in workforce metrics such as turnover rates, overtime usage, absenteeism, and sick time. Reports of violence or the need for HR involvement can also be included as key metrics. The change plan aligns with organizational priorities because it improves the capacity of leaders to lead equitably through the creation of training and learning resources. The CQI processes and tools used in the change plan will offer familiarity for nurses and leaders to implement and adapt to change while encouraging the stewardship of resources. As the change leader, I will utilize these tools and resource experts to support the change process.

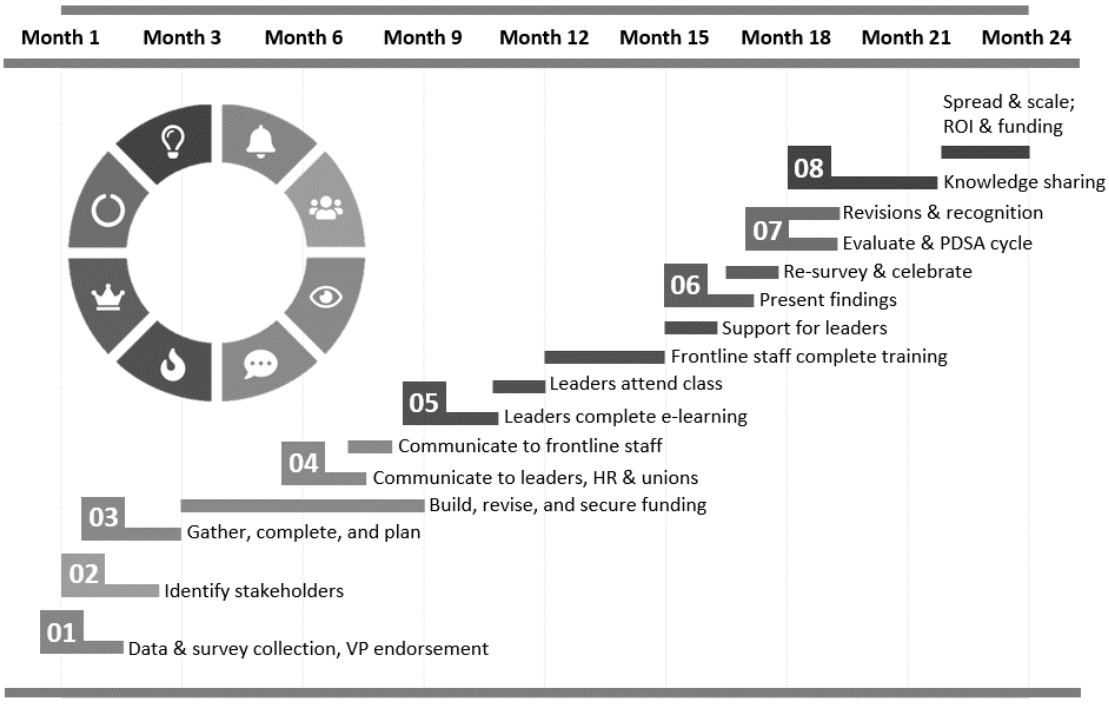
Change Implementation Alignment and Plan

This plan represents actions needed to mobilize and translate knowledge gained from academia for application to the clinical setting. ELT and CRLT approaches align with the change strategies supported by Kotter's model and CQI methodology because they share commonalities, mainly allowing meaningful connections to be made with followers. The eight-step change model with the dual operating system of hierarchy and network structures, combined with CQI's intention for grassroots empowerment allow nurses and leaders to collectively respond and work together to implement change. The change tactics are guided by the eight sequential steps in Kotter's change model and integrates CQI methodology to offer expected timelines for each goal. The acronym, SMART, refers to goals that are specific, measurable, attainable, realistic, and timely (Doran, 1981). It is crucial that all goals for the change implementation plan embed SMART principles to provide measurable outcomes. In

this plan, CQI methodology provides rationale for estimated timelines for goals, with short-term goals representing the 'Just Do It' items of the CQI framework. These are simple opportunities that are prioritized for immediate completion within a shorter timeframe: typically a few weeks. Figure 8 offers a visual representation of the timelines and goals using Kotter's model.

Figure 8

Change Implementation Timelines and Goals



Note. These estimated timelines address short-term, medium-term, and long-term goals for this HcO.

The medium-term goals of this plan align with more intensive work and increased stakeholder involvement and could occur over a few weeks to months. These tasks may be difficult to coordinate and complete because they are dependent on the effort of others, thus informing a longer timeline for completion. In CQI language, this represents 'work waiting'. Longer-term goals coincide with A3 processes of CQI methodology, acknowledging that complex plans may require the longest to complete. Appendix D outlines the comprehensive change implementation plan.

Step One: Create Urgency

Bareil (2013) identify four main reasons why failure occurs during the change process. This includes a lack of leader endorsement, insufficient change resources, employee resistance, and middle-management resistance. Thus, facilitating enabling factors would increase driving forces needed for successful change. My plan as the change leader would be to start having informal conversations with directors and VPs to introduce these concepts organically through status meetings or through shared work opportunities. I plan to do this early and often to build initial support for change. Since pertinent data will support the demonstration of the devastating impact of LA on the HcO's nursing workforce, I will work with the informatics and data analytics teams to collate KPIs and NSIs. These workforce metrics are easily accessible and include turnover rates, absenteeism, and sick time usage. Safety occurrence reporting is either being manually tracked by HS&W or is tracked automatically when staff input these occurrences. Deliberate presentations to senior leadership tables will follow and will occur formally where I will present internal and external data, the alignment to strategy, and outline the target state. This leadership approach utilizes CRLT, where adaptations are made in response to the context and to the changing needs of the system. CRLT relies on the interactions among stakeholders and across networks (Lichtenstein et al., 2006). Although my preference would be for face-to-face presentations, the reality is most senior leaders are meeting virtually. I will need to engage the President's team and the executive leadership team, consisting of the EVPs, VPs, and the board of directors. These executive teams meet at various times through virtual platforms since many are located at different sites and in-person meetings prove to be challenging. Thus, these formal presentations may need to be adapted to suit the audience of a diverse executive team to gain endorsement to proceed and to secure organizational resources. I would request resource support from the quality and performance portfolio in the deployment of a project manager. Depending on the organizational needs

at the time of this presentation, the project manager role may not be possible so these responsibilities would be led by me as the change leader.

Step Two: Build Guiding Coalition

In my role as chief nursing officer, I will bridge leaders and frontline staff to facilitate discussion and guide action. As demonstrated above, collaboration within a multi-divisional organization can be difficult since stakeholders may span multiple sites across a large urban city. This includes clinical staff and leaders, but also stakeholders from departments such as clinical practice and education (CP&E) and health/safety and wellness (HS&W). These employees will need to remain on their respective sites to provide care. In contrast, stakeholders in non-clinical divisions such as HR, OD, data analysts, marketing and communications, quality and safety, and EDI teams may be working remotely. Building a guiding coalition requires CRLT principles as it is heavily dependent on governance and inclusive relationships. As the leader of this change, I need to engage and include a CQI coach early on to help facilitate the work needed to drive change using CQI processes and tools. Such a diverse coalition would require leveraging virtual platforms as well as digital communication tools for meetings such as zoom recordings, electronic polling, and breakout rooms if spanning multiple sites. I would seek administrative support to help with coordinating these meetings and resources, as well as assist with minute-taking to document actions and discussions. Bailenson (2021) caution against the excessive use of virtual meetings and attribute Zoom fatigue with prolonged close-up eye gaze, cognitive load, and restrictions on physical mobility as reasons for staff disengagement in virtual platforms. While having virtual meetings can bridge geographical distances and reduce unnecessary travel, there is intangible value in having face-to-face interactions. Physically meeting with stakeholders will encourage connection and aligns with CRLT approaches because leaders mobilize people to work on opportunities and tackle problems. Feistrizer et al. (2022) state that if strong relationships exist between all members, this will lead to an environment that will help nurses better serve each other, their patients, and the community.

Importance of Stakeholders in Change. The inclusion of stakeholders is key to ensure success. Identifying and gathering leaders, change agents, and change recipients to collaborate and participate in change initiatives will have a great impact on the success of this plan. The driving and restraining forces in Lewinian field theory can affect behaviour and capacity for change, so the careful selection of motivated individuals in this stakeholder group to increase driving forces and overcome resisting forces will aid change efforts greatly. I will select some stakeholders based on their role, power, or authority but I will strive to select individuals to represent a wide range in experience, age, culture, gender, and race to inform multiple perspectives. Using CRLT, I will also engage with the manager and request they identify select motivated frontline individuals to serve as change agents by participating in this work. Engaging a diverse group of stakeholders would encourage shared ownership of a problem. Burke (2018) explains that forces that are owned (adopted voluntarily rather than imposed) are more likely to be embraced. This aligns with the outcome of experience-based co-design, whereby nurses and leaders can be actively involved and participate in the implementation process to improve success. Using ELT and CRLT approaches would support cohesion and collaboration from a diverse group and encourage input and feedback from these stakeholders.

Step Three: Form Strategy

During the third step of Kotter's model, further information is needed. This stage requires stakeholders to understand the full scope of the problem to create a tailored solution. As the change leader, I will enlist the OD department to work with the manager to gather existing staff's perceptions of LA actions and inactions, as well as capture the experiences from those who have recently left the surgical units. This information will be collected over the course of a few weeks through an anonymous survey for existing staff and through exit interviews to serve as a baseline comparator prior to implementing changes. The opportunity for existing staff to provide anonymous feedback to their leaders in a safe manner is representative of ELT, whereby it demonstrates ethical sensitivity to their

followers. I will work with OD to arrange an in-person strategic planning session with stakeholders in the first few months to go through a prioritization process to identify areas of focus. This will be facilitated by OD and a CQI coach to lead the group in a root cause analysis using the A3 tool to determine contributing factors. This will also allow stakeholders to co-design the curriculum by providing input and feedback and this collaborative process is supported by both ELT and CRLT principles. This in-person session will also have purposeful activities to encourage movement as it would be beneficial for discussion, idea generation, and participation. According to Oppezzo and Schwartz (2014), locomotion and other movements often result in more creative output and better performance in meetings. I would ensure these opportunities for movement are embedded in this day-long in-person session. Kotter's third step represents one of the longest periods of change implementation because sufficient time is needed to delineate roles, establish working groups, and build curriculum content, as well as revise existing tools and processes. Mintrop (2016) emphasize the impact of policy revision on organizational direction, so active involvement in decision-making by appropriate stakeholders is important. Finally, training funds need to be secured to support content creation by experts, as well as allow for training compensation of surgical staff in the model cell units. The ELT approach supports this by ensuring equitable treatment for fair compensation of expertise and time. As the change leader, I will work with operational leaders to advocate for these funds within the program's budget and explore other avenues to support funding.

Step Four: Enlist Volunteer Army

I have operational oversight of a large corporate nursing committee structure that spans all hospital sites that report to the President's team. The Nursing Quality Council (NQC) is a diverse decision-making collaborative comprised of nurses from various roles, levels, and departments. This includes nurses in formal and informal leadership roles, as well as unit champions and change agents. The NQC has five separate sub-committees, with one focused solely on health and equity for nurses to

encourage healthy working environments. There are goals embedded in the work plan to improve professional practices and for nurses to contribute to quality improvement initiatives, which include addressing LA. This aligns with Kotter's vision of the motivated volunteer army who can agilely respond to urgent needs for organizational change, as well as incorporating ELT and CRLT.

Additionally, Kotter (2014b) highlights value in communicating the vision for change. This includes dedicating a few weeks to provide timely updates to operational leaders to support conversations with staff. I will need to enlist a volunteer army consisting of the communications department and HR to assist me in this work. I will need to be involved in frequent, formal communication with operational leaders and the two nursing unions at this HcO prior to launching the learning pathways to communicate the expectations for the educational requirements. This can be done either through email or through the monthly meetings I have with these groups. The messaging can be done in collaboration with the communications and HR departments. My intention during this time will be to reinforce the expectation for professional behaviours and conduct throughout the change process and post-training for all staff, including leaders and frontline nurses. A key component when communicating expectations for the change is to explain *why* change must occur. Fear and futility are often seen as reasons why staff remain silent in the face of LA. If the reporting is likely to be deemed as futile or unable to effect real change, staff are less likely to speak up (Den Hartog, 2015). A leader employing an ELT approach would strive to see things from other perspectives so communicating clear expectations for behaviour from all parties is important. ELT leaders must clarify responsibilities so that staff know what is expected from them and this includes ethical norms. Dudar et al. (2017) identify that partisan stances may act as competing forces since unions may contend that nursing professionals should be the sole or dominant voice in creating protocols because as professionals, they know best. Thus, identifying experts with nursing backgrounds to include them in this work will jointly satisfy unions and build on existing nursing expertise. Biased protocols supporting the status quo and maintaining job

security will not bring change as it fails to prioritize job satisfaction, learning, and staff well-being (Govender, 2004; as cited in Dudar et al., 2017). Therefore, the involvement of partisan parties must be balanced through active involvement from hierarchical leaders and HR partners to help advocate for the change strategies needed to address this potential disparity. This means that I must proactively connect with HR partners to provide support for leaders for those challenging conversations.

Step Five: Enable Action for Change

Lowndes et al. (2006) examined ways to encourage staff participation and identified five enablers. These enablers include: 1) ensuring resources are available; 2) a personal connection to their work or identity is made; 3) safeguarding time from leaders to participate; 4) asking staff directly; and 5) confirming a responsive system. Relational leaders demonstrate inclusive practices and seek to empower individuals and can purposefully identify motivated individuals to participate in work. Ethical leaders actively work to remove barriers encourage the inclusion of those previously excluded. Therefore, as a change leader, I must do more than simply having opportunities available for staff. There is an added responsibility for me as a leader to encourage empowerment by approaching staff and leaders directly to be involved. I should also advocate to operational leaders to ensure there is adequate backfill for both their work and for their followers. This step addresses empowerment through capacity building and is an outcome of relational actions stemming from CRLT (Lichtenstein et al., 2006). Over the course of an estimated six-month period, there will be focused efforts on training using a phased approach. I will coordinate with CP&E and OD to ensure these training schedules are developed and posted. In the first three months of this step, leaders will undergo the training before their staff. As a leader demonstrating an ELT approach, I will also participate in the leader training to role-model expectations for participation and behaviour, as well as to lend support to those who need it and will encourage my inter-professional practice (IPP) chief colleagues to do the same.

Considering leaders will need to complete more comprehensive e-learning modules before attending the face-to-face session, three months is a reasonable amount of time to complete this education given the significant operational pressures in this complex HcO. Frontline nurses will be allotted the same length of time in the three months following their leaders. This timeframe is also reasonable due to the shorter e-learning requirement and will allow for variation in shift work hours. Lastly, I will ensure there is a conscientious effort from HR and the IPP chiefs to support leaders in following these protocols when addressing difficult encounters in the months following their training.

Step Six: Generate Wins

Since these goals are tied to project milestones at specific intervals, some are estimated to take at least a year to achieve. This aligns with A3 processes of CQI methodology, where actions and outcomes may take longer than expected given the complexity of the problem (HcO, n.d.). In this stage, knowledge sharing is a quick win and the celebration of accomplishments during this time will strengthen morale and commitment, as well as demonstrate value to others. I will be formally checking in with staff and leaders throughout the training and implementation period and will do this through scheduled meetings and drop-in sessions for frontline staff to participate. This approach integrates ELT and CRLT, which will allow for feedback to occur, demonstrate concern for people, allowing voice, and addressing sustainability. At a now projected eighteen months into this implementation plan, a second survey is needed to compare perceptions of improvements from nurses and leaders. I will work with operational leaders to deploy the same survey used during the information-gathering stage and compare the findings post-implementation. Considering the ELT leader rewards ethical conduct, I can do this by celebrating achievements such as training completion rates, adherence to protocols, or narrative accounts of wellbeing, teamwork, and self-concept. The continued analysis will likely encourage professional behaviours to continue by maintaining awareness.

Step Seven: Sustain Gains for Bigger Results

Huang et al. (2022) state that the Kirkpatrick model can support the educational requirements needed and evaluate the effectiveness of the training. The use of this model will determine the effectiveness of the training on LA. During this time, I would leverage clinical nurse specialists who are focused on quality improvement initiatives. This advanced practice role can work with the clinical educator of the surgical units to determine whether the training was successful. This is elaborated further in the evaluation plan. I would engage with the manager and CQI coach to analyze qualitative data from the survey, as well as verbal accounts and data metrics to determine other areas of focus. As the change leader, I would ask the CQI coach to mentor the manager and stakeholders from their team in improvements or refinements to existing processes. The sharing or distribution of power reflects both CRLT and ELT approaches. The course corrections would be done through PDSA cycles and would largely occur in this stage. These cycles typically have a shorter timeline, only taking a few weeks to enact these adjustments. Continued engagement with leaders and staff will help to prime the organization for the last step of the change plan.

Step Eight: Institute Change

During the last stage, I will create presentation plans to expand to meso and macro levels with the intention of using local, provincial, and national platforms to share knowledge. I will actively include unit champions and leaders to be involved in knowledge-sharing and provide mentorship support for those who have not presented at these levels before. These inclusive, ethical leadership behaviours help direct others towards ethical goals beyond the HcO. In addition, the meso-level plans broadly include using the spread and scale approach to other units or expand to other disciplines outside of the model cells of adult surgical nurses.

Further, I will engage with the CP&E team to determine whether there was a financial return on investment (ROI) into education and training. By collaborating with the education team, this will build capacity to utilize more evidence-informed models to justify educational interventions. Additionally, the

concern of impact to finances shows stewardship and is an aspect of ethical leadership. Gathering the operational metrics and cost analysis will require additional support from leaders, data analysts, finances, and HR. As a senior leader, I will collaborate with more senior decision-makers at the executive level to encourage deployment of these resources and work with the CP&E team to understand the impact of this training. The final stage will take nearly two years to reach and the ability to utilize the ROI model is dependent on outcomes, perceived value, strategic priorities, human resource limitations, and leader support. Appendix A summarizes the change tactics, their purpose, and indicators of success.

Considerations for Equity-Deserving Groups

Despite the presence of a corporate EDI team, reports of micro-aggressions continue to persist, directed at racialized minorities. Allan (2022) identifies that these ongoing discriminatory practices allow non-racialized individuals unfair access to organizational resources and to the upskilling needed for career progression. Therefore, it is important to consider the unique perspectives of racialized minorities, as they may only be offered the didactic transmission of information via e-learning. Age may also lead to unintended discriminatory practices. Labrague and McEnroe-Petitte (2018) identify younger cohorts as lacking effective and assertive communication skills when dealing with difficult situations. Thus, a younger nurse may benefit from additional learning when practicing responses in difficult encounters. Conversely, there may be an assumption that those in leadership positions such as management, education, or charge nurse roles have more lived experience compared to their younger colleagues and may be more deserving of professional development opportunities. Therefore, the involvement of the EDI team would encourage more equitable processes and outcomes related to this training. A purposeful strategy to increase equity and reduce cultural hegemony would be for all working groups to have representation from IENs, racialized minorities, and/or novices, since their perspectives would be valuable in informing strategies for successful educational approaches.

Communicating the Change Plan and the Change Process

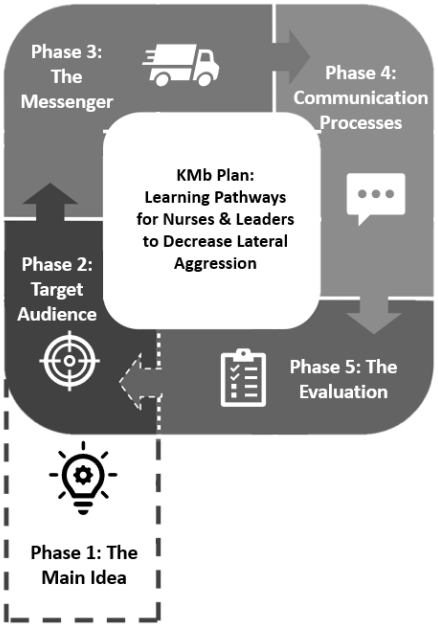
Given the size of the HcO, this KMb plan is complex because it includes a multi-directional flow of knowledge among diverse change participants in various roles and levels of the organization. Simply having organizational leaders communicate a new strategy is not enough to ensure change. There must be deliberate planning to convey research findings and translate knowledge into organization change. The KMb plan will outline the need for monitoring and evaluation of the changes in the DiP. Various CQI tools will assist during the monitoring phase and improve data collection to better analyze findings. The Kirkpatrick training evaluation model will evaluate the effectiveness of the learning pathways in increasing capacity for recognizing and responding to LA, while the Phillips ROI evaluation process and V model will act as a long-term strategy to institutionalize change in this HcO.

Knowledge Mobilization (KMb) Plan

Cooper (2014) describes KMb as an intentional effort to use evidence-informed research in policy and practice to create improvements between individual, organizational, and system levels through iterative, social processes through interaction between groups or contexts. There are similarities between emergency planning and knowledge mobilization. In both instances, there is a need for a systematic approach for communication to occur to stakeholders by synchronizing operations to support objectives. Akan et al. (2016) state that communication is not an event but a process affecting the performance of the organization with crucial impacts on stakeholders. The Planning P model is a reflexive communication framework often used in incident action planning, providing structure in the planning stages (Federal Emergency Management Agency [FEMA], 2018). This model has been adapted for use in knowledge mobilization in this DiP and will inform communication strategies. The adapted KMb Planning P model has theoretical underpinnings informed by Lavis et al. (2003)'s KMb framework and includes components such as the message, target audience, messenger, processes and supporting communication structures, and evaluation (Lavis et al., 2003). The simplified version is found in Figure 9, with the expanded version depicted in Appendix E.

Figure 9

KMb Planning P Model



Note. This simplified version represents the KMb plan, adapted from the Planning P Model.

The leg of the P model is the starting point to create situational awareness. Through each stage, the model guides the development of a simple plan and mechanisms to communicate to stakeholders. As the stages progress, more information arises leading to a natural evolution of corresponding actions and communication changes. Ongoing situational awareness informs the cyclical process of planning and operational readiness and can repeat with each change period as needed (FEMA, 2018).

Phase One: The Main Idea

Decision-makers require actionable messages from a body of research knowledge, packaged as an idea, to optimize endorsement (Lavis et al., 2003). The first phase acts as the starting point for discussions with relevant decision makers. Framing the message as the main idea demonstrates the urgent need to decrease LA among nurses to enhance PS and support long-term retention of nurses at the HcO. As the person initiating this change, I will capture this messaging by using a nursing

communication mnemonic. SBAR stands for situation, background, assessment, and recommendation, and will be used to summarize the main concepts in a succinct manner. It is an evidence-based professional communication prompt used to convey information in an explicit way to others, especially in emergency situations (Vatan & Yildiz, 2021). This communication prompt can be re-purposed and act as a starting point for conversations, such as when the manager needs to communicate to their staff at the unit level. In future reiterations at meso and macro-levels, this SBAR will ground messengers in the key points and the delivery of this message will need to be adjusted in the second phase of this model to account for the target audience.

Phase Two: The Target Audience

Analyzing the recipients of research knowledge transfer must occur and Lavis et al. (2003) emphasize the importance of identifying the right audience to target interventions. This includes recognition of those with agency for decision-making, influential opinion leaders or change agents, and engagement strategies to optimize receptivity. Lavis et al. (2003) acknowledge the need for multiple audience-specific messages since a one-message-for-all approach may not be effective for the diverse audience needed. For example, senior leaders may require earlier and detailed information to determine adequate resource allocation and economic evaluations based on deliverables or outcomes.

Although the change strategy is limited to the model cell surgical units, the target audience remains diverse. Frontline nurses and leaders such as managers, clinical leaders, educators, charge nurses, and resource nurses, make up the recipients of knowledge in this KMb plan. Frontline nurses may have a different perspective of why change needs to occur and can offer suggestions to increase uptake with their peers. I will request assistance from OD to survey nurses and leaders in the model cell units or utilize findings from the ORCA tool to focus communique, targeting gaps in evidence, context, and facilitation. This will help tailor the communication in the way that would be most beneficial for the audience. For instance, if additional literature is requested, I will seek assistance from the HcO's library

services. Depending on the resources available, there may be nursing students, modified nurses, or a project manager who I can engage with to provide physical copies of supporting literature and clinical practice guidelines for independent review. This highlights the importance of tailoring the message and delivery to the audience to maximize change adoption. Recipients will also retain information if it holds personal or professional relevance, aligning with adult learning (Clapper, 2010) and with the ELT approach where important resources are provided that are valued by employees (Ahmad et al., 2020).

Phase Three: The Credible Messenger

Lavis et al. (2003) identify the importance of having credible messengers to deliver the messages. Messengers can be individuals, groups, or the organization. Academic credibility, coupled with authority in the clinical setting, appear to influence the adoption of change (Lavis et al., 2003). In my role as chief nursing officer, this would position me as a credible principal messenger when liaising with nurses and leaders, as well as with executive leaders. Klein (1996) also recognizes the authoritative power that hierarchal leaders have when communicating processes and describes how well sanctioned information from direct supervisors is received. Thus, it would be prudent to involve the clinical manager and clinical leader of the surgical units to relay or support messages. Klein (1996) also identify the impact of opinion leaders as they have influence on swaying the attitudes of others. Thus, it would also be important to include informal leaders to promote adoption of change. The manager can identify these informal leaders who have referent power in the surgical units. With so many credible messengers, I will ensure everyone has the SBAR to guide discussions and reaffirm key messages.

Phase Four: The KMb Processes & Communication Structure

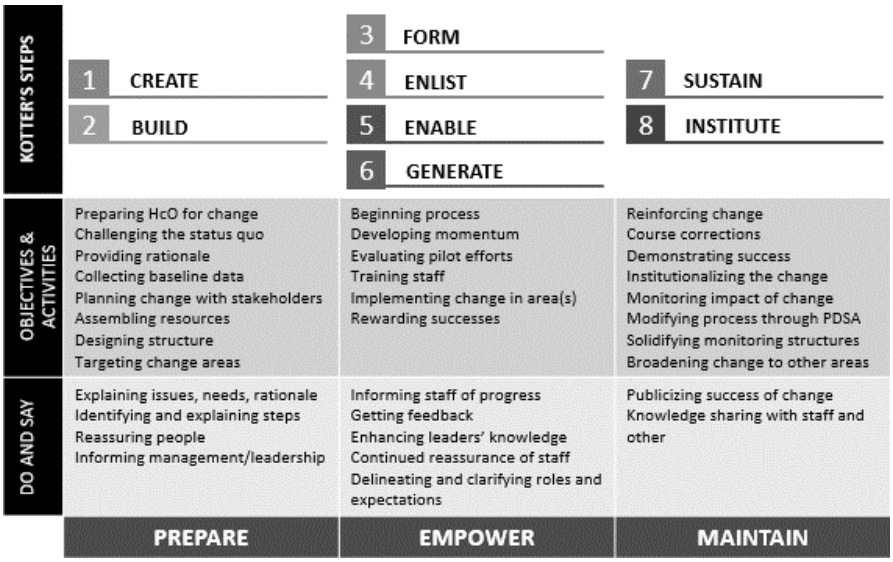
Effective communication includes consideration of timing, approach, delivery, and content of the message (Akan et al., 2016). As a change leader, I will provide clear and transparent communication of the vision, coach organizational members, lead engagement activities, and evaluate progress. Doane and Varcoe (2007) state that leaders must assess three elements of communication: *intrapersonal*

(within those involved), *interpersonal* (among and between those involved), and *contextual* (around the people and situation involved) in order to develop situational awareness and respond accordingly.

Klein (1996) offers a plan where communication needs align with the organizational objectives and activities. Figure 10 shows the integration of Kotter's change steps to demonstrate when communication needs to occur in three phases: prepare, empower, and maintain.

Figure 10

Communicating Using Kotter's Change Model



Prepare. During the first two stages of Kotter's model, the primary focus is on laying the groundwork, establishing urgency, and supporting readiness for change by preparing nurses and leaders. Husain (2013) note that resistance is expected to increase according to the enormity of the change, so it is easier to overcome this resistance if the communication strategy accounts for the initial resistance (Klein, 1996). This communication needs to include rationale and baseline data. Storytelling or first-person narratives can deliver a powerful message on the impact of LA. I will ask HR to conduct exit interviews with these nurses and obtain consent to share their stories for these units. Nurses may be more willing to offer these accounts upon their exit and sharing their stories will demonstrate the link

between bullying and resource loss. In the preparation stage, I will meet with the leaders of the model cell units to communicate the need for change, present findings and align recommendations to the organizational strategy and allow for input and feedback. From there, I would support the formal leaders of the model cell units (director and manager) to communicate this change plan with frontline staff. Klein (1996) suggest how leaders can communicate organizational changes to their followers and highlight the importance of repetition, the careful selection of media, and utilizing face-to-face communication methods. According to Husain (2013), routine and frequent opportunities for staff to dialogue with their leaders would allow for inclusion and reassurance. Lavis et al. (2003) also endorse interactive engagement as a crucial component of any successful change communication plan. Thus, the leaders need to engage with their staff frequently to communicate change and will be encouraged to meet with staff regularly throughout these initial change stages to provide additional support where needed. I will work with the leaders to leverage internal communication methods and sequence the timing of these messages. I will encourage leaders to start with their daily staff huddles and continue this messaging within virtual or in-person meetings with staff using the SBAR. Since email is the preferred vehicle, a written summary will reinforce the main ideas and strengthen communication to staff. I will craft memos and provide scripting for leaders to use in weekly email updates. These approaches align with CRLT and ELT, which may resonate with change recipients.

Empower. Uncertainty may rise if leaders neglect to provide routine updates during the busiest stages (three through six) of Kotter's model. Husain (2013) explains this uncertainty by stating that many employees do not feel a direct impact during these stages, so they may not know what is happening. Since training will target formal and informal leaders of the model cell first, I will update scripting for leaders to address rumours. The timing of communication is paramount during the change process because it will affect the employee's adjustment to change. Akan et al. (2016) noted that when leaders failed to address dissent, resistance to change would culminate in negative outcomes. Thus, I can

demonstrate CRLT by supporting through presence and empathy, and ELT by providing scripting for leaders to address role clarity and job impacts to provide reassurance. Since the momentum for training and learning is growing during this time, I will provide updates through email to inform leaders of training progress, share relevant metrics, and celebrate milestones. These written updates can be shared further, so that staff can hear these updates directly from their leaders.

Maintain. Finally, the last two steps of Kotter's model support objectives to maintain new processes. Communication during these stages should be multi-directional and continuous (Klein, 1996), while focusing on answering questions related to efficiency, benefits, and relationships to new processes brought forth in improvement cycles or through evaluative processes (Husain, 2013). Monitoring progress and communicating findings to other stakeholders should focus on publicizing success to broaden the change to other areas. As the leader, I would communicate with stakeholders outside of the model cell and highlight improvements and progress, promoting knowledge sharing. Success can be shared through visual tools such as a balanced scorecard, which will be maintained by the leaders. Externally, I would collaborate with public relations (PR) and communications departments to utilize formats such as webinars, town halls, presentations, video vignettes, website updates, and through formal reports. With these methods, I would invite formal and informal leaders to share their experiences, as they would serve as credible messengers. These messages, at strategic intervals, will shape the organization's narrative to promote a psychologically safe culture.

Phase Five: The Evaluation

Lavis et al. (2003) note through their research that the evaluation stage is a particularly underexplored area. This correlates to the HcO, where there are scarce evaluation infrastructures and finite resources place restrictions on time, attention, and personnel needed to conduct a thorough analysis. Evaluation can occur through focus groups or through the collection of individualized feedback through a survey. Depending on the level of resource support, these focus groups can be conducted by

OD to encourage exploratory conversations and debriefing sessions. Additionally, the ORCA tool can be redeployed to staff as it serves as a diagnostic and prognostic tool. The facilitation domain of the ORCA tool may provide insight into how well-executed the communication plan was and whether it supported the change implementation process. As the change leader, I would participate and lead the debrief with the leaders to determine opportunities for improvement. These reflective exercises will help to inform future learning and communication plans during the spread and scale approach.

Change Process Monitoring and Evaluation

The PoP asks, *What training is needed to ensure nurses and their leaders can identify and respond appropriately to lateral aggression in order to enhance psychological safety at this HcO?* This requires evaluation to measure the success of the training. Two evaluative frameworks will be used, along with CQI tools to track data and assist with monitoring. Data collection will ensure success of a planned change. This includes measures taken at baseline and over time to help track progress, establish priorities for the next steps, and determine how successes or milestones are celebrated (Burke, 2018). While qualitative data will reveal the lived experiences of those involved, quantitative data will determine the success by comparing KPIs and metrics throughout the change process.

CQI Tools & Processes

There are many tools aligned to CQI processes to help assess, monitor, evaluate, and revise change in this DiP. These tools range from standard work documents, process observations, balanced scorecards, and PDSA cycles (HcO, n.d.).

CQI: Standard Work & Process Observations

Firstly, the creation of standardized operating procedures (also known as standard work) can create procedural predictability to help guide training efforts or provide role clarity. Lavelle et al. (2015) state that this tool outlines ideal workflows while considering staffing, training and education, supplies, and the physical layout of the environment. Further, standard work aims to reduce unnecessary

variations and improve quality practices over time (Lavelle et al., 2015). Figure 11 depicts a standard work template and process observation tracking, while Appendix F demonstrates how leaders can ensure nurses have protected time to complete e-learning requirements during their workday. This procedural standardization allows for consistent processes to be developed and complements the process observation tool needed for auditing processes during the monitoring phase.

Figure 11

Standard Work Template & Process Observation Tracking

Note. Standard work is developed first so audits can be performed and tracked on a separate sheet.

For example, standard work can guide leaders in the steps of reviewing LA incidences with staff. A policy may offer these steps but are often too lengthy and require significant time to review. This tool provides a concise summary to adhere to organization-supported best practices and is needed to support auditing of these standardized practices. The process observation tool is used to track compliance to the standard work. This is used during the monitoring phase to perform and track audits, allowing anyone to act as an auditor. Compliance to different practices are visually tracked on a sheet and is displayed in the unit to promote accountability. Although staff are familiar with CQI processes and tools, I will request a CQI coach to support with the development and deployment of these tools.

All process observations start as daily audits and a green box is awarded if the observer noted accordance with the procedural steps. In contrast, a red box indicates a deviation from standard work. The auditing frequency changes based on compliance to the standard work and moves from daily to weekly to monthly audits. Once the frequency is changed to monthly, the process observation only requires three consecutive green boxes to discontinue the audit altogether. The premise is that once habits have been established, then change has been institutionalized (HcO, n.d.). If continued deviance is noted during this monitoring phase, it would require a PDSA cycle to initiate revisions. Additionally, process observations would allow for the continued monitoring of practices, responses, and interventions used to decrease lateral aggression, as well as prompt timely revisions when needed.

CQI: Balanced Scorecard

Another tool that would be helpful to utilize during the monitoring phase of change would involve using a balanced scorecard. According to Canaud et al. (2013), this tool combines clinical performance measures with KPIs allows for the visual tracking of monthly progress using pre-determined metrics. Figure 12 shows an example of how training compliance can be tracked every month, while Appendix G provides other metrics to demonstrate how accountability can be maintained during the monitoring phase.

Figure 12

Simplified CQI Scorecard

Pillar	Watch Indicator	Owner	Trigger	Goal	Data Source	Month 1	Month 2	Month 3
RESEARCH, INNOVATION & LEARNING	Training: Formal leaders (Manager & Clinical Leader)	CNO	75%	100%	e-learning (2) LMS In-person Manual data			
	Training: Informal leaders (Educators, Charge Nurses, Resource Nurse, Champions)	Manager	75%	100%	e-learning (1) LMS In-person Manual data			
	Training: Frontline nurses	Manager	75%	100%	e-learning (1) LMS			

A scorecard appeals to the interests of multiple stakeholders to display variables whose improvement can change overall system behaviour (Canaud et al., 2013). The watch indicators align with the HcO's pillars and are used to monitor trends with important KPIs to measure the impact of lateral aggression in the unit. This scorecard will offer information from multiple data sources. The target metric would trigger a red box or green box, while the number aligned to the goal denotes the ideal state. For example, the learning pathways will mandate all employees (nurses and leaders) to complete annual training to align with provincial legislation requirements. These completion metrics can be added as watch indicators on the unit's CQI scorecard for ongoing monitoring.

CQI: PDSA Cycles

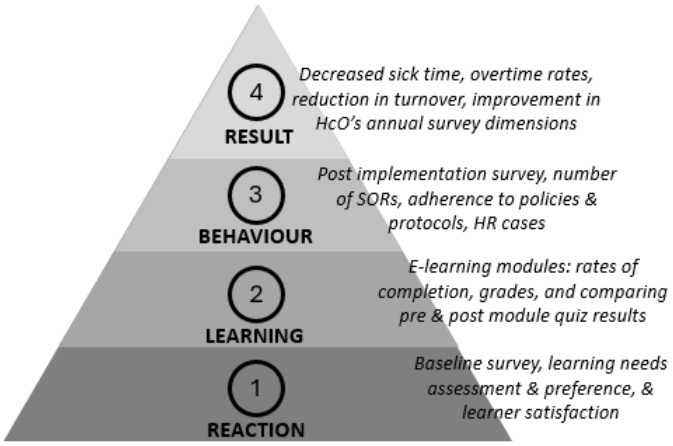
PDSA cycles allow for evolutionary changes to occur using rapid cycle improvement methodology (Lavelle et al., 2015). PDSA cycles review new data inputs, permit timely revisions, and continues until the aim is achieved (Lavelle et al., 2015). In the planning phase, adjustments are made by assembling a team for input, examining current state, and refining processes to influence outcomes. This phase identifies a new goal or purpose and success indicators. In the doing phase, the execution and communication of the new work processes occur. The studying phase analyzes findings from the auditing process to determine success, while the acting phase allow further revisions to occur and be tested during the PDSA process. In CQI methodology, the PDSA cycle is connected to both the monitoring phase and the evaluation phase of the change process. PDSA cycles may be triggered at various stages and often occur when there is low compliance with a process. For example, if the process observation tracking sheet or balanced scorecard is monitoring a process with too many red boxes, it visually signals that re-evaluation and course corrections need to occur through a PDSA cycle. This may be needed if findings through surveys or feedback collected during debriefing sessions warrant adjustments to current processes.

Kirkpatrick's Training Evaluation Model

Jones et al. (2018) state that the Kirkpatrick model offers a familiar way for healthcare professionals to evaluate training effectiveness. Huang et al. (2022) identify qualitative and quantitative data is collected through four levels of evaluation: reaction, learning, behaviour, and results. Figure 13 shows examples of how data is collected to support evaluation measures.

Figure 13

Four Levels of Evaluation Using Kirkpatrick's Model



Note. Qualitative and quantitative data will assist in the evaluation of training and learning.

This model is suitable for evaluating the training itself, and can determine the impact of the training for increasing capacity of nurses and leaders to recognize, intervene, and prevent LA. It utilizes a variety of evaluation methods including knowledge questionnaires, satisfaction surveys, rating scales, interviews, observation, forums, and reflective journalling (Jones et al., 2018).

Level One: Reaction

Huang et al. (2022) state the first level, *reaction*, collects subjective, reactionary data from participants to understand whether the training was relevant, applicable, favourable, or engaging. This also aligns with two of Knowles' (1984) Adult Learning Principles where learners are involved in evaluating their instruction and are learning subjects that have relevance to their job or personal life (Clapper, 2010). Jones et al. (2018) propose an evaluation rating using a five-point Likert scale to

evaluate reactionary data that is learner-centred, blends evaluation, and is delivered after all components of the training pathway have been completed. Level one reactionary data would assess learning needs and preference, as well as satisfaction with the methods available.

Level Two: Learning

The second level, *learning*, involves administering tests or surveys to collect objective data to measure whether learning occurred (Huang et al., 2022). Considering there are three versions of e-learning modules available (short version, long version, and leader-specific training), all will have tests to assess and compare pre and post learning knowledge. According to Jones et al. (2018), this assesses the level of learning that has occurred to acquire the knowledge, skills, attitude, and confidence needed. Additional sources will show module completion rates and test scores to determine learning.

Level Three: Behaviour

The third level, *behaviour*, measures whether participants applied the desired behaviours resulting from the training. This includes the reflective activity, qualitative findings from the post-implementation survey, and renewed adherence to the revised organizational procedures, as well as improved collaboration with HR. Jones et al. (2018) state, “training alone will not generate changes in practice and improved clinical outcomes” (p. 498). This level assesses whether application of learning occurred when nurses and leaders return to their jobs. The number of workplace harassment reports may increase but may be a welcomed behavioural consequence, signalling heightened awareness of lateral aggression in action.

Level Four: Results

Lastly the fourth level, *results*, measures outcomes. This may include the comparison of internal workforce data, as well as improvements in the annual HcO survey dimensions as indicators of success. Data can be compared to monthly and yearly comparators and benchmarked against other units at this HcO, as well as in similar-sized organizations in the region. Finally, results can be measured by

identifying clinical outcomes such as hospital length of stays, nosocomial infections, and morbidity and mortality. However, it would be difficult to isolate the effects of the training onto these NSIs so they may not function as the sole measurement of change success.

Future Considerations of the Plan for Organizational Improvement

Continued evolution of this change strategy needs to occur as more staff complete this pathway. Their input would allow for feedback and discussion to inform next steps, as well as ensure long-term sustainability. This way, awareness will be sustained and improvements can occur reflexively over time.

Expansion Through Spread & Scale

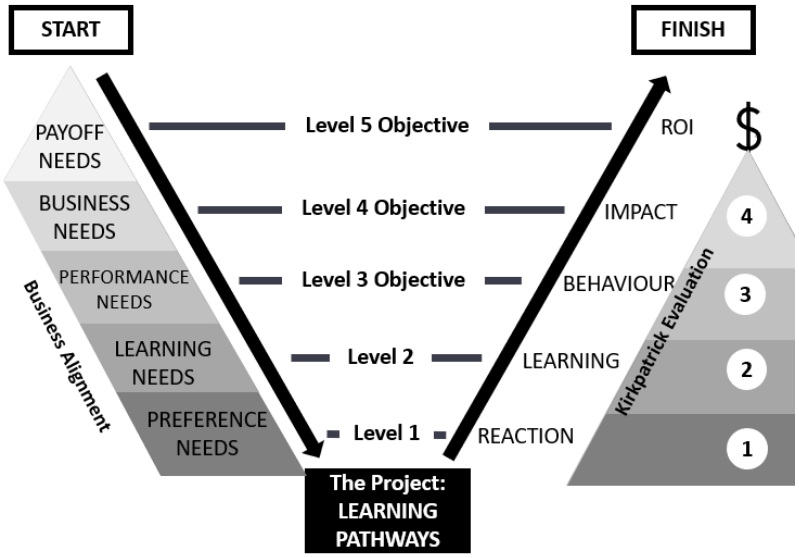
According to Johnson (2017), the model cell approach would focus efforts on an area where there is both a demonstrated need and where leaders are eager to be early adopters. The hope is that with demonstrated success, these learning pathways can be adopted by other clinical areas through a phased horizontal spread approach. Greenhalgh and Papoutsi (2019) describe spread as replicating the intervention in multiple areas, while scale-up describes the building of infrastructure to support full implementation. This approach would expand to other levels of leadership, as well as extend to other healthcare disciplines aside from nursing. Clinical units with similar populations may adopt these transitions more readily with slight adaptations to meet the needs of the area.

Return on Investment (ROI) Framework

Finally, the economic impact of the change strategies need to be demonstrated to senior leaders to ensure long-term sustainability. This later-stage evaluation model can provide financial justification to sustain and anchor long-term change success. Figure 14 portrays the Phillips ROI model and demonstrates additional steps beyond Kirkpatrick's training evaluation model.

Figure 14

Phillips ROI Evaluation Planning and V Model



Note. This framework starts on the left to determine a business case and aligns with Kirkpatrick model.

The evaluation planning and V model demonstrates the relationship between needs assessment, objectives, and evaluation to build a business case for systems-level change (ROI Institute, 2022). It allows for a financial measurement of success to determine whether a positive ROI can be achieved based on every dollar invested in training (ROI Institute Canada, 2022). Improved operational metrics such as decreased sentinel events and safety occurrences, improved compliance to required organizational practices, low rates of lost time due to workplace violence may be determined. Engaging departments such as data quality and finance will provide accurate financial data connected to the operational metrics to demonstrate continued value for senior leaders.

Chapter 3 Summary

Using evidence-informed strategies to guide the change implementation plan offers clarity and purpose for all stakeholders. The adapted KMb and communication models offer ways to strategically transfer knowledge and share findings within a large HcO while leveraging existing CQI tools to assist in effective monitoring of KPIs to measure change success. These combined efforts will ideally impact the organization as a whole by aligning to strategic priorities, contributing to a healthy work environment with highly engaged staff motivated to minimize the harmful effects and prevent LA in the workplace.

Dissertation-in-Practice Summary

The successful implementation of change requires authentic dedication from employees and from leadership. Cynicism and internalized oppression may impede these potential change processes (Boone, 2012). The declining physical and mental health of our nursing workforce is concerning and some may blame this on the nurse's own inability to cope. This discourse shifts the onus of responsibility onto the individual, rather than toward organizational or systemic social change to address these issues. According to Massoud et al. (2006), being able to close the gap between best practice and usual practice requires healthcare organizations to be able to spread and embrace new ideas. Therefore, it is the responsibility of all organizational members to commit to improving PS and shifting towards a collaborative, relational mindset as an effective means to change. The change plan offered through this DiP utilizes and applies learnings acquired through academic literature and research to encourage successful adoption of change. This requires motivated individuals to not only enact the change, but for leaders to transparently communicate a vision and remove barriers to support work on all levels to prevent, recognize, and respond to acts of lateral aggression at this HcO. In true quality improvement fashion, these changes require continuous evaluation, reflection, and refinement from diverse stakeholder groups to ensure long-term success. This will enable the HcO to strategically engage their members to create a culture that supports the well-being of nurses.

Epilogue

The harmful effects of lateral aggression perpetuates the cycle of victimization experienced by nurses and threatens public perceptions, patient safety, and the advancement of the nursing profession. While there are obvious physical demands on nurses when caring for patients in a hospital setting, there are incredible psychological demands that require emotional fortitude as well. With an extensive list consisting of prolonged staffing insufficiencies, political contradictions, scarcity in resources, wage suppression, repeated exposure to human suffering, and post pandemic recovery: it is prudent to say that frontline nurses have remained in a constant state of heightened physical and emotional stress over a challenging period. The impacts on emotional and physical wellbeing are clear and significant, so nurses and leaders have the moral and ethical responsibility to promptly intervene and respond accordingly. Although the scope of practice and skillset of nurses have expanded through the years, the enduring and fundamental belief is that nursing is a caring profession. The public expects and requires competent nurses to demonstrate professionalism and to treat all people with respect to ensure the provision of high-quality care into the future. Nurses have a duty to support and empower each other and to demonstrate solidarity in the collective goal to improve patient care. Knowing this, I am accountable for not just my own behaviour but also need to hold my colleagues accountable for their behaviour. Nurses need to adopt this 200% accountability mindset and demonstrate the kindness, compassion, and understanding that the profession is known for by purposefully extending these practices to all those who enter through the doors. This means that nurses need to develop the capacity and awareness of how their biases, beliefs, and behaviour can impact relationships with their colleagues. Since uncivil behaviours can contribute to an unsafe working environment, nurses and leaders have a responsibility to address it when it occurs and change the damaging narrative of nurses eating their own.

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Appendix A: Completed A3 Tool

Owners: Chief Nursing Officer

A3 TEMPLATE

Date: DD/MM/YY

STEP 1 **PROBLEM STATEMENT**

There are no formalized training opportunities to learn the skills to identify, communicate, and intervene in response to lateral aggression on the adult surgical units at this HcO.

Background

- High turnover (resignations accounting for 79% of voluntary exits
- 32% of nurses reported being victims of lateral aggression
- 67% of nurses reported witnessing these interactions
- Over 2 years, more than 30 informal complaints of bullying
  - 6 cases escalated to HR, 3 cases needed conduct review
  - 2 cases needed environmental separation

Measures (How will we know change is improvement?)

There will be improvements in quantitative data: turnover, sick time, overtime usage, vacancies, HR cases, SORs. Qualitative accounts: improvement in wellness, decreased incidences of bullying, teamwork, collaboration, culture

STEP 2 **CURRENT STATE**

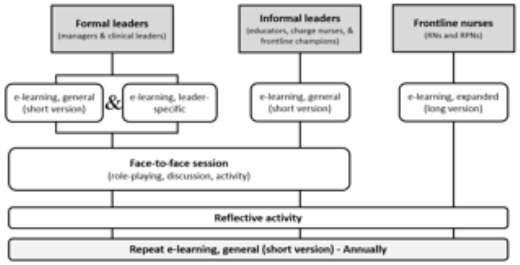
71% of nurses on these units are novices with high nurse turnover
Orientation costs are unusually high; nurses are quitting
Novice nurses are asked to preceptor others; preceptor fatigue is high
68% of nurses identify as IENs and report difficulty fitting in
Nurses & Manager identifying bullying is an issue

5 Why's: ROOT CAUSE ANALYSIS *(Ask 'WHY' 5 times to arrive at the root of the problem)*

Why?	Causes	Impact on? *(Circle one)*
1	Failure to recognize what it is	Activity, Connection, Pathway
2	Staff are not aware of existing processes	Activity, Connection, Pathway
3	Staff don't feel they can address it	Activity, Connection, Pathway
4	Current E-learning isn't helpful for this	Activity, Connection, Pathway
5	Staff are unaware of the impact	Activity, Connection, Pathway

STEP 3 **TARGET STATE**

Policy revision
New curriculum
Toolkit/resources made
E-learning modules
Content experts
Protected time to attend
Resource support
Funding support
Data metrics show improvement



Hypothesis Statement (if, then)

If leaders and nurses are provided with formalized opportunities for training through these learning pathways, **then** they will be able to identify and respond appropriately to lateral aggression to improve psychological safety.

STEP 4 **ACTION PLAN**

Who	What	By When	Test of Value
CNO/HR	Gather baseline data	Month 1	Key metrics collected
CNO	Present to senior leaders	Month 2	Endorsement received
OD	Facilitate planning session	Month 3	Co-design curriculum
CP&E	Review current education	Month 3	Inventory of courses done

Follow Up Plan

CNO to develop workplan and outline timelines. Workgroups will be developed to create curriculum content. Follow up in 1 month's time with all stakeholders

Appendix B: Organizational Change Recipients' Beliefs Scale (OCRBS)

Assess your readiness for organizational change Perspective: Former manager of model cell units		**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
DISCREPANCY	We need to change the way we do some things in this organization.		**X**			
	We need to improve the way we operate in this organization.	**X**				
	We need to improve our effectiveness by changing our operations.	**X**				
	Change is needed to improve operations	**X**				
APPROPRIATENESS	I believe the porposed organizational change will have favourable effect on our operations.	**X**				
	The change in our operations will improve the performance of our organization.	**X**				
	The change that we are implementing is correct for our situation.		**X**			
	When I think about this change, I realize it is appropriate for our organization.	**X**				
	This organizational change will prove to be best for our situation.	**X**				
PRINCIPLE SUPPORT	Most of my respected peers embrace the proposed organizational change.	**X**				
	The top leaders in this organization are 'walking the talk'		**X**			
	The top leaders in our organization support this change	**X**				
	The majority of my respected peers are dedicated to making this change work.	**X**				
	My leader is in favour of this change.	**X**				
	My leader encourages me to support change	**X**				
VALENCE	This change will benefit me.	**X**				
	With this change, I will experience more self-fulfillment.		**X**			
	I will earn higher page from my job after this change			**X**		
	The change in my job assignments will increase my feelings of accomplishment		**X**			
EFFICACY	I have the capability to implement the change that is initiated.	**X**				
	I can implement this change in my job.	**X**				
	I am capable of successfully performing my job with the proposed organizational change.	**X**				
	I believe we can successfully implement this.	**X**				
	We have the capability to successfully implement this change.		**X**			

Appendix C: Organizational Readiness for Change Assessment (ORCA)

Page 1

Proposal: *A training program would help increase recognition and therefore, target interventions to minimize the harmful effects of lateral aggression in nurses to promote psychological safety in this HcO.*

I. EVIDENCE ASSESSMENT

	Very Weak	Weak	Neither weak nor strong	Strong	Very strong	Don't know/ N/A
In your opinion, rate the strength of the evidence basis for this proposal.	1	2	3	4	**5**	99
Rate the strength of the evidence based on how you think respected clinical experts in your institution feel.	1	2	3	4	**5**	99

RESEARCH: *The proposed practice solution:*	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	Don't know/ N/A
Is supported by RCTs or other scientific evidence from nursing literature	1	2	3	4	**5**	99
Is supported by RCTs or other scientific evidence from other health care systems	1	2	**3**	4	5	99
Should be effective, based on current scientific knowledge	1	2	3	**4**	5	99
Is experimental, but may improve patient outcomes	1	2	3	**4**	5	99
Likely won't make much difference in patient outcomes	1	2	**3**	4	5	99

CLINICAL EXPERIENCE: *The proposed solution:*	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	Don't know/ N/A
Is supported by clinical experience with nurses	1	2	3	**4**	5	99
Is supported by clinical experience with nurses in other health care systems	1	2	3	**4**	5	99
Conform to the opinions of clinical experts in this setting	1	2	3	4	**5**	99
Has not been attempted in this clinical setting	1	2	**3**	4	5	99

PATIENT PREFERENCES: *The proposed solution:*	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	Don't know/ N/A
Has been well-accepted by patients cared for by nurses	1	2	3	4	5	**99**
Is consistent with clinical practices that have been accepted by patients	1	2	3	4	**5**	99
Take into consideration the needs and preferences of patients cared for by nurses	1	2	**3**	4	5	99
Appear to have more advantages than disadvantages for patients	1	2	3	4	**5**	99

Page 2: ORCA Assessment

II. CONTEXT ASSESSMENT

CULTURE: *Senior leadership / clinical management in the organization:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
Reward clinical innovation and creativity to improve patient care	1	2	3	4	**5**	99
Solicit opinions of clinical staff regarding decisions about patient care	1	2	3	**4**	5	99
Seek ways to improve patient education and increase patient participation in care	1	2	3	**4**	5	99
CULTURE: *Staff members in the organization:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
Have a sense of personal responsibility for improving patient care and outcomes	1	2	3	4	**5**	99
Cooperate to maintain and improve effectiveness of patient care	1	2	3	4	**5**	99
Are willing to innovate and/or experiment to improve clinical procedures	1	2	3	**4**	5	99
Are receptive to change in clinical processes	1	2	3	**4**	5	99
LEADERSHIP: *Senior leadership / clinical management in the organization:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
Provide effective management for continuous improvement of patient care	1	2	3	**4**	5	99
Clearly define areas of responsibility and authority for clinical managers and staff	1	2	3	**4**	5	99
Promote team building to solve clinical care problems	1	2	3	**4**	5	99
Promote communication among clinical services and units	1	2	3	**4**	5	99
MEASUREMENT: *Senior leadership / clinical management in the organization:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
Provide staff with information on nurse performance measures and guidelines	1	2	3	**4**	5	99
Establish clear goals for patient care processes and outcomes	1	2	3	4	**5**	99
Provide staff members with feedback /data on effects of clinical decisions	1	2	3	**4**	5	99
Hold staff members accountable for achieving results	1	2	3	**4**	5	99
READINESS FOR CHANGE: *Opinion leaders in your organization:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
Believe that the current practice patterns can be improved	1	2	3	4	**5**	99
Encourage and support changes in practice patterns to improve patient care	1	2	3	4	**5**	99
Are willing to try new clinical practices	1	2	3	4	**5**	99
Work cooperatively with senior leadership / clinical management to make appropriate changes	1	2	3	**4**	5	99

Page 3: ORCA Assessment

RESOURCES: *In general, when there is agreement that change needs to happen:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
We have the necessary support in terms of budget or financial resources	1	2	3	**4**	5	99
We have the necessary support in terms of training	1	2	3	**4**	5	99
We have the necessary support in terms of facilities	1	2	**3**	4	5	99
We have the necessary support in terms of staffing	1	2	**3**	4	5	99

III. FACILITATION ASSESSMENT

CHARACTERISTICS: *Senior leadership / clinical management will:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
Propose a solution that is appropriate and feasible	1	2	3	4	**5**	99
Provide clear goals for improvement in patient care	1	2	3	**4**	5	99
Establish a project schedule and deliverables	1	2	3	4	**5**	99
Designate clinical champion(s) for the solution	1	2	3	4	**5**	99
CHARACTERISTICS: *The clinical champion:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
Accepts responsibility for the success of the solution	1	2	3	**4**	5	99
Has the authority to carry out the implementation	1	2	3	4	**5**	99
Is considered a clinical opinion leader	1	2	3	4	**5**	99
Works well with the intervention team and providers	1	2	3	4	**5**	99
ROLE: *Senior leadership / clinical management / staff opinion leaders:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
Agree on the goals for this solution	1	2	3	4	**5**	99
Will be informed and involved in the solution	1	2	3	**4**	5	99
Agree on adequate resources to accomplish the solution	1	2	3	4	**5**	99
Set a high priority on the success of the solution	1	2	3	4	**5**	99
ROLE: *The implementation team members:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
Share responsibility for the success of this solution	1	2	3	4	**5**	99
Have clearly defined roles and responsibilities	1	2	3	4	**5**	99
Can accomplish intervention tasks within their regular workload	1	2	3	4	5	**99**
Have staff support and other resources required for the work	1	2	3	4	5	**99**

Page 4: ORCA Assessment

STYLE: *The implementation plan for this solution:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
Identifies specific roles and responsibilities	1	2	3	4	**5**	99
Clearly describes tasks and timelines	1	2	3	**4**	5	99
Includes appropriate provider / patient education	1	2	3	4	**5**	99
Acknowledges staff input and opinions	1	2	3	4	5	**99**
STYLE: *Communication will be maintained through:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
Regular meetings with the project champion and team members	1	2	3	4	**5**	99
Involvement of quality management staff in project planning and implementation	1	2	3	4	**5**	99
Regular updates to leaders on progress of activities & resource needs	1	2	3	4	**5**	99
Regular updates to clinicians on effects of practice changes on patient care/ outcomes	1	2	3	4	**5**	99
STYLE: *Progress of the project will be measured by:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
Collecting feedback from patients regarding proposed changes	1	2	3	4	5	**99**
Collecting feedback from nurses regarding proposed changes	1	2	3	4	**5**	99
Developing & distributing performance measures to nurses	1	2	3	4	**5**	99
Providing a forum for presentation / discussion of results and implications for continued improvements	1	2	3	4	**5**	99
RESOURCES: *The following are available to make the solution work:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
Staff incentives	1	2	3	4	**5**	99
Equipment and materials	1	2	3	4	**5**	99
Patient awareness / need	1	2	3	**4**	5	99
Staff buy-in	1	2	3	4	**5**	99
Availability of Intervention team	1	2	3	4	**5**	99
Evaluation protocol	1	2	3	4	**5**	99
EVALUATION: *Plans for evaluation and improvement of the solution include:*	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**	**Don't know/ N/A**
Periodic outcome measurement	1	2	3	4	**5**	99
Staff participation / satisfaction survey	1	2	3	4	**5**	99
Patient satisfaction survey	1	2	3	4	5	**99**
Dissemination plan for performance measures	1	2	3	4	**5**	99
Review of results by clinical leadership	1	2	3	4	**5**	99

Appendix D: Change Implementation Alignment and Plan

Page 1:

KOTTER'S CHANGE MODEL	TIMELINE	TACTIC & PERSON(S) RESPONSIBLE	PURPOSE	INDICATORS OF SUCCESS
Step ONE. Create: Establish urgency	Month 1: 1-2 Weeks	AWARENESS: Examine and present operational metrics based on impact of lateral aggression: turnover, absence, sick time, safety reports, Human Resources (HR) involvement. *[Chief Nursing Officer & Data Analysts]*	Relays urgency of need and ensures collection of quantitative data	Data is collated (shown by year & unit) for trends & communicated to leaders
	Month 1: 1-2 weeks	ENGAGEMENT: Discuss alignment to organization's strategic plan with VP. *[Chief Nursing Officer]*	Accountability	VP endorsement
Step TWO. Build: Create guiding coalition	Month 1: 1-2 weeks	PARTNERSHIPS & ENGAGEMENT: Stakeholders: nurses in various roles and levels, unit champions, formal & informal leaders, HR, Health Safety & Wellness (HS&W), Organizational Development (OD), Clinical Practice & Education (CP&E), Policy and Authorizing Mechanisms, Equity Diversity and Inclusion (EDI) Office, Quality & Safety, CQI coaches and Nursing Quality Council (NQC) *[Chief Nursing Officer & VP]*	Allows for stakeholder involvement to promote & sustain change	Representative from each major stakeholder group is present. There should be IEN and novice nurse representation.
Step THREE. Form: Develop shared vision for model cells (Surgical units)	Month 1: 1-2 Weeks	ORGANIZATIONAL DEVELOPMENT: Gather perspectives: baseline survey from nurses & leaders (how lateral aggression is addressed and impacts on wellbeing) *[Chief Nursing Officer & OD]*	Collection of qualitative data to inform next steps	Thematic analysis completed
	Month 1: 2 weeks	ORGANIZATIONAL DEVELOPMENT: Collating perspectives: exit interviews from those who've left. *[Unit Manager & HR]*	Driving force: inclusion helps to drive change.	

Page 2:

KOTTER'S CHANGE MODEL	TIMELINE	TACTIC & PERSON(S) RESPONSIBLE	PURPOSE	INDICATORS OF SUCCESS
Step THREE (Cont'd)	Month 2: 2 weeks to plan	PARTNERSHIPS & ENGAGEMENT: Planning session with stakeholders to collaborate, provide input and feedback to identify areas of focus. *[Chief Nursing Officer & OD]*	Relationship building and collaborative processes; levels hierarchy to allow for improved discussion	Action plan will be developed to build new learning pathways
		ORGANIZATIONAL DEVELOPMENT: Utilize existing CQI processes to complete a root cause analysis. *[All: session led by CQI coach]*		A3 tool will be completed to inform action plan and milestones
	Month 2: 2-4 weeks	CAPACITY BUILDING: Establish experts for content building & teaching. *[Content experts & CP&E]*	Engagement and input	Learning pathway is supported with evidence-informed practices
	Months 3 to 9	POLICY & IMPLEMENTATION: Build on existing tools & processes. *[Chief Nursing Officer & HR]*	Refining and developing resources to focus on lateral aggression	Updated processes, tools, and resources (Toolkit & policy)
		POLICY & IMPLEMENTATION: Build e-learning content for modules. *[Content experts & CP&E]*		3 e-learning modules: leader-specific; long version; short version
		POLICY & IMPLEMENTATION: Build classroom scenarios and activities. *[Content experts & OD]*		Activities and scripting for facilitators developed
		POLICY & IMPLEMENTATION: Build reflective activities. *[Chief Nursing Officer & CP&E]*		Learners will use reflective activity for learning
	Months 3 to 9	IMPLEMENTATION SUPPORT: Funding for training is secured. *[Chief Nursing Officer & VP]*	Support model cell unit in training costs	Number of nurses and leaders completing training are tracked
Step FOUR. Enlist: Communicate or put forth strategies for change	Month 6: 1-2 Weeks	AWARENESS: Update leaders & provide summary. *[Chief Nursing Officer]*	Final endorsement	Fact sheet or FAQ to support leader conversations
	Month 6: 1-2 Weeks	AWARENESS: Communicate pathway to HR & nursing unions: written memo & verbal follow up through zoom. *[Chief Nursing Officer]*	Relationship building between union nurses and non-union leaders	A clear understanding of responsibilities, training and outcomes will be voiced.
	Months 7 and 8: 2-3x per week	AWARENESS: Communicating new and/or existing processes frontline staff. *[Chief Nursing Officer and Communications & Marketing]*	Leverages existing resources	Questions will be answered in timely manner using different media and formats

Page 3:

KOTTER'S CHANGE MODEL	TIMELINE	TACTIC & PERSON(S) RESPONSIBLE	PURPOSE	INDICATORS OF SUCCESS
Step FOUR (Cont'd)	Month 8	ACCESSIBILITY: Introduce in interviews (new hires), in huddles & team meetings (existing staff) *[Unit Manager & Informal leaders]*	Driving forces: Build awareness about lateral aggression	Staff will understand leader's expectations for training, completion, and utilization
Step FIVE. Enable: Empower Others	Months 9 & 10	CAPACITY BUILDING: Formal leaders will complete the short version e-learning module & leader-specific module. *[Managers and clinical leaders]*	Knowledge building	100% of formal leaders of model cell units will complete training
	Months 9 & 10	CAPACITY BUILDING: Informal leaders will complete the short version e-learning module. *[Charge nurses, educators, and unit champions]*		100% of informal leaders (identified by manager) will complete training.
	Months 11 & 12	CAPACITY BUILDING: Leaders will attend face to face session led by content experts & participate in role playing. *[Formal and informal leaders]*	Knowledge application and cognitive rehearsal	100% of leaders will attend the session they are registered for and participate in reflective activity post.
	Months 12 to 15	CAPACITY BUILDING: Frontline staff will complete long version (e-learning), review resource materials & complete reflective activity afterwards. *[Frontline staff]*	Knowledge building	Managers will ensure time to complete will be compensated. Monthly completion rates monitored by manager
	Month 15: 2-4 weeks	IMPLEMENTATION SUPPORT: Offer toolkit, fact sheet & webinar for leaders to address problematic behaviour with coaching support & progress to discipline if required. *[Chief Nursing Officer, IPP Chiefs, and HR]*	Addresses restraining forces; Supports implementation	Leaders will identify if further gaps exist and develop learning plans with reflections to inform future learning
	Month 15: 2-4 weeks	CAPACITY BUILDING: Leaders will review occurrences with frontline staff & offer timely feedback if lateral aggression occurs. *[Formal & informal leaders]*	Stakeholder involvement; professional behaviours	Nurses and leaders will use resources available based on their role to address lateral aggression

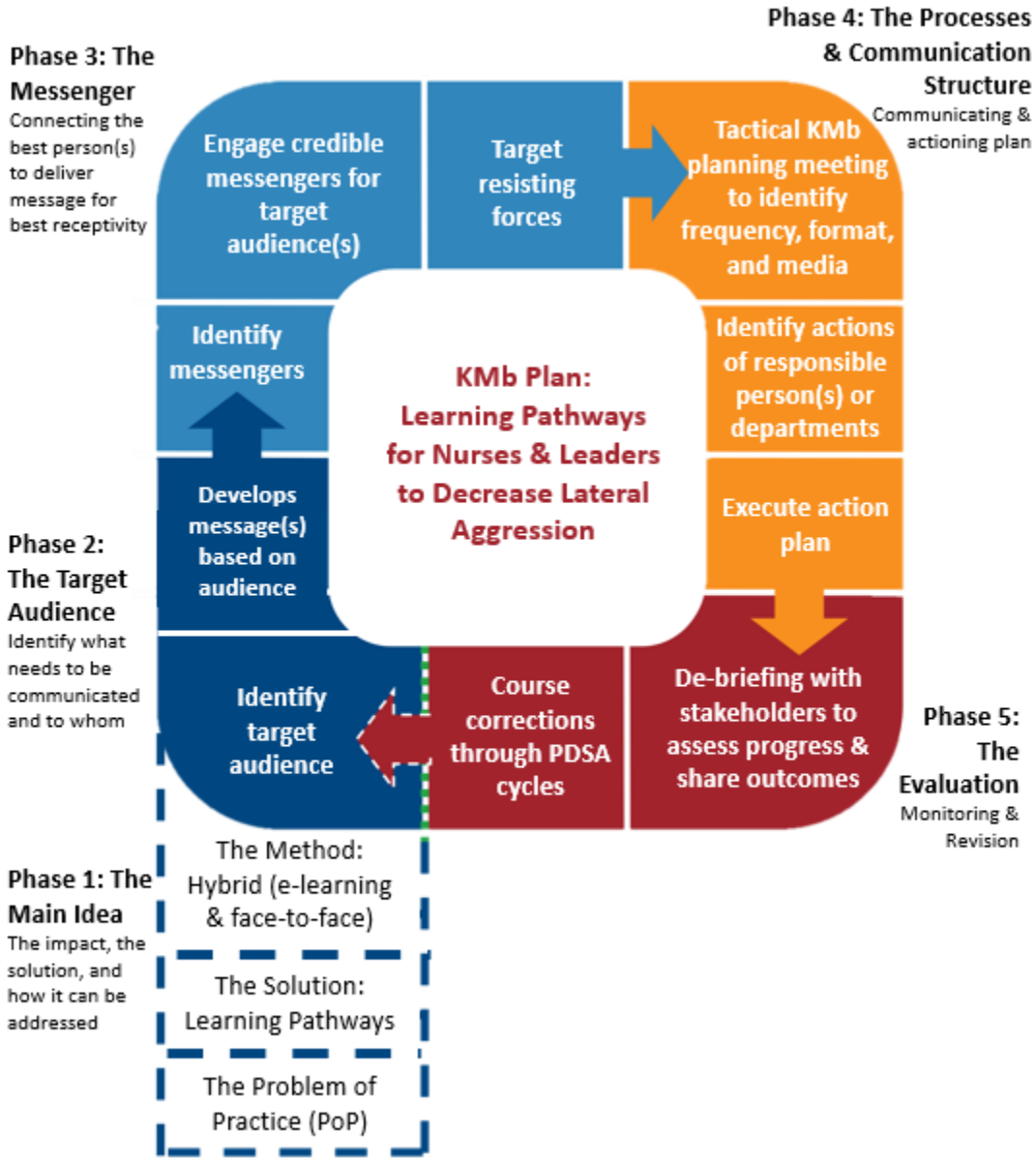
Page 4:

KOTTER'S CHANGE MODEL	TIMELINE	TACTIC & PERSON(S) RESPONSIBLE	PURPOSE	INDICATORS OF SUCCESS
Step SIX. Generate: short term wins	Month 16: 1-2 weeks	AWARENESS & ENGAGEMENT: Analyze data & present findings to leaders and unit. *[Chief Nursing Officer]*	Knowledge Sharing	Improvements will be seen in workforce metrics and NSI data
	Month 16: 1-2 weeks	PARTNERSHIPS: Presentation at nursing and interprofessional practice rounds *[Chief Nursing Officer & Manager]*		Participant data will be tracked (number of attendees, role, area)
	Month 16: 1 week	AWARENESS/CAPACITY: Survey staff to understand perception of improved processes to address conflict resolution. *[Chief Nursing Officer & OD]*	Encourages professional behaviours	Comparison to baseline survey will demonstrate improved behaviours and wellbeing
	Month 16: 1-2 weeks	IMPLEMENTATION SUPPORT: Accountability & responsibility of content experts are delineated. *[Chief Nursing Officer, IPP Chiefs, CP&E]*	Recognition & Accountability	Updates are completed regularly by experts; facilitator schedules are established for classroom days
	Month 16: 1 week	AWARENESS: Celebrate accomplishments and success stories with unit and leaders *[All]*	Recognition	Examples for shared learning are identified. Celebrations are freely shared by all levels.
Step SEVEN. Sustain: Consolidate and build on gains	Month 17: 1 week	EVALUATION: Measure outcomes of pathways using Kirkpatrick training evaluation model *[Chief Nursing Officer & CP&E]*	Evaluation	Level 1: Reaction data Level 2: Learning data Level 3: Behaviours Level 4: Impact to NSI
	Month 17: 2-4 weeks	SUSTAINABILITY: Revisit steps 3-6 using PDSA cycles. *[Chief Nursing Officer & CQI coach]*	Allows for evolutionary changes based on evaluation outcomes	Audits for tracking compliance and outcomes & PDSA cycles used. Course corrections made.
	Month 18: 4 weeks	AWARENESS: At unit level: Sharing revisions and celebrations *[Unit Manager & Leaders]* At organization level: Celebrate milestones in action plan and sets stage for spread & scale approach *[Communications & Marketing]*	Driving force: Change perceptions to impact culture	Social media metrics (likes, comments/ questions, shares, visits) will indicate engagement. Accomplishments will be used as proof of concept

Page 5:

KOTTER'S CHANGE MODEL	TIMELINE	TACTIC & PERSON(S) RESPONSIBLE	PURPOSE	INDICATORS OF SUCCESS
Step EIGHT. Institute: Incorporate changes for long-term	Months 18 to 22: Over 2-4 months	PARTNERSHIPS: Share through forums (meetings, workshops, nursing rounds, and conferences) *[Chief Nursing Officer & leaders]*	Knowledge Sharing	Presentations are completed on local, provincial, and national levels
	Months 22 to 24	ORGANIZATIONAL DEVELOPMENT: Spread and scale approach beyond model cell to another high-risk program and/or expand to other healthcare disciplines. *[Chief Nursing Officer]*	Widespread adoption	Operational leaders will see value and impact and indicate desire to expand to their portfolio.
	Month 24	EVALUATION: Utilize Return on Investment model *[Chief Nursing Officer, Data Analysts, and HR]*	Understand financial impact of strategies	Positive ROI will be observed using workforce metrics.
	Month 24 and beyond (Ongoing each fiscal year)	SUSTAINABILITY: Changes in operational budgets occur with increased education dollars allocated for training and re-education efforts	Advocacy and sustainability	Senior leaders will see value and support financial changes year over year. Operational budgets awarded.

Appendix E: Knowledge Mobilization (KMb) Planning P Model



Appendix F: Standard Work Example

Standard Work for process: ***Ensure protected e-Learning time during shift***
Name: ***Manager's name here***
Date: ***DD/MM/YY Here***

Purpose: If the nurse is not able to complete paid e-learning time at home, the manager will ensure one hour of protected time to complete training requirements for the learning pathway for lateral aggression recognition.

	Major Steps	Details (if applicable)	Reasons (Why)
1	The manager or nurse will identify the need to complete elearning during working hours.	Explore alternatives to completing e-learning module outside of work first (at home, before or after work).	Clinical demands and staffing levels can be unpredictable, so the preference is for nurses to complete during off-hours.
2	The manager will identify a suitable date and work with the charge nurse to ensure adequate coverage.	Nurses typically work twelve-hour shifts, with their rotation consisting of 2 day shifts and 2 night shifts.	Day shifts during the workweek (Monday to Friday) are easier to support since more staff are available.
3	Backfill with staff to allow elearning to be finished in a quiet setting, off the unit.	1) Modified staff (extra with no patient assignment) 2) Above-quota staff (brought in for increased activity or care needs, transfers, or special projects) 3) Charge Nurse (last resort as they look after unit needs	If backfill is unable to be obtained for the shift, elearning will be rescheduled to another day.
4	Educator will ensure a computer and quiet space is available	Educator will be readily available to troubleshoot technology, answer questions, and offer resources in a timely manner.	Connectivity and availability of equipment have been concerns in the past. Supports learning.
5	If extra time is needed beyond 1 hour, the nurse will identify challenges or concerns	Educator will review and offer support in the moment. Manager is notified if there are performance concerns or additional accessibility requirements.	Manager must notified of concerns affecting completion and support accordingly.

Appendix G: Expanded CQI Scorecard with Examples Populated

Pillar	Watch Indicator	Owner	Trigger	Goal	Data Source	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
People	Nursing Sick Hours **Definition:** Sick hours divided by worked hours	HR	3%	<4%	Workforce Dashboard	6.2%	5.8%	6.0%			
	Nursing Overtime Usage **Definition:** Actual overtime hours divided by worked hours	HR	3%	<4%		4.8%	5.5%	5.9%			
	Nursing Turnover in Unit **Definition**: Number who've left divided by number of employees	HR	3%	<2%		4%	4.3%	3.8%			
	Safety Occurrence Reports **Definition:** Number of workplace harassment or workplace violence SORs	Manager	1	0	SOR Database	0	1	1			
	Exit Interviews – Data Gathering for those who've left **Definition:** Percentage of staff interviewed to gather perspectives on how lateral aggression was addressed in unit and impacts on well-being	Manager	75%	100%	Staff	100%	100%	60%			
	Baseline Survey – Data Gathering for those who've remained **Definition:** Percentage of staff completing baseline survey to gather perspectives on how lateral aggression is addressed and impacts on well-being	CNO	75%	100%	Nurses	55%	62%	68%			
					Leaders	40%	76%	80%			
Research, Innovation & Learning	Training: Formal leaders (Manager & Clinical Leader) **Definition**: Completion of training requirements	CNO	75%	100%	e-learning (2) LMS	60%	85%	100%	100%		
					In-person Manual data	60%	75%	100%	100%		
	Training: Informal leaders (Educators, Charge Nurses, Resource Nurse, Champions) **Definition**: Completion of training requirements	Manager	75%	100%	e-learning (1) LMS	45%	60%	78%	100%		
					In-person Manual data	N/A	40%	55%	65%		
	Training: Frontline nurses **Definition:** Completion of training requirements	Manager	75%	100%	e-learning (1) LMS	N/A	N/A	45%	54%		
Sustainability	Use of supportive resources **Definition:** Leaders will use toolkit; refer to policies & protocols, and engage HR	Manager	1	2	Manual	0	1	0	1		
	Post-Implementation Survey – Data Gathering for those who've remained **Definition:** Percentage of staff completing to compare perspectives on how lateral aggression is addressed and impacts on well-being	CNO	75%	100%	Nurses	60%	65%	74%	78%		
					Leaders	64%	76%	100%	100%		
Patients	Length of Stay – Surgical Units **Definition**: The total number of days stayed by all inpatients during a year by the number of admissions or discharges.	Data Analysts	5.3	<5.2	Patient Activity Dashboard	5.8	5.9	4.5	4.7		
						Note: Training started here					

Appendix H: ROI Evaluation Planning and the V Model