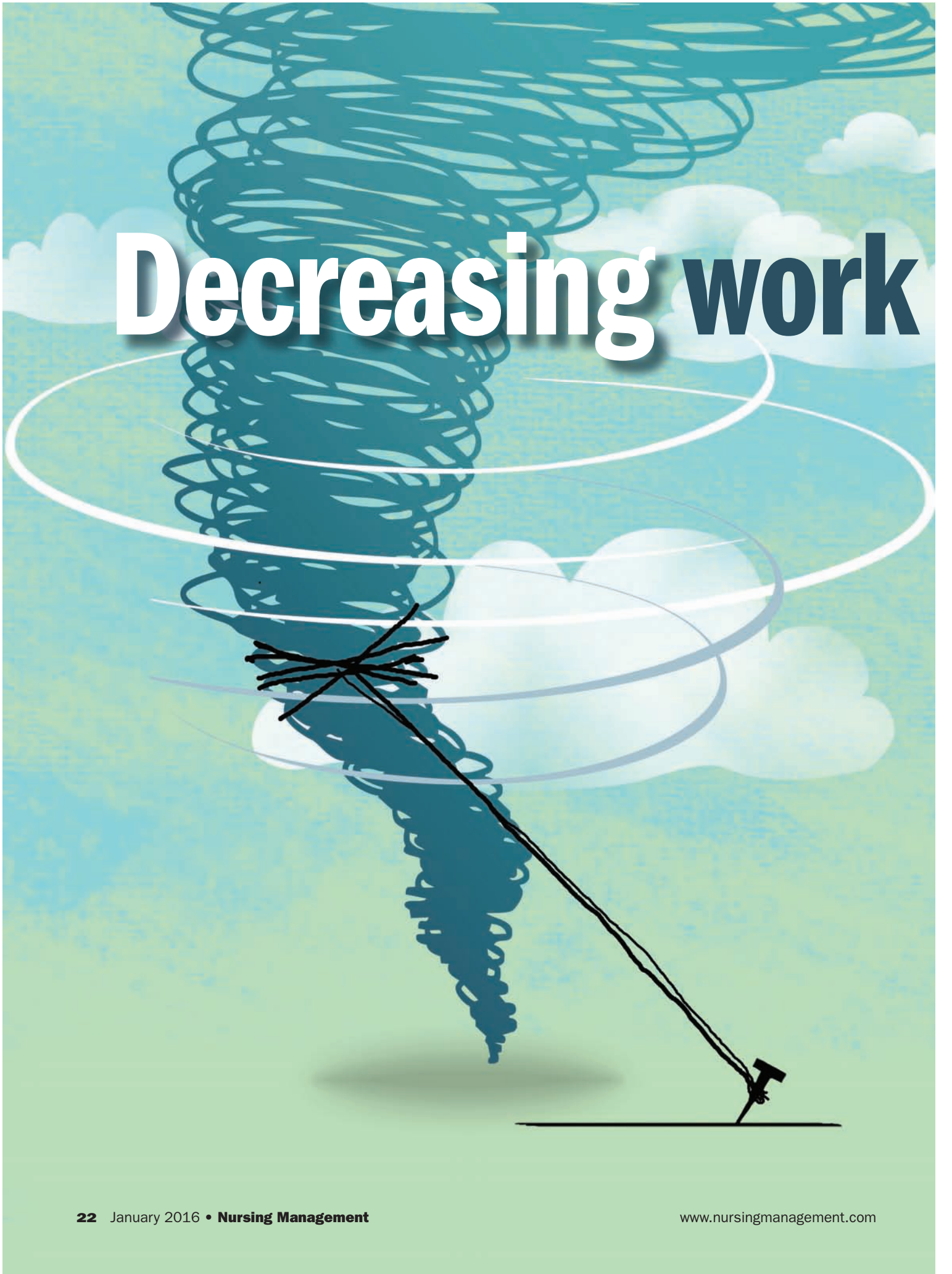
Decreasing work



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place incivility

By Judith Warrner, MSN, RN; Kathleen Sommers, EdD, RN; Mary Zappa, DPT, ATC; and Deirdre K. Thornlow, PhD, RN, CPHQ

A problem in many healthcare institutions, workplace incivility is often referred to as bullying, lateral/horizontal violence, or harassment.[1-3] It can be defined as "repeated offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions that make recipients upset and feel humiliated, vulnerable, or threatened, creating stress and undermining their self-confidence."[4] Uncivil behaviors can range from lack of support to rude or humiliating comments, and may even include verbal threats.[5] Determining the actual incidence and prevalence of workplace incivility is difficult because it's often unrecognized and underreported.[6] However, studies examining workplace incivility assert that the percentage of nurses experiencing some form of incivility ranges from 27% to 85%.[6,7]

Acts of incivility are devastating to nurses, affecting their performance, mental health, and intention to remain with an organization or even within the profession of nursing.[5,6,8] Hospitals and healthcare organizations experience additional consequences from an uncivil work environment through increased costs related to nursing turnover, absenteeism, and decreased work performance.[6] According to one report, the average hospital will spend an estimated $379,500 for every percentage point increase in turnover rates.[9] In addition, healthcare organizations spend an estimated $30,000 to $100,000 per year for each employee experiencing workplace incivility due to costs related to absenteeism, decreased work performance, staff treatment for depression and/or anxiety, and increased nursing turnover.[6]

Although the effects on nurses and healthcare organizations are clearly detrimental, a more dangerous consequence of incivility comes from its threat to patient safety. One study demonstrated a connection between incivility toward nurses and behaviors that may lead to compromised patient safety.[10] The study included 130 nurses and delineated specific unsafe nurse practices that were directly related to instances of incivility. These unsafe practices included interpreting an unreadable order rather than asking for clarification, lifting or ambulating heavy patients without asking for help, and carrying out orders not considered to be in the best interest of the patient without challenging them.

In 2009, realizing that intimidating behavior affects morale, staff turnover, and patient care, The Joint Commission put standards in place that require leaders to maintain a culture of safety.[11] According to The Joint Commission, organizations that fail to address unprofessional behavior are indirectly promoting such behavior. Uncivil behavior undermines the healthcare team's effectiveness and can lead to medical errors and preventable adverse patient outcomes.[12] Interventions aimed at reducing incivility in the workplace are beneficial to nurses, healthcare organizations, and patients.

Literature review

It has been pointed out that many perpetrators of incivility are unaware of the effects of their behaviors.[13] In order to change the behaviors associated with incivility, nurses first must be able to recognize these behaviors and the negative consequences they cause.[14]

An interventional study was conducted to determine if training on incivility and cognitive rehearsal responses to such behavior influenced the awareness of levels of incivility.[2] The study utilized a pre- and postsurvey, with a training intervention completed between the surveys. The training included a didactic session explaining incivility and the use of cognitive rehearsal as a way to address the behavior. To supplement the training, handouts for dealing with confrontation and conflict, cue cards of responses to incivility, and a list of expected professional behaviors were provided to participants. To measure the respondent's sense of empowerment, the Nurse Workplace Scale (NWS) was used.[15] A higher score on the NWS equates to a greater sense of empowerment. The total NWS scores increased slightly, although not statistically significant. However, the authors concluded that nurses felt more empowered when confronted with incivility.[2]

Another study was conducted to determine if a training intervention would increase awareness of incivility.[16] This study consisted of three phases: a pretraining survey, training sessions, and a posttraining survey. All three phases were completed in a 12-week period. Training sessions utilized case studies, presented the literature regarding the effects of incivility, and provided recommendations for a healthy work environment. A total of 21 nurses completed all three phases of the study. Although not statistically significant, the instances of incivility were perceived to be higher after the intervention. The authors concluded that after the nurses were provided with training on the concept of incivility, awareness and, thus, perception of its occurrence increased.

After awareness of the problem is raised, strategies can be put into place to combat uncivil behavior. Utilizing a systematic review of the literature, one group of authors identified that the most effective workplace incivility intervention programs included cognitively rehearsed responses to incivility.[3] Cognitive rehearsal was used in one qualitative study with 26 newly licensed RNs hired into their first nursing position.[14] The study was designed to examine the effects of cognitive rehearsal on workplace incivility. Educational sessions were provided describing incivility and its effect on nursing practice, the profession of nursing, and the nurses themselves. In addition, the nurses were instructed on the use of cognitive rehearsal, offering appropriate responses to frequent forms of incivility. Laminated cue cards were provided that delineated behavioral expectations for professionals, the most common forms of incivility, and suggested responses. A focus group session was held with all participants 1 year after the intervention.

Although participants found confrontation difficult, 100% of those who experienced instances of incivility confronted the offender. The responses from the perpetrators included shock that the new nurse felt offended (75%), apologies for the behavior (58%), and shunning of the accuser for a short period (25%). However, 100% of the instances of incivility stopped after confronting the perpetrators. The author concluded that knowledge of lateral violence, combined with behavioral responses to halt it, functioned as an empowering tool for the nurses to confront the perpetrators.

In order to measure incivility in the nursing workplace, a reliable tool specific for nursing incivility is needed. In 2010, the Nursing Incivility Scale (NIS) was developed. (See *Table 1.*) The NIS is a measurement tool designed to

Table 1: Nursing Incivility Scale

		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
For the following items, please consider **all individuals** you interact with at work, including physicians and other nurses or hospital personnel.						
1	Hospital employees raise their voices when they get frustrated.	1	2	3	4	5
2	People blame others for their mistakes or offenses.	1	2	3	4	5
3	Basic disagreements turn into personal verbal attacks on other employees.	1	2	3	4	5
4	People make jokes about minority groups.	1	2	3	4	5
5	People make jokes about religious groups.	1	2	3	4	5
6	Employees make inappropriate remarks about one's race or gender.	1	2	3	4	5
7	Some people take things without asking.	1	2	3	4	5
8	Employees don't stick to an appropriate noise level (e.g., talking too loudly).	1	2	3	4	5
9	Employees display offensive body language (e.g., crossed arms, body posture).	1	2	3	4	5
The following describes your interactions with other **nurses**. Other nurses on my unit…						
1	…argue with each other frequently.	1	2	3	4	5
2	…have violent outbursts or heated arguments in the workplace.	1	2	3	4	5
3	…scream at other employees.	1	2	3	4	5
4	…gossip about one another.	1	2	3	4	5
5	…gossip about their supervisor at work.	1	2	3	4	5
6	…bad-mouth others in the workplace.	1	2	3	4	5
7	…spread bad rumors around here.	1	2	3	4	5
8	…make little contribution to a project but expect to receive credit for working on it.	1	2	3	4	5
9	…claim credit for my work.	1	2	3	4	5
10	…take credit for work they didn't do.	1	2	3	4	5
Please think about your interactions with your **direct supervisor** (i.e., the person you report to most frequently) and indicate how strongly you agree with the following statements. My direct supervisor…						
1	…is verbally abusive.	1	2	3	4	5
2	…yells at me about matters that aren't important.	1	2	3	4	5
3	…shouts or yells at me for making mistakes.	1	2	3	4	5
4	…takes his/her feelings out on me (e.g., stress, anger, "blowing off steam").	1	2	3	4	5
5	…doesn't respond to my concerns in a timely manner.	1	2	3	4	5
6	…is condescending to me.	1	2	3	4	5
7	…factors gossip and personal information into personnel decisions.	1	2	3	4	5

continued

Table 1: Nursing Incivility Scale (*continued*)

		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
This section refers to **physicians** you work with. Please indicate your level of agreement with the following items.						
1	Some physicians are verbally abusive.	1	2	3	4	5
2	Physicians yell at nurses about matters that aren't important.	1	2	3	4	5
3	Physicians shout or yell at me for making mistakes.	1	2	3	4	5
4	Physicians take their feelings out on me (e.g., stress, anger, "blowing off steam").	1	2	3	4	5
5	I'm treated as though my time isn't important.	1	2	3	4	5
6	Physicians are condescending to me.	1	2	3	4	5
Please reflect upon your interactions with the **patients** you care for and their **family and visitors,** and indicate the extent to which you agree with the following statements. Patients/visitors…						
1	…don't trust the information I give them and ask to speak with someone of higher authority.	1	2	3	4	5
2	…are condescending to me.	1	2	3	4	5
3	…make comments that question the competence of nurses.	1	2	3	4	5
4	…criticize my job performance.	1	2	3	4	5
5	…make personal verbal attacks against me.	1	2	3	4	5
6	…pose unreasonable demands.	1	2	3	4	5
7	…have taken out their frustrations on nurses.	1	2	3	4	5
8	…make insulting comments to nurses.	1	2	3	4	5
9	…treat nurses as if they're inferior or stupid.	1	2	3	4	5
10	…show that they're irritated or impatient.	1	2	3	4	5

Source: Guidroz AM, Burnfield-Geimer JL, Clark O, Schwetschenau HM, Jex SM. The Nursing Incivility Scale: development and validation of an occupation-specific measure. *J Nurs Meas*. 2010;18(3):176-200.

capture nursing-specific workplace incivility prevalence. Forty-two items are included in the scale, which are then grouped into five subscales of sources of incivility: general, nursing, supervisor, physician, and patient/visitor. In a sample of 163 hospital nurses, alpha statistics demonstrated reliability for all subscales, with scores ranging from 0.81 to 0.94. Validity estimates demonstrated distinction from each other, having only moderate intercorrelations ($r = 0.11$ to 0.57).[1]

Presentation of the organization's policies on conduct and behavior during training on incivility can also be beneficial. These presentations provide participants with an understanding of the organization's stance on such behavior and prepare them to manage instances as they occur, as well as how to report such instances.[11] In one study on the nature and extent of healthcare workplace incivility in Australia, of the 478 (32%) respondents who experienced this behavior, only 91 (19%) felt that their organization dealt with the situation in a manner that was "very good" or "good."[17] Management has a responsibility to identify and decrease factors that allow incivility to occur.[18] In any organizational intervention aimed at decreasing incivility, management should receive parallel training to that of the staff. Teaching staff members how to respond to incivility is futile if management neither sees nor admits that the problem exists, or if leadership lacks the tools required to address it.[19]

Setting

The inpatient unit of a 60-bed orthopedic surgical specialty hospital located in the Midwestern United States was the setting for a quality improvement project that provided

training to elevate staff and management's awareness of incivility and its consequences, and decrease the instances of perceived incivility.

Stakeholders from the hospital were interviewed about the existence of incivility at the organization. All stakeholders agreed that the problem of incivility did exist within the organization both at the lateral (peer to peer) and the hierarchical (supervisor/physician to staff) levels. They agreed that a program to reduce incivility would demonstrate the organization's commitment to a quality work environment for staff to provide safe, effective care.

Methods

Permission to use the cognitive rehearsal cue cards was received from Dr. Martha Griffin; permission to use the NIS was received from Dr. Ashley Guidroz. The quality improvement project was approved by both the hospital and Duke University's institutional review boards. A time series study design was used.

The sample consisted of all care providers on the 60-bed inpatient unit, including RNs, multiskilled technicians, unit secretaries, physical therapists, respiratory therapists, case manager nurses, and members of the management team. The project included both management and staff in incivility training, cognitive rehearsal techniques, and the use of visual cue cards.

Initial training sessions were held for the management team to ensure that managers would have the same understanding of incivility as the staff, and the same tools to address it. All remaining staff training was completed during a 2-week time frame. The 45-minute training sessions were conducted by the principal investigator to ensure consistency in the presentation. Sessions were scheduled to cover all shifts and multiple days of the week for staff convenience. Participation in the training was mandatory.

To ensure that all participants recognized uncivil behaviors, the planned training started with providing definitions and examples of incivility, and the different ways it can manifest.[14] An explanation of cognitive rehearsal techniques preceded examples of appropriate ways to respond to incivility. Data were presented on the potential effects of incivility on patient safety, the costs of incivility to organizations, and the effects on nursing personnel. The training sessions concluded with specific examples of common forms of uncivil behavior and provision of assertive responses that the victims can feel comfortable using without undermining working relationships with the perpetrators. Laminated cue cards were used and provided to all attendees as a resource to use in everyday work encounters.[14] The first of these cards provided a list of behaviors that are expected of professionals. The second cue card listed the common forms of uncivil behavior aligned with appropriate responses to deal with each type of behavior as it occurs in a manner that promotes teamwork and simultaneously decreases future occurrences of uncivil actions.

Data collection and analysis

Participants completed the NIS immediately before training, immediately after training, and 2 months after training. Presurveys were taken before the training to assess initial awareness of incivility. A post-1 survey was administered immediately after the training to measure changes in awareness of incivility and capture baseline data on the frequency of perceived instances of incivility. A post-2 survey was given to all staff members 2 months after the last training session to determine if the intervention was successful in decreasing perceived instances of incivility. And, finally, participants were surveyed in the post-2 survey on the frequency of confronting the perpetrators of incivility and/or being confronted about uncivil behavior. Data were analyzed using a software program. Outcome measures included the change in awareness of uncivil behavior and the change in the frequency of perceived instances of incivility.

Statistical analyses were applied to the presurvey, post-1 survey, and post-2 survey perceived instances of incivility. Demographic data were presented using descriptive statistics. Fidelity was measured by calculating attendance at the sessions, using a log of all attendees, and comparing it with the departmental roster.

Results

A total of 99 out of 114 staff members (86.8%) participated in the presurvey, with 98 out of 114 (86.0%) participating in the post-1 survey and 41 out of 114 (36%) in the post-2 survey. Participation was higher in the first two surveys because they were administered in conjunction with the training sessions. As noted in *Table 2*, for all three surveys, the majority of respondents were female, full-time RNs employed with the organization between 1 and 5 years.

The survey utilized a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The survey was constructed in a manner that equated lower scores with a more civil environment and higher scores with an uncivil environment; thus, the higher the score, the more uncivil the environment. T-tests

were run to compare the presurvey with the post-1 survey and the post-1 survey with the post-2 survey.

Increased awareness

To determine if there was an increased awareness of uncivil occurrences after the training intervention, the presurvey results were compared with the post-1 survey results. None of the scores for the five subscales of sources of incivility were statistically significant. However, a trend was noted with all five subscales (general, nursing, supervisor, physician, and patient/visitor) demonstrating an increase in their mean, which may indicate a mild increase in awareness. (See *Figure 1.*)

Table 2: Demographics

Demographic	Frequency, Presurvey	Frequency, Post-1 survey	Frequency, Post-2 survey
	N = 99	N = 98	N = 41
Gender			
Male	11 (11.1%)	9 (9.2%)	5 (12.2%)
Female	82 (82.8%)	86 (87.8%)	33 (80.5%)
Missing	6 (6.1%)	3 (3.1%)	3 (7.3%)
Job title			
RN	39 (39.4%)	41 (41.8%)	22 (57.9%)
Multiskilled tech/unit secretary	27 (27.3%)	26 (26.5%)	10 (26.3%)
Physical therapist	14 (14.1%)	14 (14.3%)	0 (0.0%)
Case management	7 (7.1%)	7 (7.1%)	1 (2.4%)
Respiratory therapist	6 (6.1%)	6 (6.1%)	3 (7.3%)
Management	1 (1.0%)	1 (1.0%)	2 (4.9%)
Other	1 (1.0%)	1 (1.0%)	0 (0.0%)
Missing	4 (4.0%)	2 (2.0%)	3 (7.3%)
Employment status			
Full-time	65 (65.7%)	67 (68.4%)	31 (75.6%)
Part-time	13 (13.1%)	13 (13.3%)	5 (12.2%)
Casual/PRN	15 (15.2%)	15 (15.3%)	2 (4.9%)
Missing	6 (6.1%)	3 (3.1%)	3 (7.3%)
Years at organization			
Less than 1 year	20 (20.2%)	22 (22.4%)	6 (14.6%)
1 year to 5 years	43 (43.4%)	43 (43.9%)	21 (51.2%)
Between 5 years and 10 years	18 (18.2%)	17 (17.3%)	9 (22.0%)
10 years or greater	15 (15.2%)	15 (15.3%)	2 (4.9%)
Missing	3 (3.0%)	1 (1.0%)	3 (7.3%)

Total for each category may not equal 100% because of rounding.

Decreased occurrences

To measure if there was a change in occurrences of incivility 2 months after completion of the training, results of the post-1 survey were compared with the results of the post-2 survey. Two of the five subscales demonstrated a statistically significant decrease in instances of perceived incivility: general incivility (2.75 to 2.24, $p = 0.00$) and physician incivility (2.79 to 2.43, $p = 0.04$). The other three subscales also demonstrated a decrease in the occurrences of incivility, although not statistically significant. (See *Figure 2.*)

Confrontation frequency

Of the 41 respondents in the post-2 survey, 27.5% (11) stated that they had confronted someone about uncivil behavior after receiving training on incivility, whereas only 7.5% (3) responded that someone had confronted them about uncivil behavior. Although a comment section was provided, none of these respondents gave information about the confrontation or its results.

Discussion

Review of the scores indicated that three of the subscales—general incivility, physician incivility, and patient/visitor incivility—had mean scores above a 2.5 for both the presurvey and the post-1 survey, which is the midpoint of the scale. This indicates greater incivility from these sources. The mean scores for all three of these subscales dropped below the midpoint on the post-2 survey. The subscale of nursing incivility, close to the midpoint of mean scores in the presurvey (2.37) and post-1 survey (2.42), dropped to 2.16 in the post-2 survey. The subscale of supervisor incivility had the lowest mean scores on all three surveys (pre = 1.56, post-1 = 1.59, post-2 = 1.58), indicating higher

civility from this source. The use of incivility training and cognitive rehearsal techniques appears to be most effective in the areas of greater incivility. The low scores for the supervisor incivility subscale contradict other studies that show supervisors exhibiting more incivility toward staff than others.[19,20]

This project adds strength to previous studies that demonstrated increased awareness of incivility after training.[2,16] Previous literature on the use of cognitive rehearsal as a tool to decrease incivility presented mixed results.[2,14] This project provides additional information on the effectiveness of cognitive rehearsal.

The increased awareness of incivility in the post-1 survey should be treated with caution because findings weren't statistically significant. Consideration should be given to the possibility of response bias for the post-2 survey because the response rate was only 41.4% of the presurvey and 41.8% of the post-1 survey. Given the positive findings, perhaps only those who felt the program had worked completed the final survey.

Figure 1: Comparison of awareness of incivility mean scores, presurvey to post-1 survey

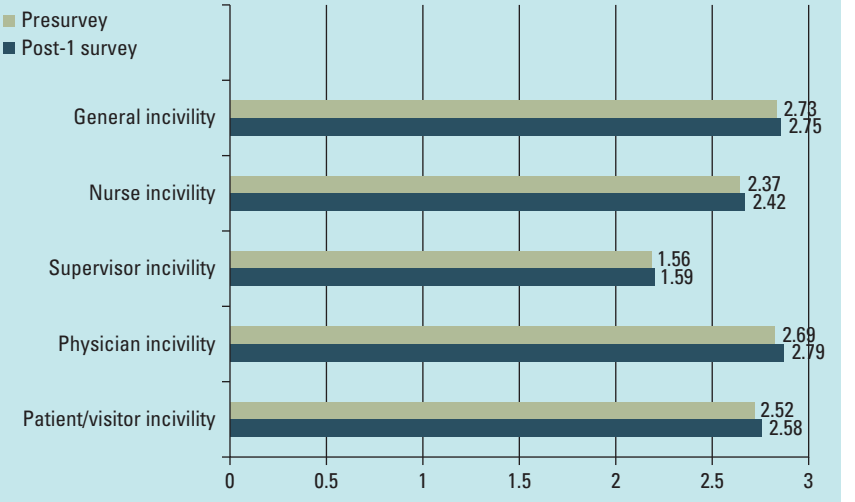
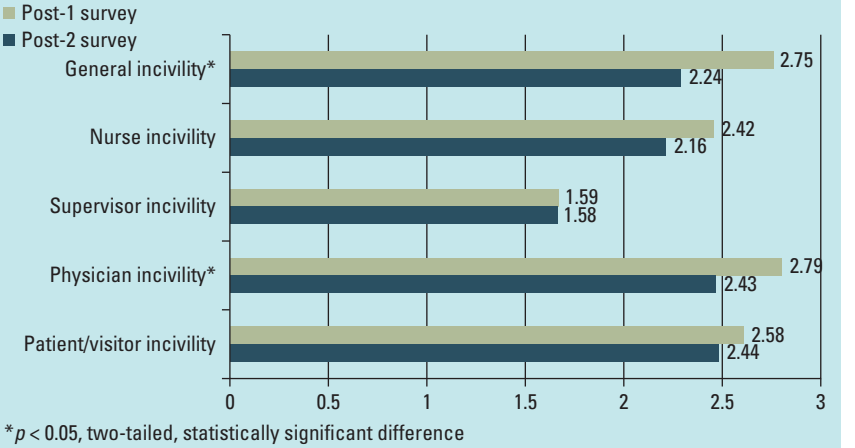


Figure 2: Comparison of perceived incivility in post-1 survey to perceived incivility in post-2 survey



*$p < 0.05$, two-tailed, statistically significant difference

Lessons learned

No time was provided to the participants to practice real-life scenarios in the training sessions. This may have contributed to the low rates of confrontation exhibited in the post-2 survey. Participants may have felt more comfortable about addressing uncivil behavior if they had more time to practice the new skills in a safe environment.

Because the response rate was remarkably lower for the post-2 survey, consideration should be given to the method of providing the survey. Participants were provided with the presurvey and post-1 survey individually in conjunction with the training class. Perhaps handing out the final survey to each staff member individually instead of having the surveys available at a common location may have increased the return rate on the post-2 survey.

Toward a healthy environment

Providing an atmosphere where nurses can perform at their best to provide quality, safe patient care is the responsibility of all healthcare organizations. As demonstrated in the literature, incivility in nursing can affect nurses' mental health, decrease their productivity, and lead to potential patient safety concerns.[5,6,8,10] The results from this quality improvement project demonstrate that a program that raises awareness of incivility, provides cognitive rehearsal techniques and resources, and incorporates management can help decrease the perceived instances of uncivil behavior. NM

REFERENCES

1. Guidroz AM, Burnfield-Geimer JL, Clark O, Schwetschenau HM, Jex SM. The Nursing Incivility Scale: development and validation of an occupation-specific measure. *J Nurs Meas.* 2010;18(3):176-200.
2. Embree JL, Bruner DA, White A. Raising the level of awareness of nurse-to-nurse lateral violence in a critical access hospital. *Nurs Res Pract.* 2013;2013:207306.
3. Stagg SJ, Sheridan D. Effectiveness of bullying and violence prevention programs. *AAOHN J.* 2010;58(10):419-424.
4. Vessey JA, DeMarco R, DiFazio R. Bullying, harassment, and horizontal violence in the nursing workforce: the state of the science. *Annu Rev Nurs Res.* 2010;28:133-157.
5. Read E, Laschinger HK. Correlates of new graduate nurses' experiences of workplace mistreatment. *J Nurs Adm.* 2013;43(4):221-228.
6. Becher J, Visovsky C. Horizontal violence in nursing. *Medsurg Nurs.* 2012;21(4):210-232.
7. Wilson BL, Diedrich A, Phelps CL, Choi M. Bullies at work: the impact of horizontal hostility in the hospital setting and intent to leave. *J Nurs Adm.* 2011;41(11):453-458.
8. Smith LM, Andrusyszyn MA, Spence Laschinger HK. Effects of workplace incivility and empowerment on newly-graduated nurses' organizational commitment. *J Nurs Manag.* 2010;18(8):1004-1015.
9. NSI Nursing Solutions, Inc. 2015 National healthcare retention and RN staffing report. www.nsinursingsolutions.com/files/assets/library/retention-institute/NationalHealthcareRNRetentionReport2015.pdf.
10. Wilson BL, Phelps C. Horizontal hostility: a threat to patient safety. *JONAS Healthc Law Ethics Regul.* 2013;15(1):51-57.
11. McNamara SA. Incivility in nursing: unsafe nurse, unsafe patients. *AORN J.* 2012;95(4):533-540.
12. The Joint Commission. Sentinel event alert, issue 40: behaviors that undermine a culture of safety. www.jointcommission.org/sentinel_event_alert_issue_40_behaviors_that_undermine_a_culture_of_safety.
13. Clark CM, Olender L, Kenski D, Cardoni C. Exploring and addressing faculty-to-faculty incivility: a national perspective and literature review. *J Nurs Educ.* 2013;52(4):211-218.
14. Griffin M. Teaching cognitive rehearsal as a shield for lateral violence: an intervention for newly licensed nurses. *J Contin Educ Nurs.* 2004;35(6):257-263.
15. DeMarco R, Roberts SJ, Norris A, McCurry MK. The development of the Nurse Workplace Scale: self-advocating behaviors and beliefs in the professional workplace. *J Prof Nurs.* 2008;24(5):296-301.
16. Nikstaitis T, Simko LC. Incivility among intensive care nurses: the effects of an educational intervention. *Dimens Crit Care Nurs.* 2014;33(5):293-301.
17. Farrell GA, Shafiei T. Workplace aggression, including bullying in nursing and midwifery: a descriptive survey (the SWAB study). *Int J Nurs Stud.* 2012;49(11):1423-1431.
18. Laschinger HK, Wong C, Regan S, Young-Ritchie C, Bushell P. Workplace incivility and new graduate nurses' mental health: the protective role of resiliency. *J Nurs Adm.* 2013;43(7-8):415-421.
19. Vessey JA, DeMarco RF, Gaffney DA, Budin WC. Bullying of staff registered nurses in the workplace: a preliminary study for developing personal and organizational strategies for the transformation of hostile to healthy workplace environments. *J Prof Nurs.* 2009;25(5):299-306.
20. Johnson SL, Rea RE. Workplace bullying: concerns for nurse leaders. *J Nurs Adm.* 2009;39(2):84-90.

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