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Exploring Incivility among Registered Nurses in the Hospital Setting

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Exploring Incivility among Registered Nurses in the Hospital Setting

by

Lesley Gillian

A thesis submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the
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Abstract

The purpose of this study was to examine the level of incivility among registered nurses in the hospital setting. A non-experimental descriptive quantitative design was used. The Nursing Incivility Scale (NIS) was sent to all registered nurses (653) employed at the hospital via email with a response rate of 24% (n=158). The NIS has source specific subscales included. The results indicated that nurses did have experiences with incivility at this facility with the sources being identified as General Hostile Climate, Nurse Gossip and Rumors, Physician Abusive Supervision and Patient and Visitor Displaced Frustration.

Keywords: incivility, registered nurses, rudeness, verbal abuse

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CHAPTER I

Introduction

Incivility in nursing is not a new concept. It is interesting to note that a profession that prides itself on caring for individuals has issues related to caring for each other. Incivility encompasses several disruptive behaviors and manifests in rudeness, disrespect, and uncooperative attitudes (Lim & Bernstein, 2014; Rocker, 2012). Vogelpohl, Rice, Edward, and Bork (2013) defined workplace incivility as “disrespectful, deviant work behaviors of a person to harm another that violates workplace rules” (p. 416) (Andersson & Pearson, 1999). Several national organizations have developed position statements that seek to discourage this type of behavior in the workplace. The American Nurses Association (ANA) (n.d.) recognized that all nursing personnel have the right to work in a place that is free of bullying, lateral violence, and intimidation. Nursing personnel should not fear reprisal for reporting such acts to administration (ANA). Incivility can involve several members of the workplace environment. The behavior can be physician to nurse, nurse to nurse, or manager to subordinate.

Several examples from the literature exist to help develop a better understanding of incivility. Lack of politeness, offensive comments, rudeness, withholding information that could be helpful to another, a general disdain for coworkers, nonverbal innuendo, verbal insults, gossiping, undermining, backstabbing, betraying confidences, scapegoating, and condescending language all encompass incivility behaviors that occur in the workplace (Blair, 2013; Dimarino, 2011; Luparell, 2011; Rocker, 2012).

The literature examining incivility and lateral violence within the nursing profession is vast. Some theories as to why incivility is prevalent in the nursing profession can offer incentives to help to combat the behavior. Rucker (2012) suggested that nurses are facing increased workloads as well as organizational restructuring that can lead to disruptive behaviors.

Some nurses may handle the increased stress by venting their emotions and taking these emotions out on a vulnerable population (new graduate or new employee) on the unit (Christie & Jones, 2013). There also may exist a unit culture with an “eat their young” mentality, allowing the new nurse to feel as if he/she has to prove himself/herself on the job (Longo, 2013). The culture of the individual unit may also lend itself to present difficulties to stand up for others by not providing tools for conflict resolution, and no management support (Vessey, Demarco, Gaffney & Budin, 2009).

Lim and Bernstein (2014) presented individual and system factors that contributed to incivility in the workplace. Some individual factors may include the following: self-centeredness, immaturity, defensiveness, and lack of conflict management skills. The system factors include the following: job pressure, empowerment roles, and continual changes related to shift rotations (Lim & Bernstein, 2014). “High patient ratio might mean low on patience” (Lim & Bernstein, 2014, p. 126).

The Joint Commission (2008), in a sentinel alert publication outlined behaviors that affect patient safety and also suggested a zero tolerance policy related to bullying and disruptive behaviors in the hospital facility. The Joint Commission sentinel alert publication (2008) also alluded to the relationship of disruptive acts that have the potential to affect patient safety. The effects of disruptive behaviors on the hospital

environment included higher operating expenses due to increased absenteeism, staff replacement, mediation, and increased turnover rates (Blair, 2013; Rocker, 2012; Luparell, 2011; Vessey et al., 2009).

Incivility can cause an increased stress load on nurses that already work in a known stressful environment such as the hospital setting (Blair, 2013; Christie & Jones, 2013; Vessey et al., 2009). Calkin (2013), outlined in her article a study by Sonya Walbank, a professor of child health, about the stress level of nurses. This study supported that nursing staff have a stress score of 43.35 (a score >44 indicates severe stress), a result that is 1.5 times higher than average of combat soldiers surveyed (Calkin, 2013).

Incivility can also cause a breakdown in staff relationships and collaboration (Longo, 2013; Rosenstein, 2011). Decreased communication as a result of intimidation or negative behaviors affects the assertiveness of the nurse (Blair, 2013) and interferes with effective communication (Bigony et al., 2009). Decreased morale along with decreased productivity and decreased communication affects the working environment (Dimarino, 2011) as well as the quality of care provided to the patients (Joint Commission, 2008; Vessey et al., 2009). Patient safety can be compromised by incivility because of the effect it has on effective communication and collaboration (Bigony et al., 2009).

Research Problem

Incivility in the nursing profession affects the nurse physically and psychologically, as well as being a deterrent to effective communication and collaboration amongst health care workers. The effects of incivility can have a negative

impact not only on nurse relationships with coworkers but also can affect patient safety and quality of care provided.

Research Purpose

Examination of the level of incivility in the workplace can provide a baseline for growth in this area as well as a guide for possible interventions to improve this area. Results from this study may be able to provide opportunities for education interventions as well as the development of a specific policy regarding incivility in the workplace. The purpose of this research study was to determine the level of incivility among registered nurses employed in a community hospital located in the southeastern region of the United States.

Conceptual Framework

The conceptual framework utilized for this study is Neuman's System Model. Neuman's model is based on general system theory (Alligood & Tomey, 2010). The model sees living organisms as open systems that interact with one another and the environment (Alligood & Tomey, 2010). Adjustment is defined by Neuman as a process in which the organism defines its needs. These needs may disrupt the client's balance or stability, so the adjustment process is continual and dynamic with life seen as a balancing act between stability and imbalance (Alligood & Tomey, 2010).

Two components of Neuman's System model that this study explored are stressors and reaction to stressors. "Stressors are tension-producing stimuli that result in stress; they may be positive or negative" (Alligood & Tomey, 2010, p. 310). Because stress increases the need for readjustment, adapting to the problem is necessary. For the purposes of this study, stressors included the incivility levels and reaction to stressors will

entail the distraction that registered nurses experience as a result of incivility in the workplace.

The Neuman Systems Model also outlined three levels of prevention. The first level is primary prevention. Primary prevention occurs when the possibility of encountering the problem has been reduced which leads to a strengthening of the normal line of defense which produces a decrease in the reaction to the stressor (Alligood & Tomey, 2010, p. 310). Secondary prevention is used after the client has been exposed to a stressor. Secondary prevention serves as a reduction because it requires an early intervention and plan to decrease the effect of the stressor. According to Neuman, secondary prevention strengthens the client's internal line of defense (Alligood & Tomey, 2010, p. 311). The last level is tertiary prevention. Tertiary prevention attempts to decrease the effects of the stressor and return the client to wellbeing (Alligood & Tomey, 2010, p. 313). Figure 1 shows the relationship of the variables of interest in this study to Neuman's Systems Model.

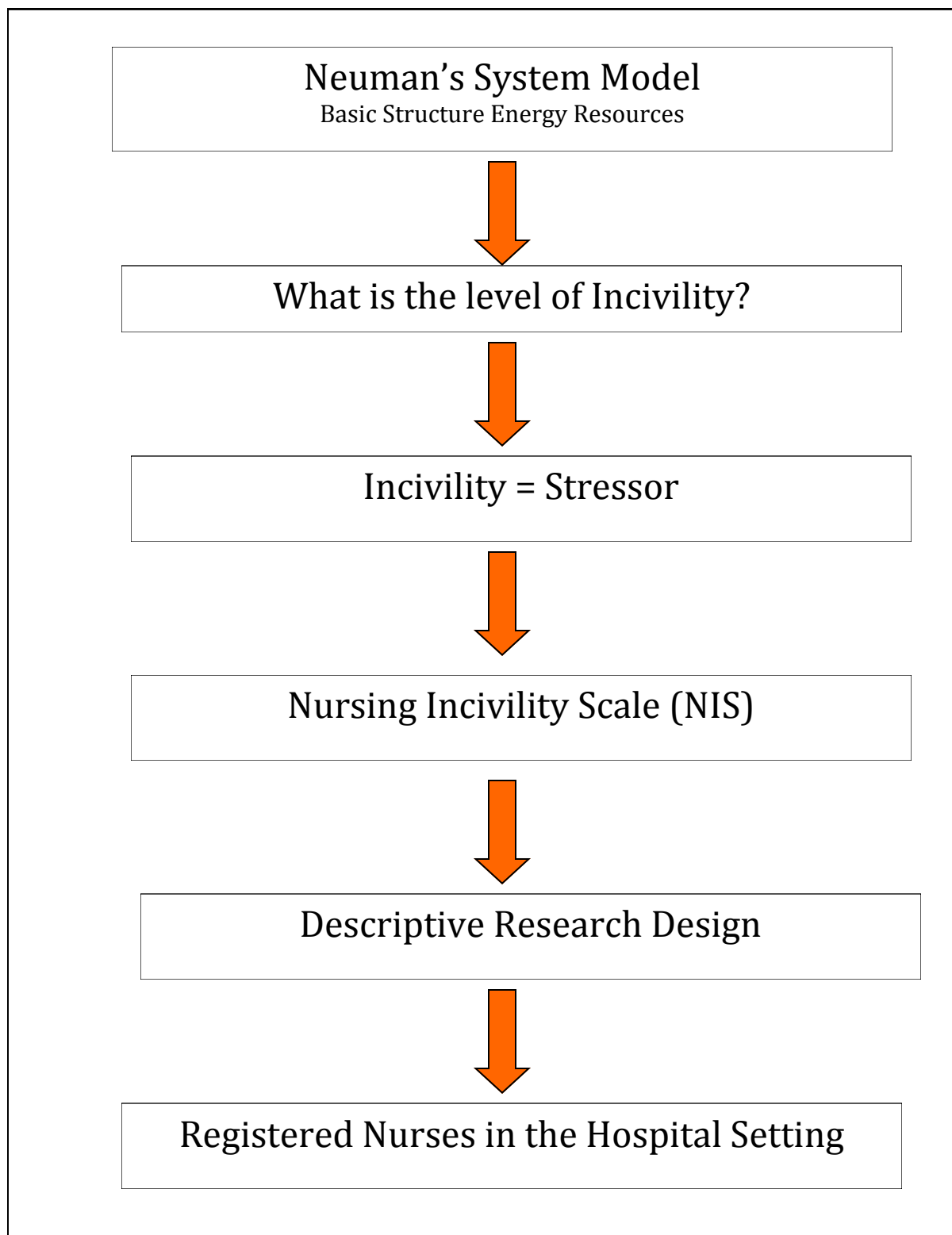


Figure 1: Conceptual Theoretical Empirical Structure for Study of Levels of Incivility among Registered Nurses in a Community Hospital Setting

As previously discussed, incivility in the workplace can cause stress. This stress can cause a breakdown in communication, teamwork and collaboration, which not only impact the employee (registered nurse) but also can affect patient safety. Neuman's System model can be utilized to understand this phenomenon. Utilizing the principles of prevention of the model can also provide guidance for interventions.

Research Question

What is the level of incivility among registered nurses employed in a community hospital located in the southeastern region of the United States?

Summary

Incivility in the workplace creates an environment that not only affects the nurse's wellbeing but also can lead to a patient safety issue. Issues related to collaboration and communications are affected by incivility. Health care organizations need to recognize and respond to the problem of incivility to not only promote a healthy workplace for their employees, but to also understand the effects incivility can have on patient care.

CHAPTER II

Review of the Literature

A nurse may experience incivility in a variety of settings as well as with a variety of people. A nurse interacts with several people throughout the day including most obviously patients, physicians, and other nurses. These interactions can provide opportunities for incivility to occur. This study sought to explore incivility that nurses experience in these areas.

A review of the literature gives insight into nurse incivility by examining generational differences, management perceptions, new graduate/employee perceptions, incivility in nursing education, and finally patient safety concerns as a result of incivility. A literature review was conducted using the search terms “incivility”, “incivility in nursing”, “workplace bullying”, and “disruptive behavior”. Databases used included the Cumulative Index to Nursing and Allied Health (CINAHL) and EBSCO. A plethora of research exists about workplace incivility including nursing workplace incivility. Several themes were identified when examining the prevalence of workplace incivility: generational differences, manager involvement, new graduate/new employee experiences, and incivility in nursing education. These areas are of particular interest to this study as these examples are exhibited in most hospital settings.

Generational Differences

Leiter, Price, and Laschinger (2010) conducted a study with Generation X and Baby Boomer nurses. Canadian nurses (n=522) completed a survey about their work life. The respondents were predominately female (n=493) with an average age of 41 years. The participants indicated having worked in their current hospital for an average

of 13 years. Generation X was categorized by having a birthdate from 1963-1981 (n=338). The Baby Boomer was categorized by having a birthdate from 1943-1958 (n=139). The measures used were the CREW Civility Scale, which measures the perception of incivility in the workplace and the Workplace Incivility Scale, which measures the frequency of incivility experiences. The results of this study supported that Generation X nurses experienced greater incivility from coworkers and supervisors than their Baby Boomer counterparts. Generation X nurses also classified nursing units as having fewer qualities of civility (Letier et al., 2010). Some distress symptoms the nurses experienced involving incivility involved exhaustion, cynicism, turnover intention, and physical symptoms (Leiter et al., 2010). The Generation X participants also reported that ongoing conflict with the immediate supervisor motivated the nurses to leave the unit or organization.

Management Perceptions of Incivility

A qualitative phenomenological study of 20 managers (18 female; 2 male) by Lindy and Schaefer (2010) examined the effect of incivility and disruptive behaviors from the nurse manager point of view. The average age of the participants was 46 years and 45% were masters prepared while 35 % had a baccalaureate degree. The themes emerging from this study are as follows: “just how she is”, “they just take it”, “a lot of things going on”, “old baggage”, and “three sides to a story” (Lindy & Schaefer, 2010). This study results found that verbal abuse was the most common form of negative behavior experienced by the participants. Managers identified the “abuser” as the most clinically competent and “best” nurse on the unit (Lindy & Schaefer, 2010). The victims were described as passive, tolerating the abuse from the other nurse (Lindy & Schaefer,

2010). The results of this study supported that disruptive behaviors increased as the workload increased (Lindy & Schaefer, 2010). The units experiencing disruptive behavior results also supported the low level of teamwork exhibited, the increase in turnover rates, and increased absenteeism (Lindy & Schaefer, 2010).

A Canadian national survey of direct patient care nurses (n=1,241) examined effects of incivility to identify the contributions of management style (Laschinger, Wong, Cummings, & Grau, 2014). The majority of the nurses surveyed were female (93.6%) and had been working in nursing for at least 16 years. The nurses indicated that the most frequently experienced uncivil behaviors were condescending remarks, devaluing of input, and doubting of judgment (Laschinger et al., 2014). The results of this study emphasized the unique opportunity management has in cultivating a relationship-focused form of leadership to help to empower nurses and limit nursing incivility (Laschinger et al., 2014).

New Graduates/New Employees Experiences with Incivility

Vogelpohl et al. (2013), examined nurse retention issues with new graduates by investigating their experience with uncivil behavior in their new positions in nursing practice (n=135). Twenty-nine and a half percent (29.5%) of the new graduates considered leaving the nursing profession because of negative behaviors in the workplace; thirty-five point four percent (35.4%) changed jobs within the past two years because of negative behavior. Thirty five point one percent (35.1%) found that management was not supportive. Ninety eight and a half percent (98.5%) indicated that health care organizations should have an organizational approach addressing disruptive

behavior. Sixty three point nine percent (63.9 %) indicated that the main bullies were there peers (Vogelpohl et al., 2013).

New graduate nurses can feel undervalued, neglected, and overwhelmed when entering the nursing workforce. Smith, Andrusyszyn, and Laschinger (2010) sought to determine if new graduate nurses who experienced increased levels of structural and psychological empowerment and low incidences of workplace incivility, will have high levels of organizational commitment. A random sample of 117 new graduate nurses was obtained from the College of Nurses in Ontario. The sample included nurses with <2 years of experience. The average age of the nurses was 27 years with the majority employed on critical care units. The Conditions for Work Effectiveness Questionnaire-II (CWEQ-11) and the Workplace Incivility Scale (WIS) were used along with two other measurements. Coworker workplace incivility was found to be a significant independent predictor of commitment. The majority of participants in this study experienced some form of workplace incivility. Some reasons postulated by the authors suggested that the culture of nursing units with multigenerational staff having different work ethics, values and goals may account for the coworker incivility (Smith et al., 2010). This study supported the correlation that exists between higher levels of incivility experienced by the nurse and nurse retention or commitment to the organization (Smith et al., 2010).

Incivility in Nursing Education

A qualitative study examining student uncivil encounters with faculty was conducted by Clark (2008). Seven former and current students representing four different nursing programs participated (four women and three men). Three major themes were identified about faculty to student incivility; Faculty behaving in demeaning

and belittling ways, faculty treating students unfairly and subjectively, and faculty pressuring students to conform to unreasonable faculty demands (Clark, 2008). The interesting thing about this study is the combination of students to include male and female as well as from different educational institutions, yet the same themes emerged.

The study by Clark, Ahten, and Macy (2014) measured the application of a problem based learning activity that students had participated in during their senior year of nursing school and how that information translated to their present working environment in dealing with incivility in the workplace. The researchers had provided the students with strategies for handling uncivil behavior in the workplace. The students were also shown a scenario depicting uncivil behavior between two coworkers. The level of learning was then assessed to determine if learning had occurred based on Kirkpatrick's Levels of Evaluation (Clark et al., 2014). In this follow up survey, a survey was sent to 30 of the previous participants who are now new graduates working as registered nurses. Most of the participants identified experiencing or witnessing uncivil behavior in the workplace (Clark et al., 2014). The new graduates were able to identify the behaviors due to the education they had received previously, however, it was indicated that barriers still exist in the reporting or handling of the behavior (Clark et al., 2014). Some of the barriers that exist included, newness to the roles and the reality of dealing with different personalities that can affect performance (Clark et al., 2014). Clark et al. (2014) highlighted the importance of these findings to include consideration of threading incivility education throughout nursing curriculum as well as providing education and awareness of uncivil behavior in the workplace environment.

Incivility and patient safety

Rosenstein and O'Daniel's (2005) study results supported that disruptive behavior had a significant impact on stress level, frustration, concentration, collaboration, communication, and information transfer. The results also indicated a link between disruptive behaviors, patient safety, quality of care, and patient satisfaction (Rosenstein & O'Daniel, 2005). Of the 1,509 participants surveyed, including physicians and nurses, 40 % responded that in their experience female nurses had a tendency to display disruptive behavior (Rosenstein & O'Daniel, 2005).

Addison and Luparell (2014) conducted a study of rural nurse perceptions of incivility. This study's results supported that nurses rather than physicians exhibit disruptive behavior more frequently. The study's results also supported the perception that disruptive behavior is linked to adverse events and has a negative impact on patient safety (Addison & Luparell, 2014). Fifty-seven nurses participated in this study: 98.2% of the participants reported witnessing disruptive behavior exhibited by physicians and 87.8 % of the participants reported witnessing disruptive behavior exhibited by nurses. An alarming statistic is that 45.5 % indicated that they knew of an adverse event that had occurred as a result of disruptive behavior. Of the 29 participants who witnessed an adverse event, 82% believed that they felt it could have been prevented. The majority of participants indicated that the facility lacked appropriate reporting and counseling policies related to disruptive behavior (Addison & Luparell, 2014).

Summary

Some common themes in the literature indicated the negative impact that incivility has on the nursing population. Themes found were: nurse retention issues (Farrell & Shaflei, 2012; Vogelpohl et al., 2013), increased stress levels (Vessey et al., 2009), quality of care and patient satisfaction (Addison & Luparell, 2014; Boev, 2012).

Nurses have the responsibility of providing safe, competent care to the patients that a health care center serves. Exploring the level of incivility among registered nurses in a health care organization is helpful because it provides the opportunity to assess the nurse's perceptions and form action plans for improvement if warranted.

CHAPTER III

Methodology

Examination of the level of incivility in the workplace can provide a baseline for growth in this area as well as a guide for possible interventions to improve this area. Results from this study may be able to provide opportunities for education interventions as well as the development of a specific policy regarding incivility in the workplace.

Study Design

The design for this study was a non-experimental quantitative descriptive design. The aim of the study was to explore the level of incivility present among registered nurses in a community hospital in the southeastern United States.

Sample and Setting

A convenience sample of registered nurses employed at a 403- bed community health center located in the Southeastern United States was used. This hospital employs approximately 653 registered nurses. The health system includes a 23- bed rehabilitation center, 280-bed community hospital, 50 –bed mental health facility and a surgical pavilion to include same day surgery. Inclusion criteria included registered nurses in all areas of the hospital; administration, care management, education, management, and unit nurses. No minimum level of experience was required. Demographic data collected included age, highest level of education, and years of experience.

Survey Instrument/Method of Measurement

The Nursing Incivility Scale (NIS) (Appendix A) developed by Guidroz et al. (2010) was the data survey instrument used in the study. The NIS is based on a five point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree) and can be

administered via paper and pencil or through electronic survey applications. The survey is divided into eight subscales including, hostile climate, inappropriate jokes, inconsiderate behavior, gossip/rumors, free riding, abusive supervision, lack of respect, and displaced frustration. The survey may also be divided further to determine source specific areas of incivility. There are 43 total questions included on the survey. Nine questions are related to all individuals that are interacted with at work. Ten questions are related to interactions with other nurses. Seven questions are related to interactions with a direct supervisor. Seven questions are related to interactions with physicians. Ten questions are related to interactions with patients/patient family/visitors. Scores were aggregated at the subscale level. Subscale scores should be summed and averaged so that more specific interventions may be discussed. Also, the source level aggregated score will be helpful at identifying source specific incivility (Guidroz et al., 2010). The survey should take approximately 5-10 minutes to complete. Instructions were provided to the participants regarding which incivility scenario to consider when indicating their level of agreement to the statement (Guidroz et al., 2010).

Reliability of the NIS was tested using alpha statistics for all of the eight subscales. The alpha statistics ranged from .81 to .94, which is above the .70 level that Guidroz et al. (2010) used as a measurement. “The average item-total correlation for all items was .76, indicating that the items demonstrate good internal consistency” (Guidroz et al., 2010, p. 190). This scale was chosen not only for its ease of use but also for its ability to provide a baseline assessment of incivility and identification of sources of incivility that are most problematic to develop a targeted intervention (Guidroz et al., 2010).

Permission to use this survey instrument was granted by Ashley Guidroz, PhD. via email correspondence on October 22, 2014 (Appendix B).

Data Collection

The demographic information questions and survey were made available to all registered nurses employed at this institution. The survey was anonymous with no specific identification information included. To encourage participation in the study, the researcher attended several unit staff meetings explaining the purpose of the study, how the results will be used, security of the results, and how to access the survey. An invitation email (Appendix C) was sent to all nurses employed at the institution containing directions for the survey, information on how to access the survey link, and how the results will be used. The survey link was available for two weeks.

The data was gathered using the electronic survey application Survey Monkey. Participants were able to click on a link to take them directly to the survey. Survey monkey was utilized for this study for its ease of use as well as for the anonymous nature that it provides the participants. Completion of the survey served as the implied consent. The researcher and advisor email information was provided on all correspondence related to this study for questions or further explanation.

Analysis of Data

Statistics Solutions Pro (SSP) version v1.15.02.16 was used to analyze the data. Descriptive statistics was utilized to describe the participants' demographic characteristics and the average score for each of the eight subscales (holistic climate, inappropriate jokes, inconsiderate behavior, gossip and rumors, free riding, abusive

supervision, lack of respect, and displaced frustration) as well as the determination of source specific causes of incivility.

Ethical Considerations

Participation in this study was voluntary. No individual was coerced to participate or faced any consequences for not participating in the study. The participant's privacy was ensured by not requiring any identifying information for the survey. The researcher and advisor were the only individuals that had access to the survey results. The survey results and statistics were kept on the researcher's password protected computer in her home office.

The researcher attached a general informed consent to participate in the study (Appendix D). This informed consent outlined the purposes of the study, the anonymity of the participants, and how the results will be used, and any risks associated with participating in the survey. Because of the opportunity for a participant to experience mild emotional distress due to the nature of some of the questions, the participants were guided to seek the assistance of the employee assistance program at the institution. Implied consent was the completed survey.

Permission for the study was obtained from the Internal Review Board (IRB) of the University as well as the Internal Review Board (IRB) of the facility where the study took place.

CHAPTER IV

Results

Exploring incivility among nurses in the hospital setting provided a baseline for growth in this area as well as a guide for possible interventions to improve this area. Results from this study may be able to provide opportunities for education interventions as well as the development of a specific policy regarding incivility in the workplace.

Sample Characteristics

The survey was sent via email to 653 registered nurses at a health care facility in the Southeastern United States, 158 nurses completed the Nursing Incivility Scale (NIS) providing a sample size of 24% of employed registered nurses. Demographic characteristics for the study participants are shown in Table 1. The majority of the participants were in the age range of 41-50 (26%) and 51-60 (21%). Over half of the participants (54%) had an associate degree in nursing, 38% had a bachelor degree, and 8% had a master degree. Fifty-six percent of the nurses surveyed indicated having between two to twenty years of experience.

Table 1

Demographic Characteristics of Participants (n=158): Age, Education Level, and Years of Experience

Variables	<i>n</i>	%
Age Range		
20-30	38	24
31-40	32	20
41-50	41	26
51-60	41	26
60+	6	4
Education		
Associates Degree (ADN)	85	54
Bachelor Degree (BSN)	60	38
Master Degree (MSN)	13	8
Experience		
Less than 2 years	17	11
2-20 years	88	56
20+ years	53	34

Note. Due to rounding error, percentages may not add up to 100.

Instrument Reliability

Cronbach alpha reliability was assessed with this sample using Guideroz et al., (2010) guidelines on reliability, where alpha values greater than .90 indicated excellent reliability: alpha values greater than .80 indicated good reliability: alpha values greater than .70 indicated acceptable reliability, alpha values greater than .60 indicated questionable reliability, and alpha values less than .60 indicated unacceptable reliability.

General Hostile Climate had a Cronbach's alpha reliability of .64 and General Inconsiderate Behavior had a Cronbach's alpha reliability of .67, suggesting questionable reliability. General Inappropriate Jokes, Nurse Gossip and Rumors, Direct Supervisor Abusive Supervision and Patient and Visitor Lack of Respect all had .90 or greater Cronbach scores indicating excellent reliability. Table 2 illustrates the Cronbach scores for the respective subscales.

Table 2

Cronbach's Alpha Reliability for Each of the Subscales of the Nursing Incivility Scale (NIS)

Composite	α	No. of items
General Hostile Climate	.64	3
General Inappropriate Jokes	.93	3
General Inconsiderate Behavior	.67	3
Nurse Hostile Climate	.89	3
Nurse Gossip and Rumors	.91	4
Nurse Free Riding	.87	3
Direct Supervisor Abusive Supervision	.94	4
Direct Supervisor Lack of Respect	.88	3
Physician Abusive Supervision	.89	4
Physician Lack of Respect	.86	3
Patient and Visitor Lack of Respect	.90	6
Patient and Visitor Displaced Frustration	.89	4

Descriptive Statistics

Means and standard deviations were calculated using Guidroz et al. (2010) directions for scoring (See Table 3). Each statement of the Nursing Incivility Scale (NIS) is rated on a five-point Likert-type agreement scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). The subscales are hostile climate, inappropriate jokes, inconsiderate behavior, gossip/rumors, free riding, abusive supervision, lack of respect, and displaced frustration. To compute subscale scores, individual item scores for each of the subscales were summed and averaged to extract more specific information for targeting interventions. Source level aggregated (e.g. Physician Abusive Supervision) subscale scores were also summed and averaged. According to Guidroz et al. (2010), this is appropriate for understanding source-specific incivility.

General Hostile Climate, General Inappropriate Jokes, and General Inconsiderate Behavior were answered considering all employees that a registered nurse encounters during the day while at work. The General Hostile Climate mean was 3.10 (SD= 0.76) and included questions related to observance of employees raising their voices when frustrated, employees blaming others for mistakes, and basic disagreements escalating into personal verbal attacks. The General Inappropriate Jokes mean was 2.27 (SD 1.02) and included questions related to jokes about minority groups, religious groups and gender. The General Inconsiderate Behavior questions explored issues of employees taking things without asking, employees talking too loudly, and employees displaying offensive body language (e.g. crossed arms and body posture). The General Inconsiderate Behavior mean was 2.97 (SD=0.83).

Table 3

Means and Standard Deviations for 12 Subscale Scores of the Nursing Incivility Scale (NIS).

Variable	<i>M</i>	<i>SD</i>
General Hostile Climate	3.10	0.76
General Inappropriate Jokes	2.27	1.02
General Inconsiderate Behavior	2.97	0.83
Nurse Hostile Climate	1.95	0.78
Nurse Gossip and Rumors	3.29	1.02
Nurse Free Riding	2.59	0.90
Direct Supervisor Abusive	1.54	0.64
Direct Supervisor Lack of Respect	1.98	0.99
Physician Abusive Supervision	3.02	0.95
Physician Lack of Respect	2.73	0.88
Patient & Visitor Lack of Respect	2.37	0.81
Patient & Visitor Displaced	3.12	0.88

Nurse Hostile Climate, Nurse Gossip and Rumors, and Nurse Free Riding were to be answered considering interactions with other nurses. The Nurse Hostile Climate subscale included questions related to nurses' arguing frequently, nurses' having heated arguments in the workplace and nurses' screaming at other employees. The Nurse Hostile Climate had a mean of 1.95 (SD=0.78). Nurse Gossip and Rumors included statements about gossip about one another, gossip about their supervisor while at work and bad-mouthing of others in the workplace. The mean for Nurse Gossip and Rumors was 3.29 (SD=1.02) and was the highest subscale category for the sample surveyed. The Nurse Free Riding mean was 2.59 (SD= 0.90). The Nurse Free Riding subscale included questions related to other nurses taking credit for work they did not do as well as making little contribution to projects and expecting to receive credit.

The Direct Supervisor Abusive Supervision subscale and the Direct Supervisor Lack of Respect subscale were to be answered with the direct supervisor (i.e. the person reported to most frequently) in mind. The Direct Supervisor Abusive Supervision subscale included questions related to the supervisor being verbally abusive, yelling about matters that are not important, shouting or yelling about mistakes, and taking their feelings out on the nurses (e.g. “blowing off steam”, stress, anger). The mean for Direct Supervisor Abusive Supervision subscale was 1.54 (SD=0.64). The Direct Supervisor Lack of Respect subscale included questions related to not responding to nurse concerns in a timely manner, being condescending, and factoring gossip into personal decisions. The Direct Supervisor Lack of Respect subscale had a mean of 1.98 (SD=0.99).

The Physician Abusive Supervision subscale and the Physician Lack of Respect subscale were to be answered with the physicians with whom the nurse associates in mind. The Physician Abusive Supervision subscale included questions pertaining to physicians yelling at nurses for making mistakes, physicians being verbally abusive to nurses, and physicians taking their feelings out on nurses (e.g. “blowing off steam”, stress, anger). The Physician Abusive Supervision mean was 3.02 (SD= 0.95). The Physician Lack of Respect subscale questions were related to physicians not responding to nurse concerns in a timely manner, nurses feeling as if the physician does not think their time is important, and physicians being condescending. The Physician Lack of Respect mean was 2.73 (SD=0.88).

The last subscales of the Nursing Incivility Scale are related to patient and visitor interactions with the nurse. The two subscales associated with patient and visitor interactions are Patient and Visitor Lack of Respect and Patient and Visitor Displaced

Frustration. The Patient and Visitor Lack of Respect subscale contains questions related to patients and visitors criticizing job performance, being condescending, making comments that question nurse competence, and making verbal attacks against nurses. The Patient and Visitor Lack of Respect mean was 2.37 (SD=0.81). The Patient and Visitor Displaced Frustration subscale explores level of agreement with statements about patients and visitors taking their frustrations out on nurses, making insulting comments to nurses, treating nurses as if they are inferior or stupid and showing that they are irritated or impatient with the nurse. The Patient and Visitor Displaced Frustration subscale mean was 3.12 (SD= 0.88).

CHAPTER V

Discussion

Exploring incivility among nurses in the hospital setting provided a baseline for growth in this area as well as a guide for possible interventions to improve this area. Results from *Exploring Incivility in the Hospital Setting* may be able to provide opportunities for education interventions as well as the development of a specific policy regarding incivility in the workplace.

Interpretation and Implication of Findings

The purpose of exploring incivility in the hospital setting at this particular facility was to garner information; if a problem of incivility exists and to what extent or level. Twenty-four percent (n=158) of registered nurses employed at this facility answered the Nursing Incivility Scale. Based on the means provided in the results, some areas of improvement can be addressed. The four areas of focus are General Hostile Climate (3.10), Nurse Gossip and Rumors (3.29), Physician Abusive Supervision (3.02) and Patient and Visitor Displaced Frustration (3.12).

The questions related to General Hostile Climate deal with all employees a nurse may encounter during a day at work. Nurses come into contact with all types of different people in the hospital setting. This type of question can lead to a wide interpretation because some of these interactions may be very short-term consisting of only a few minutes once a week, while some may be an everyday occurrence consisting of interactions throughout the day. In order to discuss or implement interventions or recommendations further investigation into this particular subscale would be warranted

with more specific definitions of types of interactions and which departments are involved.

Nurse Gossip and Rumors had the highest mean (3.29) of all the subscales in this study. This issue is one that needs to be addressed as it can affect teamwork and collaboration, which in turn can affect patient safety and care (Lindy & Schauer, 2010). The gossip that was identified not only was about other coworkers but also included gossip about direct supervisor. Literature suggested that management can have a positive impact on increasing nurse civility if it is relationship focused (Laschinger et al., 2014). Managers can also be role models for professional behavior and lead by example.

Consistent with the literature was the finding that at this facility nurses perceive that Physician Abusive Supervision is a problem (Bigony et al., 2009; Lim & Bernstein, 2014; Rosenstein, 2011; Rosenstein, 2010). This finding can not only affect teamwork and collaboration, but it can also become a patient safety issue if a nurse is intimidated to the point of neglecting to notify the physician of a change in patient status for fear of verbal abuse.

The last problem identified as an issue within this facility was the perception from the nurses that patient and visitors exhibit displaced frustration. This frustration can stem from many things that are out of the nurse's control such as, cleanliness of the facility, physician rounding time, food delivery and quality, and noise level of the unit. The frustration may not be directed at the nurse, but because in most cases the nurse is the one the patient and visitor interact with the most, he/she can become the recipient of the frustration.

Limitations and Recommendations

The amount of time allotted for this survey (two weeks) may have contributed to the low response rate that occurred with this particular survey. Statistics were calculated and the results from this sample were consistent with those of Guidroz et al. (2010) indicating reliability and validity of this instrument with this sample. However, all of the statements in the Nursing Incivility Scale were negatively worded producing a response code that can lead to allowing some respondents to see a pattern and to not answer as thoughtfully as one might with a mixture of positively and negative worded statements of agreement (Privitera, 2014, p. 233). Using a different survey instrument with a mixture of positive and negative worded statements could help to eliminate the problem of a response code (Privitera, 2014).

In the future, a more in-depth look at the demographics of the sample could be useful. For example, having the respondent answer which department he/she works in could be helpful in identifying which areas tend to have issues with incivility and targeting interventions to strengthen civility in that area. Also, the inclusion of all staff employed at a facility could provide useful information pertaining to the general climate of incivility and interventions can be directed at source specific or department levels.

A limitation of this particular study was providing ranges for the participants to answer questions such as age and level of experience. In future studies it would be more beneficial for statistical analysis to have participants provide a specific age number and specific year of experience instead of a range of years.

Implications for Nursing Practice

This study has provided information that can help guide this facility into making some positive changes for its nursing workforce. The researcher has identified that there is no specific incivility policy at this facility. Results from this study can be presented to the administration for review and consideration of the implementation of such a policy. Nurse perception of Physician Abusive Supervision should be examined further by administration as it can lead to a patient safety issue. Nurses should be familiar with the code of conduct policy and be knowledgeable of the processes in place to report abusive behavior. Administration can address problems in a timely manner so that others can see that this type of behavior is not tolerated (McNamara, 2012).

Educational offerings such as journal clubs about incivility in nursing and conflict resolution can be implemented. Workshops exhibiting effective communication and collaboration techniques can be offered to all nurses as part of their yearly competency to keep nurses evolving into better communicators.

Application to Conceptual Framework

Utilizing Neuman's first level of primary prevention can help reduce the stress a nurse may feel as a result of incivility. Some examples of primary prevention that can be used would be educational tools to teach effective communication skills, teamwork exercises to increase collaboration and unity on the nursing unit, and a zero tolerance policy that is enforced when abusive behavior occurs. According to Neuman, when these primary prevention tools are put into practice, the possibility for the stressor to cause problems is decreased, and the normal line of defense is strengthened leading to a decrease to reaction of the stressor (Alligood & Tomey, 2010).

Conclusion

This study has provided information about the different types of incivility that a nurse can experience in the hospital setting. He/she may experience it from all people that he/she comes into contact with on any given day and in any given situation. No nurse is immune to the effects of incivility and every nurse can do his or her part in helping to identify uncivil behaviors and striving to provide a safe environment for themselves and the patients in their care.

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Appendix A

Nursing Incivility Scale

Participant Instructions: Please tell us about the type of interactions you have with the people you meet at work. The following statements describe behaviors that sometimes occur in the workplace. Please indicate your level of agreement with each of the following statements using one number that best represents your present work situation.

- 1=Strongly Disagree
- 2=Disagree
- 3=Neither Agree nor Disagree
- 4=Agree
- 5=Strongly Agree

For the following items, please consider **all individuals** you interact with at work, including doctors, and other nurses or hospital personnel.

-
1. Hospital employees raise their voices when they get frustrated.
 2. People blame others for their mistakes or offenses.
 3. Basic disagreements turn into personal verbal attacks on other employees.
 4. People make jokes about minority groups.
 5. People make jokes about religious groups.
 6. Employees make inappropriate remarks about one's race or gender.
 7. Some people take things without asking.
 8. Employees don't stick to an appropriate noise level (e.g. talking too loudly).
 9. Employees display offensive body language (e.g., crossed arms, body posture).
-

The following describe your interactions with other **nurses**. Other nurses on my unit...

-
1. ...argue with each other frequently.
 2. ...have violent outbursts or heated arguments in the workplace.
 3. ...scream at other employees.
 4. ...gossip about one another.
 5. ...gossip about their supervisor at work.
 6. ...bad-mouth others in the workplace.
 7. ...spread bad rumors around here.
 8. ...make little contribution to a project but expect to receive credit for working on it.
 9. ...claim credit for my work.
 10. ...take credit for work they did not do.
-

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.
 2. ...yells at me about matters that are not important.
 3. ...shouts or yells at me for making mistakes.
 4. ...takes his/her feelings out on me (e.g., stress, anger, "blowing off steam").
 5. ...does not respond to my concerns in a timely manner.
 6. ...is condescending to me.
 7. ...factors gossip and personal information into personnel decisions.
-

This section refers to **physicians** you work with. Please indicate your level of agreement with the following items.

-
1. Some physicians are verbally abusive.
 2. Physicians yell at nurses about matters that are not important.
 3. Physicians shout or yell at me for making mistakes.
 4. Physicians take their feelings out on me (e.g., stress, anger, "blowing off steam").
 5. Physicians do not respond to my concerns in a timely manner.
 6. I am treated as though my time is not important.
 7. Physicians are condescending to me.
-

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.

Patient/visitors...

-
1. ...do not trust the information I give them and ask to speak with someone of higher authority.
 2. ...are condescending to me.
 3. ...make comments that question the competence of nurses.
 4. ...criticize my job performance.
 5. ...make personal verbal attacks against me.
 6. ...pose unreasonable demands.
 7. ...have taken out their frustrations on nurses.
 8. ...make insulting comments to nurses.
 9. ...treat nurses as if they were inferior or stupid.

10. ...show that they are irritated or impatient.

Guidroz, A., Burnfield-Geimer, J., Clark, O., Schwetschenau, H., Jex, S. (2010). The nursing incivility scale: Development and validation of an occupation-specific measurement. *Journal of Nursing Measurement*, 18(3), 176-200.

Appendix B:

Authorization to Use Nursing Incivility Scale

From: Ashley Guidroz <amguidroz@gmail.com>
Subject: Re: permission to use Nursing Incivility Scale
Date: October 22, 2014 at 12:01:32 PM EDT
To: Lesley Gillian <lann2000@aol.com>

Hi Lesley,

Thank you for your interest in the Nursing Incivility Scale. Your research sounds interesting and I support your use of the scale for your Masters Thesis. Please let me know if you have any questions about the measure. Best of luck on your research!

Ashley

On Wednesday, October 22, 2014, Lesley Gillian <lann2000@aol.com> wrote:
Dr. Guidroz,

My name is Lesley Gillian and I am currently pursuing my MSN in Nursing Education (graduate May 2015) at Gardner Webb University in Boiling Springs, NC. I am in the planning stages (proposal/IRB applications) for my thesis and would like permission to use your Nursing Incivility Scale for my research. I plan to utilize a descriptive study amongst nurses in a local hospital to assess the level of incivility. I look forward to hearing from you soon.

Thank you,
Lesley Gillian, RN

--

Ashley M. Guidroz, PhD

Appendix C

Invitation Email

Potential Survey Participant,

You are invited to participate in a research study exploring incivility among nurses in the hospital setting. This study is being conducted as part of a requirement for the Masters in Nursing degree program at Gardner Webb University.

The survey should take approximately 10 minutes to complete. You may access the survey by clicking on the link below. An informed consent is included in the survey. All responses will be anonymous. Thank you for your participation.

Any questions or concerns may be directed to:

Lesley Gillian, RN MSN Student
Lagillian@nhcs.org or lann2000@aol.com

Dr. Janie Carlton, Thesis Advisor
jcarlton@gardner-webb.edu

Appendix D

Informed Consent

Potential Survey Participant:

You are invited to participate in a research study regarding nurse perceptions of incivility in the workplace. The following information is provided in order to help you make an informed decision whether or not to participate.

The purpose of this study is to explore incivility in nursing. Participation in this study will include completion of a survey entitled Nursing Incivility Scale (NIS) and completion of some demographic information. The survey will take approximately 10-15 minutes to complete.

There are no foreseeable risks to participants in this study. The participants may experience mild emotional discomfort related to the nature of the information and experiences with incivility. Should you experience any emotional discomfort please utilize the Employee Assistance Program. Participation or failure to participate will have no impact on your employment with this facility.

Your participation in this study is voluntary. You are free to decide not to participate in this study or withdraw at any time.

If you chose to participate, all information collected will be anonymous. Data obtained via the Survey Monkey portal will be aggregate data only with no individual identifying information. The information obtained in the study may be published in journals or presented in meetings but your identity will be anonymous.

If you are willing to participate in this study, completing and submitting the survey via Survey Monkey will imply consent. Thank you for your time and participation.