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The Effects of In-Service Education on Workplace Incivility for CRNAs

Tran King

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THE EFFECTS OF IN-SERVICE EDUCATION ON
WORKPLACE INCIVILITY FOR CRNAS

by

Tran Ngoc Bao King

A Capstone Project
Submitted to the Graduate School,
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and the Department of Advanced Practice
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for the Degree of Doctor of Nursing Practice

December 2017

THE EFFECTS OF IN-SERVICE EDUCATION ON
WORKPLACE INCIVILITY FOR CRNAS

by Tran Ngoc Bao King

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ABSTRACT

THE EFFECTS OF IN-SERVICE EDUCATION ON
WORKPLACE INCIVILITY FOR CRNAS

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Workplace incivility (WPI) affects many healthcare providers, including Certified Registered Nurse Anesthetists. This project was an exploration of the prevalence, nature, and sources of WPI affecting CRNAs. The project's intervention was an in-service education on WPI for CRNAs. The purposes of the project were to measure the effectiveness of the in-service education in increasing awareness of CRNAs about WPI; and to offer a practice change proposal in terms of a policy against WPI in the anesthesia department.

A Needs Assessment Survey and Demographic Data Information form were distributed from Survey Monkey to participants' email by way of blind copy. Data was analyzed using Microsoft Excel program. Each participant completed a pre-test and a post-test on knowledge of WPI. A comparison between the pre-test and post-test mean scores was made to determine the effectiveness of the intervention.

The final sample size for the Needs Assessment was 20. On the 5-point Likert-type scale, WPI experienced by CRNAs from a variety of offenders within the anesthesia department was the highest mean score (M=3.29). WPI experienced by CNRAs from other CRNAs was the lowest mean score (M=2.49). Twelve (12) CRNAs participated in this project's in-service session and

completed a pre- and post-test on their level of knowledge of WPI. The pre-test knowledge mean score was 4.7 of 10.0 possible points; the post-test mean score was 10.0 of 10 points. These results indicated 100% of the CRNAs who participated in the in-service session increased their knowledge and awareness about WPI. This project's findings indicated that CRNAs in the participating facility have a knowledge deficit about WPI and have experienced WPI. The WPI in-service education for this project provided noticeable clinical effects in increasing knowledge and awareness about WPI among CRNA participants.

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TABLE OF CONTENTS

ABSTRACT	ii
ACKNOWLEDGMENTS	iv
TABLE OF CONTENTS	v
LIST OF TABLES	viii
LIST OF ILLUSTRATIONS	ix
CHAPTER I – INTRODUCTION	1
Problem Statement.....	1
Background and Significance	1
Needs Assessment and Clinical Questions	3
Summary of the Evidence	3
Search Strategies	3
Evidence Summary.....	4
Theoretical Framework.....	14
Doctor of Nursing Practice Essentials	15
Purpose of the Project.....	16
Target Outcomes.....	17
CHAPTER II – METHODOLOGY	18
Setting	18
Population	18

Design	18
Procedures	19
Project Instruments	19
Project Intervention	20
Ethics and Resource Requirement	20
CHAPTER III – RESULTS	22
Data Analysis	22
Results	22
CHAPTER IV – DISCUSSION	28
Summary	28
Interpretation of Results	29
Limitations	30
Future Practice Implications	31
Conclusion	31
APPENDIX A Letter of Support	32
APPENDIX B IRB Approval Letter	33
APPENDIX C Informed Consent Form	34
APPENDIX D Instrument Tool Permission for Usage	35
APPENDIX E Needs Assessment Survey	36
APPENDIX F Demographic Data Information	37

APPENDIX G Workplace Incivility Handouts	38
APPENDIX H Workplace Incivility Knowledge Pre-test/ Post-test	40
APPENDIX I Proposal for Practice Change.....	41
REFERENCES.....	42

LIST OF TABLES

Table 1 Self-reported WPI Witness and Personal Experience by the Respondents	24
Table 2 Self-reported Hospital Policy Awareness, Whistleblower Policy Awareness, and WPI Training	24

LIST OF ILLUSTRATIONS

<i>Figure 1.</i> Self-reported age of the respondents.	23
<i>Figure 2.</i> Self-reported number of years of experience of the respondents.	23
<i>Figure 3.</i> Self-reported sources of WPI by the respondents	26
<i>Figure 4.</i> Mean composite scores of WPI's sources from the Modified Nursing Incivility Scale survey	26
<i>Figure 5.</i> WPI knowledge pre-test and post-test mean scores	27

CHAPTER I – INTRODUCTION

Problem Statement

Workplace incivility (WPI) affected many occupations, especially the nursing profession (Park, Cho, & Hong, 2015). Hutton and Gates (2008) defined WPI as “low-intensity, deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect” (p. 168). Incivility was defined as “rude or disruptive behaviors that often result in psychological or physiological distress for the people involved and, if left unaddressed, may progress into a threatening situation” (Clark & Davis Kenaley, 2011, p. 158).

Studies about WPI affecting the nursing profession are abundant, but few studies about Certified Registered Nurse Anesthetists (CRNAs) exist. WPI has direct negative effects on the victims, both psychologically and physically (Waschler, Ruiz-Hernández, Llor-Esteben, & Jiménez-Barberoo, 2013). Indirectly, WPI has negative effects on patient care outcomes and professional-organizational levels (Lewis & Malecha, 2011; Waschler et al., 2013).

Background and Significance

With the high-pressure and hectic environment of operating rooms (ORs), CRNAs are at a higher risk of becoming the victims of WPI. “CRNAs work in a unique environment and hold responsibilities beyond the scope of nursing, which place them in a unique category, separating them from others in the nursing profession” (Elmblad, Kodjebacheva, & Lebeck, 2014, p. 438). Chipas and McKenna (2011) explained that intense interactions between CRNAs and other healthcare providers frequently increased stress and burnout, which further

affected CRNAs physiologically and psychologically, while also decreasing job retention.

Felblinger (2008) described many characteristics of incivility, which “includes both subtle and obvious levels of rude and discourteous behavior, exclusion from important work activities, taking credit for another’s work, withholding important information, yelling, screaming, verbal attacks, and expression of negative verbal comments in front of others” (p. 235). Other reported examples of incivility were gossiping, discounting inputs, angry outburst, interrupting others, berating coworkers, and exhibiting temper tantrums (Felblinger, 2008). From the years 2011 to 2013, workplace assaults ranged from 23,540 to 25,630 events annually, but most (70% to 74%) of assaults occurred in healthcare and social service environments (OSHA, 2015). Lewis and Malecha (2011) identified WPI as an indirect type of nonphysical violence. Medical occupation workplace violence (WPV) incidents were 10.2% as compared to all WPV incidents. According to one study on WPV in the ORs, a majority of healthcare personnel (91%, N=78) reported experiencing various forms of verbal abuse perpetrations by a physician (Cook, Green, & Topp, 2001). In a recent quantitative study of nurses (N=151,347), researchers indicated, “violence exposure rates were 36.4% (n=77,658) for physical violence, 67.2% (n=72,376) for nonphysical violence, 37.1% (n=9388) for bullying, and 27.9% (n=18,128) for sexual harassment, with 32% (n=12,947) of nurses reporting having been physically injured in an assault” (Spector, Zhou, & Che, 2014, p. 75). “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” (Warrner, Sommers, Zappa, & Thornlow, 2016, p. 23).

Needs Assessment and Clinical Questions

According to the American Association of Nurse Anesthetist (AANA), there are more than 50,000 CRNAs and Student Registered Nurse Anesthetists (SRNAs) in the United States (2016). CRNAs are the primary providers of anesthesia in rural America performing a variety of services (AANA, 2016). Maintaining a healthy civil working environment for CRNAs is crucial in order to provide the best and the safest care to the patients. Based on the literature and findings from this current study, WPI exists in ORs. The clinical questions for this study were: What were the prevalence, nature, and sources of WPI in the ORs as perceived by CRNAs in the past year? How effective was the in-service education on WPI for CRNAs?

Summary of the Evidence

Search Strategies

The evidence review for this study consisted of using the databases from The University of Southern Mississippi’s Library website. The databases include publications between 1991 and 2016 on Academic Search Premier, CINAHL, MEDLINE, and EBSCOhost. Search terms used were: workplace violence, workplace incivility, nursing, nurse anesthetists, and operating room. The search terms “workplace violence or workplace incivility” and “nursing” yielded 2,436

results, while the search terms “workplace violence or workplace incivility” and “operating rooms” yielded 27 results. The search terms “workplace violence or workplace incivility” and “nurse anesthetists” yielded 5 results, while the search terms “workplace incivility” and “nurse anesthetists” yielded 1 result. The most highly relevant articles were used for literature review below.

Evidence Summary

WPI has many negative effects on the victims, patient care outcomes, and organizational level (Lewis & Malecha, 2011; Waschler et al., 2013). Studies about WPI affecting CRNAs are limited as compared to similar studies about nurses. This evidence summary was divided into four main themes: (a) negative effects on victims, (b) negative effects on patient care outcomes, (c) negative effects on organizational level, and (d) suggestions for proposed interventions.

Negative Effects on Victims. In a study by Chipas and McKenna (2011), an electronic survey about stress, burnout, and coping mechanisms were distributed to 28,000 CRNAs and student registered nurse anesthetists (SRNAs) with the final sample size of 7,537. Eighty-five percent (85%; n=6,406) of respondents were CRNAs and 15% (n=1,131) were SRNAs. On a 10-point Likert scale, CRNAs had 4.7 as an average level of stress, where work-related was the main stressor; SRNAs had the highest average stress level of 7.2, where school was the main stressor (Chipas & McKenna, 2011). Thirty-one percent (31%; n=1,985) of CRNAs and 27% (n=305) of SRNAs utilized professional help as a coping mechanism; however, 18.9% (n=1,210) of CRNAs and 19.3% (n=218) of SRNAs took antianxiety or antidepressant prescribed medications to reduce

stress (Chipas & McKenna, 2011). Stress decreased concentration, lowered self-esteem levels, and job retention. Stress also increased financial strains and employment change. Coping mechanisms for stress included disruptive behaviors, such as alcohol use, self-criticism, quitting, negative expressions, and oversleeping (Chipas & McKenna, 2011).

Elmblad et al. (2014) conducted a study of WPI prevalence, severity, and consequences with proposed interventions affecting CRNAs through 1,700 active members of the Michigan Association of Nurse Anesthetists from October 8 to November 25, 2012. With a response rate of 22.6%, the total sample size was 385 surveys. The findings included: (a) the mean score of 63.5 for incivility experienced from all sources; (b) the mean score of 51.3 for incivility experienced with other CRNAs; (c) the mean score of 37.6 for incivility experienced from CRNA supervisors; (d) the mean score of 62.3 for incivility experienced from physicians; and (e) the mean score of 43.4 for burnout (Elmblad et al., 2014). The researchers concluded that WPI and burnout in CRNAs had a direct and linear regression relationship with the statistically significant of $p < .0001$ (Elmblad et al., 2014). The researchers found that when the respondents experienced an increase in WPI, the level of burnout also increased. The researchers stated WPI existed in operating rooms and negatively affected CRNAs by increasing their level of burnout.

Cook et al. (2001) explored the effects of physician verbal abuse on perioperative nurses (N=78). Ninety-one percent (n=71) of respondents experienced physician verbal abuse at least once in the past year (Cook et al.,

2001). Among the 91% of respondents, 45% (n=45) experienced verbal abuse several times a year; 22.5% (n=16) experienced one incident or less per month; 5.6% (n=4) with once per week; 22.5% (n=16) with a few times per week; and 4.3% (n=3) daily (Cook et al., 2001). Emotional effects on nurses from physician verbal abuse included “frustration, anger, disgust, embarrassment and humiliation, sadness, and hurt” (Cook et al., 2001, p. 325). Long-term negative effects were: (a) negative relationship with physicians, (b) decreased trust/support in the workplace, (c) decreased self-esteem or sense of well-being in the workplace, and (d) decreased job satisfaction.

Rosenstein (2002) conducted a survey of convenience sample with 24 questions to employees of 84 hospitals or medical groups of the Voluntary Hospital Association in July 2001. The purpose of the study was to explore the impact of nurse-physician relationships on nurses' employment satisfaction and retention. The respondents (N=1,200) included 720 nurses, 173 physicians, 26 administrators, and 281 other staff members. Only 1,177 of the respondents answered the question asking whether they had witnessed disruptive behavior, and 92.5% of 1,177 respondents (n=1,089) said yes (Rosenstein, 2002). The frequency of disruptive behaviors was once or twice a month with 308 respondents (28%) or weekly with 286 respondents (26%). Disruptive behaviors had a negative effect on the nurses' employment satisfaction and morale. Of 1,121 respondents who answered the question asking whether they had knowledge of other nurses leaving the hospital because of disruptive behavior, 344 (30.7%) out of 1,121 respondents said yes. Only 1,200 respondents

answered the question about the estimation of nurses that left the facility every year because of disruptive behaviors. Three hundred and sixty seven (30.8%) out of 1,200 respondents reported the average of 2.4 nurses that left the facility due to disruptive behaviors (Rosenstein, 2002).

In one study, a 21-item survey questionnaire was used to explore the disruptive behaviors of nurses, gender affected on disruptive behavior, and the perceived impact of disruptive behavior on clinical outcomes (Rosenstein & O'Daniel, 2005). The respondents included 1,091 (72%) registered nurses, 402 (27%) physicians, and 16 (1%) executive administrators (N=1,509). Many respondents said yes to negative effects of disruptive behavior on psychological and behavioral variables such as: (a) stress (n=1,475), (b) frustration (n=1,477), (c) concentration loss (n=1,459), (d) reduced team collaboration (n=1,463), (e) decreased information transfer (n=1,449), (f) decreased communication (n=1,184), and (g) impaired RN-MD relationship (n=948) (Rosenstein & O'Daniel, 2005). Among 675 nurses who responded to the question whether they witnessed disruptive behavior from physicians, 583 (86%) said yes. Of the 960 respondents who answered the question about whether they witnessed disruptive behavior from nurses, 653 (68%) said yes. Only 1447 respondents answered the question about the frequency of disruptive behaviors from physicians and the results included: (a) weekly (22%; n=315); (b) once or twice a month (26%; n=365); (c) 1 to 5 times a year (33%; n=470); and (d) daily (8%; n=110) (Rosenstein & O'Daniel, 2005). Of 1,389 respondents, the frequency of disruptive behavior from nurses consisted of: (a) weekly (13%; n=180); (b) once

or twice a month (26%; n=363); (c) 1 to 5 times a year (39% n=535); and (d) daily (6%; n=83) (Rosenstein & O'Daniel, 2005).

In another study, Rosenstein and O'Daniel (2006) used a 25-item survey questionnaire to explore the prevalence and impact of disruptive behaviors in the ORs with a total of 244 respondents. Disruptive behaviors with the most concerning findings were from: (a) surgeons, daily 15% of the time and weekly 22% of the time; (b) anesthesiologists, daily 7% of the time and weekly 2% of the time; and (c) nurses, daily 7% of the time and weekly 21% of the time. A variety of negative effects from disruptive behaviors in the ORs consisted of stress, frustration, concentration loss, decreased collaboration, decreased communication, decreased information transfer, and decreased relationships among staff members (Rosenstein & O'Daniel, 2006).

Negative Effects on Patient Care Outcomes. Sakellaropoulos, Pires, Estes, and Jasinski (2011) randomly selected 700 CRNAs from 30,168 active members of the AANA to participate in a study about workplace aggression in the field of nurse anesthesia. The study instrument was the Workplace Aggression Research Questionnaire with the final sample size of 205. The CRNAs reported that workplace aggression occurred more toward female CRNAs (20-39 years of age, M=106, 89.1%, n=129), as compared to male CRNAs of the same age interval (M=63, 83%, n=76). These researchers concluded: (a) the top two types of perpetrators were supervisors and coworkers; (b) workplace aggression occurred more in the verbal, active, and direct forms as compared to physical, passive, and indirect forms; and (c) CRNAs were made to feel incompetent by

physicians (Sakellaropoulos et al., 2011). A linear relationship ($p < .001$) existed in experiences of CRNAs between workplace stress levels and “verbal, direct, and active aggression ($r=0.45$, $r=0.43$, $r=0.41$, respectively)” (Sakellaropoulos et al., 2011, p. S54). Twenty-one percent (21%, $n=17$) reported that workplace aggression negatively impacts patient safety, such as: (a) loud music affected time out; (b) surgeons forced CRNAs to perform anesthetic procedures that were not safe for patients; and (c) surgeons rushed CRNAs to extubate patients too early (Sakellaropoulos et al., 2011).

Hutton and Gates (2008) administered 850 survey packets to all direct care staff persons at a large hospital in a metropolitan area in the Midwest United States to examine workplace incivility and productivity losses among direct care staff people. Study instruments included the Work Limitation Questionnaire and the Incivility in Healthcare Survey with the final sample size of 184. Some findings were statistically significant, including: (a) the relationship between productivity and WPI from supervisors and patients ($r=0.284$, $p=.000$) and (b) the relationship between productivity and WPI from patients ($r=0.204$, $p=.006$) (Hutton & Gates, 2008). WPI from supervisors and patients caused worsening effects on productivity compared to WPI from other sources (Hutton & Gates, 2008). The researchers demonstrated a decrease in nursing assistants' productivity led to negative patient outcomes and longer hospital stays (Hutton & Gates, 2008).

In the study of Rosenstein and O'Daniel (2005) ($N=1,50$), among 962 respondents who answered the question whether disruptive behaviors negatively

affected patient outcomes, 94% (n=904) said yes. Among 1,478 respondents answered the question whether the potential adverse events had occurred due to disruptive behavior, 60% said yes (n=896). Only 249 respondents answered the question whether they believed these adverse events could have been prevented. Seventy-eight percent (n=198) out of 249 respondents said yes. In a different study, these same researchers revealed that disruptive behaviors in the ORs not only caused adverse events and medical errors, but these disruptions also interfered with patient safety and patient quality (Rosenstein & O'Daniel, 2006).

Rosenstein (2011) conducted a study focused on the quality and economic effects of disruptive behaviors on patient care outcomes. The results indicated that disruptive behaviors affected the victims and patient care outcomes negatively. Many of the negative consequences included: low staff satisfaction and morale, decreased patient safety, negative hospital reputation, decreased patient satisfaction, increased staff turnover, and increased hospital financial loss. Disruptive behaviors increased medical errors and, therefore, decreased patient safety and quality (Rosenstein, 2011).

Negative Effects on Organizational Level. Lewis and Malecha (2011) used the Nursing Incivility Scale and the Work Limitation Questionnaire to explore the effects of WPI on the work environment, manager skill, and productivity in direct care nurses (N=659) working in Texas. The findings included: (a) WPI existed with different scores among different nursing units; (b) WPI rates in the past 12 months were 85% (n=553); (c) the ability of the nurse managers in managing

workplace incivility was inadequate according to the nurses' perception; and (d) a loss of productivity from WPI was calculated to be about \$11,581 per nurse per year (Lewis & Malecha, 2011). The more the WPI increased, the lower the productivity became (Lewis & Malecha, 2011).

The negative effects of WPI on the organizational level included: (a) nursing assistant's productivity loss of \$1,235.14, (b) registered nurse's productivity loss of \$1484.03, and (c) hospital productivity loss of \$1.2 million yearly (Hutton & Gates, 2008). Financial risks relating to disruptive behaviors included: (a) \$60,000 to \$100,000 for training new nurses; (b) \$2,000 to \$5,800 per case for medication errors with increased length of stay to 2.2 to 2.4 days; (c) a mean of \$345,000 for surgical malpractice claims; and (d) \$25,000 to \$100,000 fines per hospital (Rosenstein, 2011). Negative patient satisfaction also decreased hospital reputation (Rosenstein, 2011).

Suggestions for Proposed Interventions. Chipas and McKenna (2011) proposed interventions on the development and application of stress management education in anesthesia schools for SRNAs, while having stress management resources readily available to the CRNAs. Elmblad et al. (2014) proposed interventions against WPI affecting CRNAs included: (a) development and implementation of educational program against workplace incivility in anesthesia program for students and educators, (b) application of an educational program against workplace incivility and a zero tolerance policy to each healthcare facility, and (c) implementation of workshops and in-services on workplace incivility management to all employees of each healthcare facility.

Recommendations against WPI include: (a) further research on strategies development to maintain a civil workplace environment, (b) further evaluation on the effectiveness of the intervention against WPI, (c) an establishment of a code of conduct against WPI, and (d) emphasis on the important roles of nurse leaders in maintaining safe and civil workplace environments (Lewis & Malecha, 2011). Hutton and Gates (2008) suggested a need for more research on interventions against WPI.

Cook et al. (2001) suggested ways to prevent physician verbal abuse on perioperative nurses: (a) an implementation of an educational training about verbal abuse for nurses, administrators, and physicians; (b) a creation of a zero-tolerance verbal abuse policy; and (c) an educational program for nurses about communication with conflict resolution skills to address physician verbal abuse behavior. Spector et al. (2014) recommended a comprehensive violence prevention program with content on violence from patients, patients' families and friends, and staff members including nurses and physicians. Kvas and Seljak (2014) studied the unreported WPV in Slovenian nurses (N=692) from November 2010 to February 2011. Sixty-one percent (61%, n=426) of the respondents reported experiencing workplace violence in the past year; 14.6% (n=101) with physical violence; 28.9% (n=200) with economic violence; 60.1% (n=416) with psychological violence; and 11.4% (n=79) with sexual violence. Researchers offered two suggestions: (a) training should focus on communication and conflict resolution skills as a workplace violence prevention method, and (b) all employees should receive a WPV training program through the organization

(Kvas & Seljak, 2014). Recommendations for improvement of nurse-physician relationships from Rosenstein's study (2002) were educational and training programs at the facility, development of zero-tolerance policies against disruptive behaviors, and development of a forum of discussion groups. Rosenstein and O'Daniel (2005; 2006) discussed several strategies for improvement against disruptive behaviors, such as: (a) staff educational training to increase the issue of awareness, (b) policy development and implementation of acceptable codes of behaviors, (c) communication tool development, (d) staff collaboration, and (e) conduction of organizational self-assessment.

One group of researchers sampled 970 female nurses from 47 nursing units at a university hospital in Seoul, Korea from January to February 2013 on the prevalence and perpetrators of WPV as well as the relationship between violence and the perceived work environment (Park et al., 2015). Findings on prevalence of WPV were: (a) verbal abuse, 63.8% (n=619); (b) threats of violence, 41.6% (n=402); (c) physical violence, 22.3% (n=216); (d) sexual harassment, 19.7% (n=191); and (e) bullying, 9.7% (n=94). Conclusions drawn from the findings included: (a) a greater work demand and a decrease in trust and injustices were among many factors that increased the violence exposure to nurses; (b) patients and physicians were the top two main sources of WPV in this study; and (c) nurses with less years of experience, as compared to more experienced nurses, were at a higher risk of becoming the victims of WPV (Park et al., 2015). The researchers emphasized the importance of a decrease in WPV, the creation of a healthy workplace environment in nursing, and more violence

prevention programs specifically aimed at the different characteristics on each nursing unit (Park et al., 2015).

Warrner et al. (2016) developed and implemented a quality improvement program to decrease WPI at inpatient units of 60-bed orthopedic surgical specialty hospitals. Participants (N=114) completed a pre-survey of the Nursing Incivility Scale before the training session began. The participants also completed a post-1 survey immediately after the training and a post-2 survey 2 months after the training to determine if the training was successful. The finding of the post-1 survey of nursing incivility was 86% (n=98) and the post-2 survey of nursing incivility was 36% (n=41). In addition, the post-1 survey results indicated a slight increase in awareness about WPI with a general incivility mean score of 2.75, as compared to a pre-survey mean score of 2.73 (Warrner et al., 2016).

Theoretical Framework

This project explored the prevalence, nature, and sources of WPI affecting CRNAs as well as the relationship among CRNAs and other caregivers. The caring theory of Jean Watson serves as the theoretical framework for this DNP project because the theory encourages each person to love, trust, and honor self and others (Watson, 1985). Watson (1985) stated “caring is the moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity” (p. 29). Watson’s caring theory can increase love and respect among CRNAs and among other caregivers. Therefore, workplace incivility affecting CRNAs will also be decreased. “Watson’s theory of caring has played a major

role in helping professional nurses honor their unique and distinct values” (Duffy, 2015, p. 504).

Doctor of Nursing Practice Essentials

Doctor of Nursing Practice (DNP) Essential I is the scientific underpinning for practice (Zaccagnini & White, 2014). This project met DNP Essential I because it was developed from the most current evidenced-based practice about the negative effects of WPI affecting healthcare providers. The organizational and systems leadership for quality improvement and systems thinking is DNP Essential II (Zaccagnini & White, 2014). WPI caused negative physical and psychological effects on victims. These negative effects increased turnover rate, which also decreased patient care safety, and decreased organizational benefits.

DNP Essential III includes clinical scholarship and analytical methods for evidence-based practice (Zaccagnini & White, 2014). Watson’s theory of human caring served as the framework for this DNP project. Organizations and hospitals focusing on patient care quality improvement and a healthy work environment had used and applied Watson’s theory of human caring as a basis for practice. DNP Essential IV focuses on information systems or technology and patient care technology for the improvement and transformation of care (Zaccagnini & White, 2014). This DNP project utilized electronic database for the review of literature. An educational presentation and handouts were used to inform CRNAs about the prevalence, negative impact, and preventions of WPI.

DNP Essential V centers on healthcare policy for advocacy in healthcare (Zaccagnini & White, 2014). This DNP project met this essential because the

project had the potential to be applied in the Quality Improvement Project of the facility. The second potential of this DNP project included the development and a recommendation of implementation of a zero-tolerance policy against WPI in the anesthesia department. DNP Essential VI emphasizes interprofessional collaboration for improving patient and population health outcomes (Zaccagnini & White, 2014). This DNP project increased awareness about WPI among CRNAs. CRNAs would be able to share knowledge with other professionals in the surgical setting. This DNP project could be applied to other healthcare professionals such as stakeholders, directors, and managers. Shared knowledge and interprofessional collaboration could improve patient care outcomes.

DNP Essential VII reinforces clinical prevention and population health for improving the nation's health (Zaccagnini & White, 2014). This DNP project provided an in-service educational program focusing on negative impacts, recognition, confrontation, and preventions of WPI. Increasing knowledge about WPI encouraged CRNAs and other health care members to develop a WPI prevention plan, which could provide a healthy working environment and positive patient care outcomes. DNP Essential VIII encompasses Advanced Nursing Practice (Zaccagnini & White, 2014). This DNP project was developed on the most current evidenced based practice to provide a healthy working environment for the healthcare providers. The final purpose of this DNP project was to improve patient care safety and outcomes.

Purpose of the Project

The proposed project was to explore the prevalence, nature, and sources

of WPI affecting CRNAs. The project's intervention was an in-service education on WPI for CRNAs. The first purpose of the project was to measure the effectiveness of the in-service education in increasing awareness of CRNAs about WPI. The second purpose was to create a practice change by developing a policy against WPI in the anesthesia department after the intervention. The DNP project's PICOT format was: Would an in-service education on WPI (I) increase the awareness (O) among CRNAs (P)?

Target Outcomes

The project's initial outcome was premise that the mean score of the post-test would be higher as visually compared to the pre-test mean score. The higher post-test mean score would indicate that the intervention was effective in increasing the awareness about WPI among CRNAs. The primary goal of this project was to increase the awareness about WPI among CRNAs. The secondary goal of this project was to recommend a practice change proposal. The recommended practice change included the development of a policy against WPI in the anesthesia department.

An intermediate outcome (3 months after the intervention) will be that 50% or more of the CRNAs will confirm their increased confidence in confronting, reporting, and preventing WPI in the OR. A long-term outcome (1 year or more after the intervention) will be an implementation of the educational program in other departments within the facility with the aims of better adherence to the facility's zero tolerance policy and therefore a reduction of WPI.

CHAPTER II – METHODOLOGY

Setting

The chosen facility was a 512-bed hospital in South Mississippi. The surgical department provides a variety of services from outpatient to inpatient surgical services. A total of 17 operating rooms consisted of 13 designated rooms for general surgery, three designated rooms for open-heart surgery, and one designated room for vascular surgery.

Population

A convenience sample was used to recruit CRNA participants for the project. The target's population included all 40 CRNAs employed by the facility. CRNAs are registered nurses who graduated from accredited anesthesia programs and have unrestricted licenses to practice anesthesia. The sampling criteria were: (a) male and female CRNAs of the age of 18 and older; (b) full time, part-time, or seasonal employment status; and (c) able to read and write English. The maximum potential sample size was 40 CRNAs. Participants' identities were protected throughout the project. Exclusion criteria include CRNAs who had restricted licenses, and those in administrative position that no longer provided direct patient care.

Design

This DNP project was an interventional initiative with the conduction of a needs assessment before the intervention. The participants completed a pre-test before and a post-test after the intervention. The mean score for the pre-test was

calculated, as well as a calculation of the mean score for the post-test. The researcher's visual comparison was used to confirm the effectiveness of the interventional program.

Procedures

A letter of support from the chosen facility with approval from the Institutional Review Board (IRB) of The University of Southern Mississippi were obtained before data collection and implementation of the interventional program (see Appendices A & B). Though anonymity was not entirely possible because of the exposure between participants within the in-service session, the researcher attempted to protect the CRNA participants' identity as much as possible.

Confidentiality was maintained. After obtaining the informed consents from the participants, each participant was assigned a code number, which was placed on the informed consent form to anonymize the data (see Appendix C). Participants could withdraw from the study at any time without being questioned or any negative consequences.

Project Instruments

Elmblad et al. (2014) modified the Nursing Incivility Scale and used it as one of the instruments to explore the prevalence, nature, and sources of WPI affecting CRNAs. Permission to use the questionnaires from the authors was obtained, and the Modified Nursing Incivility Scale was created as a Needs Assessment for this project (see Appendices D and E). Participants received a Survey Monkey link by way of blind copy that took them to the Needs

Assessment Survey (the Modified Nursing Incivility Scale) and Demographic Data Information (see Appendices E and F). Participants had 4 weeks to complete the surveys. Data for these surveys was analyzed by Microsoft program.

Project Intervention

The in-service education program was a 10- to 15-minute presentation about the needs assessment survey results. Each participant received handouts including WPI information, such as definition, how to recognize, report, and prevent WPI (see Appendix G). The in-service session also provided information about available resources along with facility's policies. Each CRNA participant completed a pre-test on knowledge of WPI prior to the in-service session and a post-test at the end of the in-service session (see Appendix H). A visual comparison between the pre-test and post-test mean scores was made to determine the effectiveness of the intervention.

Ethics and Resource Requirement

The approvals from Institutional Review Boards of the chosen facility and The University of Southern Mississippi were obtained before the implementation of the project. Participation in this study was voluntary, and CRNAs had the right to terminate participation at any time during the project without any fear of retaliation by the researcher or the facility. There were potential inconveniences and discomforts that participants could experience. Workplace incivility is a sensitive topic, which could result in minimal occupational discomfort if there was

a violation of confidentiality of the participants by the researcher or participants. Although anonymity was not entirely possible, confidentiality was paramount in this study. Data from the research was protected. No information could be used to identify any individual CRNAs. This DNP project and completion required some resources. Those resources included The University of Southern Mississippi Library, computer access, Internet access, and related books.

CHAPTER III – RESULTS

Data Analysis

One of the independent variables for this project was the in-service education. Other independent variable was the demographic data information of the participants, such as gender, age, years of experience, and employment status. The dependent variable was the mean score of knowledge post-test. Data was analyzed by Microsoft Excel program.

Results

A total of 29 CNRAs participated in the study after all informed consents were completed and collected. Participants had 4 weeks with a 2-week reminder to complete the Demographic Data Information form and the Modified Nursing Incivility Scale needs assessment survey, on the 5-point Likert-type scale. Twenty-three (23) surveys were collected From March 6, 2017, to April 6, 2017. The final sample size was 20 because 3 of the 23 surveys were incomplete.

Most of the survey respondents were male (80%, n=16). All the respondents were full time CRNAs. There was a variety of age ranges and years of experiences among the respondents. Respondents were divided into five age groups: (a) 18-29 years old (5%, n=1), (b) 30-39 years old (50%, n=10), (c) 40-49 years old (30%, n=6), (d) 50-59 years old (10%, n=2), and (e) 60 or above (5%, n=1) (see Figure 1). Years of experience ranged from 5 years or less to 21 years or more: (a) 0-5 years (45%, n=9), (b) 6-10 years (15%, n=3), (c) 11-15 years (15%, n=3), (d) 16- 20 years (10%, n=2), and (e) 21 years or more (15%, n=3)

(see Figure 2).

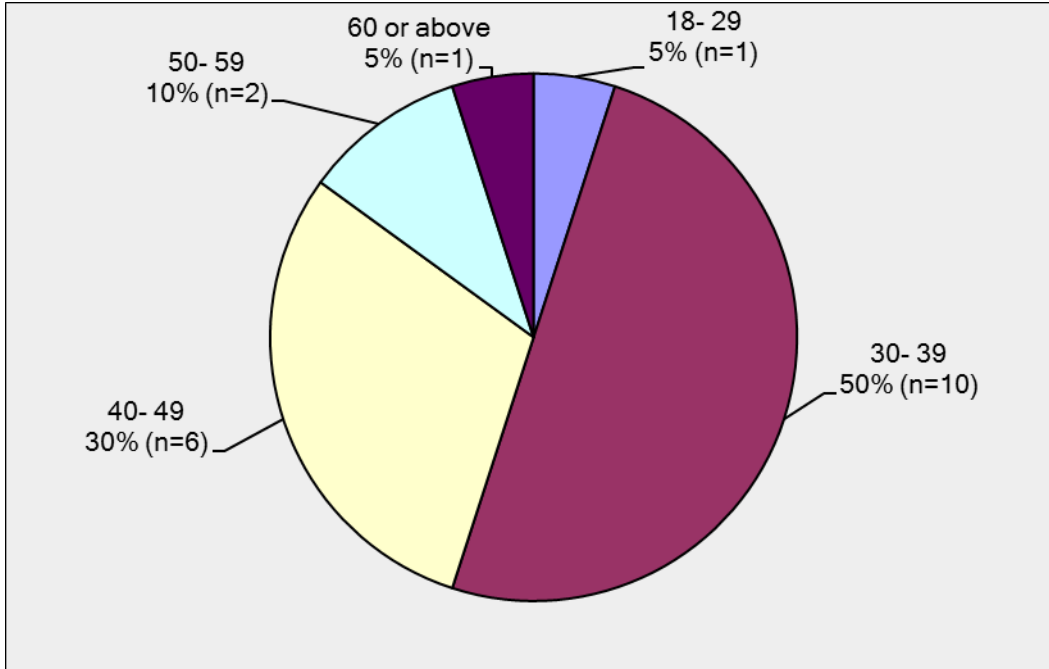


Figure 1. Self-reported age of the respondents.

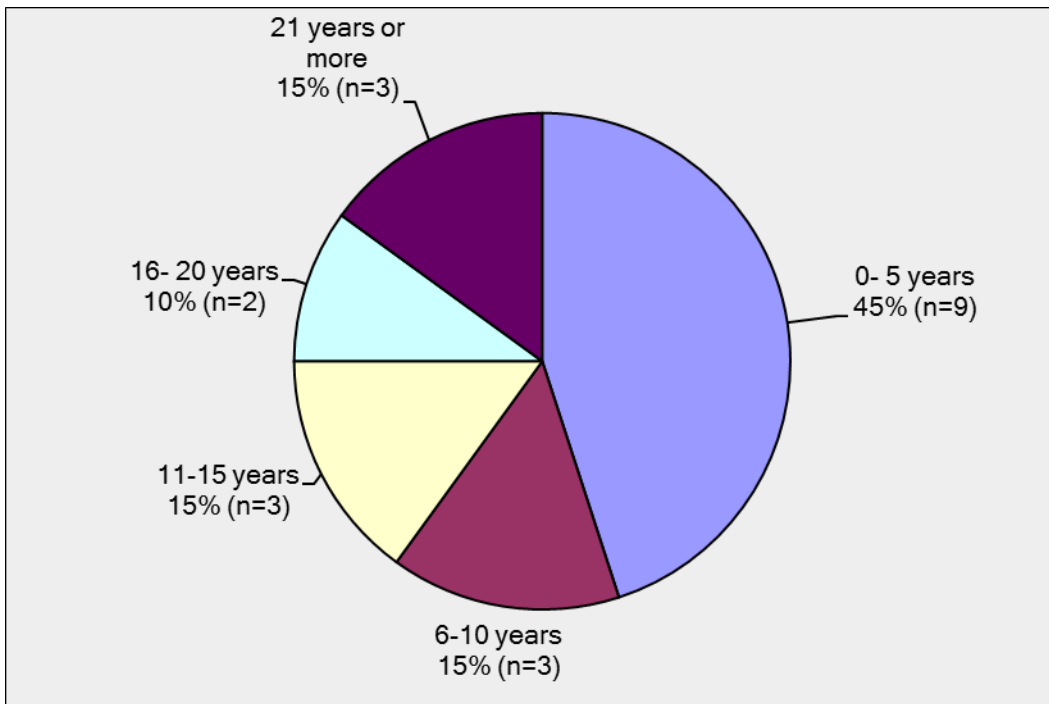


Figure 2. Self-reported number of years of experience of the respondents.

On the question, Have you witnessed WPI at your current department? 80% (n=16) of respondents said yes, 10% (n=2) said no, and 10% (n=2) said unsure. On the question, Have you personally experienced WPI at your current department? 55% (n=11) said yes, 40% (n=8) said no, and 5% (n=1) said unsure (see Table 1). Seventy percent (70%, n=14) of respondents were unaware of the hospital's policy against WPI and Whistleblower policy. Ninety percent (90%, n=18) of respondents had not received training about WPI at their current department (see Table 2).

Table 1

Self-reported WPI Witness and Personal Experience by the Respondents

	Yes	No	Unsure
Have you witnessed WPI at your current department?	80% (n=16)	10% (n=2)	10% (n=2)
Have you personally experienced WPI at your current department?	55% (n=11)	40% (n=8)	5% (n=1)

Table 2

Self-reported Hospital Policy Awareness, Whistleblower Policy Awareness, and WPI Training

	Yes	No
Are you aware of the hospital policy against WPI?	30% (n=6)	70% (n=14)
Are you aware of the "Whistleblower policy" at your facility?	30% (n=6)	70% (n=14)
Have you received training about WPI at your department?	10% (n=2)	90% (n=18)

On the question about the sources of WPI that respondents have witnessed or experienced, ranking from highest to lowest included an all that apply format, respondents reported: (a) surgeons/physicians (88.9%, n=16), (b) anesthesiologists (77.8%, n=14), (c) nurses (61.1%, n=11), (d) surgical staffs (61.1%, n=11), (e) family and/or friends of patients (38.9%, n=7), (f) patients (33.3%, n=6), and (g) administrators (27.8%, n=5) (see Figure 3). The Modified Nursing Incivility Scale needs assessment, on the 5-point scale, revealed that the highest WPI experienced was from all sources, and the lowest WPI experienced was from CRNAs. The mean composite scores for WPI were: (a) 3.29 from all individuals, (b) 2.87 from physicians, (c) 2.52 from the direct supervisor, and (d) 2.49 from CRNAs (See Figure 4).

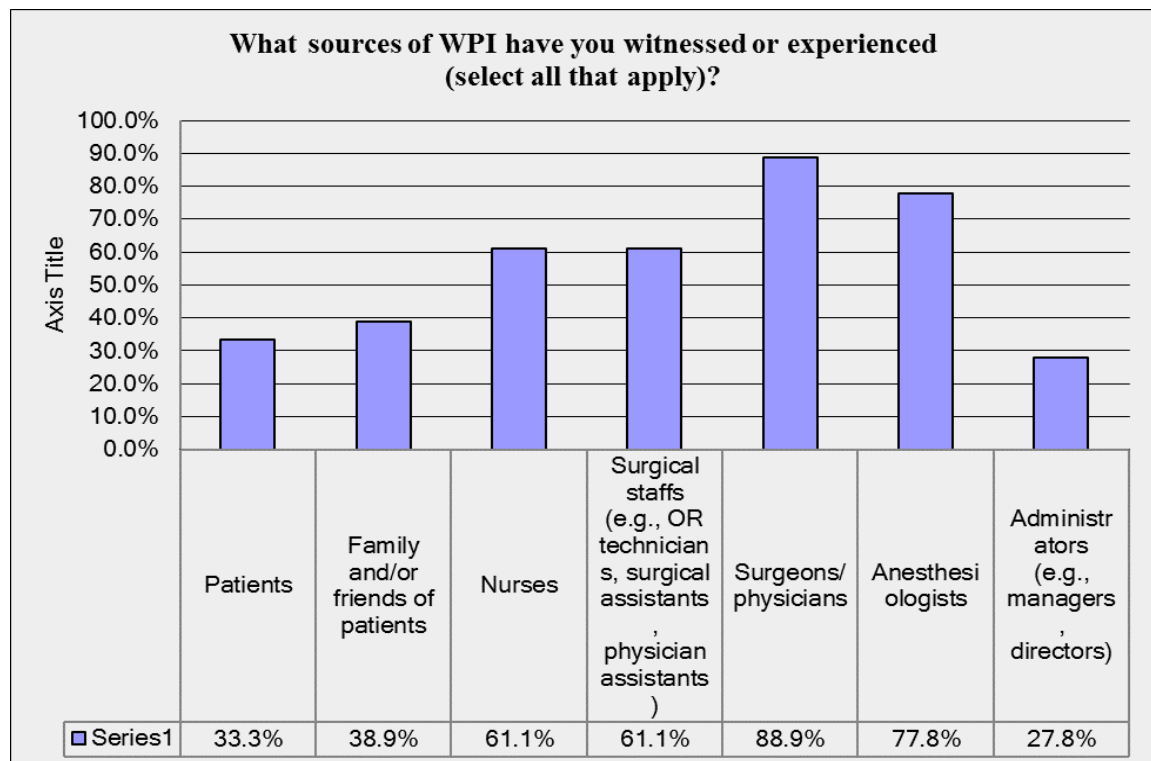


Figure 3. Self-reported sources of WPI by the respondents

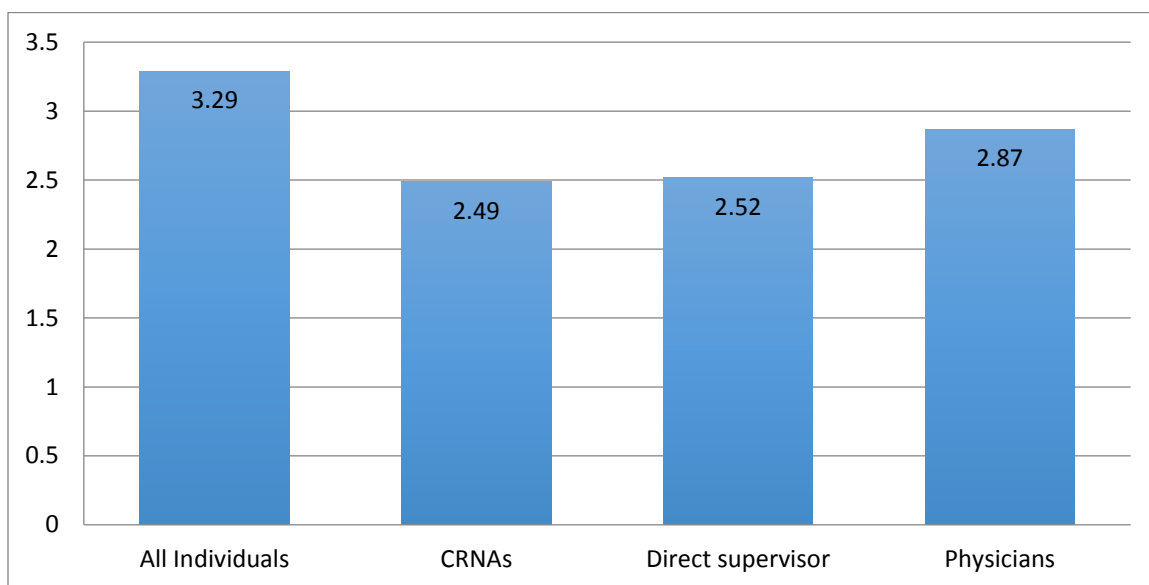


Figure 4. Mean composite scores of WPI's sources from the Modified Nursing Incivility Scale survey

The project's intervention was a 10- to 15- minute in-service educational session on WPI. Each participant was provided with a handout (see Appendix G) containing information about WPI along with the facility's available resources against WPI. Among those 20 consenting CRNAs, only 12 CRNAs agreed to complete the in-service session along with the WPI knowledge pre-test and post-test (see Appendix H). The pre-test and post-test means score were collected and visually compared. The WPI knowledge pre-test mean score was 4.7 of 10.0, and the post-test mean score was 10.0 of 10.0 (See Figure 5).

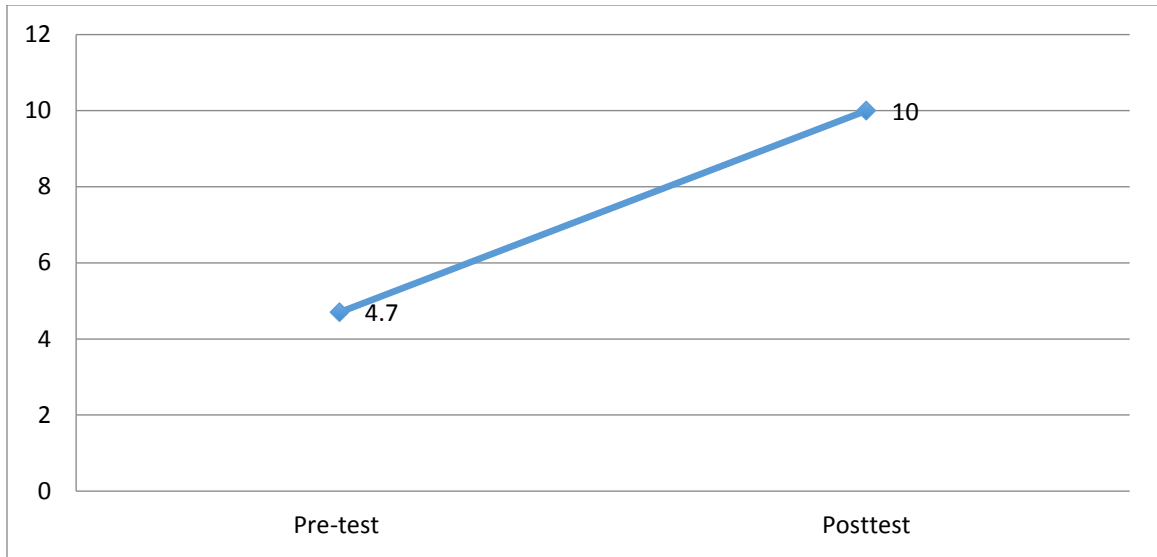


Figure 5. WPI knowledge pre-test and post-test mean scores

CHAPTER IV – DISCUSSION

Summary

Firstly, this project provided the information about the prevalence and sources of WPI affecting CRNAs in this chosen facility. The Modified Nursing Incivility Scale results showed CRNAs were exposed to WPI in their current department. WPI experienced from all individuals was the highest with the mean composite score of 3.29, followed by physicians, direct supervisors, and CRNAs with the lowest mean composite score of 2.49. The facility had intensive policies against WPI, workplace bullying, disruptive and inappropriate behaviors, along with zero-tolerance policy against WPV and WPI. However, most of the participants were unaware of the policy and available resources provided by the facility. Knowledge deficit about WPI in this population existed. Ninety percent of the respondents have not received WPI training. Therefore, a recommendation for WPI training should be implemented in the anesthesia department for new hired CRNAs as well as annually training for current CRNAs to reinforce knowledge about WPI.

Secondly, no policy against WPI existed in the anesthesia department. Therefore, the secondary goal of this project was to recommend a practice change proposal, which included the development of a policy against WPI (see Appendix I) in the anesthesia department. The proposed policy change content supports the facility's existing zero tolerance policy on violence and incivility and re-emphasizes that the anesthesia department follow the facility's policy to

maintain a healthy civil working environment. A discussion with the operating room director was made regarding the addendum of the policy against WPI into anesthesia department. The director appreciated the input; however, she refused to add the suggested policy into the current policies of the anesthesia department stating that the anesthesia department could always refer back to the Human Resources' policies of the facility.

Lastly, the in-service education session was successful in increasing awareness about WPI among participating CRNAs. Compared to the WPI knowledge pre-test mean score of 4.7, the post-test mean score was 10.0 of 10 points. These results indicated 100% of the CRNAs who participated in the in-service session increased their knowledge and awareness about WPI.

Interpretation of Results

Compared to the results of the study of Elmlad et al. (2014), there was a difference in the order of the WPI prevalence. According to Elmlad et al. (2014), the WPI mean composite score ranking from the highest to the lowest was from all sources, then physicians, then CRNAs, and supervisors. This study also showed similar results with the two highest WPI mean composite score from all sources and physicians. However, in this study, WPI experienced by CRNAs was the lowest, compared to supervisors as the lowest in Elmlad et al. (2014) study. In conclusion, CRNAs mainly experienced WPI from all sources and from the physicians. Further research should emphasize on strategies development to decrease WPI experienced from these two particular sources. Administrators

should actively participate in WPI policy development, WPI prevention program development, and WPI training.

Mean score of the WPI knowledge pre-test was higher than the WPI knowledge post-test. This visual comparison showed the benefits of the in-service education in increasing knowledge and awareness about WPI among the participants. According to a previous study about the benefits of the implementation of WPI training, the post-1 survey incivility mean score was 2.75, as compared to a pre-survey mean score of 2.73 (Warrner et al., 2016). Similar to Warrner et al. (2016), the post-test mean score was also higher than the pre-test mean score. However, the difference from post-test and pre-test mean scores was more noticeable in this study. CRNAs could play a leading role in WPI policy development, WPI training development, and delivering WPI knowledge to other staff members within and outside the anesthesia department. With the refusal to add the suggested WPI policy into the anesthesia department policy, individual CRNAs should become an advocate to continue pursuing the implementation of the WPI policy into the anesthesia department policy.

Limitations

The risk of bias in this project was higher with the use of convenience sampling. Therefore, the result of the project might not truly reflect the result for the overall CRNA population throughout the United States. Another limitation was the pre-test effect that could influence the post-test result (Melnyk & Fineout-

Overholt, 2015). Data collected from this study was illustrated as summary data and not discrete data.

Future Practice Implications

One of the future practice implications of this doctoral project is the implementation of a WPI in-service educational program into the facility's Quality Improvement Project. The WPI in-service educational program can be applied to other departments to improve knowledge about WPI among nurses, managers, and directors. Another future practice implication is the application of the in-service educational program into the Nurse Anesthesia Program. SRNAs who receive this educational program can have a better understanding of how to recognize, confront, prevent and eliminate WPI before starting clinical rotations.

Conclusion

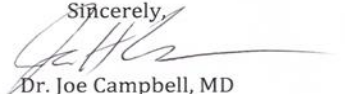
WPI exists in the healthcare profession. It affects all healthcare providers, including CRNAs. The results of this project showed that CRNAs in this facility have been exposed to WPI, and all of the participating CRNAs had a WPI knowledge deficit. WPI in-service education for CRNAs in this project provided positive effects in increasing knowledge and awareness about WPI among CRNAs. Therefore, each facility should develop its own WPI training session for not only CRNAs but also for other healthcare providers in different departments. Each individual plays an important role in maintaining a healthy working environment. In fact, an individual's awareness about WPI and policies against WPI are among the most important factors preventing incivility in the workplace.

APPENDIX A Letter of Support

December 8, 2016

I, Dr. Joe Campbell, MD support Tran King's doctoral project focusing on the effects of in-service education on workplace incivility for CRNAs.

Sincerely,



Dr. Joe Campbell, MD

APPENDIX B IRB Approval Letter



INSTITUTIONAL REVIEW BOARD

118 College Drive #5147 | Hattiesburg, MS 39406-0001

Phone: 601.266.5997 | Fax: 601.266.4377 | www.usm.edu/research/institutional.review.board

NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months.
Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: 17020207

PROJECT TITLE: The Effects of In-Service Education on Workplace Incivility for CRNAs

PROJECT TYPE: New Project

RESEARCHER(S): Tran King

COLLEGE/DIVISION: College of Nursing

DEPARTMENT: Advanced Practice

FUNDING AGENCY/SPONSOR: N/A

IRB COMMITTEE ACTION: Expedited Review Approval

PERIOD OF APPROVAL: 02/24/2017 to 02/23/2018

Lawrence A. Hosman, Ph.D.
Institutional Review Board

APPENDIX C Informed Consent Form

Code number:

THE UNIVERSITY OF SOUTHERN MISSISSIPPI AUTHORIZATION TO PARTICIPATE IN RESEARCH PROJECT

Participant's Name:
Age:
Email:

Consent is hereby given to participate in the research project entitled The Effects of In-Service Education on Workplace Incivility for CRNAs. All procedures and/or investigations to be followed and their purpose, were explained by Tran King. The procedures in this study are not considered experimental. Information was given about all benefits, risks, inconveniences, or discomforts that might be expected.

The opportunity to ask questions regarding the research and procedures was given. Participation in the project is completely voluntary, and participants may withdraw at any time without penalty, prejudice, or loss of benefits. All personal information is strictly confidential, and no names will be disclosed. Any new information that develops during the project will be provided if that information may affect the willingness to continue participation in the project.

Questions concerning the research, at any time during or after the project, should be directed to Dr. Janie Butts, Committee Chair, at (601) xxx- xxxx, or via email at xxxxx.xxxxx@usm.edu, or Tran King at (601) xxx- xxxx, or via email at xxxx.xxxx@usm.edu. This project and this consent form have been reviewed by the Institutional Review Board, which ensures that research projects involving human subjects follow federal regulations. Any questions or concerns about rights as a research participant should be directed to the Chair of the Institutional Review Board, The University of Southern Mississippi, 118 College Drive #5147, Hattiesburg, MS 39406-0001, (601) 266-5997.

Use the following only if applicable: The University of Southern Mississippi has no mechanism to provide compensation for participants who may incur injuries as a result of participation in research projects. However, efforts will be made to make available the facilities and professional skills at the University. Information regarding treatment or the absence of treatment has been given. In the event of injury in this project, contact treatment provider's name(s) at telephone number(s).

A copy of this form will be given to the participant.

Signature of participant

Date

Signature of person explaining the study

Date

APPENDIX D Instrument Tool Permission for Usage

Instrument Tool Permission for Usage

12/15/2016

Good Morning Tran,
You have my permission to use my study in your paper; which is titled "Workplace Incivility affecting CRNAs: A study of prevalence, severity, and consequences with proposed interventions."

I wish all the best and would like to learn the results.

Best regards, Ray

Ray P. Elmblad, CRNA, DrAP
Clinical Site Educational Coordinator
Pager 734-396-6266 #12244
remblad@umich.edu
Department of Anesthesiology
University of Michigan

APPENDIX E Needs Assessment Survey

Modified Nursing Incivility Scale (Needs Assessment Survey)

General, nursing, supervisor, and physician subscales We would like to know about the type of interactions you have with the people you work with.	Possible responses
<p>For the following items, please consider all individuals you interact with at work, including patients, visitor, doctors, other nurses or hospital personnel.</p> <ol style="list-style-type: none"> 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. Some employees take things without asking. 7. Employees don't stick to an appropriate noise level (eg, talking too loudly). 8. Employees display offensive body language (eg, crossed arms, body posture). 	<p>1 = Strongly disagree 2 = Disagree 3 = Neither agree or disagree 4 = Agree 5 = Strongly agree</p>
<p>The following items ask about your interactions with other CRNAs. How often do other CRNA in your department...</p> <ol style="list-style-type: none"> 9. ...argue with each other frequently? 10. ...have violent outburst or heated arguments in the workplace? 11. ...scream at other employees? 12. ...gossip about one another? 13. ...gossip about their supervisor at work? 14. ...bad-mouth others in the workplace? 15. ...spread bad rumors around here? 16. ...make little contribution to a project, but expect to receive credit for working on it? 17. ...claim credit for my work? 18. ...take credit for work they did not do? 	
<p>Please think about your interactions with your direct supervisor (ie, the person you report to most frequently) and indicate how strongly you agree with the following behavior. My direct supervisor...</p> <ol style="list-style-type: none"> 19. ...is verbally abusive. 20. ...yells at me about matters that are not important. 21. ...shouts or yells at me for making mistakes. 22. ...take his/her feelings out on me (eg, stress, anger, "blowing off steam"). 23. ...does not respond to my concerns in a timely manner. 24. ...factors gossip and personal information into personal decisions. 25. ...is condescending to me. 	
<p>This section refers to physicians you work with. Please indicate your level of agreement with the following items.</p> <ol style="list-style-type: none"> 26. Some physicians are verbally abusive. 27. Physicians yell at nurses about matters that are not important. 28. Physicians shout or yell at me for making mistakes. 29. Physicians take their feelings out on me (eg, stress, anger, "blowing off steam"). 30. Physicians do not respond to my concerns in a timely manner. 31. I am treated as though my time is not important. 32. Physicians are condescending to me. 	

(Elmblad et al., 2014, p. 439)

APPENDIX F Demographic Data Information

Demographic Data Information

By Tran King

1. Are you currently a licensed and practicing Certified Register Nurse Anesthetist in Mississippi?
 - Yes
 - No
2. What is your gender?
 - Male
 - Female
3. Which option best describes your age in years?
 - 18-29
 - 30-39
 - 40- 49
 - 50- 59
 - 60 or above
4. Which option best describes the number of years you have practiced as a CRNA?
 - 0- 5
 - 6- 10
 - 11-15
 - 16- 20
 - 20 or more
5. Have you witnessed workplace incivility (WPI) at your current department?
 - Yes
 - No
 - Unsure
6. Have you personally experienced WPI at your current department?
 - Yes
 - No
 - Unsure
7. What sources of WPI have you witnessed or experienced (select all that apply)?
 - Patients
 - Family and friends of patients
 - Nurses
 - Surgical staff (e.g., OR technicians, surgical assistants, physician assistants)
 - Surgeons/physicians
 - Anesthesiologists
 - Administrators (e.g., managers, directors)
8. Are you aware of the hospital policy against WPI?
 - Yes
 - No
9. Are you aware of the "Whistleblower policy" at your facility?
 - Yes
 - No
10. Have you received training about WPI at your department?
 - Yes
 - No

APPENDIX G Workplace Incivility Handouts

Workplace Incivility In-service Educational Session

By Tran King

Definition:

- “*Low-intensity, deviant behavior* with *ambiguous intent* to harm the target, in violation of workplace norms for mutual respect”.
(Hutton and Gates, 2008, p. 168)
- “One or more *rude, discourteous, or disrespectful* actions that may or may not have a negative intent behind them”.
(ANA, 2017, para. 2)
- In comparison with:
 - Workplace Bullying: “repeated, unwanted harmful actions intended to humiliate, offend and cause distress in the recipient”.
(ANA, 2017, para. 2)
 - Workplace Violence: “the act or threat of violence, ranging from verbal abuse to *physical assaults* directed toward persons at work or on duty”, it can include psychological issues to physical injury, or even death”!
(CDC, 2016, para. 1)

Background and Significance:

- High pressure + hectic working environment ✍ CRNAs are at a higher risk of becoming the victims of WPI.
- **\$11,581** per nurse per year loss of productivity from WPI (Lewis & Malecha, 2011).
- WPI could cause a productivity loss of **\$1.2 million yearly** (Hutton & Gates, 2008).
- **\$30,000 to \$100,000 per year for each employee** experiencing WPI because of absenteeism, decreased work performance, depression or/anxiety treatment for staff, and increased nursing turnover” (Warner, Sommers, Zappa, & Thomlow, 2016).
- Negative effects on **healthcare providers**:
 - Increased burnout, absenteeism
 - Decreased job satisfaction
 - Decreased sense of well-being in workplace
 - Decreased trust and support in the workplace
 - Decreased self-esteem
(Cook, Green, & Topp, 2001; Rosenstein & O’Daniel, 2006)
- Negative effects on **patient care outcomes**:
 - Increased staff turnover
 - Increased med errors
 - Decreased productivity
 - Decreased patient safety
 - Decreased patient satisfaction
(Rosenstein, 2011)
- Negative effects on **professional-organizational level**:
 - Increased staff turnover
 - Increased hospital financial loss.
(Hutton & Gates, 2008; Lewis & Malecha, 2011)



What are the characteristics of WPI?

- Yelling, shouting, screaming, violent outburst, gossiping, spreading rumor, verbally abuse.
- Turning disagreement into verbal attacks, blaming others for their mistakes, taking thing without asking.

- Taking feeling out on others, displaying offensive body languages, making joke about minority/religious group.
- Failing to respond to your concern in a timely manner, showing condescending to you. (Elmblad, Kodjebacheva, & Lebeck, 2014)

What are the available resources at your facility?

- F████████████████████ Hospital (F████████████████████) Human Resources' policies against
 - Harassment (p. 3-5), workplace violence (p. 17-18), disruptive and inappropriate behavior (p. 25-29)
 - <http://approd.fghnet.com/apps/policies/Files/hospital/HumanRes/Policy.doc>(Internal computer access only)
- F████████████████████ Chain of command that you can report the incident or conflict:
 - Immediate Supervisor / *Department Director* / Director of Employee Relation / Department Chief / Chief Human Resource Officer / President and Chief Executive Officer. (F████████████████████, 2017)
- Federal protection for Whistleblower by OSH Act, *Section 11 (c)*
 - <https://www.whistleblowers.gov/index.html> (OSHA, 2017)

What are WPI preventions?

- Management commitment against WPI (e.g., developing policy, providing resources to employee).
- Employee participation:
 - Be aware of the working environment
 - Be able to recognize WPI characteristics
 - Early address and report the issue.
 - Participate employee training and continuing education programs. (OSHA, 2015)



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APPENDIX H Workplace Incivility Knowledge Pre-test/ Post-test

Workplace Incivility Knowledge Pre-test/Post-test

By Tran King

- 1) Is Workplace Incivility (WPI) the same as Workplace Violence?
 - a. Yes
 - b. No
- 2) Only healthcare providers and patient care outcomes are negatively affected by WPI.
 - a. True
 - b. False
- 3) What are some of the characteristics of WPI?
 - a. Yelling, screaming, gossiping, spreading rumors, blaming others.
 - b. Involving physical assaults
 - c. Both a and b
 - d. None of these above
- 4) At your facility, who is the second individual of the Chain of command that you can report a WPI incident to?
 - a. Director of Employee Relation
 - b. Immediate supervisor
 - c. Department director
 - d. Department Chief
- 5) Occupational Safety and Health (OSH) Act of 1970, section 12 (c) provides federal protection for Whistleblower.
 - a. True
 - b. False

APPENDIX I Proposal for Practice Change

Proposal for Practice Change

Addendum Policy against Workplace Incivility in

Anesthesia Department

By Tran King

1. F [REDACTED] [REDACTED] has a zero tolerance for violent and uncivil acts or threats of violence and incivility directed toward any employee or non-employee by an employee or non-employee.
2. Anesthesia Department follows F [REDACTED] [REDACTED] policy to maintain a healthy civil working environment.
3. Anesthesia providers are encouraged to report uncivil incidence to immediate supervisors. F [REDACTED] [REDACTED] will not condone any form of retaliation against an anesthesia provider for making a report. See Human Resources Policies for further details.
4. Anesthesia providers have full federal protection under OSH Act, Section 11 (c) regarding Whistleblower policy.

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