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**Exploring & Mitigating Workplace Incivility at a Rural Community Hospital**

Jacquelyn R. Ethier

Dr. Cathleen Colleran

NURS 982 Doctoral Scholarly Project III

Department of Nursing, University of New Hampshire

**Author Note**

Jacquelyn Ethier

I have no conflicts of interest to disclose

Correspondence concerning this article should be addressed to Jacquelyn Ethier, 15 Foley Road, Chesterfield, NH 03443, United States.

Email: [jacquelynethier@gmail.com](mailto:jacquelynethier@gmail.com)

Faculty Mentor: Deborah Simonton, EdD, MS, RN, CNL

Practice Mentor: Jodi Stack, MSN, RN

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### **Abstract**

Workplace Incivility (WI) is a well-known challenge in healthcare, with decades of mounting evidence showing the effects on workplace culture, healthcare worker retention and patient safety. The nursing workforce has become increasingly vulnerable to all stressful elements of the work environment. Organizational leadership must develop and deploy mitigation strategies to minimize the negative consequences of these behaviors for nurses, and the entire healthcare team. The purpose of this quality improvement project is to assess the current state of nurse perceptions of WI at a rural community hospital and deploy evidence-based education on strategies to address and mitigate WI. The method utilized a validated tool for measuring workplace incivility, the Short-Negative Acts Questionnaire (S-NAQ-Appendix C), this tool was used pre and post intervention. Deployment of education for the leadership and nursing cohorts across campus included defining WI, with a current state assessment for the organization, education including a self-assessment, how to manage gossip, and respectful conversations in difficult situations. The S-NAQ pre-intervention assessment had a response rate of 23%, showing fairly significant levels of WI present at this organization in some categories. Gossip, exclusivity, offensive remarks & volatile reactions scored as the highest concerns for nurse respondents. Overall, the results of the S-NAQ post intervention showed changes in perception of WI behaviors by the nursing cohort in some areas, these changes could be the result of varying participation, as well as an increase in awareness of WI behaviors post education. Participants also reported an increased level of comfort in addressing gossip and initiating difficult conversations when WI behaviors occur in the work environment post education. In conclusion, assessing nursing perceptions of WI brings clarity to elements of WI that require increased focus and attention by the leadership team. Providing evidence-based education on mitigation strategies to address high priority areas, may influence toward an improved culture of civility over time, by fostering professional behaviors and a language of collaboration. Key words: workplace incivility, nurse, nurse retention, civility

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### Introduction

The nursing workforce is in ongoing jeopardy, exacerbated by the pandemic over the last three years and multiple other factors, including ongoing workplace incivility (WI). A 2022 American Nurses Association survey found that 70% of acute care nurses report being exhausted, with 21% intending to leave their positions within 6 months (Rutledge et al., 2022). Unfortunately, this number is continuing to rise with a recent AMN Healthcare survey reporting that about 30% of nurses state they will leave their nursing career in 2023, a significant increase over a very short period (Muchmore, 2023). The emotional toll facing nurses at the bedside has become unmanageable for many, leading to increased turnover and vacancy rates at many healthcare organizations. Nurses are committed to providing high-levels of energy and attention to complex patient care over long shifts, providing this intense caregiving increases the potential incidence for burnout and compassion fatigue (Sullivan & Germain, 2020). Moral distress, burnout and compassion fatigue are running rampant amongst nurses: pre-pandemic, female nurses had double the suicide rate risk compared to women in general (David et al, 2021). The pandemic has exacerbated two main suicide risk factors; work-related stress and mental health stress, with those in the medical field having shown to be more at-risk for work-related suicides over all (Sullivan & Germain, 2020). Of eighty-four nurses studied, over 60% met the criteria for burnout, with 45% of participants reporting symptoms of depression (Stocchetti, et al, 2021). Sullivan & Germain (2020) note, nurses are twice as likely to experience depressive symptoms (a leading cause of suicide) compared to any other profession. Nurse leaders are compelled to strategically implement efforts that will create a culture of physical, mental, and emotional well-being for nurses in order to more effectively support this essential workforce (Weston, 2022).

According to the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission, healthcare organizational leadership bears the responsibility of developing and supporting programs that promote patient and staff safety, inclusive of professional behaviors (CMS, 2023 & The Joint

Commission, 2019). Workplace Incivility (WI) is defined as “low-intensity social behaviors that are generally considered unacceptable in the workplace, may intend to cause harm” (Armstrong, 2018). While this definition is generic, the available research expounds on incivility taking many forms of rude and discourteous behaviors, including while not limited to: gossiping, refusal to assist, condescending verbal tones, public criticism, name-calling, avoidance and non-verbal behaviors such as eye-rolling, heavy sighs or other types of body language that can be perceived negatively (American Nurses Association, 2023, Meier, Evans & Ives Erickson, 2021). Repeated occurrences of these behaviors directed intentionally or unintentionally, are often more commonly known as bullying or horizontal violence (Robert Wood Johnson PACERS, 2015). With 34% of nurses reporting that they are not feeling emotionally healthy, the moral obligation to our teams in managing these types of behaviors in the healthcare environment is evident, while the business case is also compelling given the cost of ongoing turnover and risks of a temporary, traveling workforce (American Nurses Foundation, 2021).

### **Problem Description**

In 2015, the American Nurses Association (ANA) developed a position paper stating that the nursing profession will not tolerate violence of any kind, from any source. In addition, the ANA challenged healthcare organizations to adopt evidence-based strategies that prevent and mitigate incivility, bullying and workplace violence in order to promote health, safety, wellness and optimal outcomes in healthcare. Today, the ANA continues to advocate at the federal level and within our profession, to end verbal acts of aggression by colleagues that have serious consequences for the well-being of nurses and their ability to care for patients (American Nurses Association, 2023). While the presence of workplace incivility has been known, researched and published for decades, little progress has been made in the presence of workplace incivility in the healthcare culture. With the pandemic, many organizations reverted to core direct patient care operations out of necessity, further exposing the impact of disruptive behaviors (Meier, Evans & Ives Erickson, 2021). As the pandemic recedes and more

normal operations commence, we have increasing capacity for awareness of uncivil behaviors. In our renewed capacity post-pandemic, we must capitalize on the opportunity to refocus efforts in empowering ourselves and all nurses, to promote civility, improving the overall safety and sustainability of the healthcare environment.

With the average cost of turnover for the bedside RN at \$52,350, continuing to climb and significantly higher for specialty trained nursing positions, the fiscal urgency for healthcare organizations to increase nursing retention by improving the work environment is evident (NSI Nursing Solutions, Inc., 2023). This is especially salient for small rural hospitals without the security of a larger hospital system or network of financial support. Organizations and nurses can experience decreased productivity, increasing turnover, compounding worry and stress when workplace incivility occurs (Bar-David, 2018, Kanitha & Naik, 2021, Neubert, Hunter & Toletino, 2020, Sullivan & Germain, 2020). According to Weston (2022), resilient workplaces are created by mitigating the cumulative 'pile-up' of all stressors, internal and external, in order to reduce the demand on individual resilience. The recent pandemic deeply impacted the routines and type of care provided by nurses. These disruptions include; impacts in nurse-patient and family connection, fear of limited personal protective equipment (PPE) and being infected, lack of evidence-based guidance in a rapidly changing environment and limited appropriate staffing for the care required (Witkoski Stimpfel et al., 2022). A study by El Ghaziri, et al. (2022), notes that reports of workplace incivility (WI) and cyber-incivility within the nursing profession have been exacerbated by the pandemic, with increased incidence of witnessed incivility reported. These workplace dynamics are imperative to understand and mitigate in organizational culture, to ensure we are able to retain and recruit nurses for the future.

### **Available Knowledge**

The available knowledge on the subject of workplace incivility in healthcare, and specifically affecting nurses, is expansive. In a randomized controlled trial, Johnson et al. (2019) found evidence to



support the anecdotes that exposure to incivility may contribute to errors in clinical performance. Interestingly, “the study findings suggest that exposure to a brief, relatively low-level incident of incivility may contribute to medical errors” (Johnson et al., 2019, p.74). This evidence supports that even perceived low-intensity episodes of workplace incivility may put our individual team members and patient’s safety at risk. An interdisciplinary study by Riskin, et al. (2016) stated that “exposure to rudeness debilitated the very collaborative mechanisms recognized as essential for patient care and safety” (p.1). Recently, the Emergency Care Research Institute, ECRI, (2023), has released their “Top 10 Patient Safety Concerns 2023 Special Report”, identifying “Physical and Verbal Violence against Healthcare Staff” as their number two concern (ECRI, 2023, p.7). The report states that acts of physical and verbal violence can be perpetrated by staff members in the form of disruptive behaviors or bullying (ECRI, 2023). The National Institute for Occupational Safety (NIOSH) and The Joint Commission (TJC) have established expectations that organizations will develop and enforce a workplace violence prevention program, inclusive of managing behaviors from all sources (Kroning, 2019). These efforts emphasize the importance for healthcare organizations of all sizes to take a measured and consistent approach at the leadership level, toward promoting a culture of civility.

Real-time management of workplace incivility is an imperative leadership strategy in addressing the emotional burden carried by registered nurses (Meier, Evans, & Ives Erickson, 2021). Organizational leaders have implemented workplace incivility programs throughout the industry, in an effort to mitigate negative outcomes associated with emotional distress being experienced amongst the healthcare team. Kunts & Searly (2023) state, “When a lack of clear social norms that promote and define the parameters of positive workplace behaviors is accompanied by a weak accountability system that fails to sanction negative acts, there is a greater risk that WI and WB will occur, which over time produces a toxic culture” (p. 2936). It is important to recognize that incivility is in the “eyes of the receiver” according to Christine Porath (2016), effected not only by individuality, but by gender,

generation, culture, organization and industry (p. 10). Given the pandemic pressures applied to all healthcare organizations over the last three years, focus drastically shifted away from consistency in communication and accountability around these behaviors, out of sheer necessity.

Leadership of an organization has a key role in influencing any organizational or departmental change. Meier, Evans & Erickson (2023) note, "In a study of more than 700 nurses, the transformational leaders' influence was affirmed in reducing toxic behavior and empowering frontline staff in creating positive work environments. In addition, actions taken by transformational leaders to reduce toxicity in the workplace showed improvement in clinical performance and job satisfaction" (p.476).

Transformational leaders are described as those that: model the way, inspire a shared vision, challenge processes, enable others to act and encourage the heart (Abd-El Aliem & Hashish, 2021). The nursing leader is key in setting consistent behavioral standards for their teams. According to Kroning (2019), "Nurse leaders set the organizational tone by modeling good behavior, hiring for civility, creating group norms, seeking out employee feedback, following up on repercussions for negative employee behavior, and even knowing when it's time to let the bullies in the organization go" (p. 53). Ensuring that nurse leaders, and all organizational leaders, role model professional behaviors, and understand the presence of workplace incivility behaviors within their teams, is imperative in establishing behavioral expectations, influencing change and cultivating a collaborative environment of respect for safety.

Current literature indicates that individuals are influenced by workplace incivility when reporting safety concerns. Fear of behavioral repercussions from colleagues has a direct impact on an individual's willingness to report the concern or propensity to normalize a concern based on the culture. "When incivility occurs in the healthcare workplace, it may lead staff members to be less likely to report both safety and quality issues, which can increase errors causing patient harm" (Kroning, 2019, p. 52). According to the Occupational Safety and Health Administration (OSHA) and the American Society for Healthcare Risk Management (ASHRM), safety and quality concerns can range from a "near miss" (didn't

occur, caught prior to), all the way to a “serious safety event”, with deviation from generally accepted practice or process, that reaches a patient causing severe harm or death (ASHRM, 2014, p.3). As noted, workplace incivility behaviors do not have to be severe in order for communication and sharing of safety concerns to be impacted. According to Ebberts & Sollars (2020), “While it is obvious how egregious offenses can lead to adverse patient safety events and staff turnover, more mild incivilities should not be overlooked or downplayed. Work environments that are characterized by these milder behaviors have been described as “death by a thousand stings” and can lead to poor teamwork, high turnover, and potential patient harm” (p.64). This reality must be acknowledged and mitigated continuously, with broad organizational effort to ensure workplace incivility behaviors do not further jeopardize the stability of the nursing workforce and a burgeoning culture of safety.

### **Rationale**

As nurses report experiencing higher levels of workplace incivility, with increasing risks to safety for staff and patients; all efforts must be made to mitigate these behaviors in an organizational culture. According to the Robert Wood Johnson (RWJ) Foundations’ PACER (**P**assionate **A**bout **C**reating **E**nvironments of **R**espect and **C**ivilities) work (2015), the Social-Ecological Model (SEM) offers an applicable framework that combines multimodal solutions to address bullying in order to sustain environments of respect and civility. This conceptual model outlines how elements of behavior and communication are interdependent and must be considered in an effort to improve workplace civility. Education for nurses to navigate through the challenges of workplace incivility is crucial, in order to shift the culture and retain nurses in our profession. “There is a growing base of evidence available to support the use of a combination of education about workplace incivility and active, experiential learning exercises in assisting nurses in managing incivility in health care settings” (Armstrong, 2018, p. 409). A multimodal approach to education provides nurses not only the didactic knowledge, interactive and simulated educational activities also provide the ability to develop skills and apply these skills in a

protected setting (Armstrong, 2018). Given the pervasive nature of this problem, the Robert Wood Johnson Foundation has invested significantly in the PACERS “Stop Bullying Now” campaign. The program includes a “Stop Bullying Toolkit” with significant resources to support an organizational initiative, including messaging, organizational and individual assessments, recommended metrics to monitor and educational templates. These types of resources are essential elements in building a strong workplace incivility mitigation program in response to this known problem.

### **Specific Aim**

The specific aim for this DNP quality improvement (QI) project was to evaluate the effectiveness of evidence-based education on perceptions of workplace incivility within the nursing cohort at a small community hospital. The goal of these educational interventions was to increase overall awareness and ability to identify acts of incivility, with skill development in addressing uncivil behaviors as they occur in the workplace. An expected outcome would also include the individual skill and ability to promote civility within teams, nurses leading with a language of collaboration, thereby shifting culture and ultimately decreasing the perceptions of workplace incivility in the hospital environment.

## **Methods**

### **Context**

This site of this quality improvement intervention, is a 61-bed community hospital located in a rural region of Vermont, serving 22 surrounding towns. This hospital is not currently affiliated with another organization nor part of a larger hospital system, limiting all types of resources available. Currently, this hospital employees approximately 191 nurses. Prior to the commencement of these interventions, the current state anecdotal assessment from organizational leadership and staff reported moderate levels of incivility perceived, across disciplines, affecting communication, collaboration, and patient care at times. Supporting this anecdotal assessment, is forty-two occurrence reports having been submitted and reviewed since January 2021, that were identified by the Quality Improvement

Department as related to “Behavioral” or “Bullying or Intimidation” in the employee incident reporting system. There is no organizational policy that specifically addresses workplace incivility or a facility benchmark assessing the presence of it, while there is a Code of Conduct that outlines expected professional behavior.

A cost-benefit analysis for this work consists of: project leader time spent on all aspects of this work, CNO time for oversight and paid time for nurses to participate in education. Dedicated time was allocated from a pre-existing quarterly all-nursing staff meeting, planned and budgeted by nursing leadership. Based on the literature, there are significant potential benefits to allocating leadership and education time to this topic, including: increased nurse retention and engagement, along with decreased negative patient impacts. While these potential benefits are currently challenging to quantify, a singular serious patient safety event could be financially devastating to a small organization. Given the time volunteered by the project leader in developing a baseline survey and educational curriculum, these tools can be moved forward with very minimal further financial investment required of the organization with integration into pre-existing onboarding and annual required educational curriculum.

### **Interventions**

Initial interventions began in August 2023, assessing Executive Leadership and Chief Nursing Officer commitment to WI prevention, Figure 1. Partnering with the CNO, the Workplace Bullying Assessment Checklist (RWJ Stop Bullying Toolkit, 2015-Appendix A) was reviewed and completed with gaps in assessment, education and training identified. On August 24<sup>th</sup>, 2023 the pre-intervention survey (Appendix B), incorporating the S-NAQ: Simplified Negative Acts Questionnaire (Appendix C), a validated tool to measure incivility in the workplace, was deployed to the campus-wide nursing cohort to elicit pre-educational intervention perceptions of WI on campus (Harris, Usseligo & Chapman-Rodriguez). Categorical survey questions were established regarding: age, gender, years in the nursing profession,

location of work (inpatient or outpatient), primary shift worked, and number of hours worked. Pre-intervention survey questions also included: awareness of organizational reporting system, willingness to report and have follow-up dialogue with colleagues when WI occurs. These additional survey questions were developed based on established literature and in collaboration with the CNO. Measurement of incivility in the facility preceded the education completion and dissemination, with current state quantitative and qualitative data collected from the nursing cohort. Aspects of RWJ PACERS Incivility Toolkit (2015) buckets of Truth, Wisdom, Courage and Renewal, were selected as part of the educational curriculum and refined for priority dissemination, based on data collected in collaboration with the Chief Nursing Officer (CNO). A message was crafted to nursing establishing: why this work matters to us based on current evidence, definitions of terms used in the survey, that the survey was anonymous, confidential, and only to be used for educational purposes. The CNO sent the message and survey link, the survey was available for completion for 3 weeks, with a reminder sent by the CNO to the nursing cohort mid-way through the distribution period.

**Figure 1**

*Timeline of Interventions*



Subsequent to closing the survey in September 2023, results were reviewed to determine areas for educational focus. Development of initial education for the leadership team was rolled out in November 2023 focusing on defining WI, a WI self-assessment, survey results from the nursing cohort and their role in fostering a culture of civility. Deployment of education in November 2023, led to the participation of 42 members of the interdisciplinary leadership team, 25 members of the nursing cohort, inclusive of nursing leaders.

Aspects of the Robert Wood Johnson Foundation “Stop Bullying” educational curriculum for nursing, in leadership and front-line roles, were incorporated with a focus on workplace incivility at a small rural community hospital. Education was completed November 16<sup>th</sup>, 2023 for the nursing cohort, outlining survey results and WI mitigation strategies focused on RWJ PACERS “Respectful Conversations for Difficult Situations”, strategies to disengage from gossip, fostering a language of collaboration, as well as internal reporting and escalation processes for when needed. Nursing cohort education was refined based on the pre-intervention survey to include:

- a. “The Civility Quotient Assessment”: an incivility self-assessment (RWJ Stop Bullying Toolkit, See Appendix D) provided to all members of leadership and nursing cohorts. This self-assessment element of education is imperative to begin to increase self-awareness, self-governance and the ability to role model & engage in civil behaviors in the workplace. This tool was provided to all participants in advance via link and QR code for convenience with all elements remaining anonymous and confidential, with the primary focus for completion on self-driven, professional growth emphasized.
- b. Interactive activities completed:
  - i. “Respectful Conversations for Difficult Situations” Framework (RWJ Stop Bullying Toolkit, See Appendix E). While the totality of this content is time prohibitive for front-line nursing staff education, the framework was applied in a smaller segment. This content ensured nurses had the opportunity for interactive group discussion and scenario-based role-playing exercises for necessary skill development in addressing workplace incivility behaviors as they occur.
  - ii. “The Language of Collaboration” (RWJ Stop Bullying Toolkit, See Appendix F). This content was incorporated into the education and scenario-based

curriculum for increased awareness of word choice during interdisciplinary communication and collaboration.

The format of the education was a virtual based PowerPoint, in order to include the possibility of almost 200 nurse participants campus-wide, with collaborative scenario-based activities, smaller breakout group sessions to foster an opportunity for learning and role-playing in a protected environment. A post-education intervention survey, including the S-NAQ, was completed for the nursing cohort.

### **Study of Interventions**

The approach chosen for assessing the impact of the interventions included statistical analysis of the S-NAQ pre and post intervention survey data, to determine whether there was any change in outcomes due the intervention. Comparisons were also made to pre and post intervention survey questions related to perceived incidence of WI and follow-up dialogue with colleagues.

### **Measures**

Pre-intervention survey sent to nursing cohort, inclusive of S-NAQ elements, to collect current state data. Determining current state of WI behaviors is imperative in designing effective educational curriculum customized to the appropriate audiences. Subsequent to the educational intervention, the S-NAQ was redeployed, in addition to specific education effectiveness outcome questions around ability to identify WI behaviors and preparedness to attempt difficult conversations with colleagues. It is important to note, according to Anusiewicz, Li & Patrician (2021), "In nursing, only the internal consistency reliability of the SNAQ has been evaluated in a Norwegian nursing sample (Cronbach's  $\alpha = 0.75$ ; Reknes et al., 2017)".

Occurrence report data for the organization was reviewed with the Quality Department for any reports that may have included incivility. Forty-two occurrence reports having been reviewed since January 2021, that were identified by the Quality Improvement Department as related to "Behavioral"



or “Bullying or Intimidation” in the employee incident reporting system. Since the educational intervention was completed on November 16<sup>th</sup>, 2023, one additional occurrence report has been submitted for these types of behaviors. Occurrence reports will continue to be monitored and addressed by Human Resources and Leadership.

Staff Engagement Survey data collected from across campus in May of 2023, was reviewed for correlation to this quality improvement project. The question: “Communication among the people that I work with at this organization is never a problem.” was identified as potentially relatable to WI behaviors. With 71.2% of those surveyed campus-wide reported this is not accurate to varying degrees based on Likert scale provided within survey. An organization wide Pulse Survey will be repeated in Spring of 2024 for comparison to baseline.

### **Analysis**

Analysis of measures utilized both pre and post-test quantitative and qualitative data. Descriptive statistics was applied to analyze S-NAQ quantitative data pre and post intervention in order to determine any quantifiable impact.

### **Ethical Considerations**

Confidentiality with survey participation is a consideration, while all survey data collected was anonymous, there are often organizational cultural influences around perceptions related to lack of anonymity with any surveying process, and was considered related to levels of participation. The nursing cohort at this organization is unionized and the current climate between collective bargaining agreement nurses and nursing leadership is strained based on recent grievances that may also have impacted participation. Vulnerability is always a consideration when participating in this type of surveying and educational curriculum, whether volunteering personal experiences or completing a thoughtful self-assessment regarding our own individual behaviors, this can feel daunting, therefore impacting participation.

**Results**

Given that WI is a known issue in the healthcare setting, the initial assessment focused on the nursing cohort, utilizing the S-NAQ and other survey questions to assess the magnitude of the problem. The following tables outline the categorical survey data collected (questions 1-7) and S-NAQ frequencies, with pre and post results comparisons. Demographic data collected revealed that the majority of respondents were aged 45-65 years old, with over 80% identifying as female in gender, the majority having “more than 10 years” of experience working in the nursing profession.

In reviewing categorical data results, Table 1, the initial survey question revealed a high level of perceived instances of incivility within the last six months, with 75% (n=33) responding “Yes” to the question. Additionally, in question 9, 71% reported that they did not have follow-up dialogue with their involved colleague following the WI episode. Question 13 outlined incidence of reporting WI episodes, with 74% of respondents reporting they did not report the occurrence. In the subsequent follow-up question, 47% of respondents reported the primary reason they did not report the WI behaviors was “Apprehension due to repercussions (retaliation/retribution)”. Lack of training is also noted, with only 45% of respondents having received any training on this topic. Questions 10, 11 and 12 are outlined in figures 2, 3 and 4.

**Table 1**

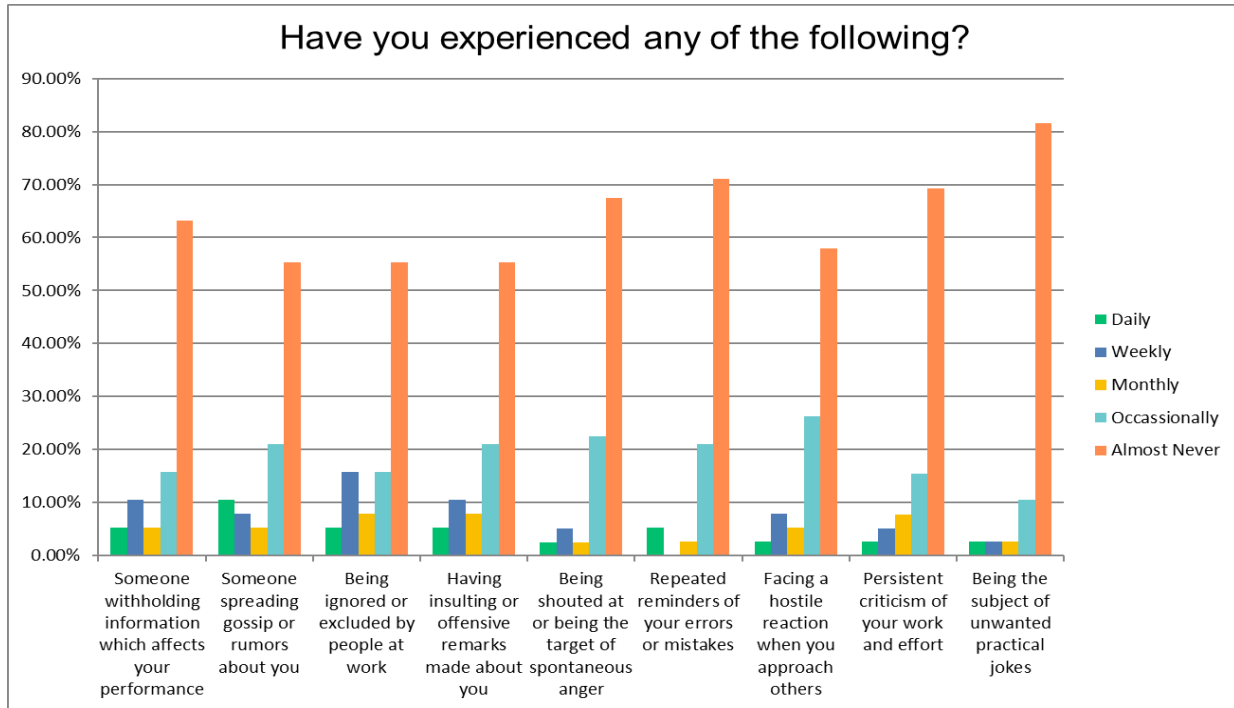
***Survey Categorical Information***

<b>Categorical Data</b>	<b>Total Sample (N=44) n (%)</b>
<b>Q8. Experienced or Witnessed Incivility, Bullying or Horizontal Violence</b>	
Yes	33 (75)
No	11 (25)
<b>Q9. If yes, did you have a follow-up dialogue with the colleague involved?</b>	
Yes	10 (29.41)
No	24 (70.59)
No answer	10 (22.72)
<b>Q13. When you’ve experienced or witnessed incivility, bullying or horizontal violence, did you report it?</b>	

Yes	10 (25.64)
No	29 (74.36)
No answer	5 (11.36)
<b>Q14. Primary Reason for Not Reporting?</b>	
Unaware of reporting system in facility	1 (3.13)
Did not believe act was intentional	4 (12.5)
Apprehensive due to repercussions (retaliation/retribution)	15 (46.88)
I didn't know I should	4 (12.5)
Other (please specify)	8 (25)
<b>Q15. Standardized Method of Reporting?</b>	
Yes	13 (30.23)
No	3 (6.98)
I am not sure	27 (62.79)
<b>Q16. Encouraged to Report?</b>	
Yes	22 (52.38)
No	20 (47.62)
<b>Q17. Feel Protected?</b>	
Yes	16 (40)
No	24 (60)
<b>Q18. Feel Supported?</b>	
Yes	20 (50)
No	20 (50)
<b>Q19. Received Any Training?</b>	
Yes	10 (45.24)
No	23 (54.76)
<b>Q20. Training Required or Optional?</b>	
Required	13 (65)
Optional	4 (20)
Other (please specify)	3 (15)
<b>Q21. Training Useful/Helpful?</b>	
Yes	12 (57.14)
No	9 (42.86)
If yes, how was the training helpful?	6

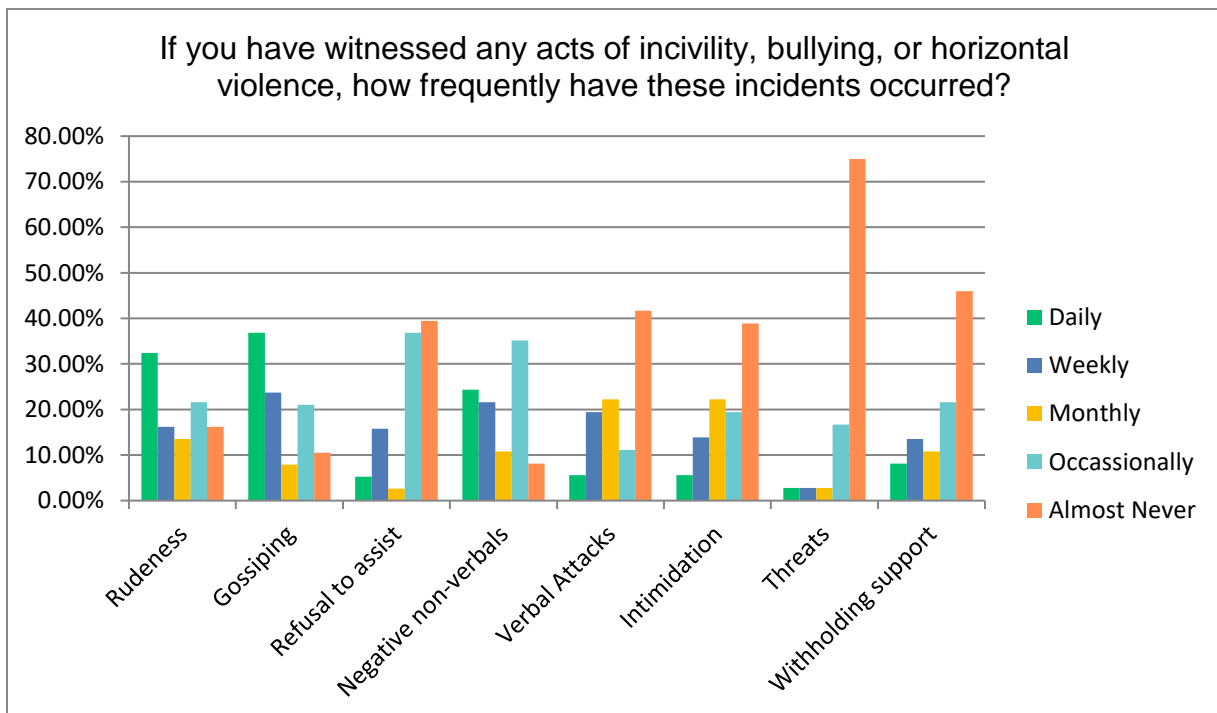
S-NAQ pre-intervention results (Figure 2) demonstrated that many of these specific types of behaviors are “almost never” experienced by individuals within the organization. The S-NAQ pre-intervention data shows the highest reported incidence of individuals feeling that they are the target of gossip (M=1.97), being ignored or excluded (M=2) or having insulting remarks made (M=1.90), table 2. Figures 3 and 4 delineate between acts that were only witnessed, may have occurred with others around you, versus individually experienced or been the target of.

**Figure 2**  
**S-NAQ Pre-Intervention Results**



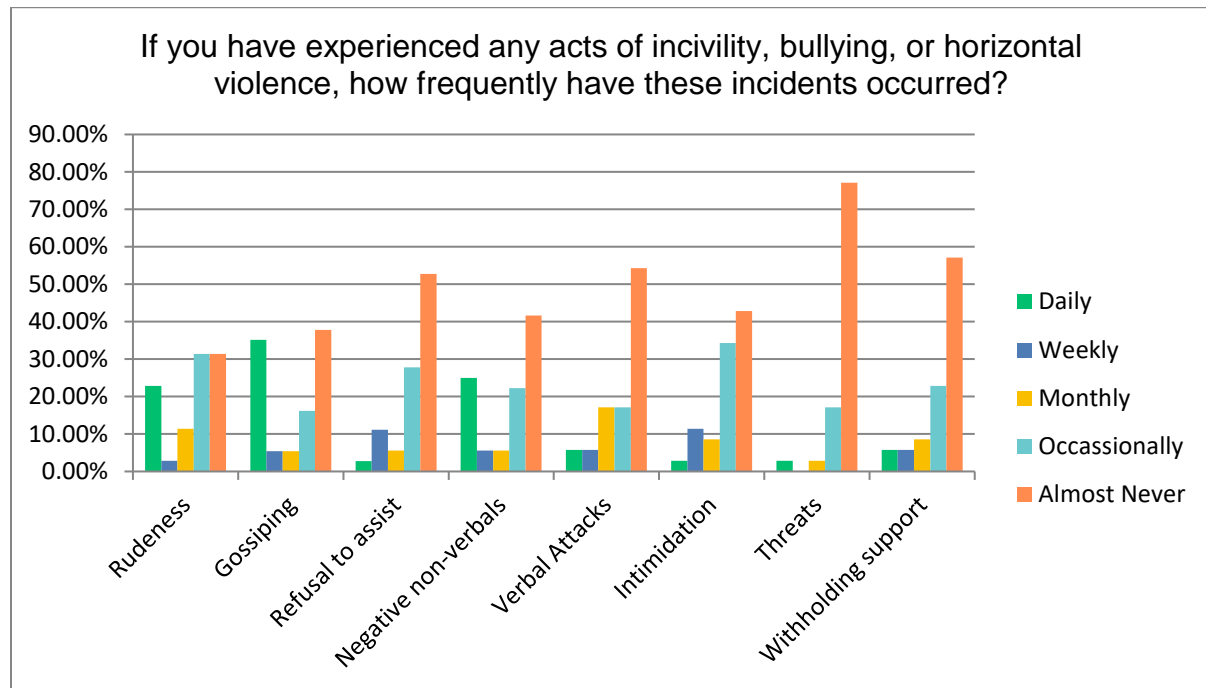
**Figure 3**

**Pre-Intervention Witnessed Acts of Incivility**



**Figure 4**

***Pre-Intervention Experienced Acts of Incivility***



The S-NAQ pre and post-intervention results, including mean, standard deviation and range are represented in Table 2. Overall, improvements post intervention were highest for spreading gossip and rumors (question 2), having offensive remarks made (question 4), and being the subject of unwanted practical jokes (question 9), which shows that the educational intervention may have had a slight impact in respondent perceptions, with a slight improvement in the mean score following the intervention. Additional questions were surveyed regarding more generic types of behaviors that may be considered uncivil, Figures 3 and 4, in an attempt to add more specificity to data collected in order to refine understanding of current state and educational curriculum. Rudeness, gossiping and negative non-verbal behaviors were the highest reported behaviors identified by respondents, reinforcing these as high priority areas for focus mitigation efforts.

Table 2

*S-NAQ Pre & Post-Intervention Results (Q12 of the survey, consisting of 9 individual components)*

Variable	Pre-Intervention Survey			Post-Intervention Survey		
	M	SD	Range	M	SD	Range
Q1. Someone withholding information which affects your performance.	1.79	1.26	1-5	1.88	1.05	1-5
Q2. Someone spreading gossip or rumors about you.	1.97	1.38	1-5	1.68	0.99	1-5
Q3. Being ignored or excluded by people at work	2	1.34	1-5	1.96	1.14	1-5
Q4. Having insulting or offensive remarks made about you	1.90	1.24	1-5	1.52	1	1-5
Q5. Being shouted at or being the target of spontaneous anger	1.53	0.98	1-5	1.32	0.56	1-5
Q6. Repeated reminders of your error or mistakes	1.47	0.98	1-5	1.44	0.77	1-5
Q7. Facing a hostile reaction when you approach others	1.71	1.06	1-5	1.68	0.9	1-5
Q8. Persistent criticism of your work and effort	1.56	1.03	1-5	1.32	0.75	1-5
Q9. Being the subject of unwanted practical jokes	1.34	0.88	1-5	1.04	0.2	1-5

Post-intervention respondents were also surveyed regarding the effectiveness in the education on their ability to better recognize incivility in the workplace and in their preparation to manage conversations with their colleagues in response to WI. Eighty-seven percent of participants answered “Yes” that “As a result of this activity, I will be able to better recognize incivility & civility in our work environment” and 67% of participants answered “Yes” to “Do you feel better prepared to manage respectful conversations that may arise from acts of incivility in the workplace?”. Those that answered

“No” to these questions, commented that additional education would be helpful due to the complex nature of difficult conversations.

## Discussion

### Summary

The specific aim of this DNP quality improvement (QI) project was to evaluate the effectiveness of evidence-based education on perceptions of workplace incivility within the nursing cohort at a small community hospital, which was met. This required an assessment of the severity and types of WI amongst a nursing cohort of 191 nurses on a hospital campus, to identify areas of focus in delivering evidence-based education to empower nurses in fostering a culture toward greater civility. All levels of WI are shown to have detrimental impacts to the nursing workforce, interdisciplinary team-members, communication and collaboration that can devastatingly affect employee retention and patient care. These factors contribute to the ongoing decline of our nursing workforce and must be better understood in order for leadership teams to effectively develop and implement effective mitigation strategies. The results of this work show that WI is perceived to be an issue by the nursing cohort, with 75% of respondents having experienced or witnessed incivility within the last six months while at work. This reported high incidence of these behaviors, unwillingness to follow-up with colleagues or report due to fears of retribution, with a lack of awareness on reporting processes, is cause for concern and validates that ongoing leadership action is needed for staff and patient safety. Certainly, there are behavioral and perceptual differences related to WI based on generation, gender and tenure in the nursing workforce (Thompson, 2023). These influence our organizational culture and may contribute to an increase in WI behaviors within a predominantly female population, in a generation that may be less likely to speak up, and more likely to tolerate WI behaviors due to longer-term exposure, and these behaviors being normalized in the healthcare setting over time.

While the S-NAQ pre-intervention data may have shown an overall low incidence of some specific WI behaviors in totality, the negative impact of even one episode of incivility cannot be effectively quantified. Existing research shows that exposure to even a single, “brief low level of incivility”, can have negative consequences in diagnosis, problem solving, and team processes central to patient care, potentially resulting in medical errors (Johnson et al., 2019 & Riskin et al., 2016). Given these risks and the areas identified in the pre-intervention S-NAQ related to gossip, being ignored/excluded or having insulting remarks made, educational objectives related to disengaging from gossip, and developing skills in having professional conversations during difficult situations, are necessary areas of ongoing focus.

### **Interpretation**

This quality improvement project assessed the current state of WI within the nursing cohort of a small community hospital, with the results collected validating the presence of WI in this workplace, as well as opportunities for improvement. Deploying evidence based educational curriculum to leadership and nursing cohorts, stimulated discussion with aspirations of leadership to expand the dialogue, evidenced by several leaders requesting this education be spread to their department level staff meetings. The Robert Wood Johnson PACER’s (2015) work exemplifies that focusing on identified areas of concern and providing individual tools for real-time response, can have an impact on fostering a culture of civility.

Based on the pre-intervention assessment, specific evidence-based strategies were provided within a protected learning space, with the intention for translation to action. Based on post-intervention feedback, spread of current education is needed, with a renewed focus on developing additional curriculum in strengthening critical conversation skills across disciplines and departments. Post-assessment S-NAQ results showed variations in scoring compared to pre-assessment, with positive and negative changes in survey respondents’ perceptions of some types of WI. Variation in pre and post



assessment participation is likely given that this opportunity was offered to the entire nursing cohort with varied and limited participation. Perceptions of WI were impacted post-education; possibly due to increasing the nurses' ability to identify acts of incivility, resulting in an increased report of these perceived behaviors. Post-intervention feedback of participants "feeling better prepared" to identify incidents of WI and to have difficult conversations with colleagues following WI occurrences, may be impactful. Survey results post-intervention, validate that providing this type of focused education can have a positive impact on participants' ability to identify WI behaviors and feel increasingly prepared to address these behaviors when they occur. There is literature that is consistent with these findings in the healthcare workplace, while the time-bound nature and participation rates in the educational content, indicate that these results are not fully developed in reflecting the potential impact (Armstrong, 2018). In cultures where WI is present, the climate and culture can be improved upon when there is increased awareness, expectations and accountability are in place.

### **Limitations**

The time-bound nature of this quality improvement project limited participation of the nursing cohort across campus, with a 23% response rate in pre-intervention assessment and 13% participation rate in the educational intervention. As this work continues to be embraced by organizational leadership, with spread further across nursing and interdisciplinary teams, the scope of impact will grow. More educational offerings, with expanded dates and times of availability will be critical in engaging the entire nursing cohort and interdisciplinary teams. Longer-term analysis of these interventions is needed to evaluate overall effectiveness, with the potential repeat utilization of the S-NAQ with comparison to these baseline measures. A limitation noted in the S-NAQ assessment relates to the context of this quality improvement project; the tool's applicability for use as a post-education intervention measure, this tool may be better suited to a singular or annual assessments in evaluating the state of WI, not immediate effectiveness of educational content provided. In addition, there is the

potential that the female gender may be more prone to display more covert acts of incivility in the workplace, while this is an area that requires more study.

### **Conclusions**

The time is now for ongoing organizational commitment to better understanding and promoting workplace civility. Given the vulnerabilities of our workforce, these behaviors can no-longer be an accepted part of our healthcare culture. The tension that exists between maintaining an adequate workforce, and allowing behaviors that impact staff and patient safety negatively, must be managed effectively. Given the size of the nursing workforce, we play a critical role in turning the tide, with transformational nursing leaders modeling and promoting workplace civility thereby influencing staff behavior. The ongoing research with support of the ANA, and countless other organizations over decades, is evidence that we have not made the necessary changes to mitigate negative outcomes related to our own behaviors.

A supportive program that acknowledges these realities and educates nurses on the tools needed to combat workplace incivility and promote a culture of civility is required. We cannot only recognize the behaviors that occur, we must give our team the tools needed to combat it, including a vital self-assessment. Education for nurses to navigate through the challenges of workplace incivility is crucial, in order to shift the culture and retain nurses in our profession. Education for nurses on how to identify acts of WI and manage these situations with learned skills, can be an effective tool in mitigating WI. Spreading organizational education on WI, across the interdisciplinary team, is imperative to eliminate these behaviors from our culture and to foster a culture of civility.

Next steps for this quality improvement project include: implementing a WI zero-tolerance policy, developing and deploying additional leadership and campus wide education, with ongoing comparative annual S-NAQ assessments for the entire campus. As well as, additional monitoring and review of the following: employee occurrence reports, nursing turnover data, and the Employee Engagement Pulse

Survey in 2024 with comparison to 2023 results around communication. The measurements outlined can provide a holistic view regarding the state of workplace incivility within an organization, and the impact on the nursing workforce. The S-NAQ allows a validated mechanism to assess the state of WI behaviors within the workplace, this tool could be used singularly or for routine reoccurring measurement, with comparisons to baseline. Measuring and tracking participation in evidenced-based educational curriculum offers many benefits, including: the ability to set standard expectations for professional communication at the individual and department level, while ensuring accountability will occur. Ensuring there are multiple mechanisms for employees to report incivility is imperative to eradicating covert behaviors and that these behaviors do not go unaddressed. Allowing for anonymous occurrence reporting, while always encouraging direct professional communication when appropriate, allows individuals to raise concerns without fears of retribution. When voluntary turnover occurs, a standardized exit interview process conducted by skilled objective interviewers, can provide valuable information regarding any departmental or organizational elements related to WI that may have influenced the individuals' departure. Maintaining consistent processes that can identify when and where incivility may be occurring, allows organizational leaders an opportunity to mitigate these behaviors with education and accountability based on an established code of conduct. Granular data, inclusive of turnover at the department level, can be indicative of toxic cultures requiring additional support in growing civility practices. This comprehensive approach to evaluating the ongoing state of culture, will ensure targeted mitigation measures are developed and implemented.

Investing the time and energy in consistently establishing a culture that minimizes workplace incivility will benefit the overall health of the organization. Faced with declining revenues and increased expenses, insuring the work environment for our nurses is conducive to collaboration, support and an inclination to report safety concerns decreases our risks of ongoing turnover and potentially patient

harm. In our effort to continuously improve patient care, we must prioritize the vulnerabilities that make the healthcare work environment so challenging for nurses to endure.

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Appendix A: Workplace Bullying Assessment Checklist

[Company Name] Workplace Bullying Assessment Checklist

BULLYING RISK FACTORS	YES	NO	
<b>Organizational Change</b>			
Has there been recent significant organizational change or is change pending?			If YES to any, implement risk control measures, such as: <ul style="list-style-type: none"> <li>consult with workers and health and safety representatives about proposed changes and provide them with an opportunity to influence proposals;</li> <li>provide workers and health and safety representatives with information to help them understand the proposed or actual changes, and the impact of the changes;</li> <li>consult with workers and health and safety representatives about any support or re-training needed as a result of the changes;</li> <li>seek and act on feedback during change process;</li> <li>review and evaluate the change processes, if appropriate.</li> </ul>
Has a takeover occurred or is it pending?			
Has there been a major internal restructure or is it pending?			
Has technological change occurred or is it pending?			
Has there been a change in management or is it pending?			
Are there any other changes that might lead to high job instability and uncertainty about ongoing employment?			
<b>Leadership Styles in the Company</b>			
Does the workplace have authoritarian or autocratic management styles? (this includes a strict 'command and control' style of management where workers may have little control or flexibility over their work and are not involved in decision making)			If YES to any, implement risk control measures such as: <ul style="list-style-type: none"> <li>provide managers and supervisors with leadership training;</li> <li>provide managers and supervisors with training on:                             <ul style="list-style-type: none"> <li>communicating effectively and engaging workers in decision making, if appropriate,</li> <li>providing constructive feedback,</li> <li>effectively managing workloads,</li> <li>bullying prevention;</li> </ul> </li> <li>use mentoring and coaching to improve managers/supervisors interpersonal skills;</li> <li>mentor and support new managers;</li> <li>provide regular feedback on management performance;</li> <li>implement and review performance improvement plans;</li> <li>train managers and supervisors to adopt inclusive</li> </ul>
Does the workplace have laissez-faire, or relaxed management styles? (this may be adopted by a manager, or leader, who tends to avoid decisions, does not delegate tasks appropriately, provides little supervision and feedback or guidance to workers)			
Do managers and supervisors lack appropriate leadership training?			
Do managers and supervisors have poor interpersonal skills?			

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[Company Name] Workplace Bullying Assessment Checklist

BULLYING RISK FACTORS	YES	NO	
			management styles as part of a culture that emphasises open communication, support and mutual respect; <ul style="list-style-type: none"> <li>Include questions regarding conduct and performance of manager/supervisors in exit interviews and worker opinion surveys.</li> </ul>
<b>Work systems</b>			
Are there staff shortages?			If YES to any, implement risk control measures, such as: <ul style="list-style-type: none"> <li>review and monitor workloads and staffing levels</li> <li>consult workers on possible job redesign;</li> <li>consult workers about improving work patterns, including increasing their control over the pace of work, rest breaks, etc;</li> <li>improve the availability of flexible working arrangements;</li> <li>assess whether demands on workers are achievable within the agreed hours of work;</li> <li>provide clear job descriptions that outline roles and responsibilities;</li> <li>develop and implement standard operating procedures, where appropriate;</li> <li>seek regular feedback from staff regarding concerns about their roles or responsibilities (eg in staff surveys, performance reviews)</li> </ul>
Is there a heavy workload?			
Is there uncertainty about job requirements and role definition?			
Is there uncertainty about the way that work should be done?			
Are there unreasonable performance measures or timeframes?			
<b>Workplace relationships</b>			
Are workplace relationships poor?			If YES to any, implement risk control measures, such as: <ul style="list-style-type: none"> <li>provide training in communication and conflict resolution skills;</li> <li>treat all workers with fairness and consistency;</li> <li>communicate openly at all levels and involve workers in decision-making processes that affect their work, where practicable;</li> </ul>
Is there inadequate or no consultation?			
Is communication poor?			
Is the work environment competitive?			

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## Appendix B: Pre-Intervention Survey on Workplace Incivility

All information gathered is anonymous & will only be used for educational purposes.

Please review the following definitions prior to beginning the survey, as this survey includes questions about different types of incivility, bullying and horizontal violence in the healthcare setting.

**Incivility:** can take the form of rude and discourteous actions, of gossiping and spreading rumors, and of refusing to assist a coworker where the intent to harm is ambiguous or unclear. Such actions may also include name calling, using a condescending tone, expressing public criticism, and negative non-verbal behaviors such as eye-rolling, heavy sighs or other types of body language that can be perceived negatively.

**Bullying:** repeated, unwanted harmful actions intended to humiliate, offend and cause distress in the recipient. Bullying actions include those that harm, undermine, and degrade. Actions may include, but are not limited to, hostile remarks, verbal attacks, threats, taunts, intimidation, and withholding of support.

**Horizontal violence:** physically and psychologically damaging actions that occur in the workplace or when on duty.

(Meier A., Evans, R., & Ives Erickson, J. (2021). *Journal of Nursing Administration*, vol. 51, number 10, pp. 475-477).

### Part I: Demographics

What is your age (select one):

- 18-28
- 29-45
- 46-65
- 65+
- I prefer not to answer

How do you identify?

- Male
- Female
- Non-binary
- I prefer not to answer
- Other: \_\_\_\_\_

How long have you worked as a nurse?

- 0-2 years
- 2-5 years
- 5-10 years
- More than 10 years

Are you employed: (Please choose only one response)

- Part-time
- Full-time
- Per-diem
- Contractor/Traveler

Which shift do you normally work?

- Days
- Evenings
- Nights
- Varies

How many approximate hours worked per work day:

- 1-5
- 5-10
- 10-12
- >12

Within the past six months, what setting have you primarily worked in?

- Hospital Setting (includes ED?)
- Outpatient Setting
- Other: \_\_\_\_\_

## Part II: Incivility in nursing

Within the past six months, have you **experienced** incivility, bullying or horizontal violence with colleagues at your place of work?

- Yes
- No

If you answered Yes, did you have follow-up dialogue regarding the occurrence with the colleague(s) involved?

- Yes
- No

If you have **experienced** any acts of incivility, bullying or horizontal violence, how frequently have these incidents occurred?

	Daily	Weekly	Monthly	Occasionally	Almost
Never					
Rudeness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gossiping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refusal to assist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Negative non-verbals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbal attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intimidation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Withholding support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**S-NAQ-Shortened Negative Acts Questionnaire (using same Likert scale above):**

Have you experienced any of the following:

1. Someone withholding information which affects your performance
2. Spreading of gossip or rumors about you
3. Being ignored or excluded by people at work
4. Having insulting or offensive remarks made about you (i.e., habits, background, attitude or private life)
5. Being shouted at or being the target of spontaneous anger (or rage)
6. Repeated reminders of your errors or mistakes
7. Facing a hostile reaction when you approach others
8. Persistent criticism of your work and effort
9. Being the subject of unwanted practical jokes

Have you ever **witnessed** uncivil, rude, or disrespectful interactions with colleagues at your place of work?

- Yes
- No

If you have **witnessed** any acts of incivility, bullying or horizontal violence, how frequently have these incidents occurred?

	Daily	Weekly	Monthly	Occasionally	Almost
Never					
Rudeness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gossiping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refusal to assist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Negative non-verbals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbal attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intimidation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Threats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Withholding support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When you've **experienced or witnessed** incivility, bullying or horizontal violence while working in the healthcare setting, have you reported or documented it to a person in leadership (Department Leader, Nursing Supervisor, or Incident Report)?

- Yes
- No

If not, what was your primary reason for not reporting?

- Unaware of reporting system in facility
- Did not believe act was intentional
- Apprehensive due to repercussions (retaliation/retribution)
- I didn't know if I should
- Other: \_\_\_\_\_

Is there a standardized tool, form, policy, or protocol in your facility to report acts of incivility, bullying or horizontal violence committed by team-members?

- Yes
- No
- I am not sure

Does your Department Leader or supervisor encourage you to report incidents of incivility, bullying or horizontal violence when they occur, regardless of circumstance?

- Yes
- No

Do you feel protected from acts of incivility, bullying or horizontal violence at work?

- Yes
- No

If yes, how do you feel protected? \_\_\_\_\_

Do you feel supported by your Department Leader or Senior Leadership Team when you experience incivility, bullying or horizontal violence at work?

- Yes
- No

Have you received any training or continuing education regarding workplace incivility, bullying or horizontal violence?

- Yes
- No

If you answered YES above, was this training required or optional?

- Required



- Optional
- Other: \_\_\_\_\_

Did you find the training helpful (or useful) when team-members are uncivil?

- Yes
- No
- If yes, how was the training helpful? \_\_\_\_\_

Are there any additional comments/concerns you have as a nurse that are important to consider?  
(Please do not include identifying or confidential patient information in your response.)

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Appendix C: Short Negative Acts Questionnaire (S-NAQ)

<b>Short Negative Acts Questionnaire (SNAQ)</b>							
<b>Dimension &amp; Item #</b>		<b>Behavior</b>	<b>How Often</b>				
Work	1	Someone withholding information which affects your performance	1	2	3	4	5
Person	2	Spreading of gossip and rumors about you	1	2	3	4	5
Person	3	Being ignored or excluded by people at work	1	2	3	4	5
Person	4	Having insulting or offensive remarks made about you (i.e., habits, background, attitude or private life)	1	2	3	4	5
Physical	5	Being shouted at or being the target of spontaneous anger (or rage)	1	2	3	4	5
Person	6	Repeated reminders of your errors or mistakes	1	2	3	4	5
Person	7	Facing a hostile reaction when you approach others	1	2	3	4	5
Work	8	Persistent criticism of your work and effort	1	2	3	4	5
Person	9	Being the subject of unwanted practical jokes	1	2	3	4	5
<b>Workplace Bullying Self-Labeling Item</b>							
<p><b>Definition:</b> We define bullying as a situation where one or several individuals persistently, over a period of time, perceives themselves to be on the receiving end of negative actions from one or several person, in a situation where they have difficulty defending him or herself against these actions. It is not bullying when two equally strong opponents are in conflict with each other. A one-time incident of being the target of negative actions is not referred to as bullying.</p>							
How often have you been bullied at work in the past six months?			1	2	3	4	5

Appendix D: The Civility Quotient Assessment

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### The Civility Quotient Assessment

Gaining an understanding of civility happens when we identify the primary values associated with civil behavior, then drill down for a deeper comprehension of each. The Civility Pledge below spells out our definition of civility.

#### The Civility Pledge

**I pledge** to behave with civility, treating myself and others with respect and consideration.

**I pledge** to compassion & curiosity.

**I pledge** to be gracious, honest, authentic and wholly present – right here, right now.

**I pledge** to invite others to take the Pledge and to engage in intentional and civil conversations.

**Instructions:** To take the Civility Quotient assessment, read each question related to the civility value listed. Give your organization (or yourself) a grade of 1-10 (1 is lowest) for each of the questions. If there is a question that is not relevant to you or your situation, skip to the next question.

SCALE 1-10 1 = lowest	<b>Respect</b>
	1. Do you demonstrate respect to all stakeholders at all times?
	2. Do you look for opportunities to let others speak, shine and get the credit?
	3. Do you refrain from belittling or critical comments?
	<b>Consideration</b>
	1. Do you normally consider the personal and professional impact of your decisions on the broadest number of people?
	2. Do you aim to think of others' feelings 1 <sup>st</sup> in your communications and actions?
	<b>Compassion</b>
	1. Do you strive to meet the human needs of your stakeholders?
	2. Do you communicate in ways that calms rather than inflames the fear?
	<b>Curiosity</b>
	1. Do you seek to know and understand the true needs of all of your stakeholders? Vendors? Employees? Customers? Share Owners?
	2. Do you have processes or events to solicit innovative ideas and suggestions?

## Appendix E: Respectful Conversations for Difficult Situations Framework

1

# Respectful Conversations for Difficult Situations<sup>®</sup>

## Facilitator Guide

from the

**Civility Tool-kit: Resources to Empower Healthcare Leaders to  
Identify, Intervene, and Prevent Workplace Bullying<sup>®</sup>**

[www.stopbullyingtoolkit.org](http://www.stopbullyingtoolkit.org)

### Intended Audience:

- This **FREE** tool is designed to help those of us who work in healthcare to learn to respectfully manage conversations regarding incivility or bullying in our workplaces.
- It is specifically intended for use with students during their preparation for careers in healthcare and for employers to use with new hires during their onboarding experience. However, it can also be used by anyone or any profession working to build a respectful workplace.

### Objectives:

- Define incivility and bullying
- Describe common situations of incivility and bullying
- Describe the impact of incivility and bullying on human capital and patient outcomes
- Develop a list of terms that are deleterious to collaboration, can invoke a negative emotional response in the listener, and are disrespectful
- Reflect on personal contribution to an incivil workplace
- Describe the approach to respectful conversations for difficult situations
- Model the respectful conversations approach to managing difficult situations
- Apply the respectful conversations approach to managing difficult situations in a safe training setting



Bolick, B., Edmonson, C., Adeniran, R., Cuming, R., Khan, B., Lawson, L., & Wilson, D. (2015). Respectful conversations for difficult situations.

Facilitator guide and videos. Retrieved from [www.stopbullyingtoolkit.org](http://www.stopbullyingtoolkit.org)

## Appendix F: The Language of Collaboration Framework

## The Language of Collaboration

Words have power and how they are used can lead to collaboration or to disrespect. Insulting and judgmental terms are so ingrained in our practice that we often don't realize how the terms are perceived by others.

For example, Leape et al. (2012) note that even what might be considered an innocuous term, the "waiting room" can have a disparaging intent. It implies that it is acceptable to have patients and families wait, that the provider's time is more important than that of the client. In most settings, the term "reception room" describes the room's intent more accurately and is more collaborative. If patients and families need to wait because of unintended delays, then an apology for the wait demonstrates respect.

Other examples:

- The term "noncompliant." The word infers a hierarchal relationship to subordinates and punishment or other negative consequence for disobedience. The term is regularly used for patients who do not follow a prescribed treatment plan. However, if a patient or family doesn't follow the prescribed plan, we instead need to step back and reflect on the reasons why, rather than label them in such a judgmental manner. Today's healthcare is no longer a hierarchal system in which clients are subordinates. It is a business, one in which clients hire us to help them manage their health. In the new system, we are to identify the goals that they have for their health, explore the barriers to achieving this vision, and develop a mutually acceptable plan. If the patient and family are unable to achieve the goals, we are to again explore which aspects of the plan were problematic and develop a new plan to overcome the barriers. The words "compliant" and "noncompliant" are disrespectful and have no place in this new partnership.
- The term "proper". When this term is used to describe the way in which one is to complete a task or think through a problem, it infers that all other methods are unacceptable and that those providers not doing it "properly" are substandard. It is a judgmental term. In truth, there are often many ways to achieve the same outcome and the employees of high functioning organizations are encouraged to constantly look for more efficient and more effective alternatives.
- The term "versus". The word is often used to compare two groups of providers such as physician assistants versus nurse practitioners or nursing versus medicine. The term can have negative or judgmental connotations based on the context so must be used judiciously to maintain respectful collaboration.
- The last example is the term "order." This word also infers an authoritarian or hierarchal relationship with commands to subordinates and punishment or other negative consequence for disobedience. It is contrary to a partnership in health management. The term "prescribe" does not have the same inference and yet conveys the intended meaning so is the preferred term.



These are several examples of language, though commonly used, that are contrary to the respectful cultures we all strive for in our organizations. Consider convening a workgroup to identify disrespectful language in your organization and make a conscious plan to move to a language of collaboration.

## Reference

Leape, L., Shore, M., Dienstag, J., Mayer, R., Edgman-Levitan, S.,...Healy, G. (2012). Perspective: A culture of respect, part 1: The nature and causes of disrespectful behavior by physicians. *Academic Medicine*, 87(7), 1-8.

