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Addressing Bullying and Incivility Among Nurses

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Abstract

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Project Submitted in Partial Fulfillment

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Abstract

For decades, nurses have experienced some form of bullying and incivility throughout their careers. Incivility contributes to behaviors that constrain the sense of empowerment among nurses and directly encroach upon Provision 6 of the American Nurses Association code of ethics, which addresses sustaining a moral environment and the need to create a contagious culture of respect that is free from uncivil behavior. The nature of this staff education project was to bring awareness to the bullying behaviors and incivility that exist within an organization's culture by assessing for the incidence of bullying and by providing an educational program for the nursing staff. The project question addressed whether continuing education, awareness, and focus on a mandated zero-tolerance policy could provide a foundation for a bullying-free and civil milieu in nursing staff on medical-surgical units. The use of Kotter's change theory and Watson's theory of human caring functioned cohesively to guide the transformation of a hostile milieu. The Nursing Incivility Scale was employed to collect data from nurse participants prior to, the pretest, educational initiative, posttest, and evaluation. The educational initiative was centered on awareness and training on the organizations workplace harassment policy. The data from the pretest and posttest were analyzed by calculating the change scores which reflected a 44.17% increase in awareness of the zero-tolerance policy. The findings support positive social change through recommended routine educational initiatives. The education must continue to promote awareness and prevention of uncivil behavior through cognitive rehearsal, conflict resolution, and emotional intelligence training to enhance communication among nurses.

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Section 1: Nature of the Project

Introduction

Bullying and incivility, which are defined as disruptive behaviors, have been experienced by 80% of the registered nurse workforce (Elmblad, Kodjebacheva, & Lebeck, 2014). This represents a dramatic increase since the Joint Commission (2008) survey revealed that 50% of nurses were victims of bullying behavior and 90% of nurses surveyed have witnessed incivility within their organization. The nature of this project is the development and implementation of an educational program for nursing to bring awareness to the bullying behaviors and incivility that exist within the organization's culture by assessing for the incidence of bullying. The intention is to promote change and to reverse the negative impact nurses are experiencing to establish a healthy work environment and improve retention (Smith, Gillespie, Brown, & Grubb, 2016).

This project is a recognition of the need for social change within the nursing profession. Anderson and Morgan (2017) have addressed the nationwide norm for nurses to "eat their young", and there is no logical reason why this behavior has been accepted. The expression "eat their young" refers to the lack of nurturing behavior perceived by novice nurses from proficient to expert nurses. Even though most organizations have a zero-tolerance policy to addresses these concerns, some factors that may contribute to these behaviors are a lack of feelings of empowerment and the nursing leaders' reluctance to reinforce the policy.

Problem Statement

There have been first-hand observations of bullying behaviors within the community hospital being used for this DNP project. The observations included nurses refusing to take students, verbal abuse among nurses, and the lack of effective communication needed to enhance learning opportunities for new graduate nurses. Patton (2018) suggested that bullying can result in decreased staff morale and inflict mild to severe illness on its victims such as stress, depression, powerlessness, psychological complaints, and posttraumatic stress disorder. More importantly, the American Nurses Association (ANA, 2015) code of ethics addresses the workplace environment in Provision 6: "The nurse through individual and collective action, establishes, maintains, and improves the moral environment of the work setting and the conditions of employment, conducive to quality health care" (p. 5). The intentional engagement in bullying behavior directly undermines this expectation.

The American Association of Colleges of Nursing (2019) predicted that, as the nursing shortage continues to increase, the workforce will need an additional 203,700 or 15% more new graduate nurses each year through 2026 in order to effectively deliver care to the masses. Some examples for the dramatic increase include the retiring of an aging workforce, an increase in the population seeking healthcare services, and the inability to provide adequate educational avenues for individuals interested in pursuing a career in nursing. Therefore, there is a need to focus on what can be controlled. The one inconspicuous cause of the decrease in nursing staff that can be controlled is bullying or incivility.

The community hospital involved in this project has lost 30% of their nursing staff due to low job satisfaction as a result of perceived bullying behavior. As nurses are leaving the hospital, in their exit interviews with the human resources department, the new graduate nurses are describing bullying episodes such as receiving the highest acuity patients and nurse-to-patient ratios that are much higher than those for the proficient nurses. The new graduate nurses expressed feeling the importance of letting the organization know why they are leaving with the hope of improving the experiences of newly hired nurses and for those who chose to remain. The hospital recently sponsored a job fair with the major focus of hiring nursing staff. The job fair resulted in the receipt of more than 150 applications, and only two of the applicants applied for a staff nurse position. The other applications were for other positions in the hospital, such as dietary and housekeeping. The current nursing staff consists primarily of 70% agency nurses. An agency nurse is a nurse employed by a nursing agency authorized to work temporarily for hospitals and other nursing care agencies to help during busy periods or to cover for staff absences. In this instance, the agency nurses are needed to replace the staff nurses that are continuously leaving the organization in order to maintain an appropriate level of care. In many situations, agency nurses do not have the same sense of ownership and are not vested to the hospital agenda due to their temporary status which may only last 8 to 12 weeks. This project will allow the organization to reflect on the feedback from their nurses to gain a better understanding for the need for a change in culture. The education will assist in directing nursing leadership toward implementing interventions to decrease the incidents of perceived bullying or uncivil behavior.

Purpose

The purpose of the DNP project is to, ultimately, reduce the incidence of bullying and incivility at the site through an educational initiative. Sauer (2012) suggested that the population most vulnerable to bullying are the new graduate nurses who tend to leave their jobs and the nursing profession within the first year of employment. According to Moses-Steele, Creel, and Carruth (2019), new nurses often begin their work-life at a hospital working on a medical-surgical unit due to the continual retirement of proficient nurses on the medical-surgical units.

At the site, there is an overall laissez-faire attitude among the nursing leadership towards bullying and incivility. Incidents of bullying are not tracked and often not reported until staff nurses leave the organization and report the abuse in the exit interviews with human resources due to fear of retaliation. Thus, the major gap in practice is the lack of attention to this important issue by nursing administration at the site. Therefore, the practice-focused question for this staff education program is "Will continuing education, awareness, and focus on a mandated zero-tolerance policy provide a foundation for a bullying-free and civil milieu in the nursing staff of medical-surgical units"? The nursing profession is facing a severe shortage and it is imperative to move beyond simply researching bullying behaviors and incivility and begin to provide education, promote change, and increase retention rates.

Nature of the Doctoral Project

The literature review included database searches using CINAHL Plus with Full Text and PDF, Medline, Pub Med, Cochrane Reviews, and the Joanna Briggs Institute.

All referenced journal articles were written between 2014 and 2017. Search terms included *nurs*, workplace incivility, workplace bullying, workplace violence, nurse-to-nurse incivility, nurse-to-nurse bullying, horizontal bullying, horizontal violence, lateral bullying,* and *lateral violence*.

The project was initiated with measuring existing levels of bullying and incivility in staff members who presently worked on or rotate to the medical-surgical nursing units at the DNP project site. Once the data was collected from the nurses, the results in the aggregate was presented to the nursing leadership within the context of an educational program. The program addressed the research evidence on the incidence and reasons for bullying as well as management strategies to reduce these behaviors. A zero-tolerance policy has been in place at the organization for several years now, but these notwithstanding, bullying behaviors are largely ignored by the nurse managers, charge nurses and managers alike. The casual attitude towards bullying represented the preeminent gap in practice. A knowledge and attitude-based pretest, posttest, and evaluation was distributed to the nursing staff.

Significance

The primary stakeholders are the nurses on the medical-surgical units, unit managers, unit directors, and high-level management. Ultimately, it was noted that management could be adversely affected if reaction to the results were negative, rather than taking a proactive approach to reassure the nurses of the importance of their roles and show appreciation for their efforts.

Hoffman and Chunta (2015) suggested that incivility can be triggered by stressful working conditions, which can result from such issues as inadequate staffing, the expectation to complete work assignments with the lack of appropriate equipment and supplies, and the possibility of jeopardizing patient safety with increased nurse-to-patient ratios. In addition, Hoffman and Chunta proposed that when these issues are not effectively addressed, the staff become aggravated and begin to take their frustrations out on each other. The ANA (2015) suggested that this type of behavior must be addressed by enforcing policies and procedures in a zero-tolerance policy. Unfortunately, this is only a small part of the problem. The issues that cause the frustrations must be addressed as well to decrease stressful working conditions.

The strategy that was intended to be implemented during the educational interaction was the use of cognitive rehearsal involving case studies to help raise the nursing staff's awareness of bullying and incivility (Kile, Eaton, deValpine, & Gilbert, 2019). Bandura's (1977) social learning theory was proposed to represent a cognitive behavioral approach to model and synthesis the learned behavior as techniques or interventions were implemented to adopt the behavior and decrease the incidents of nurse-to-nurse incivility. The effort to incorporate the interdisciplinary staff to evaluate their relationships with nurses and toward each other could have been utilized to identify precipitating factors that led up to the bullying behavior. By creating awareness among the interdisciplinary team social change could occur by enhancing a positive work ethic which promotes retention. In addition, the project incorporated two theories, Kotter's (2008) change theory and Watson's theory of human caring (Sitzman & Watson, 2018),

which work cohesively to transform a hostile work environment. Unfortunately, the COVID-19 pandemic restricted the ability to educate nursing leadership in this phase of the process.

Summary

In summary, nurse-to-nurse incivility is destructive and creates a hostile work environment which violates zero-tolerance. Incivility may also lead to decreased retention rates as a result of increased stress and lack of job satisfaction. This DNP project focused on creating self-awareness of bullying and incivility among the nursing staff and promoting emotional intelligence. Self-awareness promotes emotional intelligence and can promote social change within the organization. The process allowed nurses to reflect upon the results and possibly implement processes to decrease any identified triggers that create the hostile environment (Meires, 2018).

Section 2: Background and Context

Introduction

The ANA (2019) identified incivility as one or more abusive, abrupt, or contemptuous actions that may or may not have a negative intent between and among nurses. For this DNP staff education project, incivility was used to describe the intentional uncivil behavior between nurses. The term *incivility* encompassed other terminology used interchangeably in other literature. These terms include, but are not limited to *bullying, lateral violence, horizontal violence, workplace violence,* and *harassment*.

ANA's (2015a) *Code of Ethics for Nurses with Interpretive Statements* states that the profession is required to uphold a humane climate and culture of civility and compassion. This includes displaying the same level of appreciation, decency, and respect toward colleagues within the interdisciplinary healthcare team, peers, students, and others that we as nurses expect to receive. More importantly, the nursing profession will no longer tolerate nurse-to-nurse violence.

The ANA's (2015a) *Code of Ethics* also elaborates on the importance of the disciplines need to collaborate to create a contagious culture of respect free of uncivil behavior in the workplace. This can be achieved by researching and implementing evidence-based best practices that avert and mitigate incivility, promoting wellness of registered nurses while performing in a healthy interprofessional work environment, and ensuring optimal outcomes across the health care continuum.

Numerous theories and conceptual frameworks associated with incivility are mentioned throughout the literature. In this section, I examine two theories that work cohesively to transform a hostile workplace: Kotter's (2008) change theory and Watson's theory of human caring (Sitzman & Watson, 2018).

Kotter's (2008) change theory is applicable to addressing the necessary change of behavior among nurses as it sets the premise for preforming self-assessments in the workplace, initiating interventions, and evaluating outcomes while supporting change. The nursing profession is continually evolving, which supports the need for all nurses to recognize their responsibility to be leaders. As leaders, nurses frequently face challenging situations that can place tremendous stress on the profession. The stress can contribute to the ineffective coping, which may result in disruptive behaviors such as bullying. These behaviors can in turn produce high turnover rates due to negativity in the workplace.

Kotter and Rathgeber (2016) explained that the eight steps of change include (a) embedding a sense of urgency, (b) building a guiding team with individuals that have credibility and quality leadership skills, (c) focusing in on the visions developed by the team, (d) gaining buy-in through effective communication, (e) empowering action and removing barriers, (f) acknowledging short-term wins, (g) remaining focused on the ultimate goal, and (h) making the change in culture long-lasting. Kotter's model is embedded with a high influence on personal empowerment as it encourages team building and places focus on individual roles and responsibilities. As individuals are allowed to evaluate their self-perception of how their own actions influence hostility in

the workplace, they are able to put their best forward to contribute to the culture change and/or new concepts.

The second theory is Watson's theory of human caring (Sitzman & Watson, 2018), which includes spirituality and promotes the art of caring as the premise for nursing care. The theory unites the art and science of nursing to meet the needs of diverse cultures (Arslan-Ozkan, Okumus, & Buldukoglu, 2014). Watson's theory of human caring encourages nurses to begin caring for one another and initiate nurturing practices to peers and new graduate nurses. The theory allows nurses to become compassionate mentors to assist in changing the impact of the current nursing shortage and decrease the turnover rates in the nursing profession.

Watson's theory utilizes 10 caritas processes. Watson defines *caritas* as a means to "cherish, appreciate, and give special or loving attention with charity, compassion, and generosity of spirit" (Watson, 2008, p. 22). The theory of Human Caring is formulated around 10 Caritas Processes which are as follows:

1. Commitment to loving-kindheartedness and equability within context of caring consciousness;
2. Being authentically present, empowering, and sustaining the beliefs of hope and faith while honoring self and others;
3. Cultivating one's own spiritual practices by going beyond self-worth to transpersonal existence;
4. Developing and sustaining a helping-trusting, trustworthy caring connection with others;

5. Being present and sympathetic to the expression of positive and negative emotional states while genuinely listening to another person's story;
6. Artistically using self and all ways of knowing as part of the caring-healing process;
7. Engaging in genuine teaching-learning experiences that exhibit meaning while attempting to stay within other's frame of reference;
8. Creating a healing environment at all levels that utilize an authentic caring presence;
9. Assisting with basic needs while exhibiting intentional caring of the mind, body, and spirit; and
10. Opening and attending to spiritual unknowns that allow for miracles.

The processes that specifically related to this educational project are developing and sustaining a helping-trusting, trustworthy caring connection with others, being present and sympathetic to the expression of positive and negative emotional states while genuinely listening to another person's story, and creating a healing environment at all levels that utilize an authentic caring presence (Watson, 2018). The combination of these theories creates a foundation to permit nurse leaders to appropriately speak to incivility in the workplace and promote the spirit of nursing beyond the evidence-based practices related to patient care.

Bullying and Incivility

Internationally, workplace bullying and incivility are measured as one of the most common work-related psychological complications. Workplace incivility impacts nurses'

physical, emotional, mental, and spiritual health. It destabilizes and eventually affects the organizational culture and contributes to undesirable personal, professional, and negative patient outcomes (Crawford et al., 2019).

The continuous installation of incivility can lead to the creation of a toxic work environment. A toxic work environment can initiate the occurrence of a decline in staff morale and collaboration among the interprofessional team. It is imperative for nursing leadership to strive to reestablish a healthy work environment where nurses are invigorated and empowered to stand up for themselves in the midst of an increased presence of uncivil behavior (Crawford et al., 2019).

Contributing Factors

Workplace incivility is prevalent and continues to progress in the health care milieu among nurses and the interprofessional healthcare team. The literature suggests that low autonomy, excessive workloads, physical burnout, which leads to psychological distress, lack of rewards, poor organizational climate, and nonexistence managerial support and communication, are some of the factors encouraging bullying and incivility in the workplace (Giorgi et al., 2016). As a result, there can be an array of incivility which can include lack of support from other nurses to discourteous or humiliating remarks that may include verbal threats. These acts of incivility can be overwhelming to nurses, disrupting performance, affecting mental health, and diminishing the intention to remain within an organization or even in the nursing profession.

Barriers to Success

The major issue impeding a solution to successfully evicting incivility in the workplace among nurses relates to many institutions' denying the existence of the behavior. Unfortunately, ignoring the issue of incivility has created a culture that has accepted the behavior as the norm (Castronovo, Pullizzi, & Evans, 2016).

An important factor to consider is the position of the perpetrator. At times, the individual contributing to the uncivil behavior may be a member of nursing leadership such as the director, manager, or charge nurse. If this situation exists, the individual that is being bullied may have no recourse to report and/or to gain assistance to have the issues resolved. Additionally, if the perpetrator is a member of nursing leadership, the fear of retaliation can prevent the victim from reporting the incidence. Thus, this fear can lead to the victim leaving the organization (Castronovo et al., 2016).

In addition, our society has not been made aware of the prevalence of nurse-to-nurse incivility and bullying among interprofessionals in the health care arena. The lack of public awareness may contribute to the resolution of this serious problem.

Strategies to Reduce Bullying

This project utilized the Nursing Incivility Scale as a means to bring awareness to the progressive issue of incivility in the workplace. There will be a pre- and post-survey, with a training intervention completed between the surveys. The training included a Power Point presentation explaining perceived bullying and incivility and the consequences when displayed in the workplace.

Another strategy that was presented to help resolve the problem was adherence to a mandated zero-tolerance policy. The Joint Commission (2008) suggested that hospitals develop and implement zero-tolerance policies to address the issue of intimidating and disruptive behaviors. Furthermore, the Joint Commission issued two leadership standards to specifically addressed the issue of incivility. They are as follows:

- "A code of conduct which defines acceptable and disruptive and inappropriate behaviors"; and
- "Leaders must create and implement a process for managing disruptive and inappropriate behaviors" (The Joint Commission, 2008, p. 2).

In addition to the Joint Commission guidelines, there was the "Healthy Workplace Bill" presented in 2003 that provided guidelines for employers in relation to managing an "abusive work environment". This bill protects employers from liability risk when preventative measures are in place and give employers the reason and/or guidelines to adhere to when terminating or sanctioning offenders (Healthy Workplace Bill, 2019).

Relevance to Nursing Practice

Incivility in nursing has been around for decades, and the idiom "nurses eat their young" has been globally recognized for over 30 years. Meissner (1999) in 1989, described nurses as cannibalistic, genocidal caregivers by announcing the phrase and the concept of "nurses eating their young". Unfortunately, more than 10 years later, in 1999, Meissner reported that the same culture existed within the nursing profession. In the present year, 2019, the concept of "nurses eating your young" is still present and is not being addressed by nursing leadership. Novice nurses are more frustrated than ever by the

treatment they incur from their expert nurses in the profession as they enter internships and receive on-the-job training.

The number of nurses who have understanding of incivility due to being victims of the behavior is devastating. The research reflects that up to 85% of nurses reported having experienced incivility and that 21% of organizations reported a turnover in employment due to the problem. In addition, up to 70% of nurses have reported knowing of errors which occurred because of bullying and uncivil behaviors among professionals (Edmonson, Bolick, & Lee, 2017).

There have been strategies implemented and deemed successful in addressing this gap-in-practice by nurse/clinical leaders. They include utilizing surveys to examine nurse perceptions of the organizations culture, which enlightened nurse executives of the perceived behaviors and possible mechanisms to enhance change. This included emphasizing the ANA Code of Ethics related to bullying and incivility by creating and/or reinforcing policies with concise guidelines of prohibited behaviors. This method was successful when nursing leadership did not ignore the evidence presented by the outcomes of the surveys and interactions with the nurses. Additionally, providing professional development to nurses and nurse leaders which include conflict management, conflict resolution, emotional intelligence, relationship building, and cognitive rehearsal have been effective in minimizing uncivil behavior (Crawford, Chu, Judson, Cuenca, Jadalla, Tze-Polo, Kawar, Garvida, 2019).

Beserra et al. (2018) emphasized communication for nurses encompasses managing conflict and building relationships. When the nurse can appropriately and

effectively manage conflict, it helps to foster a work environment that produces positive outcomes for all involved to include the nurses, interdisciplinary healthcare team, the clients, and nursing management. Thus, providing professional development for nurses is essential.

Griffin (2004) provided research and evidence from subsequent studies promoting the use of cognitive rehearsal as an effective method for practicing strategies to enhance effective communication in a safe and protected environment. In 2014, Griffin & Clark re-evaluated the role of cognitive rehearsal to continue to address and modify the role of incivility and lateral violence in nursing and still found it to be a constructive means to address the ongoing problem. In addition, Sanner-Stiehr (2018) provided research in a longitudinal, quasi-experimental investigation supporting the findings of Griffin. The findings supported cognitive rehearsal interventions as an effective means in increasing positive results toward minimizing disruptive behaviors.

This doctoral project focused on the same proven strategies to fill the gap-in-practice with emphasis on promoting awareness and reinforcing current organizational zero-tolerance and/or harassment policies to minimize the occurrence of bullying and incivility in the workplace. The presentation of the results of the Nursing Incivility Scale assisted in allowing nursing leadership to become aware of the issues and assist them in implementing strategies to address changing the status quo.

Local Background and Context

The facility where this project was implemented was a not-for-profit, network system-based healthcare organization in Maryland. The organization has a very active

Shared Governance model which allows the staff to be involved in the decision-making processes on the unit. When the project was presented to the assigned unit, the nurses began contributing their experiences in relation to incivility in the workplace. Initially, the conversations were in relation to incivility among the disciplines and not of uncivil behavior among each other.

Some of the examples of incivility have been provided by several nurses who have since left the organization and acquired employment at a neighboring hospital. All examples were obtained during casual conversations. Nurse A was a new graduate from a BSN program who was about to complete her first year at the bedside. During the conversation, she discussed being bullied by an expert charge nurse with more than 30 years of experience. Nurse A expressed being upset over the assignments she received on a daily basis. The assignments almost always gave Nurse A the patients with the highest acuity on the unit and she was always maxed out in the nurse-to-patient ratio. When Nurse A approached the charge nurse about the assignment, the charge nurse advised her all new nurses have to pay their dues. Nurse A described the lack of support she felt from her charge nurse as well as from her peers because of the cliques being formed on the unit. Nurse A also revealed she did not feel comfortable reporting the behavior to the unit director because of the fear of retaliation from the charge nurse. As a result, Nurse A resigned from the organization exactly one year from her date of hire.

Nurse B was a colleague who was under my supervision at another organization. She accepted a position at the current organization in order to be closer to home and improve her work-life balance. Nurse B has 4 years of experience and has obtained her

Masters of Science in Nursing (MSN) within the last 6 months. Nurse B immediately expressed dismay of never being accepted as a productive member of the unit. In her opinion, it was due to her nationality and having English was her secondary language. Nurse B has applied for vacant charge nurse positions twice and was never granted an interview. The unit director advised her that she did not have enough education and time at the bedside. However, the organization hired a nurse with an Associate's Degree in Nursing (ADN) and 5 years of experience at the bedside for the most recent position. Nurse B left the organization after being awarded a position of Charge Nurse at a neighboring hospital.

Definition of Terms

Bullying and *incivility:* These terms are defined as disruptive behaviors which have been experienced by 80% of the registered nurse workforce (Elmblad et al., 2014). All of the terminology defined below are descriptive of disruptive behaviors. Bullying and incivility are an umbrella term encompassing the following phrases:

Horizontal or *lateral bullying:* Griffin and Clark (2014) describes horizontal or lateral bullying as the tenacious, belittling, and downgrading from nurse-to-nurse through malicious and spiteful dialogue accompanied with cruel acts attacking the victim's self-esteem. The terms lateral and horizontal refers to the relationship of nurse-to-nurse or from one interdisciplinary professional to the other.

Horizontal or *lateral violence:* Elmblad et al. (2014) describe this term as a deviant behavior targeting the victim with intent of bodily injury. Griffin & Clark (2014) explain horizontal and lateral violence evolved from oppression theory. It refers to the

actions manifested toward each other. The descriptors lateral and horizontal refer to the relationship of nurse-to-nurse or from one interdisciplinary professional to the other.

Hostile work environment and/or *workplace mobbing:* Griffin and Clark (2014) explained these terms refer to harassment that can result in severe psychological and work-related catastrophic events for the victim. Castronovo et al. (2016) referred to workplace mobbing as a malicious effort to overpower, humiliate, and at times terrorize another individual to leave the workplace.

Incivility or *Uncivil behavior:* DeMarco, Fawcett, & Mazzawi (2018) explain this as a type of undesirable behavior displaying lack of unrespectful intent toward co-workers and/or peers in the workplace. Griffin & Clark (2014) explains this type of malicious behavior may result in psychological or physiological distress for the individuals involved.

Workplace incivility or *violence:* A low-intensity, aberrant societal behavior projected toward individuals in the workplace to cause possible injury. This allowable behavior can create adverse consequences causing financial and socioeconomic tension on organizations (Armstrong, 2018).

Role of the DNP Student

Professional Context

As I considered my project subject, I echoed the relevance of incivility in nursing that I have witnessed and experienced. It was imperative for me to expand upon the reasons why so many nurses, including myself, were tolerating the status-quo in our jobs. Upon reflection of the stories being cited and my own personal experiences, it is

relatively exhausting to continue to watch compassion being given to the external customer while the profession continuously berated and lacked the sense of nurturing behavior to their own.

My role in this DNP project was to edify and empower the professional nurses within this facility to exercise their privileges to care for one another. It was also necessary to enlighten the staff to the organizational policy to successfully inhibit this type of behavior. More importantly, it created an opportunity to permit nursing leadership to reflect on their poor management of a highly visible problem which has created high turnover within the organization. Some of the stories reflected the staff's unwillingness to consult nursing leadership regarding uncivil behavior due to the perception that they simply did not care and have demonstrated a lack of responsibility in resolving the issues.

Summary

Incivility is a global problem with evidentiary support in the literature (ANA, 2015; The Joint Commission, 2008). While the issues are staggering, increasing awareness through education creates great opportunities to begin to address and possibly impose solutions to this age-old issue.

More importantly, as the profession, specifically nurse leaders begin to take notice of the problem of incivility, tools can be put into place to improve self-awareness and empower nurses to stand up to their aggressors and decrease the statistics of reported incivility. If change is not made, the nursing professional will continue to suffer and nurses will continue to leave the profession. The American Association of Colleges of Nursing is projecting the RN workforce to grow from 2.9 million in 2016 to 3.4 million

in 2026, which is an increase of 438,100 or 15%. However, there is a projected need for an additional 203,700 new RNs each year through 2026 to fill newly created positions and to replace the retiring baby boomer nurses. The professional cannot afford to lose nurses due to uncivil behavior when we face such a shortage crisis.

Section 3: Collection and Analysis of Evidence

Introduction

Bullying and incivility, which is defined as disruptive behaviors, have been experienced by 80% of the registered nurse workforce (Elmblad et al., 2014). This is a dramatic increase from the Joint Commission (2008) survey which revealed that 50% of nurses were victims of bullying behavior and 90% of nurses surveyed have witnessed incivility within their organization. I have observed these behaviors firsthand during practicum in the assigned community hospital. The observations included nurses refusing to take students, verbal abuse between nurses, and the lack of effective communication needed to enhance learning opportunities for new graduate nurses. As a result, several new graduate nurses have begun to seek employment in other institutions. Bullying can result in decreased staff morale and inflict mild to severe illnesses on its victims, such as stress, depression, powerlessness, psychological complaints, and post-traumatic stress disorder (Patten, 2018). Also, the principles of nonmaleficence, to do no harm; beneficence, to prevent and remove harm; and justice, fair treatment of all, are all sacrificed when bullying occurs (ANA, 2015).

The ANA code of ethics addresses the workplace environment in provision six: "The nurse through individual and collective action, establishes, maintains, and improves the moral environment of the work setting and the conditions of employment, conducive to quality health care" (ANA, 2015, p. 5). The intentional engagement in bullying behavior directly undermines this expectation.

Practice-Focused Question

The practice-focused question for this staff education program was "Will continuing education, awareness, and focus on a mandated zero-tolerance policy provide a foundation for a bullying free and civil milieu?" The question focused on the behaviors of the nursing staff on a 40-bed medical-surgical unit, which consisted of novice to competent nurses with 1 to 5 years of experience and proficient to expert nurses with 5 to 30 years of experience. Upon completion and analysis of the nursing incivility scale (see Table 1), staff education was provided in accordance to the organizations zero-tolerance policy to reduce the bullying and uncivil behavior.

The nursing profession is facing a severe shortage, and it is imperative to move beyond simply researching bullying behaviors and incivility and begin to provide education and promote change in culture to reverse the negative impact our nurses are experiencing to establish healthy work environment and improve retention (Smith et al., 2016). The unit director at the project site confirmed that the primary reasons given in exit interviews from nurses whom have left the medical-surgical unit related to bullying behaviors which included unfair nurse-patient assignments/ratios, rude comments, verbal abuse, and lack of support.

Sources of Evidence

In my attempt to address the practice-focused question, I relied upon the literature for referenced recommendations. The literature clearly indicated raising self-awareness, gaining nursing leadership buy-in, and providing continuing education on effective methods to minimize bullying and uncivil behavior are crucial (Beserra et al., 2018;

Crawford et al., 2019; Griffin & Clark, 2014; Sanner-Stiehr, 2018). The DNP staff education project was designed to educate and provide continuing education to staff regarding their perceptions of bullying and incivility and to employ ways to improve overall job satisfaction by beginning to change the organizations culture.

Nursing theory promotes the underlying essentials to the profession's evidence-based research and positive patient outcomes. The Joint Commission's (2008) Sentinel Alert 40 was also essential in relation to evidence-based practices. The alert required health care organizations to examine and make all staff aware of disruptive behaviors that can affect the provision of quality patient care.

Nursing theory provides a self-governing conceptual framework for nursing education and practice. This project incorporated two theories, Kotter's (2008) change theory and Watson's theory of human caring (Sitzman & Watson, 2018), which work cohesively to transform a hostile workplace.

The literature review included database searches in CINAHL and Medline for literature pertaining to workplace incivility, nurse-to-nurse incivility, horizontal bullying, horizontal violence, and lateral violence.

Published Outcomes and Research

A comprehensive search of the literature for incivility in nursing included the following databases: CINAHL Plus with Full Text and PDF, Medline, Pub Med, Cochrane Reviews, and the Joanna Briggs Institute. All referenced journal articles were written between 2014 and 2017. Key search terms and combinations of search terms used included *nurs*, workplace incivility, workplace bullying, workplace violence, nurse-to-*

nurse incivility, nurse-to-nurse bullying, horizontal bullying, horizontal violence, lateral bullying, and *lateral violence*. The scope of the review included searches from 2014 to 2019 to comprise peer-reviewed articles and education-based materials.

Evidence Generated for the Doctoral Project

The following is a step-by-step description of how the evidence was collected for this DNP project.

Participants. The project took place within a not-for-profit, network system-based healthcare organization in Maryland. The population included nursing staff on an 80-bed medical-surgical/telemetry unit. There were no exclusion criteria for this project with the exception of not being licensed as a Registered Nurse. The sample, because it was inclusive of all licensed nursing staff, was a convenience sample. Because all licensed nursing staff were included, the sample size of 100 nurses represented the target population.

Procedures. The nursing incivility scale (see Appendix A), implemented in 2010, was designed to measure nurse's perceptions of incivility. "It was developed using focus groups with nurses at a hospital in the midwestern United States and validated during a second survey administered to 173 hospital nurses" (Guidroz, Burnfield-Gelmer, Clark, Schwetschenau, & Jex, pg. 176, 2010). I administered the nursing incivility scale to staff nurses to identify incidences of bullying or uncivil behavior in the workplace.

The nursing leadership on the medical-surgical nursing units was invited to participate in an interactive educational program on their role in managing and reducing the incidence of bullying and incivility. The organization's zero-tolerance policy was

reviewed and incorporated into the staff education program. The incivility survey results were shared with the nursing leadership from the medical-surgical units during the educational program. It was suggested that the impact of the education be reviewed in 6 months by the organization's education and training department by re-surveying the unit nurses utilizing the nursing incivility scale (see Appendix A).

Protection. The nurses must be assured that the data collection process will remain anonymous through de-identification. The surveys were labeled as Nurse #1, Nurse #2, Nurse #3, etc. prior to distribution and collected via a secured box located on the identified unit. The data was compiled prior to distribution to management to inhibit the identification of individual nurses.

I obtained institutional review board (IRB) approval from Walden University (IRB approval number 01-29-20-0178912) to ensure the protection of the participants. To ensure all parameters of the study were met at the project host site, the information was entered into their IRB system via **www.gumedstarirb.georgetown.edu**. The host site determined that since Walden University's was providing oversight, the additional IRB approval for study 00001670 was not needed as it would cause potential double IRB effort. Walden University's informed consent page was signed for approval to implement the project by the host site. The Walden Education manual was utilized to provide an explanation regarding the protection of patients at all times.

The purpose of this DNP staff education project was to increase awareness of incivility and thereby reduce uncivil behavior in the organization. The evaluation was composed of 42 questions in a Likert-scale format to allow for question item analysis.

The data was de-identified to protect participants from actual or perceived retribution for answers that are given.

Analysis and Synthesis

During the process of implementation, the Nursing Incivility Scale was distributed for completion for 2 weeks. The aforementioned de-identification process was utilized to protect the integrity of the evidence. The data was compiled into an educational presentation for nursing leadership and staff for review.

The educational presentation was intended to be offered to all nursing staff to complete over a period of 3 weeks to account for staff members on vacation. Missing numbers included those staff members having maternity leave, sick leave, or family medical leave. The educational program initially included a cognitive rehearsal dialogue to allow the nursing staff to have a better understanding of how to handle and deter uncivil behavior. However, due to the COVID-19 pandemic, the cognitive rehearsal dialogue had to be excluded. The summative evaluation was used to decide if the educational project should continue within the organization as routine education.

The educational project included a pre- and posttest, and summative evaluation. After all course pre- and posttest, evaluations are completed, item analysis of the questions will be performed. The overall scores from the pretests and posttests were evaluated to determine if the education was effective as evidenced by higher posttest scores than pretest scores.

Summary

The first step in defeating the problem of incivility was increasing awareness of the problem. This staff education project with pretest, Nursing Incivility Scale, and posttest was administered to the nursing staff to increase awareness of nurse-to-nurse incivility. The intent was to decrease the uncivil behaviors in the future as well as empower and equip nurses to stand up to their aggressors. Once the project was completed, a summative evaluation was completed and discussed in later sections of this paper.

Section 4: Findings and Recommendations

Introduction

The nature of the project was to bring awareness to the bullying behaviors and incivility currently existing within the organization's culture by assessing for the incidence of bullying, and by providing an educational program for the nursing leadership and nursing staff. The intention was to promote change and to reverse the negative impact nurses are experiencing to establish a healthy work environment and improve retention (Smith et al., 2016). The current nursing staff consists primarily of 70% agency nurses. These are nurses contracted through a nursing agency to supplement the nurse staffing levels to maintain an appropriate level of care. This project will allow the organization to reflect on the feedback from their nurses to gain a better understanding for the need for a change in culture. The education will assist in directing nursing leadership toward implementing interventions to decrease the incidents of perceived bullying or uncivil behavior.

This project recognizes the need for social change within the nursing profession as indicated by the results of the Nursing Incivility Scale questionnaire (see Appendix A). The Nursing Incivility Scale was distributed over a 2-week period to the nursing staff at a small community hospital in Maryland. This questionnaire addressed interactions with other nurses. Certain sections of the Nursing Incivility Scale were used to gather information on nurse-to-nurse interactions related to incivility among them and to identify possible perpetrators. The additional information might be beneficial for future

work at this facility. However, for this project, I used the data gathered from the Nursing Incivility Scale pertaining to other nurses.

Findings and Implications

The project took place on a medical-surgical unit. Out of the 30 possible nurses available on the nursing unit who were qualified to participate in the project, 12 nurses were able to complete the pretest. The same 12 nurses completed the educational initiative, posttest, and evaluation. Demographic data were not collected during the de-identification process to protect nursing staff from any means of perceived retaliation.

The Nursing Incivility Scale findings, summarized in Figure 1, show a relatively high percentage of nursing staff either agreed or strongly agreed to being bullied or observed bullying behavior in the hospital.

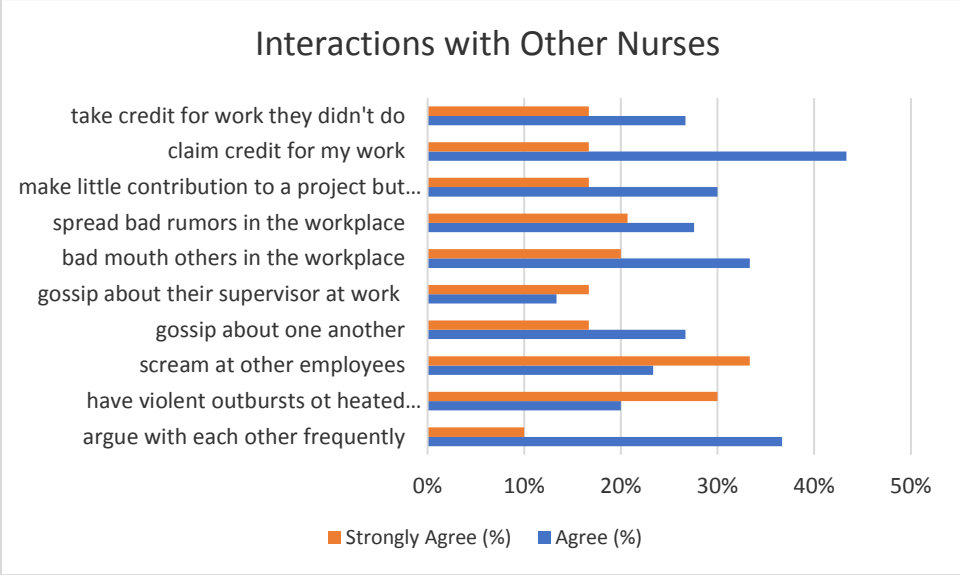

Figure 1. Nursing Incivility Scale results that reflect Agreed/Strongly Agreed response data for "Interactions with Other Nurses."

As previously discussed, the practice-focused question for this staff education program is: "Will continuing education, awareness, and focus on a mandated zero-tolerance policy provide a foundation for a bullying-free and civil milieu in the nursing staff of medical-surgical units"? The average pretest score was 55.83, while the average posttest score was 100.00. Based on the results of the paired samples *t* test, the difference is statistically significant, $t\ (12) = 5.853$, $p < .05$. Therefore, the implemented educational initiative was effective in improving knowledge of the organization's Workplace Harassment Prevention policy and procedures.

Table 1

Results of Paired Samples t *test*

	Mean	Mean diff.	*t*	*Df*	Sig.
Pretest	55.83	44.17	5.853	11	.05
Posttest	100.00				

Upon returning to the host site to deliver the educational presentation to nursing leadership and the nursing staff, it was impossible to get a meeting with nursing leadership due to the coronavirus crisis that quickly turned into a pandemic. The leadership team was immersed in preparing a plan to care for the rapid admissions of patients experiencing COVID-19 symptoms and implementing measures to protect the healthcare interdisciplinary team. The host site also decided to suspend all students from practicing on the hospital campus until further notice. I was reassured that the Education Department would assist me to the best of their ability to successfully complete my DNP program.

In order to present and complete the pretest (see Appendix C), educational material (see Appendix B), posttest (see Appendix D), and evaluation (see Appendix E), the host site provided me with the names and company email addresses of the staff working on the medical-surgical unit. The information was emailed to the nursing staff on March 21st, 2020. The charge nurse assisted in informing the nursing staff about the email and collected the pretest, posttest, and evaluations from the nursing staff upon completion. The 12 participants completed the pretest, posttest, and evaluation. Arrangements were then made for me to collect the materials from the host site.

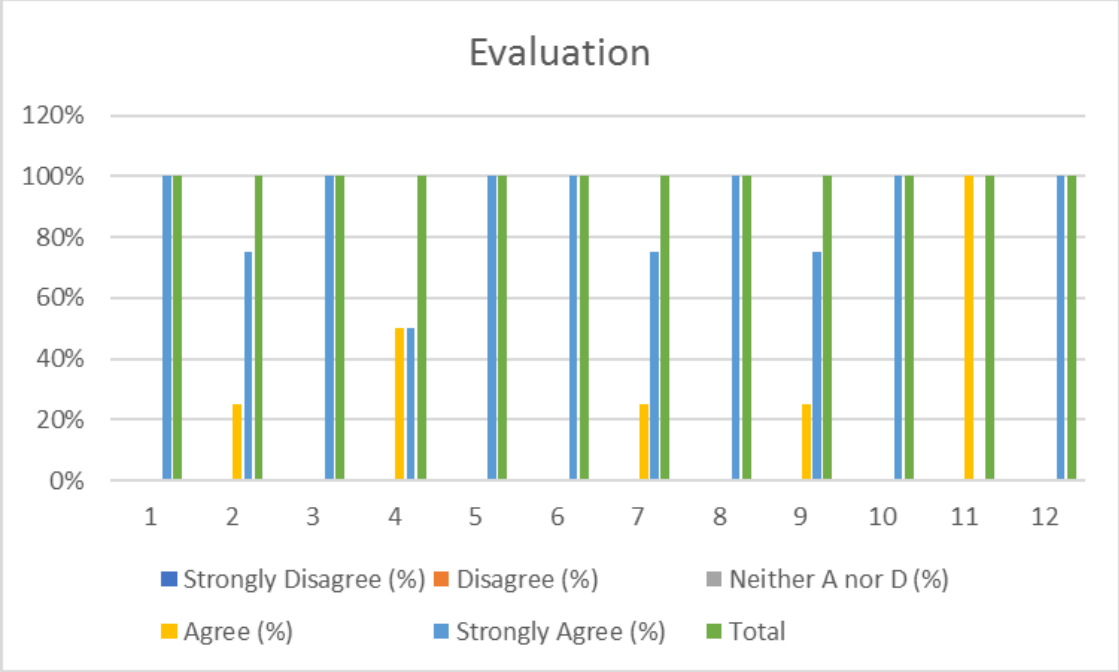

Figure 2. Evaluation percentages based on a Likert scale.

The data from the evaluation (see Table 2) indicated that the majority of the nurses surveyed had advanced their knowledge of the perception of bullying and incivility within their organization. The evaluation received 0% ratings in the categories

of *Strongly Disagree*, *Disagree*, and *Neither A nor D*. The majority rated the educational initiative as either *Agree* or *Strongly Agree*.

Table 2

Evaluations Scores for the Majority Ratings of Agreed/Strongly Agreed

Number	Question	Agree	Strongly agree
1	The results of the Likert scale questionnaire were informative	8%	92%
2	The education increased my awareness of perceived bullying & incivility within my organization	33%	67%
3	I understand the workplace harassment policy and my rights as they apply to bullying & uncivil behavior	25%	75%
4	The educational initiative was easy to follow and understand	8%	92%

Recommendations

The recommended solution to address the recurrent perceived bullying and uncivil behaviors in nursing include continuing education on the awareness of these actions in the workplace. The increase in the scores from pretest to posttest regarding the organization's zero tolerance policy during this project reflected that a modification in knowledge occurred with continuing education. Due to the coronavirus pandemic, the plan for staff nurses on the medical-surgical nursing units to participate in an interactive educational program on their role in managing and reducing the incidence of bullying and incivility had to be eliminated. Once the pandemic is over, it would be beneficial for the organization to revisit this plan with the incorporation of proven educational activities such as cognitive rehearsal, conflict resolution, and emotional intelligence training to

enhance communication among nurses. The results of the Nursing Incivility Scale revealed a gap-in-practice among nurses and these activities could improve the parameters of this vital working relationship.

The coronavirus pandemic also created ongoing issues with providing education to the medical-surgical nurses on the units. The host site decided it was best to restrict access of students to the hospital during the crisis. The project had to be completed with the distribution of the educational materials to the nursing staff via assigned hospital email addresses. The education department provided email addresses for the nursing staff on one medical-surgical unit as opposed to the multiple units used to obtain the initial data utilizing the Nursing Incivility Scale. The organization would benefit from incorporating the information provided in the educational presentation into a module on their training site that can be accessed by all personnel to increase awareness of bullying and incivility. As a follow-up to increasing awareness, additional educational modules can be developed and presented as mandatory training on an annual basis to improve interactions between all disciplines.

Contributions of the Doctoral Project Team

Although there was no designated project team, there were key players in the implementation of this project: the site preceptor, site educator, and the charge nurse on the designated unit. The site preceptor was responsible for granting access to the nursing staff and in obtaining hospital policies and procedures needed to successfully design and complete the education. The site educator was responsible for granting approval for the project and for access to nursing staff email addresses. The charge nurse on the

designated unit assisted in gathering the completed forms which included the Nursing Incivility Scale, pretest, posttest, and evaluation during all phases of the project.

Strengths and Limitations of the Project

Several strengths were evident throughout this project. During the initial stages of data collection, the host site granted access to two medical-surgical units, which contributed to having 30 possible participants. The nurses expressed feeling comfortable with completing the survey because it was being initiated by someone outside of the hospital network and the de-identification process meant there would not be a way to specifically identify who completed the surveys. Therefore, they would not have to worry about possible retaliation from nursing leadership.

The limitations became a part of the equation once the coronavirus pandemic began to attack the United States. The easy access to the hospital campus and nursing staff was quickly restricted in order to gain as much control over the pandemic as possible. The small completion rates with 12 participants due to the COVID-19 pandemic and hospital restrictions of the pretest, posttest, and evaluation was a limitation even though the results showed in increase in knowledge on every question.

An additional option would be to present the data and educational summary as an online module for nurses after the COVID-19 pandemic. In order to continually address the issue of bullying and incivility, the modules can be updated annually and included in the mandatory annual training.

Summary

This DNP staff education project was successful as it increased the awareness of bullying and uncivil behavior in the workplaces, as well as the knowledge from pretest to posttest of the organization's harassment policy guidelines.

Furthermore, in reference to the practice-focused question for this staff education program, "Will continuing education, awareness, and focus on a mandated zero-tolerance policy provide a foundation for a bullying-free and civil milieu in the nursing staff of medical-surgical units"?, there has been an increase in awareness and focus. The nursing staff have increased their knowledge of the current policy regarding harassment in the workplace and feel equipped to educate their fellow nurses and interdisciplinary team on the organization's current climate in order to promote change.

Section 5: Dissemination Plan

Dissemination of the findings from this staff education DNP project is multifaceted. Initially, the results were meant to be delivered to the host sites nursing leadership team. However,, due to the rapid onset of the coronavirus/COVID-19 pandemic, this plan failed to materialize. The nursing leadership team was obligated to place their primary focus on a solid plan to effectively manage and influx of patients and the safety of their interdisciplinary team and staff during the pandemic. Therefore, the reaction of nursing leadership regarding the data collected from their nursing staff is unknown. This host site's plan also included suspending the attendance of all students from the hospital until further notice.

The second phase involved delivering an education initiative to the nursing staff which was prepared from the results of the data gathered from the Nursing Incivility Scale. Due to the suspension of all students from the host site, the education department provided hospital-issued email addresses to nursing on one medical-surgical unit as to allow the education material to be delivered via email. An email was prepared and sent to all of the email addresses supplied by the education department. The email included the pretest, educational material, posttest, and evaluation. The unit's charge nurse assisted in gathering the completed pretest, posttest, and evaluation and delivered them to me via a remote gathering.

Analysis of Self

I am proud to be a nurse and an educator. In this DNP project, I was able to illuminate a topic that has been haunting the professional of nursing for decades. This

topic resonated with me deeply due to a past experience that I had with a chief nursing officer while caring for a loved one in my home while practicing in the role of clinical nurse manager on a 42-bed telemetry unit. The unprofessional and uncivil behavior that was thrust upon me has made me an advocate for those nurses that have, are, or will encounter the same destructive behavior from others in the nursing profession. During this DNP project, so many of my peers approached me and contributed their stories of bullying and incivility to my cause. Their honesty about their encounters inspired me to accept the challenge to attempt to change their current milieu and offer encouragement to those who were involved in current situations of bullying and uncivil behavior.

As the project progressed, it would have been difficult to complete without the assistance of my preceptor, hospital educator, and fellow nurses, especially the charge nurse on the designated medical-surgical unit. I would even like to extend my gratitude to the IT expert that helped me gain access to the organization's internal research approval website to ensure that all guidelines were met and approved for this project. It was extremely satisfying to relay the Nursing Incivility Scale data back to the nurses, which allowed them to unite and understand that they were not alone in their battles with dealing with incivility.

Toward the end of the project, completion became difficult. The unexpected coronavirus pandemic created a milieu that had to be focused on survival and placed some challenges on gaining access to the nursing staff to deliver the education as planned. There were also challenges with my own work-life balance. The pandemic caused my employer to shift the educational platform from face-to-face to virtual

learning. The change included didactic, clinical, lab, and simulation. The learning curve created work hours that increased from 8-hour days to 12 to 14-hour days due to additional training on the new online virtual platforms. These changes interfered dramatically with the ability to effectively balance work, school, and personal life obligations. With the help of family, friends, colleagues, and my chair, I was motivated to finish by keeping myself on task.

Summary

The goals of this staff education DNP project were, ultimately, to reduce the incidence of bullying and incivility at the site through an educational initiative. I met the goals by initially collecting data utilizing the Nursing Incivility Scale, conducting a pretest on the organizations harassment/zero tolerance policy, implementing an educational initiative, conducting a posttest on the organizations harassment/zero tolerance policy, and conducting an evaluation of the overall staff education DNP project.

During this project, there were many fellow nurses who were willing to share their stories, document their concerns, and participate in the education initiative. Unfortunately, this project's goal will not entirely come to fruition until nurses begin to treat each other with respect, dignity, and begin to nurture their young.

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Appendix A: The Nursing Incivility Scale

Table 1: Nursing Incivility Scale			**Nurse No. _____**		
Please circle the number on the Likert scale that corresponds to your answer from strongly disagree to strongly agree.	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**
For the following items, please consider **all individuals** you interact with at work, including physicians, other nurses or hospital personnel					
1. Hospital employees raise their voices when they get frustrated	1	2	3	4	5
2. People blame others for their mistakes or offenses.	1	2	3	4	5
3. Basic disagreements turn into personal attacks on your employees.	1	2	3	4	5
4. People make jokes about minority groups.	1	2	3	4	5
5. People make jokes about religious groups.	1	2	3	4	5
6. Employees make inappropriate remarks about one's race or gender.	1	2	3	4	5
7. Some people take things without asking.	1	2	3	4	5
8. Employees don't adhere to an appropriate noise level (e.g. talking too loudly)	1	2	3	4	5
9. Employees display offensive body language (e.g., crossed arms, body posture)	1	2	3	4	5
The following describes your interactions with other **nurses**. Other nurses on my unit……					
10. …argue with each other frequently.	1	2	3	4	5
11. …have violent outbursts or heated arguments in the workplace.	1	2	3	4	5
12. …scream at other employees.	1	2	3	4	5
13. …gossip about one another.	1	2	3	4	5
14. …gossip about their supervisor at work	1	2	3	4	5
15. …bad mouth others in the workplace.	1	2	3	4	5
16. …spread bad rumors in the workplace.	1	2	3	4	5
17. …make little contribution to a project but expect to receive credit for working on it.	1	2	3	4	5
18. …claim credit for my work.	1	2	3	4	5
19. …take credit for work they didn't do	1	2	3	4	5
Please think about your interactions with your **direct supervisor** (i.e., the person you report to most frequently) and indicate how strongly you agree with the following statements. My direct supervisor…					
20. …is verbally abusive	1	2	3	4	5
21. …yells at me about matters that aren't important.	1	2	3	4	5
22. …shouts or yells at me for making mistakes.	1	2	3	4	5
23. …takes his/her feelings out on me (e.g., stress, anger, "blowing off steam").	1	2	3	4	5
24. …doesn't respond to my concerns in a timely manner.	1	2	3	4	5
25. …is condescending to me.	1	2	3	4	5
26. …factors gossip and personal information into personal decisions.	1	2	3	4	5
This section refers to your interactions with **physicians** that you work with. How frequently….					
27. …are some physicians verbally abusive?	1	2	3	4	5
28. …do physicians yell at nurses about matters that are not important?	1	2	3	4	5
29. …do physicians shout or yell at me for making mistakes?	1	2	3	4	5
30. …do physicians take their feelings out on me (e.g., stress, anger, "blowing off steam").	1	2	3	4	5
31. …do physicians not respond to my concerns in a timely manner?	1	2	3	4	5
32. …do physicians treat me as thought my time is not important?	1	2	3	4	5
33. …do physicians treat me in a condescending manner?	1	2	3	4	5

(table continues)

Please reflect upon your interaction with the patients you care for and their family and visitors and indicate the extent to which you agree with the following statements. Patients/Visitors…					
34. …do not trust the information I give them and ask to speak with someone of higher authority.	1	2	3	4	5
35. …act condescending to me.	1	2	3	4	5
36. …make comments that question the competence of nurses.	1	2	3	4	5
37. …criticize my job performance.	1	2	3	4	5
38. …make personal verbal attacks against me.	1	2	3	4	5
39. …pose unreasonable demands.	1	2	3	4	5
40. …have taken out their frustrations on nurses.	1	2	3	4	5
41. …treat nurses as if they were inferior or stupid.	1	2	3	4	5
42. …show that they are irritated or impatient.	1	2	3	4	5

Appendix B: Addressing Bullying & Incivility Among Nurses

ADDRESSING BULLYING AND INCIVILITY AMONG NURSES

Caroline Combs, MSN, RN
Walden University DNP Capstone Project

INCIVILITY

- Bullying and incivility, which are defined as disruptive behaviors, have been experienced by 80% of the registered nurseworkforce
- This is a dramatic increase from The Joint Commission (2008) survey which revealed that 50% of nurses were victims of bullying behavior and that 90% of nurses surveyed have witnessed incivility within their organization
- Perceived behaviors of incivility and/or harassment include
  - Eye rolling or giving someone a "dirty look"
  - Speaking to a co-worker or peer in a condescending tone
  - Interrupting others
  - Sending a nasty and demeaning note
  - Talking about someone behind his or herback
  - Emotional put-downs
  - Disrespecting workers by comments, gestures, or proven behaviors
  - Making accusations about professional competence
  - Giving public reprimands, and insults to others
  - Giving the silent treatment
  - Emotional tirades and losing one's temper

EVIDENCE

- Even though most organizations have a zero-tolerance policy that addressesthese concerns,some factorsthatmaycontribute tothese behaviorsare a lack of feelings of empowerment and thenursing leaders' reluctance to reinforce the policy.
- Bullying can result in decreased staff morale and inflict mild to severe illness on its victims such as stress,depression,powerlessness, psychologicalcomplaints,and post-traumatic stress disorder.
- American Nurses Association (ANA) code of ethics addresses the workplace environment in provision six: "The nurse through individual and collective action, establishes, maintains, and improves the moral environment of the work setting and the conditions of employment, conducive to quality health care" (ANA, p. 5).

CAUSES OF INCIVILITY

Incivility can be triggered by stressful working conditions which can result from such issues as

- Inadequate staffing
- Physical burnout which leads to psychological distress
- Expectation to complete work assignments with the lack of appropriate equipment and supplies
- Lack of rewards
- Confrontational interactions with other members of the healthcare team
- Nonexistence managerial support and communication
- Poor organizational climate
- Increased nurse-to-patient ratios that can jeopardize patient safety

CAUSES OF INCIVILITY

As a result, there can be an array of incivility which can include lack of support from other nurses to discourteous or humiliating remarks that may include verbal threats.

These acts of incivility can be overwhelming to nurses, disrupting performance, affecting mental health, and diminishing the intention to remain within an organization or even in the nursing profession.

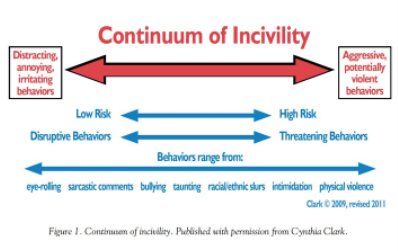

Figure 1. Continuum of incivility. Published with permission from Cynthia Clark.

PRACTICE-FOCUSED QUESTION

"Will continuing education, awareness, and focus on a mandated zero-tolerance policy provide a foundation for a bullying free and civil milieu"?

NURSING INCIVILITY SCALE

Table 1: Nursing Incivility Scale — Nurse No. _____

Please circle the number on the Likert scale that corresponds to your answer from strongly disagree to strongly agree.	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
For the following items, please consider all individuals you interact with at work, including physicians, other nurses or hospital personnel					
1. Hospital employees raise their voices when they get frustrated	1	2	3	4	5
1. People blame others for their mistakes or offenses.	1	2	3	4	5
1. Basic disagreements turn into personal attacks on your employees.	1	2	3	4	5
1. People make jokes about minority groups.	1	2	3	4	5
1. People make jokes about religious groups.	1	2	3	4	5
1. Employees make inappropriate remarks about one's race or gender.	1	2	3	4	5
1. Some people take things without asking.	1	2	3	4	5
1. Employees don't adhere to an appropriate noise level (e.g. talking too loudly)	1	2	3	4	5
1. Employees display offensive body language (e.g., crossed arms, body posture)	1	2	3	4	5
The following describes your interactions with other nurses. Other nurses on my unit……					
1. ….argue with each other frequently.	1	2	3	4	5
1. ….have violent outbursts or heated arguments in the workplace.	1	2	3	4	5
1. ….scream at other employees.	1	2	3	4	5
1. ….gossip about one another.	1	2	3	4	5
1. ….gossip about their supervisor at work	1	2	3	4	5
1. ….bad mouth others in the workplace.	1	2	3	4	5
1. ….spread bad rumors in the workplace.	1	2	3	4	5
1. ….make little contribution to a project but expect to receive credit for working on it.	1	2	3	4	5
1. ….claim credit for my work.	1	2	3	4	5
1. ….take credit for work they didn't do	1	2	3	4	5

The nursing incivility scale was distributed to the nursing staff anonymously over a 2-week period. The guidelines under the Walden "Manual for Staff Education" was followed and each participant received a copy of the consent form for anonymous questionnaires prior to participation. A total of 30 nurses participated and I have no idea who they were. The scale represented on the slide reflects a small portion of the questionnaire. A Likert scale was used to record nurse responses. The following slides reflects the recorded results of the questionnaire.

NURSING INCIVILITY SCALE RESULTS

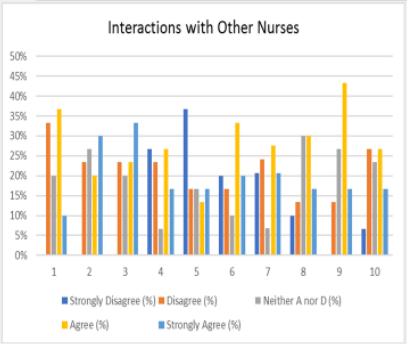

Figure 2. The following describes your interactions with other nurses.

The results from figure 2 were comprised of the following questions:

(1) Other nurses on my unit argue with each other frequently
SD 0%, D 33%, N 20%, **A 37%,** SA 0%;
(2) Other nurses on my unit have violent outbursts or heated arguments in the workplace
SD 0%, D 23%, N 27%, A 20%, **SA 30%;**
(3) Other nurses on my unit scream at other employees
SD 0%, D 23%, N 20%, A 23%, **SA 33%;**
(4) Other nurses on my unit gossip about one another
SD 27%, D 23%, N 7%, **A 27%,** SA 17%;
(5) Other nurses on my unit gossip about their supervisor at work
SD 37%, D 17%, N 17%, A 13%, SA 17%;
(6) Other nurses on my unit bad mouth others in the workplace
SD 20%, D 17%, N 10%, **A 33%,** SA 20%;
(7) Other nurses on my unit spread bad rumors in the workplace
SD 21%, D 24%, N 7%, **A 28%,** SA 21%;
(8) Other nurses on my unit make little contribution to a project but expect to receive credit for working on it
SD 10%, D 13%, N 30%, **A 30%,** SA 17%;
(9) Other nurses on my unit claim credit for my work
SD 0%, D 13%, N 27%, **A 43%,** SA 17%; and
(10) Other nurses on my unit take credit for work they didn't do
SD 7%, **D 27%,** N 23%, **A 27%,** SA 17%.

The overall scores suggest that the nursing staff agree (A) that the interactions at work with other nurses reflects episodes of bullying and/or uncivil behavior.

EDUCATIONAL INITIATIVE

- The results of the Nursing Incivility Scale are being shared with the nursing staff
- Due to the Coronavirus pandemic and the temporary changes in hospital policy prohibiting student presence, the documents were distributed as follows:
  - The following documents have been forwarded via hospital email to the nurses on the designated unit
    - Pre-test on MedStar Health's Workplace Harassment Prevention Policy No. 303
    - Educational initiative on "ADDRESSING BULLYING AND INCIVILITY AMONG NURSES"
    - Post-test on MedStar Health's Workplace Harassment Prevention Policy No. 303
    - Evaluation on educational initiative
  - The pre-test and post-test on MedStar Health's Workplace Harassment Prevention Policy No. 303 was also given to the units Charge Nurse for distribution, completion, and collection as a back-up plan
- Upon completion, the documents will be collected from the units Charge Nurse by April 3rd, 2020.

REVIEW OF MEDSTAR HEALTH' S WORKPLACE HARASSMENT PREVENTION POLICY NO. 303

Policy Statement:
MedStar Health is committed to providing a work environment for all of its associates that is free of harassment, including harassment based on race, color, creed, religion, national origin, citizenship, sex, age, physical or mental disability, veteran status, marital status, personal appearance, family obligations, political affiliations, sexual orientation, gender identity or expression, genetic information or any other characteristic protected by federal, state or local law and regulations.

Prohibited Behavior:
Harassment is defined as unwelcome or unsolicited comments or conduct that targets a person based on his/her race, color, creed, religion, national origin, citizenship, sex, age, physical or mental disability, veteran status, marital status, personal appearance, family obligation, political affiliations, sexual orientation, gender identity or expression, genetic information or any other characteristic protected by federal, state or local laws and regulations, and that is so severe or so pervasive that it interferes with an associate's job performance or creates an intimidating, hostile or offensive working environment.

All such conduct is unacceptable in the workplace, in any work-related settings – such as business trips and business-related social functions – and when representing MedStar Health, regardless of whether the conduct is engaged in by a leader, co-worker, physician, client, patient, vendor, or third party.

Some examples of what may be considered harassment, depending on the facts and circumstances, are the following:

a. Verbal Harassment: Derogatory or vulgar comments including slurs, jokes, insults, teasing, and threats of physical harm
b. Visual Harassment: Offensive gestures, posters, symbols, cartoons, drawings, computer displays, and emails that show hostility
c. Physical Harassment: Hitting, pushing or other aggressive physical gestures and contact, inappropriate touching, etc.
d. Behaviors that undermine a "Culture of Safety and Quality": Examples include but are not limited to verbal or nonverbal conduct that harms or intimidates others; demeaning, offensive or degrading conduct; use of profanity or disrespectful language; and failure to respond to patient care needs or staff requests for assistance
e. Sexual Harassment: Any unwelcome conduct, such as solicitated sexual advances

REVIEW OF MEDSTAR HEALTH' S WORKPLACE HARASSMENT PREVENTION POLICY NO. 303

Procedure:

I. Reporting Harassment in the Workplace by promptly notifying a leader, Human Resources and/or the Compliance Department. If the associate making the compliant does not receive an acknowledgement within 5 business days, contact the HR leader immediately.
II. Compliance Department Hot Lines – Associates who wish to contact the Compliance Department should call the Integrity Hotline at 1-877-811-3411.
III. Internal Investigations – MedStar Health will promptly and effectively investigate complaints
    a. Exceptions: It is important to note that complete confidentiality cannot be guaranteed in such investigations
    b. Harassment Complaints: MedStar will investigate all complaints of harassment. Intentionally making false claims or reports of harassment are serious in nature, and will be handled appropriately.
        i. Upon completion of the investigation, MedStar Health will take corrective measures against any person who has emerged in conduct in violation of the workplace harassment prevention policy, if deemed necessary.
IV. Non-Retaliation: MedStar Health acknowledges, and will take appropriate steps to protect this legal right.
    a. Retaliation that is prohibited by the Medstar Workplace Harassment policy includes but is not limited to the following:
        i. Explicit or implied threats, verbal or physical, inappropriate comments, and acts of intimidation
        ii. Presence in the associates work area without business reasons
        iii. change in working conditions
        iv. Unwarranted corrective actions or unwarranted exclusion from meetings, conferences, or other work-related events
    b. If an associate believes that he/she is being subjected to retaliation, he/she should immediately notify a leader, Human Resources and/or the Compliance Department

RECOMMENDED STRATEGIES FOR CONTINUED IMPROVEMENT

i. Utilize surveys to examine nurse perceptions of the organizations culture
ii. Provide professional development to nurses and nurse leaders which include:
    1. Conflict Management
    2. Conflict Resolution
    3. Emotional Intelligence
    4. Relationship Building
    5. Cognitive rehearsal to minimize uncivil behavior
        a. Cognitive rehearsal can be utilized as an effective method for practicing strategies to enhance effective communication in a safe and protected environment

CONCLUSION

This doctoral project focused on the same proven strategies to fill the gap-in-practice with emphasis on

- Promoting awareness
- Providing education
- Reinforcing the organizational harassment policy to
  - Prevent and/or minimize the occurrence of bullying and incivility in the workplace
- Implementing strategies to promote change
- Increasing retention rates

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American Nurses Association, (2015a). Code of ethics for nurses with interpretive statements. Retrieved from http://nursingworld.org/DocumentVault/Ethics-1/CodeofEthicsforNurses.html

American Association of Colleges for Nursing. (2015). The essentials of doctoral education for advanced nursing practice. Retrieved from www.aacn.nche.edu

Elmblad, R., Kodjebacheva, G, & Lebeck, L. (2014). Workplace incivility affecting CRNAs: A study of prevalence, severity, and consequences with proposed interventions. *American Association of Nurse Anesthetists Journal, 82*(6), 437-*445.*

Kile, D., Eaton. M., deValpine, M., & Gilbert, R. (2019). The effectiveness of education & cognitive rehearsal in managing nurse-to-nurse incivility: A pilot study. *Journal of Nursing Management, 27*, 543-552. doi:10.1111/jonm.12709

Medstar Health Workplace Harassment Prevention Policy No. 303

The Joint Commission. (2008). Behaviors that undermine a culture of safety. *Sentinel Event Alert, 40*, 1-3

Appendix C: Pretest

Policy Statement:

MedStar Health is committed to providing a work environment for all of its associates that is free of harassment, including harassment based on race, color, creed, religion, national origin, citizenship, sex, age, physical or mental disability, veteran status, marital status, personal appearance, family obligations, political affiliations, sexual orientation, gender identity or expression, genetic information or any other characteristic protected by federal, state or local law and regulations.

Prohibited Behavior:

Harassment is defined as unwelcome or unsolicited comments or conduct that targets a person based on his/her race, color, creed, religion, national origin, citizenship, sex, age, physical or mental disability, veteran status, marital status, personal appearance, family obligations, political affiliations, sexual orientation, gender identity or expression, genetic information or any other characteristic protected by federal, state or local laws and regulations, and that is so severe or so pervasive that it interferes with an associate's job performance or creates an intimidating, hostile or offensive working environment.

All such conduct is unacceptable in the workplace, in any work-related settings – such as business trips and business-related social functions – and when representing MedStar Health, regardless of whether the conduct is engaged in by a lender, co-worker, physician, client, patient, vendor, or other third party.

Pre-test:

It's time to test your knowledge of MedStar Health's Workplace Harassment Prevention policy 303 by answering the following 10 questions.

1: Some examples of what may be considered harassment include…. **(Select all that apply)**

_____ a. Verbal Harassment
_____ b. Visual Harassment
_____ c. Physical Harassment
_____ d. Sexual Harassment

2: Visual Harassment is defined as…

_____ a. Derogatory or vulgar comments
_____ b. Offensive gestures, posters, symbols, cartoons or drawings
_____ c. Aggressive physical gestures and contact or inappropriate touching
_____ d. Verbal or non-verbal conduct that harms or intimidates others to the extent that safety could be compromised

3: The most effective way to prevent harassment in the workplace is to…

_____ a. Keep it to yourself to avoid retaliation
_____ b. Report it to a peer and join forces against the abusive co-worker
_____ c. Report the unwanted behavior to Human Resources and/or the Compliance Department
_____ d. Make plans to leave the organization in order to get away from the unwanted behavior

4: To the extent possible, investigations under policy 303 will be treated as…

_____ a. Confidential; however, confidentiality cannot be guaranteed
_____ b. Confidential; however, any members of the leadership team will be protected
_____ c. Confidential; however, participants in the investigation are free to disclose information
_____ d. Confidential; however, witnesses are free to spread rumors regarding the investigation

5: Intentionally making false claims or reports of harassment are

_____ a. Serious in nature and will be handled appropriately
_____ b. Serious in nature but will be excused if the employee agrees to apologize to the victim
_____ c. Serious in nature; however, the first offense will only result in disciplinary documentatio
_____ d. Serious in nature and may result in retaliation toward the staff member

6: Upon completion of an investigation regarding a complaint of harassment, MedStar Health will

_____ a. Assist in plotting retaliation against the victim(s)
_____ b. Reprimand any witnesses that cooperated in the investigation
_____ c. Take corrective measures against any person who has engaged in conduct in violation of the workplace harassment prevention policy, if deemed necessary
_____ d. Assist the victim in acquiring another means of employment to get away from the unwanted behavior

7. Retaliation that is prohibited by the MedStar Workplace Harassment policy includes, but is not limited to, the following conduct that occurs as a direct result of an associate's report of and/or assistance in the investigation of a harassment policy violation: **(Select all that apply)**

_____ a. Explicit or implied threats, verbal or physical, inappropriate comments, and acts of intimidation
_____ b. Presence in the associate's work area without business reasons
_____ c. Negative change in working conditions
_____ d. Unwarranted corrective action or unwarranted exclusion from meetings, conferences or other work-related events

8. If an associate believes that he/she is being subjected to retaliation, he/she should

_____ a. Keep it to yourself to avoid additional retaliation
_____ b. Report it to a peer to have a witness in the event the retaliation continues
_____ c. Report the unwanted behavior immediately to Human Resources and/or the Compliance Department
_____ d. Resign from the organization in order to stop the retaliation

9: Behaviors that undermine a culture of safety and quality include… **(Select all that apply)**

_____ a. Verbal or non-verbal conduct that harms or intimidates others
_____ b. Demeaning, offensive or degrading conduct
_____ c. Use of profanity or disrespectful language
_____ d. Failure to respond to patient care needs or staff requests for assistance

10: If an associate makes a complaint under the MedStar Health Workplace Harassment policy and has not received an acknowledgement with five (5) business days, he or she should

_____ a. Call the Integrity Hotline at 1-877-811-3411
_____ b. Report it to your Unit Director immediately
_____ c. Contact the Human Resources Leader immediately
_____ d. Allow the Human Resources to have an additional five (5) days to respond to your complaint because they are busy

Appendix D: Posttest

Policy Statement:

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Post-test:

You have just reviewed the results of the Nursing Incivility Scale questionnaire completed by you peers and MedStar Health's Workplace Harassment Policy 303. It's time to evaluate how much you have retained from the Power Point presentation by answering the following 10 questions.

1: Some examples of what may be considered harassment include…. **(Select all that apply)**

_____ a. Verbal Harassment
_____ b. Visual Harassment
_____ c. Physical Harassment
_____ d. Sexual Harassment

2: Visual Harassment is defined as…

_____ a. Derogatory or vulgar comments
_____ b. Offensive gestures, posters, symbols, cartoons or drawings
_____ c. Aggressive physical gestures and contact or inappropriate touching
_____ d. Verbal or non-verbal conduct that harms or intimidates others to the extent that safety could be compromised

3: The most effective way to prevent harassment in the workplace is to…

_____ a. Keep it to yourself to avoid retaliation
_____ b. Report it to a peer and join forces against the abusive co-worker
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_____ d. Make plans to leave the organization in order to get away from the unwanted behavior

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_____ c. Confidential; however, participants in the investigation are free to disclose information
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10: If an associate makes a complaint under the MedStar Health Workplace Harassment policy and has not received an acknowledgement with five (5) business days, he or she should

_____ a. Call the Integrity Hotline at 1-877-811-3411
_____ b. Report it to your Unit Director immediately
_____ c. Contact the Human Resources Leader immediately
_____ d. Allow the Human Resources to have an additional five (5) days to respond to your complaint because they are busy

Appendix E: Evaluation

Addressing Bullying and Incivility Among Nurses

Caroline Combs, MSN, RN

Walden University DNP Capstone Project

Date: _____

INSTRUCTIONS

Please circle your response to the items. Rate aspects of the educational initiative on a 1 to 5 scale:

1 = "Strongly disagree," or the lowest, most negative impression
2 = “Disagree”
3 = "Neither agree nor disagree," or an adequate impression
4 = “Agree”
5 = "strongly agree," or the highest, most positive impression

Choose N/A if the item is not appropriate or not applicable to this workshop.

Your feedback is appreciated. Thank you.

1	The results of the Likert scale questionnaire were informative	1	2	3	4	5	N/A
2	The education increased my awareness of perceived bullying & incivility within my organization	1	2	3	4	5	N/A
3	I understand the workplace harassment policy and my rights as they apply to bullying & uncivil behavior	1	2	3	4	5	N/A
4	The educational initiative was easy to follow and understand	1	2	3	4	5	N/A

5. Any comments?

_____

_____

_____

_____