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The effectiveness of education and cognitive rehearsal in managing nurse-to-nurse incivility

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The Effectiveness of Education and Cognitive Rehearsal in Managing Nurse-to-Nurse Incivility

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Abstract

This project was designed to evaluate the effectiveness of education on nurse-to-nurse incivility and use of cognitive rehearsal techniques on registered nurses' perception of their ability to recognize and confront incivility, along with resulting job satisfaction. Nurse-to-nurse incivility negatively affects nurses, organizations and patients. The Tri-Council for Nursing's proclamation calls nurses to recognize incivility and take steps to eliminate this in practice ("Tri-Council" 2017). A mixed method, pilot study was conducted. Participants, (registered nurses employed in a Post-Anesthesia Care Unit in a community hospital in Virginia), received education on incivility and cognitive rehearsal techniques. Data was collected through online adapted surveys, the Nurse Incivility Scale (NIS) and the Nurse Interaction subscale of the NDNQI Adapted Index of Work Satisfaction, along with two open-ended questions. Mixed effects (quantitative) analysis and content (qualitative) analysis was conducted. Significance was found in two subscales. The remaining NIS subscale means and the NDNQI nurse interaction subscale decreased over time. Qualitative data supported these findings. The NDNQI Index of Work Satisfaction indicated a neutral effect on nurse job satisfaction. This intervention was found to be effective in increasing nurses' recognition of incivility and ability to confront this behavior. It is recommended that nurse leaders consider implementation of this intervention in their workplaces as a means for managing incivility.

Keywords: nurse incivility, lateral violence, workplace bullying, horizontal violence job satisfaction

Introduction

Workplace incivility pervades nursing practice and adversely effects nurses, patients, and organizations. Incivility is described as rude and discourteous behavior that conveys disrespect to others (Leiter, Laschinger, Day, & Oore, 2011). This behavior is displayed in a variety of ways including: fighting among nurses, intentional withholding of information, passive-aggressive behavior, eye rolling, verbalizing snide, rude, or demeaning remarks and failing to respect confidences in privacy (Griffin, 2004). Nurse-to-nurse incivility is the most common form of incivility in healthcare organizations with as many as 64% of uncivil behavior that nurses experience coming from their peers (Gilbert, Hudson, & Strider, 2016).

In an effort to emphasize how important civil behavior is to nursing practice and to the outstanding care for all patients, the Tri-Council for Nursing (American Association of Colleges of Nursing (AACN); American Nurses Association (ANA); American Organization of Nurse Executives (AONE); and the National League for Nursing (NLN)), recently issued a call to advance civility in nursing. This proclamation calls upon “all nurses to recognize nursing civility and take steps to systematically eliminate all acts of incivility in their professional practice, workplace environments and in our communities” ("Tri-Council," 2017, p. 1).

Nurses must be educated on how to recognize incivility, how this behavior impacts themselves, their patients, and their organizations, and how to confront and eliminate incivility in the workplace for this resolution to be successfully enacted.

Background

Failure to address uncivil behaviors can negatively affect the physical and mental health of nurses (Griffin & Clark, 2014). As a result, nurses may experience decreased job satisfaction, increased turnover, absenteeism and work-related injuries (Lasater, Mood, Buchwach, & Dieckmann, 2015).

Organizations are also affected by incivility. The annual lost cost of productivity due to incivility is estimated to be as high as $12,000 per nurse (Lewis & Malecha, 2011). Factors involved with this cost include increased absenteeism, work effectiveness, altered workload and activity impairment (Letvak & Buck, 2008). Incivility has a profound influence in the hospital setting on nurse job satisfaction and contributes to absenteeism and high turnover rates (Wilson, Diedrich, Phelps, & Choi, 2011). In the United States, it is estimated that $23.8 million is spent annually to cover direct and indirect costs associated with uncivil behavior (Laschinger, Cummings, Wong, & Grau, 2014).

The effects on patients are of particular concern. According to Nikstaitis & Simko (2014), incivility has harmful effects on patient safety including increased medical errors, decreased quality of care and negative patient outcomes. Nurse turnover is associated with higher nurse-to-nurse patient ratios and compromised patient care. In addition, nurse turnover has a negative effect on group cohesion and communication among healthcare providers, which in turn negatively affects patient safety (Wilson et al., 2011). Nurses who are dealing with the effects of negativity are less likely to respond fully to the needs of their patients and are less likely to speak up if there are safety concerns (Weinand, 2010). Poor job satisfaction, professional

disengagement and increased turnover are all related to decreased quality of care (Vessey, DeMarco, & DiFazio, 2011).

Literature Review

The landmark study by Griffin (2004) indicated that education and use of cognitive rehearsal programs raised nurses' awareness of incivility and enabled them to confront the offender. Since that time, additional studies have supported this finding (Stagg, Sheridan, Jones, & Speroni, 2013; Stagg, Sheridan, Jones, & Speroni, 2011; and Chipps & McRury, 2012).

Two studies implemented programs using education and cognitive rehearsal techniques developed by Dr. Martha Griffin (2004) and evaluated the perceived instances of nurse-to-nurse incivility (Lasater et al., 2015; Stagg et al., 2013). Findings indicate this training resulted in decreased frequency of perceived uncivil behaviors.

Education on incivility and the utilization of cognitive rehearsal programs have mixed effects on nurses' ability to confront incivility. Five studies evaluated the effects of education and cognitive rehearsal techniques on nurses' ability to confront incivility. In the study conducted by Griffin (2004), one hundred percent of all nurses who experienced incivility confronted the responsible individual. This high percentage was nurses confronting incivility was not noted in the other studies. According to Stagg et al. (2013) 70% (n=10) of nurses believed they could intervene in bullying situations, only 16% reported they responded at the time of occurrence. In the study conducted by Warner, Sommers, Zappa, & Thornlow (2016), 27.5% of participants (n=99) stated they had confronted someone about uncivil behavior after completing the incivility training. Findings of the study conducted by Stagg et al. (2011) indicated that the

nurses' confidence in defending themselves against bullying was significantly more positive after the educational and cognitive rehearsal program. The mixed method study by Lasater et al. (2015) also indicated staff were more likely to recognize and confront acts of incivility upon completion of the education and role-play intervention.

Studies involving the implementation of education and interventions aimed at decreasing incivility have minimally evaluated the effect on nurse job satisfaction. The outcome of job satisfaction was measured in only one study. In the study conducted by Chipps & McRury (2012) in which a 3-month educational program was introduced, overall job satisfaction remained unchanged during the course of the study (81% pre-intervention and 81% post-intervention).

Given that civil behavior is critical to excellence in nursing practice and to outstanding care for all patients and there is a need for all nurses to recognize and eliminate all acts of incivility ("Tri-Council," 2017), a study on the use of education and cognitive rehearsal techniques and its effects on nurse-to-nurse incivility is warranted to add to the current body of knowledge.

Aim

The aim of this study is to assess the effect of education and the use of cognitive behavioral techniques on registered nurses' ability to recognize and confront incivility and its resulting effect on job satisfaction.

Theoretical Model

Bandura's Social Learning Theory (1977) was utilized as the underpinning for the educational intervention and introduction of cognitive rehearsal techniques to address nurse-to-nurse incivility. Bandura's Social Learning Theory represents a cognitive-behavioral approach and emphasizes the importance of modeling or learning a behavior. The cognitive aspect of this theory results in synthesizing observed behavior into action. Performance of this newly learned behavior follows, which facilitates the reinforcement of the learned behavior (Bahn, 2001). Bandura (1977) concludes that this reinforcement increases the likelihood of the individual adopting the behavior. This concept of learning and role-playing serves as the foundation for teaching nurses cognitive behavioral techniques to be used when confronting acts of incivility.

Methodology

Study Design

A mixed method, pilot study design was utilized. The study replicated the cognitive rehearsal educational program developed by Dr. Martha Griffin (2004). This program involved educating nurses about incivility in practice and used cognitive rehearsal techniques to teach appropriate responses to frequent forms of incivility (Griffin, 2004).

Study Sample

This study used a convenience sample of registered nurses working in the Post-Anesthesia Care Unit (PACU) in a 238-bed, ANCC Magnet® designated rural community hospital located in Virginia. Thirty-two RNs are employed in the department.

This unit was chosen because of increased staff reports and manager observation of uncivil behaviors among team members. This unit had recently experienced an 18% turnover rate. In addition, there was a 6.3% decrease in staff engagement survey scores in the past year.

Participants were informed and recruited to participate in the study via email, flyers displayed in the unit and personal contact. Inclusion criteria included all registered nurses employed in the PACU. Exclusion criteria included ancillary personnel and the inability to read or write in the English language.

Ethical Considerations

Institutional Review Board (IRB) approval was obtained from the principal investigator's institution and the hospital. Participation was voluntary. Consent was obtained prior to participation. The surveys were administered electronically via Qualtrics. Participants were de-identified through the provision of an anonymous ID.

Sources of Data

Sources of quantitative data include the Nursing Incivility Survey (NIS), the Nurse Interaction subscale of the National Database of Nursing Quality Indicators (NDNQI) and a questionnaire with two-open ended questions. The NIS is designed to capture nursing-specific workplace incivility prevalence. Forty-two items are rated on a 5-point Likert scale (ranging from 1= strongly disagree to 5 = strongly agree) and are grouped into five sources of incivility: general, nursing, supervisor, physician and patient/visitor. These five sources of incivility are divided into subscales. General incivility has three subscales: hostile climate, inappropriate jokes and inconsiderate behavior. Nursing incivility has three subscales: hostile climate, gossip and rumors, and free-riding. Supervisor and Physician each have two subscales: abusive supervision

and lack of respect. Patient/Visitor has two subscales: lack of respect and displaced frustration (Guidroz, Burnfield-Geimer, Clark, Schwetschenau, & Jex, 2010). Reliability estimates for the NIS include Cronbach's alpha statistics ranging from 0.81 to 0.94. Evidence of convergent and discriminate validity has been demonstrated in predicted patterns of correlation with measures of workplace conflict, nurse stress, and job satisfaction (Guidroz et al., 2010).

The Nurse Interaction subscale of the NDNQI-Adapted Index of Work Satisfaction assesses formal and informal social and professional contact during working hours and measures job satisfaction on the unit level. This subscale consists of nine items rated on a 6-point Likert scale (1= strongly agree to 6 = strongly disagree). Reliability for the nurse-to-nurse interaction subscale include Cronbach's alpha statistics ranging from 0.66-0.82 (Zangaro & Soeken, 2005).

Demographic questions including age, ethnicity, sex, number of years participants had been licensed as a registered nurse and number of years worked in the PACU were included in the survey.

Two qualitative open-ended questions were designed to evaluate how nurses have dealt with nurse-to-nurse incivility and how nurse incivility affects job satisfaction. Credibility was addressed by creating questions that did not lead participants. These questions were:

1. In what ways have you dealt with nurse-to-nurse incivility?
2. Describe how nurse-to-nurse incivility affects your job satisfaction?

Implementation

Bandura's Social Learning Theory (1977) served as the foundation of the implementation plan. Five training sessions approximately two hours in length took place over

three weeks. These sessions were scheduled to cover all shifts and multiple days of the week for staff convenience and to encourage full participation. The principal investigator (PI) conducted each session to ensure consistency in the presentation.

Participants began each session by completing a survey which included the NIS and the Nurse Interaction subscale of the NDNQI Adapted Index of Work Satisfaction. This survey also included two open-ended questions aimed at assessing a how they have dealt with incivility and the degree to which uncivil behaviors affected their job satisfaction.

The first hour of training included a didactic session providing definitions and examples of incivility and the different ways it can manifest. Information was presented on the potential effects of incivility on nurses, patient safety, and organizations. Participants were instructed on the top 10 forms of incivility and the appropriate cognitive rehearsal techniques for responding to each of these. This education included the use of cue cards containing written visual cues for the appropriate responses to the most common uncivil behaviors. Permission to use the cognitive rehearsal cue cards was received from Dr. Griffin. These reference cards were designed to fit in the pocket of a standard nursing uniform (Figure 1).

The second hour of the sessions involved role-playing. Bandura's Social Learning Theory (1977) posits that people learn from one another via observation, imitation and modeling. Scenarios which exemplified each of the top10 forms of incivility specific to a PACU were shared in an effort to customize the training and make the information applicable to the participants' work environment. These scenarios included the appropriate cognitive behavioral technique to be used when addressing each type of uncivil behavior. The PI and a participant

role-played the first two scenarios in front of the entire group to demonstrate the activity. Participants were then divided into small groups and asked to role play each of the scenarios.

Upon conclusion of this role-play session, participants were encouraged to use these techniques in their daily work experiences. Participants completed a survey containing the NIS and Nurse Interaction subscale of the NDNQI Adapted Index of Work Satisfaction. Six weeks after completion of the last training program, participants repeated the survey containing the NIS, Nurse Interaction subscale of the NDNQI Adapted Index of Work Satisfaction and two open-ended questions.

Data Analysis

Quantitative Data Analysis

Changes in the NIS and the Nurse Interaction subscale of the NDNQI Adapted Index of Work Satisfaction measures were analyzed using IBM SPSS Statistics (2017) across three time points: initial, immediate post-intervention and final (6 weeks). lA linear mixed effects model procedure was used to account for any participant's missing data over time (see Table 1 for sample size variations). An advantage of the mixed-effects model is the ability to fully provide maximum likelihood estimation (FIML) with unequal variances in repeated data collection points (Verbeke & Molenberghs, 2000; SPSS website, n.d.; and (Little & Rubin, 2002).
All statistical analyses were conducted for a level of P = .05. Descriptive statistics were conducted on demographic data and each of the subscales of the NIS and the Nurse Interaction subscale of the NDNQI Adapted Index of Work Satisfaction measure.

Qualitative Data Analysis

A latent content analysis method was chosen so the data could be analyzed at an interpretive level and the underlying meaning of what the text is talking about could be determined (Bengtsson, 2016). Bengtsson's four stage process was used for data analysis. These stages include decontextualization, recontextualization, categorization and compilation (Bengtsson, 2016). The decontextualization stage began with immersion in the data, reading and rereading each survey question response. The data was then broken down into meaning units. A meaning unit is the smallest grouping of words, sentences and phrases that answer the survey question (Bengtsson, 2016). Examples of meaning units identified include "lack of respect", "raised voices" and "dreaded coming to work". These meaning units were then labeled with codes. These codes facilitated the identification of concepts and allowed data to be grouped into blocks or patterns (Bengtsson, 2016). Examples of identified codes were "direct conversation", "teamwork" and "awareness". Constant comparison was performed to code data in each survey, comparing each response to each other and to the survey responses in its entirety. This process was repeated to increase familiarity with the data and ensure accurate coding.

In the recontextualization stage, the original text was re-read alongside the final list of meaning units in the original text. This process ensured all aspects of the content had been coded in relation to the aim of the study (Bengtsson, 2016). For the first survey question which asked how the participants have dealt with nurse-to-nurse incivility, these codes were divided into two categories: Dealt with and Experienced.

During the categorization stage, the coded meaning units were condensed into themes. Themes are broad concepts of an underlying meaning on an interpretative latent level (Bengtsson, 2016). Because the two different categories, “dealt with” and “experienced” were identified for the first question during the recontextualization stage, the responses were separated in the respective categories and themes were identified. Examples of these themes included “Addressed with nurse exhibiting incivility” and “Gossip”.

Finally, during the compilation stage, the analysis was completed. The categories, themes and codes were compiled into a table. Frequency of responses were calculated according to the number of responses in each theme.

A second coder also analyzed the data and categorized into themes and patterns using the same methodology, and findings were compared. To supplement this manual process QSR International’s NVivo 10 qualitative analysis Software (NVivo Version 10, 2012) was used to assess the text frequency counts in each of the surveys. A nurse scientist who is an expert in qualitative research and the use of NVivo performed an additional text analysis of the surveys to ensure accuracy of findings.

Results

Participant Characteristics

Nineteen PACU RNs participated in the study for a response rate of 59%. Two participants were excluded due to failure to create an anonymous ID making it impossible to track data over time. Of the remaining 17 participants, a majority (35%) were between the ages of 25-39 and 50-54, respectively. Forty-seven percent (n=7) had over 20 years of nursing

experience and 55% (n=6) had less than one year's experience in the PACU. Table 1 describes participant characteristics.

Quantitative Results

The mean scores of each NIS subscale and the NDNQI Nurse Interaction subscale were compared over each measurement time. Two of the NIS subscales were found to have statistical significance over time. These subscales were *Displaced Frustration* (DF) p=.042 and *Inappropriate Jokes* (IJ) p=.003. Displaced Frustration falls under the Patient/Visitor source of incivility and Inappropriate Jokes falls under General Incivility. Although not statistically significant, the remaining six NIS subscale means and the NDNQI Nurse Interaction subscale mean decreased over time from the initial data collection point to the final data collection point which was movement in the desired direction according to the scale scoring guidelines. Results of the NDNQI Nurse Interaction subscale indicated a neutral effect relating to nurse-to-nurse incivility and job satisfaction. Mean scores for each subscale across time are shown in Table 2.

Qualitative Results

The category counts and percentages of total frequencies from analysis of the initial and final surveys are found in Tables 3-6. Responses to the first question which inquired how participants have dealt with nurse-to-nurse incivility were classified into two categories: *dealt with and experienced*. Answers on how participants have dealt with nurse-to-nurse incivility were similar in both the initial and final surveys. Thirty-five percent (n=7) of the responses in the initial survey and 33 % (n=4) in the final survey indicated the participants' confronted the nurse exhibiting uncivil behavior. Twenty-five percent of the responses in the initial (n=5) and

final (n=3) surveys indicated participants reported the behavior to their supervisor. The category of awareness emerged in the final survey which was not present in the initial survey. Twenty-five percent (n=3) of participants reported they tried to monitor body language, minimized or halted discussion of co-workers and demonstrated self-awareness of their own actions uncivil behavior. Responses regarding how incivility was experienced were also similar between the initial and post-surveys. Initial survey responses indicated that participants experienced incivility through gossip (20%, n=4), verbal affronts (15%, n=3) and lack of teamwork (10%, n=2). Final survey responses also indicated uncivil behavior was experienced through gossip (8.3%, n=1) and verbal affronts (8.3%, n=1).

Responses to the second question described how nurse-to-nurse incivility affected job satisfaction. Initial survey responses indicated the behavior negatively affected the work environment (55%, n=10), others (50%, n=9) and job satisfaction (27%, n=5). Final survey responses were similar indicating incivility had a negative effect on job satisfaction (63.6%, n=7) and others (18.1%, n=2).

Discussion

Nurse-to-nurse incivility negatively affects nurses, organizations and patients. Nurses must be able to recognize and confront incivility in order to manage this behavior in their work environments. This pilot study using both quantitative and qualitative methods sought to understand how educating nurses on incivility and teaching them cognitive behavioral techniques to deal with this behavior affected their ability to recognize and confront incivility and examined the effect on perceived instances of incivility and job satisfaction.

Recognition of incivility, ability to confront incivility and the effect on perceived instances of incivility were assessed by comparing the NIS mean scores over each time point. Although only the mean scores for the subscales of Inappropriate Jokes (General source) and Displaced Frustration (Patient/Visitor source) indicated a statistically significant decrease, all mean scores including the Nursing Source subscales (Hostile Climate, Gossip and Rumors and Free- riding) decreased over time. This indicates the intervention was effective in increasing the participants' recognition and their ability to confront incivility as well as decreasing perceived instances of incivility over time.

The qualitative results supported these quantitative findings. The participants' awareness of incivility was noted in the final survey that was not present in the initial survey. The statements (i.e. "try to monitor body language", "minimize/halt discussions of co-workers" and "self-awareness of my own actions") indicate the participants recognized and confronted uncivil behavior. In addition, the theme of "addressing the nurse exhibiting incivility" was noted in the initial and final qualitative findings. Although the frequency remained much the same (35% initial and 33% final), the statements indicated the participants did confront uncivil behavior ("spoke directly to the person", "discussed with nurse").

The relationship of nurse-to-nurse incivility to job satisfaction was assessed quantitatively through examination of the NDNQI Nurse Interaction subscale. No measurable effects were noted. The initial and final responses to the qualitative survey question addressing job satisfaction indicated that nurse-to-nurse incivility negatively affects job satisfaction (i.e. "workplace very unenjoyable" and "incivility makes your job miserable"). However, because the

question was not worded to assess if a change in job satisfaction occurred after the intervention, the effect of the intervention on job satisfaction cannot be determined qualitatively.

This study adds to the body of knowledge and supports previous study findings regarding the effectiveness of education and cognitive behavioral techniques in increasing nurses' awareness and ability to confront of uncivil behavior (Warner, Sommers, Zappa, & Thornlow, 2016; Stagg et al., 2013; Chipps & McRury, 2012; Stagg et al., 2011; and Griffin, 2004). Bandura's Social Learning Theory (1977) represents a cognitive behavioral approach in learning new behavior and supports this intervention.

This study had several limitations. This was a pilot study with small initial sample size with loss of subsequent subjects and responses due to missing or improperly collected data. The second qualitative question was not worded to assess if a change in job satisfaction occurred after the intervention. Social desirability bias may have influenced participants' responses although anonymity was emphasized.

Implications for Nursing Management

Nurse leaders are responsible for creating a positive work environment for staff, providing safe care to patients and supporting fiscal goals of their organizations. Nurse-to-nurse incivility can negatively affect each of these areas. This pilot study adds support to the evidence that education and the use of cognitive behavioral techniques is an effective method for increasing nurses' awareness and their ability to confront uncivil behavior leading to a decrease in the incidence of this behavior. Further research is needed to expand generalizability to other settings. Teaching nurses about incivility and providing them with tools to confront this behavior

is necessary. Repeated training and education is recommended for sustainability. Healthcare organizations are encouraged to invest in civility training for nursing staff.

Appendix A

Table 1
Participant Characteristics

Characteristics	n (%)
Age (n=17)	
25-39	6(35)
40-44	1 (6)
50-54	6 (35)
55-60	3(18)
61-65	1(6)
Gender (n=17)	
Female	17 (100)
Male	0
Ethnicity (n=17)	
White	17 (100)
Male	0
Years in Nursing (n=15) (LPN and RN)	
<1	0
1 to 5	2 (13)
6 to 10	2(13)
11 to 15	1(6)
16 to 20	3(20)
>20	7(47)
Years in PACU (n=11)	
<1	6(55)
1 to 5	0
6 to 10	2(18)
11 to 15	1(9)
16 to 20	1(9)
>20	1(9)

Appendix B

Table 2

Changes in Mean Scores at Each Measurement Time Point

Mean (SE)			
NIS Subscales	**Time 1 Initial**	**Time 2 Immediate Post-Intervention**	**Time 3 (6-weeks) Final**
GR (Gossip and Rumors)	15.06 (.728)	15.0 (.550)	12.65 (1.14) p=.078
HC (Hostile Climate)	16.18 (.984)	16.62 (1.0)	13.80 (1.68) p=.156
IB (Inconsiderate Behavior)	8.47 (.54)	9.04 (.351)	8.51 (.646) p=.432
IJ (Inappropriate Jokes)	8.47 (.557)	6.35 (.794)	5.50 (.639) p=.003*
LR (Lack of Respect)	22.18 (1.61)	22.48 (1.64)	18.75 (2.23) p=.003
AS (Abusive Supervision)	22.35 (1.71)	23.27 (1.83)	21.38 (2.61) p=.470
DF (Displaced Frustration)	10.47 (.86)	10.55 (9.21)	8.29 (.989) p=.043*
FR (Free-Riding)	7.0 (.466)	7.48 (.421)	6.16 (1.11) p=.283
NDNQI Nurse Interaction Subscale	**Time 1 Initial**	**Time 2 Immediate Post-Intervention**	**Time 3 (6-weeks) Final**
NRS (Nurse Satisfaction)	21.04 (1.50)	22.87 (1.54)	20.90 (1.97) p=.109

NIS, Nurse Incivility Scale

NDNQI, National Database of Nursing Quality Indicators

Note: Asterisk indicates significance across time points $p < .05$

A lower score indicates a stronger affinity toward the subscales attributes

Appendix C

Table 3

Content Analysis- Dealing with Incivility-Initial Survey

Dealt with Incivility		**Word/Phrase Coding**	**Theme**	**Frequency**
		Directly called the nurse to discuss her actions Direct conversation Asked nurse to lower her voice Spoke directly to the person Direct conversation Go to private area for discussion Used humor	Addressed with nurse exhibiting incivility	35%
		Discussing things together with charge nurse or manager Spoke to my manager Go to my supervisor with concerns Report to supervisor Gone to my manager	Speaking to nurse manager/supervisor	25%
		Let slide Not dealt with Ignored	Ignored	15%
Experienced Incivility		**Word/Phrase Coding**	**Theme**	**Frequency**
		Bad mouthing Bullying Raised Voices	Verbal	15%
		Gossip	Gossip	20%
		Unfair work distribution Lack of willingness to help or be a team player	Team Work	10%
		Body language Hearing other nurses make inappropriate remarks about patients	Miscellaneous	5%

Appendix D

Table 4

Content Analysis- Dealing with Incivility-Final Survey

Dealt with Incivility	**Word/Phrase Coding**	**Theme**	**Frequency**
	Faced it straight up, usually with humor Addressed it myself Taken confrontation into the supply room Discussed with nurse Know how to give it back	Addressed with nurse exhibiting incivility	33%
	Talked to my supervisor Reported to my supervisor Spoken to my supervisor	Speaking to nurse manager/supervisor	25%
	Ignore Changed the subject Dreaded coming to work Not taken personal responsibility	Ignored	42%
	Try to monitor body language Minimize halt discussions of co-workers Self-awareness of my own actions	Awareness	25%
	Left a previous job	Left job	0.08%
Experienced Incivility	**Word/Phrase Coding**	**Theme**	**Frequency**
	Bullying Gossip Usually supervisor to staff	Verbal Gossip Miscellaneous	8.30% 8.30% 8.40%

Appendix E

Table 5

Content Analysis: Job Satisfaction- Initial Survey

Word/Phrase Coding	Theme	Frequency
We are not a team…are against each other Feeling that your team does not have you back	Lack of Teamwork	11%
Workplace very unenjoyable If allowed to continue, it can make you not want to come to work Greatly Lessens job satisfaction to the point I leave an area and find something else Adversely	Effects Job Satisfaction	27%
Poor work environment Less than professional work environment Making the workplace hostile Decreasing morale, work ethic and team spirit Incivility can become a snowball effect causing people to focus on negative aspects of others Adds stress to the workplace Hinder productivity Supervisor lack of dealing with difficult employees	Negative Work Environment	56%
Made me feel terrible Leads to nit picking and disgruntlement with others Effects some more than others based on personality Strips me and the people involved of experiencing joy in my job Creates personal conflict Creates feelings of insecurity Makes you feel uncomfortable	Effect on Others	50%

Appendix F

Table 6

Content Analysis: Job Satisfaction- Final Survey

Word/Phrase Coding	**Theme**	**Frequency**
Greatly Incivility makes your job miserable Decrease satisfaction Has caused me to look at other job opportunities Makes you hate coming to work	Effect Job Satisfaction	64%
Causes stress Makes me frustrated that staff members are not respected by the leads of the department	Effects on Others	18%
Impartial It does not because I am confident in myself It does not	Impartial/No effects	27.20%

Appendix G

Figure 1

Scripting Cue Card

Prompting Card
Possible Pre-Rehearsed Response

1. Nonverbal innuendo (raising of the eyebrows, face making)
    - "I sense (I see from your facial expression) that there may be something you wanted to address with me, it's ok to speak with me directly."
2. Verbal (covert/overt) affront (snide remarks, lack of openness, abrupt responses).
    - "The individuals that I learn the most from, are clearer in their directions and feedback. Is there some way we can structures this type of learning situation?"
    - "That may be information that I don't need to know/hear, what would help me is..."
3. Undermining activities (turning away, not available)
    - "When an event happens that is contrary to my understanding, it leaves me with questions. Help me to understand how this situation happened."
4. Withholding information (practice or patient)
    - "It is my understanding that there (is) was more information available, regarding this situation, and I believe that if I had known that, it would (will) affect how I handle what I learn or need to know."
5. Sabotage (deliberate setting up of situation)
    - "There is more to this situation than meets the eye could 'you and l' (whatever/whoever) meet in private and explore what happened?"
6. Infighting (bickering with peers) Open 'contentious' discussion is unprofessional and should be avoided
    - "This is not the time or place- please stop" (physically move to a neutral spot)
    - "I'm moving to another location"
7. Scapegoating (attributing all that goes wrong to one individual) rarely is one individual one incident or one situation that cause for ALL that goes wrong, and scapegoating is an easy route to travel, but rarely solves problems
    - "I don't think that is the right connection."
8. Backstabbing (complaining to others about an individual but not speaking with that individual). Like 'scapegoating; is maladaptive and nonproductive.
9. Failure to respect
    - "It bothers me to talk about that without their permission"
    - "I only overheard that and it shouldn't be repeated"
10. Broken confidences
    - "Wasn't that said in confidence?"
    - "That sounds like information that should remain confidential"
    - "He/she asked me to keep that confidential"

Responses adapted from "effective communication" (Glod, 1998) For cognitive rehearsal by M. Griffin, RN, CS, PhD (2003)

Appendix H

Nurse Incivility Scale

Test Administrator Instructions: Each statement is rated on a 5-point Likert-type agreement scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree).

The subscales are HC=Hostile Climate, IJ= Inappropriate Jokes, IB= Inconsiderate Behavior, GR= Gossip/Rumors, FR= Free-Riding, AS= Abusive Supervision, LR- Lack of Respect, and DF= Displaced Frustration. Scores should be aggregated at the subscale level. To compute subscale scores, individual items scores should be summed and averaged (e.g., aggregated Nurses' Hostile Climate score) to glean more specific information for targeting interventions. The source-level aggregate score (e.g., aggregated Physician Incivility score) may be appropriate for understanding source-specific incivility.

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

1= Strongly Disagree

2= Disagree

3= Neither Agree or Disagree

4= Disagree

5= Strongly Agree

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

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

The following describe your interactions with other **nurses.**

Other nurses on my unit…

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

Please think about your interactions with your **direct supervisor** (i.e. the person you report to most frequently) and indicate how strongly you agree with the following statements.

My direct supervisor…

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

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

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

Please reflect upon your interactions with the **patients** your care for and their **family and visitors** and indicate the extent to which you agree with the following statements.

Patient/visitors…

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

Appendix I

Adapted Index of Work Satisfaction- Nurse Interaction Subscale

Rate the items below according to this scale:

1= Strongly agree

2= Agree

3= Agree more than disagree

4= Disagree more than agree

5= Disagree

6= Strongly disagree

Interaction

(Opportunities and requirements presented for both formal and informal social and professional contact during working hours)

1. The nursing personnel on my service don't hesitate to pitch in and help one another when things get in a rush.
2. New employees are not quickly made to "feel at home" on my unit.
3. There is a good deal of teamwork and cooperation between various levels of nursing personnel in my service
4. The nursing personnel on my service are not as friendly and outgoing as I would like.
5. The is a lot of "rank consciousness" on my unit: nursing personnel seldom mingle with others of lower ranks.
6. Nursing personnel pitch in and help each other when things get in a rush
7. It is hard for new nurses to feel "at home" on the unit.
8. There is a good deal of teamwork among nursing personnel.
9. Nursing personnel are not as friendly and outgoing

Appendix J

Nurse Incivility Questionnaire

1. In the past year, I have experienced or witnessed nurse-to-nurse incivility in the workplace.

    a. Yes
    b. No

2. In what ways, have you dealt with nurse-to-nurse incivility?

3. Describe how nurse-to-nurse incivility affects your job satisfaction.

Appendix K

Demographic Questions

1. How many years have you been a nurse (LPN and RN)?

    - Less than one year
    - Number of years

2. How many years have you been employed in the PACU?

    - Less than one year
    - Number of years

3. What is your age?

    - 20-24
    - 25-29
    - 30-34
    - 35-39
    - 40-44
    - 45-49
    - 50-54
    - 55-59
    - 60-64
    - 65-69

4. What is your ethnicity?

    - White
    - Hispanic or Latino
    - Black or African American
    - Native American or American Indian
    - Asian/Pacific Islander
    - Other

5. What is your gender?

    - Male
    - Female
    - Non-binary

Appendix L

The 10 Most Frequent Forms of Incivility in Nursing Practice*

1. Nonverbal innuendo (raising of eyebrows, face-masking).
2. Verbal affront (covert or overt, snide remarks, lack of openness, abrupt responses).
3. Undermining activities (turning away, not available).
4. Withholding information (practice or patient).
5. Sabotage (deliberately setting up a negative situation).
6. Infighting (bickering with peers).
7. Scapegoating (attributing all that goes wrong to one individual).
8. Backstabbing (complaining to others about an individual and not speaking directly to that individual).
9. Failure to respect privacy.
10. Broken confidences.

*Ordered from most current often encountered to less frequently encountered.

Adapted from Duffy, 1995; Farrell 1997; McCall, 1996; McKenna, Smith, Poole, & Coverdale, 2003.

(Griffin, 2004)

Appendix M

Informed Consent

Identification of Project	The Effectiveness of Education and Cognitive Rehearsal in Managing Nurse-to-Nurse Incivility in a Post Anesthesia Care Unit
Statement of Age of Subject	I state that I am over 18 years of age, in good physical health, and wish to participate in this program of research being conducted by Deborah Kile MSN, RN, NE-BC
Purpose	The purpose of this study is to add to the existing body of knowledge regarding awareness of nurse-to-nurse interactions among nurses and the impact education and cognitive rehearsal techniques have on decreasing the incidence of perceived incivility. This project will also examine the effect of an education and cognitive rehearsal program has on nurse job satisfaction and empowerment to confront incivility.
Procedures	The procedures of this research involve participants attending an education session on nurse-to-nurse incivility and training on cognitive rehearsal techniques to teach appropriate responses to frequent forms incivility. At the beginning each training session, participants will complete the Nursing Incivility Scale (NIS) and the Nurse Interaction subscale of the NDNQI Adapted Index of Work Satisfaction. In addition, participants, will answer two open-ended questions aimed at assessing their perceptions of the frequency of uncivil behaviors in their work environment and the degree to which uncivil behaviors affect their job satisfaction. Upon completion of the training session, participants will be complete the NIS again. One month after the last training session, participants will be asked to complete the NIS and the Nurse Interaction subscale of the NDNQI Adapted Index of Work Satisfaction again. Participants will also be asked to answer the two open-ended questions again.
Confidentiality	All the information collected in this study in confidential to the extent permitted by law. I understand that the data I provide may be grouped with data others provide for reporting and presentation and that my name will not be used.
Risks	The risks involved in this research are minimal. Participants will be assigned an anonymous ID to protect their identity.
Benefits	Potential benefits include receiving education on nurse-to-nurse interactions and cognitive rehearsal techniques which may be helpful in increasing awareness of incivility and confronting uncivil behavior. This project will add to the body of knowledge by the studying

	the effects didactic lecture has on job satisfaction, awareness of incivility, frequency of incivility and nurses' perceptions of their ability to confront incivility.
Freedom to withdraw or ask questions	I understand that I am free to ask questions or withdraw from participation at any time and without penalty.
Medical Care	There is no medical care included in this research… Sentara SRMH Medical Center does not provide any medical or hospitalization insurance for participants in this research or any compensation for any injury sustained as a result of my participation in this research.
Contact Information	If you have any questions about your rights as a research subject or wish to report a research related injury, contact: Stewart Pollock, MD, Chairman Sentara RMH Medical Center Institutional Review Board 2010 Health Campus Drive Harrisonburg, VA 22801 540-689-1000 If you have questions about this particular study, contact: (Principal Investigator Name, PI Address and phone number)
Subject Information	Subject Name: _____ Subject signature: _____ Date signed: _____

References

Bahn, D. (2001). Social learning theory: Its application in the context of nurse education. *Nurse Education Today, 21,* 110-117. http://dx.doi.org/10.1054/nedt.2000.0522

Bandura, A. (1977). *Social learning theory*. New Jersey: Prentice Hall.

Bengtsson, M. (2016). How to plan and perform a qualitative analysis using content analysis. *Nursing Plus Open, 2,* 8-14. https://doi.org/10.1016/j.npls.2016.01.001

Chipps, E., & McRury, M. (2012). The development of an educational intervention to address workplace bullying. *Journal for Nurses in Staff Development, 28*(3), 94-98. https://dx.doi.org/10.1097/NND.0b013e31825514bb

Gilbert, R. T., Hudson, J. S., & Strider, D. (2016). Addressing the elephant in the room: Nurse manager recognition of and response to nurse-to-nurse bullying. *Nursing Administration Quarterly, 40*(3), E1-E11. http://dx.doi.org/10.1097/NAQ.0000000000000175

Graneheim, U. H., & Lundman, B. (2004). Qualitative concept analysis in nursing research: concepts, procedures, and measures to achieve trustworthiness. *Nurse Education Today, 24,* 105-112. https://doi.org/10.1016/j.nedt.2003.10.001

Griffin, M. (2004, November-December). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *Journal of Continuing Education in Nursing, 35*(6), 257-263. http://dx.doi.org/10.3928/0022-0124-20041101-07

Griffin, M., & Clark, C. (2014). Revisiting cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later. *Journal of Continuing Education in Nursing, 45*(5), 535-542. http://dx.doi.org/10.3928/00220124-20141122-02

Guidroz, A. M., Burnfield-Geimer, J. L., Clark, O., Schwetschenau, H. M., & Jex, S. M. (2010). The nursing incivility scale: Development and validation of an occupation-specific measure. *Journal of Nursing Measurement, 18*(3), 176-200. http://dx.doi.org/10.1891/1061-3749.18.3.176

Lasater, K., Mood, L., Buchwach, D., & Dieckmann, N. F. (2015). Reducing incivility in the workplace: Results of a three- part educational intervention. *Journal of Continuing Education*, *46*(1), 15-23. http://dx.doi.org/10.3928/00220124-20141224-01

Laschinger, H. K., Cummings, G. G., Wong, C. A., & Grau, A. L. (2014, January- February). Resonant leadership and workplace empowerment: The value of positive organizational cultures in reducing workplace incivility. *Nursing Economics*, *32*(1), 5-15,44. Retrieved from http://www.nursing economics.ref/cgi-bin/WebObjects/NEJournal.woa

Lavrakas, P. J. (Ed.). (2008). Social desirability. Retrieved from http://methods.sagepub.com/reference/encyclopedia-of-survey-research-methods/n537.xml

Leiter, M. P., Laschinger, H. K., Day, A., & Oore, D. G. (2011). The impact of civility interventions on employee social behavior, distress, and attitudes. *Journal of Applied Psychology*, *96*(6), 1258-1274. http://dx.doi.org/10.1037/a0024442

Letvak, S., & Buck, R. (2008, May-June). Factors influencing work productivity and intent to stay in nursing. *Nursing Economics*, *26*(3), 159-163. Retrieved from http://www.nursing economics.ref/cgi-bin/WebObjects/NEJournal.woa

Lewis, P. S., & Malecha, A. (2011, January). The impact of workplace incivility of the work environment, manager skill, and productivity. *Journal of Nursing Administration*, *41*(1), 41-47. http://dx.doi.org/10.1097/NNA.0b13e3182002a4c

Little, R. A., & Rubin, D. B. (2002). *Statistical analysis with missing data* (2nd ed.). New York, NY: Wiley-Interscience.

Nikstaitis, T., & Simko, L. C. (2014, September/October). Incivility among intensive care nurses. *Dimensions of Critical Care Nursing*, *33*(5), 293-301. http://dx.doi.org/10.1097/DCC.0000000000000061

NVivo (Version 10) [Software]. (2012). Retrieved from www.qrsinternational.com/nvivo/support-overview/downloads/nvivo10-for-windows

SPSS website. (n.d.). http://www.spss.ch/upload/1126184451_Linear%20Mixed%20Effects%20Modeling%20in%SPSS.pdf

Stagg, S. J., Sheridan, D. J., Jones, R. A., & Speroni, K. G. (2013, November 8). Workplace Bullying: The effectiveness of a workplace program. *Workplace Health & Safety*, *61*(8), 333-338. http://dx.doi.org/10.3928/21650799-20130716-03

Stagg, S. J., Sheridan, D., Jones, R. A., & Speroni, K. G. (2011). Evaluating a workplace bullying cognitive rehearsal program in a hospital setting. *The Journal of Continuing Education in Nursing*, *42*(9), 395-401. http://dx.doi.org/10.3928/00220124-20110823-22

Tri-Council for nursing issues proclamation on nursing civility. (2017). Retrieved from http://tricouncilfornursing.org/documents/Tri-Council-Nursing-Civility-9-26-17.pdf

Verbeke, G., & Molenberghs, G. (2000). *Linear mixed models for longitudinal data*. New York, NY: Springer.

Vessey, J. A., DeMarco, R., & DiFazio, R. (2011, April 1). Bullying, Harassment, and Horizontal Violence in the Nursing Workforce. *Annual Review of Nursing Research*.

Warner, J., Sommers, K., Zappa, M., & Thornlow, D. (2016, January). Decreasing workplace incivility. *Nursing Management*, 22-30. https://doi.org/10.1097/01.NUMA.0000475622.91398.c3

Weinand, M. R. (2010, Fall). Horizontal violence in nursing: History, impact, and solution. *Journal of Chi Eta Phi Sorority*, *54*(4), 23-26. Retrieved from http://www.worldcat.org/title/joceps-the-journal-of chi-eta-phi-sorority/ocls/225100713

Wilson, B. L., Diedrich, A., Phelps, C. L., & Choi, M. (2011, November). Bullies at work: The impact of horizontal hostility in the hospital setting and intent to leave. *Journal of Nursing Administration*, *41*(11), 453-458. http://dx.doi.org/10.197/NNA.0b013e3182346e90

Zangaro, G. A., & Soeken, K. L. (2005, Spring/Summer). Meta-analysis of the reliability and validity of part B of the index of work satisfaction across studies. *Journal of Nursing Measurement*, *13*(1), 7-22. Retrieved from https://searchproquest.com/openvies/574ce440dbaaccee?pq8972e2f0e1eaada1/1?pq-origisite=gscholar&cbl=46673