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Civility in the Workplace: A Lesson in Humanity

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CIVILITY IN THE WORKPLACE: A LESSON IN HUMANITY

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Abstract

Incivility across the nursing continuum has been widely documented in the literature and is growing in prevalence. Incivility is a phenomenon defined as low intensity rude or inconsiderate conduct that is psychological in nature with an unclear intent to harm the target. These acts have devastating effects on nurses, adversely affecting the quality of their performance, mental health and work satisfaction. Moreover, experiencing acts of incivility in turn, influence their intention to stay with an organization or even the nursing profession. The negative consequences of healthcare organizations are seen through increased costs related to nurse turnover, absenteeism and decreased work performance. More dangerously, these behaviors threaten patient safety through nurses' unsafe practices related to incivility. The purpose of this project is to create an evidence based educational experience for practicing nurses. Bandura's social learning theory provides the framework and is based on constructivist's idea that there is a direct relationship between learned, observed behavior and our actions. Through a comprehensive literature review, results show problem based learning strategies along with cognitive rehearsal is an effective way to address incivility in the workplace.

Civility in the Workplace: A Lesson in Humanity

Incivility across the nursing continuum has been widely documented in the literature for a number of years and is growing in prevalence. Warrner, Sommers, Zappa & Thornlow (2016) identified incivility as "repeated offensive, abusive, intimidating or insulting behavior, abuse of power or unfair sanctions that make recipients upset and feeling humiliated, vulnerable or threatened, creating stress and undermining their self-confidence" (p. 22). Some studies have estimated that nearly 85% of nurses had either seen incivility or personally experienced it (Lynette, Echevarria, Sun & Ryan, 2016). These acts have devastating effects on nurses, adversely affecting the quality of their performance, mental health and work satisfaction. Moreover, experiencing acts of incivility in turn, influences their intention to stay with an organization or even the nursing profession. This comes at a time when there is an unprecedented nursing shortfall predicted for the near future. The negative consequences of healthcare organizations are seen through increased costs related to nurse turnover, absenteeism and decreased work performance. More dangerously, these behaviors threaten patient safety through nurses' unsafe practices related to incivility (Warrner et al., 2016; Lynette et al., 2016; Lachman, 2015). Unfortunately, many perpetrators of incivility are unaware of the effects of their behaviors and often these acts go unrecognized and are under-reported (Warrner et al., 2016).

In order to change this destructive path of incivility, there needs to be an understanding of what it is and an action plan with effective strategies to address these behaviors in the workplace. This independent project sought to produce evidence-based strategies to combat incivility with the application of Bandura's social learning theory. According to Lynette et al. (2016),

Bandura's theory is based on the constructivist idea that there is a direct relationship between learned, observed behavior and our actions. For example, often we mimic the behaviors of others we observe. Then the seen or learned behaviors are modeled with social reinforcement either correcting or rewarding.

Purpose

While there is an expanding body of literature on the topic of incivility in the nursing profession, according to Jones et al. (2016) nurses may have difficulty accurately describing these behaviors because some are subtle, nonverbal and socially embedding. A good first step in addressing incivility was to define it and acknowledge the implications these behaviors have on the nurse, nursing profession, organization and most importantly safe patient care. After defining this issue it was important to understand the reasons for the prevalence of incivility so it can be addressed with evidence-based strategies. This individual project sought to improve the understanding of incivility in the nursing profession by creating an evidenced-based lesson plan that can be used to educate practicing nurses on strategies to address uncivil behaviors in their workplace.

Significance

Workplace incivility appears to be on the rise. The World Health Organization recently identified it as a serious threat to public health and is reaching epidemic levels worldwide (Laschinger, 2014). The term incivility is used synonymously with abuse, bullying, conflict, lateral violence, disruptive behaviors and 'nurses eating their young', an initiation to determine if a new nurse can survive in the profession (Hoffman & Chunta, 2015). These terms describe behaviors that harass, intimidate or publically humiliate others. Examples of uncivil behaviors include complaining, lying, gossiping, abusive language, insubordination, scapegoating and

physical/verbal intimidation (Blevins, 2015). Additionally, actions that are rude, condescending, mean, and are a threat to a person's physical, emotional and psychological well-being are considered uncivil or hostile. In some cases, nurses may have difficulty identifying uncivil behaviors such as eye rolling, facial expressions sighs or isolating one another by forming cliques, because they may be nonverbal and socially embedded (Lynette et al., 2016).

An uncivil environment takes a toll on the victim, often leading to absenteeism as employees miss work to avoid the perpetrator before leaving the organization altogether. Nurses subject to bullying are twice as likely to leave the organization within two years (Blevins, 2015; Hoffman & Chunta, 2015; Laschinger, 2014). Other adverse effects include anxiety, depression, sleep disturbances, reduced work performance, job dissatisfaction, morale and decreased communication to name a few (Hoffman & Chunta, 2015; Mikaelian & Stanley, 2016). These effects can cost an institution an estimated, $30,000-$100,000 for each individual per year (Hoffman & Chunta, 2015).

In 2015, the ANA released a position statement on incivility, bullying and workplace violence. The purpose of the statement was to express shared responsibilities of organizations, management and nurses to create an organizational culture built on respect. Healthcare leaders are expected to maintain a safe work environment for all and nurse managers are expected to role model civility and professional conduct (MacLean, Coombs & Breda, 2016). Moreover, the ANA Code of Ethics for Nurses is the profession's non-negotiable ethical standard which includes statements that are relevant to ethical issues surrounding disruptive behaviors (ANA, 2001).

According to Blevins (2015) as early as 2008, The Joint Commission identified disruptive behavior as a root cause for more than 3,500 sentinel events over a 10 year period and

as a result issued a zero tolerance of uncivil behaviors, mandating organizations to have written policies in place to address this issue. Mikaelian & Stanley (2016) reported a correlation between workplace incivility with a variety of poor patient outcomes (ie. patient falls, medication delays and errors, and poor patient care and satisfaction). Poor communication, burnout and diminished team work resulting from incivility in the workplace were central to the cause of these poor outcomes, all of which have the potential to lead to lawsuits. These factors perpetuate a vicious cycle and it is imperative to address this phenomenon without delay so it can be dismissed as the social norm.

Theoretical Framework

A number of frameworks have been used to explain incivility in the nursing profession, however, I felt Bandura's Social Learning Theory provides a practical framework to explain this phenomenon and can be used to develop evidence-based strategies to address uncivil behaviors. According to Kay & Kibble (2016), Bandura is widely cited in educational literature and his model is useful when learning is best achieved by instructional modeling, demonstration and imitation. Observational learning is one concept to describe behavior change and is a core model used throughout society, such as in marketing and advertisement where companies influence consumers to buy their product. It is also seen with parents and caregivers of children who model social norms to form outcome expectancies.

In Bandura's 1971 classic work on social learning theory, all learning results from direct experiences or can occur on a vicarious basis through observation of other people's behavior and its consequences. Learning rooted in direct experience is largely governed by the rewarding and punishing consequences that follow any given action. McLeod (2016) also stated reinforcement can be either positive or negative, but it will have little impact if the external reinforcement does

not match with the individual's needs. Regardless of whether the reinforcement is positive or negative it will usually lead to a change in behavior.

Although behavior can be shaped to some extent by rewarding and punishing consequences, learning would be tedious and laborious if this was the only method of learning. According to Bandura (1971), the capacity to learn by observation enables an individual to acquire integrated units of behavior by example without having to build up these patterns gradually by trial and error. Most of the behaviors people learn are deliberate or unintentional through the influence of modeling. Bandura also pointed out that there are several reasons why modeling influences learning in everyday life. For example, when mistakes are costly and hazardous, new ways to respond can be developed without disastrous errors, by providing models who demonstrate how the activity should be performed. When new behaviors can be conveyed only by social cues, modeling the behavior provides a crucial aspect of learning. Ultimately, the process of acquisition can be shortened through these models. Therefore, under most circumstances, a good model is a better teacher than the consequences of unguided actions (Bandura, 1971). The concept of good role modeling was the premise to creating the lesson plan and in turn, with a goal of inspiring a culture of civility.

Definitions

There are a number of different terms that describe behaviors that humiliate, belittle and intimidate others which include incivility, horizontal violence, lateral violence, bullying or harassment. According to Lynette et al. (2016), these terms are not used consistently throughout the literature and are not interchangeable. Lachman (2015) attempted to clearly define these terms and the behaviors commonly linked to them. The operational definitions used for this project are presented in Table 1. Incivility is characterized by rudeness and disrespect for others.

The behaviors are considered to be “low intensity and are psychological in nature with an unclear intent to harm the target”. Behaviors commonly seen with incivility include: “rude comments, offensive or condescending language, name calling, public criticism or attacking a person’s integrity” (p. 40). Lachman also defines horizontal violence and lateral violence as one of the same and are commonly used interchangeably. It is the “unkind, discourteous, antagonistic interactions between nurses who work at comparable organizational level and is commonly characterized as backbiting and infighting”. Behaviors seen with horizontal/lateral violence are: “complaints shared with others without first discussing with the individual, sarcastic comments, withholding support, insulting, condescending or patronizing behaviors and ignoring or discounting an individual’s input” (Lachman, 2015 p. 40).

Lastly, bullying is “repetitive behavior that happens a minimum of twice a week and continues for a minimum of 6 months. The targeted person finds self-defense difficult and cannot stop the abuse”. Behaviors associated with bullying include: “persistent hostility, regular verbal attacks, repeated physical threats, refusal to assist with duties, taunting the nurse in front of others and speaking negatively about the nurse to administrators” (Lachman, 2015, p. 40). Peters (2014) states, workplace harassment differs from these other terms in that “harassment is considered to be cultural, racial or sexual in nature” (p. 214).

Table 1
OPERATIONAL DEFINITIONS

Type	Definition	Behaviors	Sources
Incivility	Lack of respect for others. Psychological in nature. Low intensity, rude or inconsiderate conduct. Unclear intent to harm target.	• Rude comments • Offensive or condescending language • Name calling • Public criticism • Ethnic or sexual jokes • Screaming • Attacking a person's integrity • Being unapproachable • Condescending • Inflexible • Harassing • Rude gestures • Eye rolling • Facemaking • Abrupt responses • Lack of openness • Broken confidences • Complaining • Lying • Gossiping • Abusive language • Insubordination • Scapegoating • Physical/verbal intimidation	Lachman (2015) Blevins (2015) Peters (2014)
Horizontal / Lateral Violence	Unkind, discourteous, antagonistic interactions between nurses who work at comparable organizational levels and commonly characterized as divisive backbiting and infighting.	• Complaints shared with others without first discussing with the individual • Sarcastic comments • Withholding support • Ignoring or discounting individual's input • Insulting, condescending or patronizing behaviors	Lachman (2015)
Type	Definition	Behaviors	Sources
Bullying	Repetitive behavior that happens a minimum of twice a week. Long term behavior that continues for minimum of 6 months. Targeted person finds self-defense difficult and cannot stop the abuse.	• Persistent hostility • Regular verbal attacks • Repeated physical threats • Refusal to assist with duties • Taunting the nurse in front of others • Speaking negatively about the nurse to administrators	Lachman (2015)
Harassment	Differs from bullying in that it is considered to be cultural, racial or sexual in nature.	• Cultural • Racial • Sexual	Peters (2014)

Process

Literature for this review was retrieved from search of the databases, CINAHL and PubMed from 2012-2017 using the Harley French Library at the University of North Dakota. Key words "incivility" and "incivility in the workplace" resulted in multiple articles addressing this topic. The limits of the literature search were peer reviewed journal articles available in full-text English, published within the last five years and accessible via electronic form. Literature relating to academia and nursing students was critically appraised for relevance to the focus of this project on practicing nurses. Relevant articles found in the reference section of the included journal articles were also analyzed and added to the review when they met the inclusion criteria. After a comprehensive literature review was completed, 10 articles met the inclusion criteria and were analyzed and synthesized for evidence relating to the topic of focus. Inclusion criteria consisted of evidence-based strategies to decrease workplace incivility. Melnyk's pyramid was used to determine the level of evidence (Appendix A). The target audience for this project was practicing nurses in the workplace. An experiential lesson plan was developed using the evidence-based strategies found in the literature review.

Review of Literature

This section of the paper is organized through themes identified by analysis of evidence identified in the review of literature. The themes related to workplace civility or lack thereof, uncovered in this project included (1) nursing, social power and oppression, (2) organizational structure and culture, (3) educational contribution to the solution for a culture of civility.

Nursing Social Power and Oppression

There are a number of explanations of why incivility happens in the workplace and it is imperative to understand the nature of workplace incivility to prevent and effectively address the

problem. Mikaelian & Stanley (2016) sought to offer a theoretical understanding to why incivility happens in the nursing profession by using the oppressed group model. Throughout history, nursing has been a female dominant profession which implies a gender disparity. In the 1900's male physicians constructed nursing programs which created and ingrained a gender bias, which set the groundwork for oppressive behavior by physicians. This led to conflict between the two professions, which still may be present today. Peters (2014), described the major principle of oppression theory as "oppressed groups learn self-hate because of the dominant group's ability to create norms for what holds value" the oppressed group then "tries to mimic the actions/attributes of the dominant group. These values then become adopted as part of the culture" (p. 216). She also explained that oppressed groups are often powerless to create and drive outcomes for the future, because of the belief that they do not deserve to achieve the goals (Peters, 2014). The oppressed group is prevented from being empowered because of their low self-esteem, the group remains status quo, and the cycle continues. This type of oppressed group behavior among nurses has a negative impact in the workplace, and the act of not speaking up is one of the most frequently described oppressed group behaviors in nursing (Griffin & Clark, 2014).

Organizational Structure and Culture

Workplace incivility has also been identified as part of an organizational climate or culture rather than an individual phenomenon. These behaviors are more likely to continue or increase if it is seen as the norm rather than the exception (Hoffman & Chunta, 2015). These uncivil behaviors can be an expression of the character of the workplace, therefore ignoring these disruptive behaviors contributes to workplace incivility. Incivility is allowed because it is modeled and leaders fail to take action when action is warranted (Clark, 2011). Behavioral

norms form the foundation for effective team functioning and organizations that fail to address unprofessional behavior through formal systems are indirectly promoting it.

Torkelson et al. (2016) used the social power theory to relate incivility as a means of exercising power. Employees of lower social status or those whom are lower in the organizational hierarchy, are more susceptible to incivility from higher status employees. For instance, a supervisor who acts in an uncivil manner can become a role model for this type of behavior in the workplace. These behaviors can cascade downwards through the organization as third parties to the uncivil interaction observe and subsequently adopt similar behaviors. Therefore, incivility affects both those exposed and those who observe the process, which ultimately can influence the culture of the entire organization. Nurses most vulnerable to uncivil work environments are new to nursing practice, new to a particular area of practice, such as those transitioning to a new health care environment and those who are not permanent members of a unit i.e. floating and per diem nurses (Griffin & Clark, 2014).

Triggering factors contributing to workplace incivility have also been proposed. Torkelson et al. (2016) have identified specific organizational pressures that have been potential causes of workplace incivility such as changes at work resulting from restructuring and mergers, high demands, new technologies for communication, poor leadership and information overload. Stressors can also serve as triggers for lateral violence and other disruptive behaviors. Healthcare environments are often stressful with life or death situations especially in areas with limited resources (Sanner-Stiehr, 2017). Emotionally and spiritually draining work environment aggressive managers and increased internal and external demands on the nurse also contribute to uncivil behaviors (Thomas, 2010). For some people it can be ignorance, whereas for others it may be the loss of control or a desire for power (Thomas, 2010).

Organizational leaders have the responsibility to develop zero tolerance policies and procedures which are clear and consistent, regarding safe and civil work environments (Hoffman & Chunta, 2015; McLean et al., 2016; Thomas, 2010). Education in both academic settings and in continuing and staff education can also be effective in driving the goal for civil workplaces.

Educational Contribution for a Culture of Civility

The impact of education on changing behavior in work places can begin before or after nurses enter practice. Griffin (2004) used an exploratory descriptive design study with an applied intervention (cognitive rehearsal) to understand how/if lateral violence in practicing nurses could be controlled by allowing newly registered nurses the opportunity to acquire knowledge and skills to address lateral violence. Griffin's behavioral technique of cognitive rehearsal consisted of 26 newly registered nurses participating in didactic instruction about incivility, identifying and rehearsing specific phrases to address incivility. Nurses also practiced these phrases to become competent at using them.

Moreover, Griffin's (2004) project was intentionally designed to encourage continuation of the effective behavior. Cueing cards with the frequent forms of lateral violence and the responses were attached to the employee's identification badge for reference. A questionnaire regarding the effectiveness of the didactic instruction and the interactive cognitive rehearsal was sent out 6-12 months later. The results of the questionnaire showed the intervention of cognitive rehearsal raised consciousness of lateral violence immediately and persistently empowered nurses to confront uncivil coworkers. Despite the small sample size, this study was pivotal to the evidence for addressing incivility and continues to be a useful strategy and referenced in current literature (Russell, 2014; McLean et al., 2016; Warrner et al., 2016; Roberts et al., 2017; Clark et al., 2013; & Ceravolo et al., 2012). Ten years after her original work, Griffin & Clark (2014) revisited this cognitive rehearsal strategy for their retrospective article and found through a

review of literature that this intervention continues to be a useful technique in addressing incivility.

Simulation provides a familiar platform to provide student centered education to promote civility in the workplace. Simulation education is beginning to include communication and inter-professional education to enhance communication among members of the interdisciplinary healthcare teams. Sanner-Stiehr (2017) presented a guideline to integrate response training into simulations as a strategy to address lateral violence. Two main objectives for response to disruptive behaviors were identified as restoration of respectful communication and to ensure delivery of safe patient care because these are threatened when lateral violence occurs.

Before simulation events occur Sanner-Stiehr (2017) recommended pre-briefing provide participants with information for the simulation. The information would include definitions of disruptive behaviors and overall goals of response strategies. During simulation, facilitators should role model a variety of scenarios, demonstrating effective response strategies and provided an opportunity for discussion to assimilate information and understand how to apply the response strategies. Participants can then be immersed in the simulated scenarios with a debriefing to reflect on the experience to follow. According to Sanner-Stiehr (2017), simulation with response training can help establish effective responses that can decrease the negative effects of disruptive behaviors on the target, organizations and patients.

Ulrich et al., (2017) used a qualitative exploratory design to evaluate role play as an active learning strategy to address bullying in nursing practice. A sample of 334 senior level nursing students from five college campuses in the Midwest volunteered to participate in a classroom based simulation. The students were assigned to groups of four and randomly drew a role card, the aggressor, target, nurse bystander or patient. The students were informed of role

play and simulation instructions, as well as the intended learning outcomes to examine the experience and identify outcomes of the simulated bullying. Following the role play simulation, students completed an individual reflection worksheet. A facilitator led a debriefing session to explore students' responses to the simulation and discuss professional strategies to reduce bullying. The results showed the student's responses were similar to those exhibited in real life bullying situations. The researchers concluded role playing simulations can be effective way to examine the experience and outcomes of bullying.

Through a quality improvement project, Ceravolo et al. (2012) attempted to reduce nurse to nurse lateral violence and create a respectful workplace culture in a five hospital healthcare delivery system. Within a three year time period, 203 workshops were delivered to over 4,000 practicing nurses. The 60-90 minute workshops were designed to enhance assertive communication skills and raise awareness of the impact of lateral violence behaviors with an emphasis on conflict resolution and eliminating a culture of silence for nurses. Survey items were adapted from the Verbal Abuse Survey and used before and after the workshop to measure program outcomes. The most significant result of this quality improvement project was a decrease in nurses who reported being verbally abused at work from 90% to 76%. Ceravolo et al. (2012) pointed out that sadly, 76% of nurse are still experiencing lateral violence. Further investigation is necessary to sustain a positive culture change.

Problem based learning (PBL) is another effective teaching strategy in a classroom or clinical setting because of its applicability to real life situations encountered in professional practice. It engages students with real problems to identify what they know and don't know and prompts them to gather additional information and establish a way of communicating it.

Problem based learning encourages students to consider a variety of potential solutions to relevant scenarios (Clark, Ahten & Macy, 2013).

In their qualitative study, Clark, Ahten & Macy (2013) designed content for a senior level leadership class as preparation for using problem based learning as a teaching strategy for nursing faculty. They used levels one and two of the Kirkpatrick model of evaluation to assess student reaction and learning after a problem based scenario. Live actors portrayed a charge nurse and two staff nurses acting out a situation in which one of the staff nurses was uncivil to her two coworkers. Sixty-five students observed the scenario, provided feedback on the effectiveness of the scenario and participated in a small group debriefing. Students found the scenarios to be realistic and heightened their awareness of incivility and its impact on practice and patient care. It also allowed them to reflect on their own behaviors and how they would handle the situation.

In a 10 month follow up study from their original work, Clark, Ahten & Macy (2014) used level three of the Kirkpatrick's model of evaluation to determine how participants transferred knowledge and how their behavior has changed since participating in the problem based learning. A survey via email was sent to 30 former students who participated in the original study. Eighteen of the 30 were newly licensed RNs and participated in the survey. The benefits of the PBL identified by the participants were role modeling of desired behaviors, improved collegiality and effective communication skills. The longitudinal design helped to show continued benefit of PBL; however, limitations of this study was a small sample size from only one cohort of students which may lack generalizability.

Discussion

Interpretation

It is clear workplace incivility has continued to exist within the nursing profession for several decades with little headway on eradicating it. Oppressed group behaviors found in nursing can affect patient safety, contribute to lack of job satisfaction and decreased retention of nurses. These oppressed behaviors that manifest into lateral violence in nursing practice will not change unless there is a conscious effort to point out the destructive behaviors of those involved (Griffin, 2004; Griffin & Clark, 2014; Mikaelian & Stanley, 2016; Roberts, 2015).

In review of the 10 journal articles for this project, two themes emerged and were used as the underpinning for this experiential lesson plan. First, cognitive rehearsal is a powerful tool to raise awareness of incivility and the use of scripted language can empower nurses stop the silence and address this problem immediately (Ceravolo et al., 2012; Clark et al., 2013; Griffin, 2004; Griffin, 2014; McLean et al., 2016; Roberts et al., 2017; Russell, 2014; Warrner et al., 2016). Secondly, simulation can be used in a variety of ways to effectively address incivility, for example, facilitators can role model a variety of scenarios seen in practice, nurses may actively participate in acting out different roles or live actors have been used to imitate behaviors seen with incivility (Clark, Ahten & Macy, 2013; Sanner-Stiehr, 2017; Ulrich et al., 2017).

All learning results from direct experiences or can occur on a vicarious basis through observation of other people's behavior and its consequences (Bandura, 1971). Consistent with Bandura's framework of the socially constructed nature of behavior, problem based learning strategies such as group scenarios, simulation and role playing can reinforce the ability of a socially approved behavior to be changed when the group ceases to tolerate unacceptable behaviors (Lynette, et al., 2016).

Outcomes/Dissemination

Griffin & Clark (2014) identified new nurses in the workforce as one of the most vulnerable to workplace incivility, therefore both scenarios included this population. The experiential activity was proposed to take place in the simulation laboratory (Appendix B). A pre-briefing would include a power point presentation (Appendix C) on the significance of the problem, defining incivility and identify the behaviors associated with it. According to Sanner-Stiehr (2017), pre-briefing provides students with the information needed to prepare and participate in simulation. Participants should be introduced to the content in the scenario beforehand to apply during the simulation. Participants would select a role from a hat to role play in the scenario (Appendix D). Scenario one: change of shift report with role play of a night shift nurse, day shift nurse, charge nurse and physician. Scenario two: new nurse on orientation with role play of a charge nurse, preceptor, new nurse on orientation and two staff nurses. The participants will then act out the scripted roles of the scenario.

Engaging in simulated experiences allows students to apply the information presented during pre-briefing to various situations. Simulations designed to teach lateral violence response strategies can be presented as stand-alone scenarios which involves students engaged in role playing to gain experience formulating responses to uncivil behaviors through dialogue. Stand-alone scenarios allow students to focus on strategizing their responses without contextual distractions which may be seen in existing patient care simulations (Sanner-Stiehr, 2017). A facilitator led debriefing concludes this experience.

Eppich & Cheng (2015) describe debriefing as a facilitated reflection in the cycle of experiential learning to help identify and close gaps in knowledge and skills. Debriefing includes essential elements such as, active participation with more than just passive feedback; the focus is on learning and improvement; discussion of specific events; and input from multiple

sources. Effective debriefings can provide a forum for feedback that is essential for performance improvement and deliberate practice that promotes expertise (Eppich & Cheng, 2015).

The take home messages of this particular lesson are to recognize uncivil behaviors, practice scripted language to address these behaviors and relate deficient communication to potential poor patient outcomes. Having knowledge of incivility and using cognitive rehearsal for countering uncivil behaviors can empower nurses to confront instigators and episodes of incivility (Griffin & Clark, 2014).

Implications for Nursing

Nursing practice.

Currently, one fourth of all nurses are 55 years or older and only 8% are younger than 30 (Thomas, 2010). As aging nurses retire younger nurses will need to replace them. Violence toward nurses by nurses and other staff members, is inadvertently contributing to the nursing shortage and creating a culture of safety is critical to the recruitment and retention of nurses especially the most vulnerable, newly registered nurses.

Educational experiences such as the one described in this individual project, must be carried forward into and reinforced within the practice environment beginning with employee orientation and nurse residency programs (Clark, Ahten & Macy, 2014; Griffin, 2004;Thomas, 2010). Eliminating workplace violence is an ongoing collaborative process. The nurse educator has a crucial role in this process and may need to hold annual workshops, conduct periodic surveys of staff and update information on violence to ensure the workplace remains violence free (Thomas, 2010).

Nursing across the continuum has an obligation to our patients and coworkers to role model professional behaviors that uphold the standards consistent with our code of ethics. This

includes respectful conversations and creating an environment based on trust, collaboration and integrity. Nurses are the only one, who have the power to change this toxic milieu.

Nursing education.

The negative effects of lateral violence can be reduced markedly through education. The goal of an educational process for teaching about lateral violence is to liberate the oppressed individuals by helping them see that stopping the dominant group or individual from oppressing them is within their capabilities. Further, by not allowing lateral violence to continue, they become liberated. That liberation is what allows learning to continue and change to happen (Griffin, 2004).

The literature suggests that the topic of incivility and bullying be embedded into the nursing curriculum as part of clinical experiences, during lecture and integrated into simulations and post conference content. Threading this topic into nursing curriculum is a way to make students aware of the phenomenon before entering practice as well as laying the groundwork for creating cultures of civility in professional nursing practice (Clark, Ahten & Macy, 2013; Russell, 2015; Sanner-Stiehr, 2017; Thomas, 2010). The need for this type of education has never been greater. Nurse educators can address these critical issues by including lateral violence response training into pre-licensure curriculum.

Nursing policy.

Despite explicit professional standards, codes and expectations, uncivil interactions among nurses persist in the profession. It is of vital importance these behaviors come to an end to save the profession of nursing. Organizational policies and procedures must clearly define violent behaviors and a detailed plan should be in place to address specific behaviors within the organization. Abusers must be held accountable for their actions and consequences mandated.

Reviewing the organizational policies and procedures regarding incivility in nursing orientation and nurse residency programs as a way of promoting a zero tolerance in the workplace is also imperative (Ceravolo et al., 2012; Dillon, 2012; Hoffman & Chunta, 2015; Sanner-Stiehr, 2017).

Teaching staff members how to respond to incivility is futile if management neither sees nor admits that the problem exists, or if leadership lacks the tools required to address it (Warrner et al., 2016). Nursing managers are accountable for creating a healthy work environment for their staff. Managers must role model appropriate behavior that promotes a zero tolerance policy. Employee negativism and resentment can manifest in a workplace which tolerates poor leadership, fosters abuse among coworkers and lacks policies and procedures for dealing with unprofessional conduct. Furthermore, staff should feel comfortable reporting behaviors to the nurse manager and not fear retaliation for sharing their concern (Hoffman & Chunta, 2015). Ultimately, the end goal is to create and sustain a safe, healthy, and thriving work environment where the organizational vision, mission and values are shared, lived and embedded in civility and respect (Griffin & Clark, 2014).

Nursing research.

The literature proposes different strategies to change this toxic environment but research studies on how to sustain a positive work environment are inconsequential. An in-depth exploration of the development of a systematic educational program that can be utilized in academia, new employee orientation, nurse residency and staff education would be beneficial. It would also be helpful to capture qualitatively the experiences and perspectives of these programs and determine their impact, if any, on patient safety, job satisfaction and retention of nursing staff.

Summary and Conclusions

Strategies for addressing uncivil behaviors can be summarized into two categories, education and policy (Russell, 2014). Education on the effects of lateral violence should be established throughout the nursing curriculum, organizational orientation programs as well ongoing staff education. Nursing managers need to create a safe environment for employees and patients by creating clear and concise policies that are enforced as well as a zero-tolerance protocol. The importance of role modeling the values of honesty, integrity and compassion cannot be overstated. In addition, ensuring personal accountability through reflection, self-assessment and peer feedback can help meet these responsibilities of a nurse (Russell, 2014). Nursing cannot afford to ignore this problem any longer. Empowering each other in a grass roots approach may be the only way of maintaining an adequate nursing workforce and preserve the profession of nursing.

This project was designed to contribute to a solution to this scourge in the nursing profession. Problem based teaching strategies along with cognitive rehearsal are valuable evidence-based tools to address this problem of incivility. Being well prepared, speaking with confidence and using respectful expressions can empower nurses to break the silence of incivility and oppression (Griffin & Clark, 2014). This can also create a safe environment for nurses and patients.

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Appendix A

LEVEL OF EVIDENCE

Author	**Title**	**Study Design**	**Level of Evidence**
Ceravolo et al. (2012)	Strengthening communication to overcome lateral violence	Quality improvement project used workshops designed to enhance assertive communication skills and raise awareness of impact of lateral violence. Pre and post workshop surveys were used to measure outcomes.	6
Clark et al. (2013)	Using problem based learning scenarios to prepare nursing students to address incivility	Qualitative study evaluated level of learning acquired after observing scenarios of nurse bullying behavior.	6
Clark et al. (2014)	Nursing graduates' ability to address incivility: Kirkpatrick's level-3 evaluation	Retrospective ten month follow up study from original work (2013) using surveying.	6
Griffin (2004)	Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses	Exploratory design using cognitive rehearsal intervention to understand how/if lateral violence could be controlled in newly registered nurses.	6
Griffin & Clark (2014)	Revisiting cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later	Retrospective article with synthesis of 3 decades of research on the effectiveness of cognitive rehearsal as an evidence-based intervention against incivility.	5

Roberts et al. (2017)	Peer training using cognitive rehearsal to promote a culture of safety in health care	Two teaching methods compared the effectiveness for preparing nursing students to respond to incivility.	6
Sanner-Stiehr (2017)	Using simulation to teach responses to lateral violence: Guidelines for nurse educators	Step by step guideline for educators to integrate lateral violence response training into simulations	7
Thomas (2010)	Teaching nursing students and newly registered nurses, strategies to deal with violent behaviors in the professional practice environment.	The article discusses terminology, standard of practice, causes of violence and the effect on newly registered nurses. Specific strategies to address violence are discussed.	7
Ulrich et al. (2017)	Reflective responses following a role play simulation of nurse bullying.	Qualitative exploratory design used to evaluate role play simulation as an active learning strategy.	6
Warrner et al. (2016)	Decreasing workplace incivility	Quality improvement project provided training to elevate staff and management awareness of incivility and its consequences and decrease the instances of perceived incivility.	6

Appendix B

CIVILITY LESSON PLAN

Date: 03/20/18 **Content Focus:** Incivility in the Workplace **Duration:** 1 hour 15 min

Venue: Simulation Laboratory **Modality:** Simulation

Previous Relevant Knowledge: Practicing nurses, new graduate nurses to seasoned nurses

Objectives: At the end of simulation the participants will be able to:	**Duration**	**Content & Development**	**Method & Materials Needed**	**Student Activity**	**Rationale**
1. Recognize behaviors of incivility (Cognitive-Comprehension)	**15 min**	**PRE-BRIEF:** **Introduction to incivility** -WHO -TJC -ANA statement -Cost of WI -Definitions -Why it happens -10 most common forms of incivility - How to address incivility **Introduce scenarios**	**Power Point Presentation**	Listen to presentation on incivility and introduction of scenarios	Prebriefing provides students with the information needed to prepare for simulation. Participants should be introduced to the content in the scenario beforehand to apply during the simulation. Information can be given specifically for the simulation or can be content received in didactic coursework (Sanner-Stiehr, 2017).

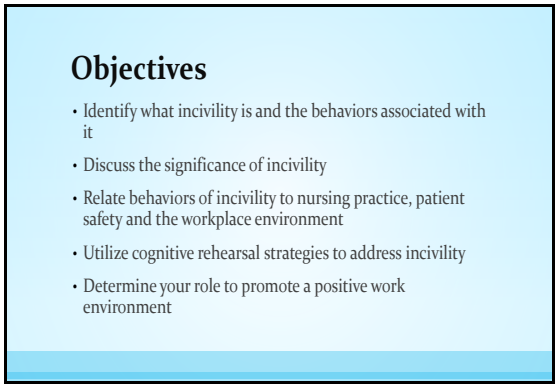
2. Willingly participates in simulation vignettes (Psychomotor-Guided Response)	**20 min**	Two scripted scenarios were developed to simulate 2 forms of incivility most commonly seen in nursing practice.	**Simulation: Scenario 1** Change of shift report at 0700 **Scenario 2** New nurse on orientation	**Scenario 1:** Group of 4 participants select a role from hat. Roles: Night nurse, day nurse, physician & charge nurse. Each participant acts out scripted scenario **Scenario 2:** Group of 4 participants select role from hat. Roles: New nurse, preceptor, staff nurse 1 & staff nurse 2. Each participant acts out scripted scenario	Simulation provides a milieu for integrating lateral violence response training into nursing education within an established yet flexible framework. Response training can help increase effective responses and maintaining composure in stressful situations decreasing the negative effects on lateral violence on targeted individuals, organizations and patients (Sanner-Stiehr, 2017). In stand-alone scenarios, incivility response training involves students engaging in role play to gain experience formulating responses to uncivil behaviors through dialogue. Stand- alone scenarios allow students to focus on strategizing their responses without contextual distractions (Sanner-Stiehr, 2017).
3. Verbalize professional health care providers role in creating a culture of safety (Affective-Responding)	**40 min**	Examples of cognitive rehearsal discussed for each role.	Instructor led debrief of content	Participants reflect on personal feelings of scenarios. Participants identify uncivil behaviors.	Debriefing is a facilitated reflection in the cycle of experiential learning to help identify and close gaps in knowledge and skills. Debriefing includes following essential elements: Active participation with more than just the passive receipt of feedback; developmental intent focused on

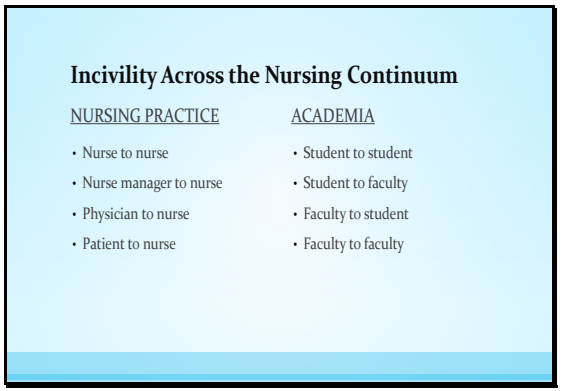
				Participants identify how incivility can compromise patient care. Participants use cognitive rehearsal statements to address uncivil behaviors.	learning and improvement; discussion of specific events and input from multiple sources. Effective debriefings can provide a forum for feedback that is essential for performance improvement and deliberate practice that promotes expertise (Eppich & Cheng, 2015).

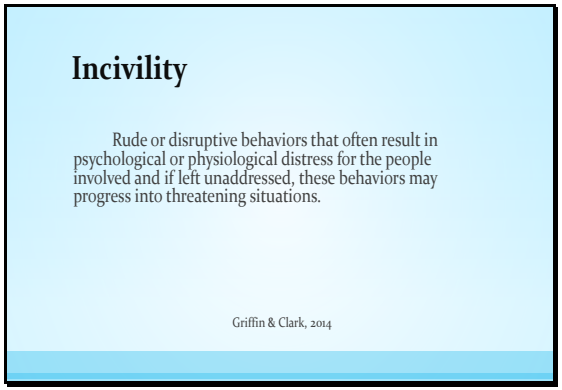
Table adapted from Dix & Hughes (2005)

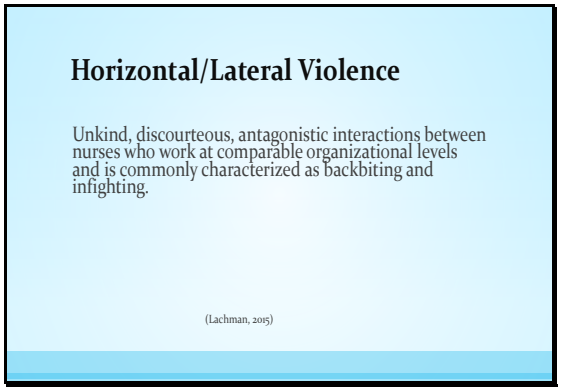
Appendix C

CIVILITY IN THE WORKPLACE









Bullying

The persistent, demeaning and downgrading of an individual through vicious words and cruel acts that gradually undermine confidence and self-esteem. In essence bullying is considered to be an ongoing, systematic pattern of behavior designed to intimidate, degrade and humiliate another

(Griffing & Clark, 2014)

Bullying

Repetitive behavior that happens a minimum of twice a week. Long term behavior that continues for a minimum of 6 months and the targeted person finds self-defense difficult and cannot stop the abuse.

(Lachman, 2015)

Behaviors Associated With Bullying

- Threatening and abusive language
- Constant and unreasonable criticism
- Deliberately undermining another person
- Hostile verbal attacks
- Rumor spreading

(Griffin & Clark, 2014)

Significance

- Some studies have estimated that nearly 85% of nurses had either seen incivility or personally experienced it
- Nurses may have difficulty accurately describing these behaviors because some are subtle, nonverbal and socially embedding and often these acts go unrecognized and underreported

Jones et al. (2016)

The World Health Organization

Recently identified workplace incivility as a serious threat to public health and it is reaching epidemic levels worldwide

Laschinger, 2014

The Joint Commission

- In 2008 TJC identified disruptive behaviors as a root cause for more than 3,500 sentinel events over a 10 year period
- As a result, a sentinel event alert was released to mandate all organizations to adopt a zero tolerance policy of uncivil behaviors

Blevins (2015)

ANA Statement

- In 2015 ANA released a position statement on incivility, bullying and workplace violence
- The purpose was to express the shared responsibilities of employers (organizations & management) and employees (nurses) to create an organizational culture built on respect without incivility
- Healthcare leaders are expected to maintain a safe work environment for all, and nurse managers are expected to role model civility and professional conduct

MacLean, Coombs & Breda (2016)

Correlation Between Workplace Incivility

- Patient falls
- Medication delays and errors
- Poor patient care
- Poor patient satisfaction
- Due to: poor communication
- Burnout
- Reduced therapeutic functioning
- Diminished team work
- Diminished cognitive functioning and critical thinking
- Lead to potential lawsuits

Mikaelian & Stanley (2016)

Appendix D

Scenario I: Change of shift report at 0700

Anna is a post op day 1 patient who has rated her pain 6/10 at 0600. The night nurse has given her the scheduled Norco and has implemented a few complimentary interventions such as warm compresses to the incisional area as well as aromatherapy. At 0700 the night nurse returns to Anna's room to see if her pain has improved. Despite these interventions Anna is still experiencing severe pain 6/10. The night nurse explains to Anna that the doctor will be called and get something different to manage her pain better.

Night Nurse: Gives report to oncoming shift who is a new RN to the unit. The night nurse explains that Anna rated her pain 6/10 and was given her scheduled Norco along with complimentary interventions of warm pack to her incisional site and aromatherapy. "I was just in her room to see if her pain was better and she is still rating it 6/10. Would you mind calling the physician to get something stronger? I have to get out of here on time today so I can get my kids off to school."

Day Nurse: The new nurse on the unit is eager to please and wants to be accepted as a member of the team. She wants to come away from the day with many lessons learned and to form a new body of knowledge. "Sure, I can call the physician."

Day Nurse on the phone with the physician: "Hi Dr. Stitch, I'm taking care of Anna in room 413. She is a post-op day 1 patient who is rating her incisional pain 6/10. She has received her scheduled Norco as well as warm compresses to her incisional area and aromatherapy but continues to rate her pain 6/10. Is there something else I can try to control her pain better?"

Physician: The physician is sounding annoyed and talks in a condescending tone. With a big sigh he replies in a stern voice, "You know, I have been called 4 times during the night and I have a

busy day today. I don't have time for this. Just give her some Percocet." The physician hangs up the phone abruptly.

Day Nurse hangs up the phone and is noticeably upset. She seems flustered and shakes her head in disbelief.

The charge nurse notices the new nurse is upset and asks, "What's wrong?"

The new nurse explains, "I called Dr. Stitch because my patient in room 413 needed something different to manage her pain better and he was a jerk."

Charge nurse says to the new nurse, "Oh yeah, he's always like that. No one likes calling him."

Scenario II: New Nurse on Orientation

A new nurse is on orientation and is in the nurse's station with her preceptor along with two other staff nurses.

The new nurse tells her preceptor that "an order has just been placed for a Foley catheter for our patient in room 413". She is a bit nervous and tells her preceptor, "I've never done one on a real patient before, just on the manikin".

The preceptor takes the new nurse aside and has a quiet side conversation. "Tell me what you have done in nursing school and what you remember about the procedure". They talk about what supplies they will need and then talk through the procedure before placing the Foley catheter in their patient.

Staff Nurse I: says to Staff Nurse II- "What does she mean, she's never put a Foley in before? How do you get out of nursing school without cathing someone?" She shakes her head and rolls her eyes in disbelief. They continue to whisper to each other about the new nurse and occasionally looks back/over at her as they whisper.

Staff Nurse II: Giggles and says to Staff Nurse I – "I know, can you believe it? I'm glad I'm not her patient." They continue to whisper to each other about the new nurse and occasionally looks back/over at her as they whisper.