

Personal Resilience, Workplace Civility, and Staff Retention in Behavioral/Mental Health

Crisis Stabilization Units

Paula Stover

Georgia College and State University

October 30, 2017

**Committee:**

Krystal Canady, DNP, APRN, FNP-C

Carol Dean Baker, PhD, RN, PMHCNS-BC

Trisha Velasco, LCSW

Dedication

To the CSU staff who provide a safe haven for society's most vulnerable.

May you have high resilience and enjoy being civil with each other.

You are a treasure in a society who often ignores and underfunds your work.

Never forget that we need you ... and you are not alone.

### Acknowledgements

Thanks go to this project's committee members: Dr. Krystal Canady, Chair and DNP project coach and role model, Dr. Dean Baker, awesome writing coach and guide, and Ms. Trisha Velasco, smart and eloquent site administrator and supporter. Each of you offered just the right guidance at just the right time and allowed me the freedom to discover my own path. I am grateful for each of you.

Camille Pace, your brilliant, quick mind was amazing and fun to work with during data analysis and synthesis. Thank you for making the process so easy to understand. You are a great teacher and mentor.

A special thank you goes to all the CSU staff who welcomed me and helped to make this project a success. Your ownership of this project was outstanding and is a demonstration of your desire to be the best you can be – both internally and externally. Thank you for all that you do!

Much gratitude is sent to my classmate and study buddy, Debbie Amason. You picked me up when I was down and you celebrated my successes as only a fellow nurse and friend can do. Thank you for walking this road with me and staying with me every step of the way!

Enormous gratitude goes to my husband, Sonny Stover, who supported and championed every step toward completion of this goal. Thank you – my heart, my partner, and my friend.

## Table of Contents

	Page
Dedication .....	2
Acknowledgements .....	3
Tables .....	6
Figures .....	7
Abstract .....	8
Chapter One: Background and Significance	9
Introduction .....	9
Problem Statement .....	10
Background and Significance .....	11
Purpose of the Study .....	15
Research Question and Hypothesis .....	16
Concepts and Definitions .....	17
Significance to Advanced Nursing Practice .....	18
Feasibility and Limits .....	19
Benefit to Clinical Setting .....	20
Chapter Two: Theoretical Framework and Review of Literature	21
Theoretical Frameworks .....	21
Appraisal of Evidence .....	24
Literature Review .....	24
Personal Resilience, Workplace Civility, and Staff Retention .....	25
Summary .....	45

Chapter Three: Methodology	47
Design .....	47
Population, Setting, Sample, and Recruitment .....	48
Human Protection, Benefits and Risks .....	50
Instrumentation .....	52
Data Collection Process, Data Entry, and Data Security .....	55
Study Limits and Expected Outcomes .....	57
Data Analysis .....	58
Summary .....	60
Chapter Four: Results	61
Demographics .....	61
Hypothesis Testing .....	62
Findings .....	65
Summary .....	66
Chapter Five: Discussion, Conclusions, and Project Evaluation	67
Discussion .....	67
Strengths, Limitations, and Lessons Learned .....	74
Recommendations .....	75
Conclusion .....	76
Chapter Six: Project Evaluation .....	77
References .....	84
Appendices.....	98

## List of Tables

	Page
Table 1. Associations Tested .....	123
Table 2. Category Changes for Selected Variables .....	124
Table 3. Sample Characteristics and Staff Population .....	125
Table 4. Age by Generations .....	126
Table 5. Frequency and Distribution of Independent and Dependent Variables .....	127
Table 6. Spearman's Rho Correlations between Variables (2-tailed) .....	128
Table 7. Differences between Variables .....	129
Table 8. Staff Comments after Survey Administration .....	130

## List of Figures

	Page
Figure 1. Age by Generations .....	131
Figure 2. Education Level .....	132
Figure 3. Years of Experience in the CSU .....	133
Figure 4. Years of Experience in BMH .....	134
Figure 5. Personal Resilience Scores .....	135
Figure 6. Workplace Civility Scores .....	136
Figure 7. Intention to Continue Working at the CSU .....	137

### Abstract

Retention of behavioral/mental health (BMH) staff is a critical need in public safety net systems, but a challenge to sustain. Chronic attrition in BMH settings is costly and can have adverse effects on client care. Researchers recommend investigation of personal resilience and workplace civility as potential retention factors. However, no studies explored relationships between these factors in BMH crisis stabilization units (CSU). A southeastern United States public safety net agency needed baseline data to inform workforce retention initiatives. A correlation design was used to measure relationships between personal resilience, workplace civility, and the intention to continue working at three CSUs for nurses and direct care staff. The Conner-Davidson Resilience Scale 25 (CD-RISC) measured personal resilience and the Civility Norms Questionnaire-Brief (CNQ-B) measured workplace civility. Descriptive data were gathered, and subjects were asked how long they intended to continue working in the CSU. Results indicated a significant but weak difference in CD-RISC scores with direct care staff scoring lower than nurses, and significant associations between age and CNQ-B scores with Millennials scoring lower than other generations. No relationships were noted between retention and other variables. Results are limited by the small purposive sample and further study is needed to fully understand these factors. Retention of resilient and civil health care workers in BMH public safety net settings is a crucial public health concern. Future research is needed to inform retention efforts so that high-quality BMH care can be assured for a vulnerable and severely underserved population.

*Key words:* behavioral, civility, direct care staff, mental health, nurses, resilience, retention



Personal Resilience, Workplace Civility, and Staff Retention in Behavioral/Mental Health Crisis  
Stabilization Units

**Chapter One:**

**Background and Significance**

Clients who depend on behavioral/mental health (BMH) services are some of society's most vulnerable and underserved (The Mental Health & Substance Use Disorder Parity Task Force [Parity], 2016). However, a national crisis exists in the BMH workforce pipeline for all disciplines and levels of care (Annapolis Coalition on the Behavioral Health Workforce [Annapolis], 2007; Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). The most acute level, the crisis stabilization units (CSU), are dedicated to rapid stabilization of acute episodes, improvement of recovery outcomes, and a return to the safest and highest level of independent living possible. Nurses and direct care staff are crucial partners in assisting clients with successful transitions to the community after a crisis. Client outcomes depend on an adequately staffed and well-trained workforce (Annapolis, 2007; Parity, 2016; SAMHSA, 2013).

Retention of experienced BMH staff can be difficult and costly for public safety net service agencies (Annapolis, 2007; Parity, 2016; SAMHSA, 2013). The work is challenging and turnover is a common problem (Annapolis, 2007; The Lewin Group, 2008; SAMHSA, 2013). Client aggression and disruptive behaviors can overwhelm staff coping skills in acute care units (Itzhaki, et al., 2015; Lim, 2011). Burdensome costs associated with training new staff could be used to provide much needed services (Annapolis, 2007; SAMHSA, 2013). Chronic attrition negatively affects client care because it takes time for staff to learn the nuances of evidence-based psychiatric interventions (Annapolis, 2007; SAMHSA, 2013; The Lewin Group, 2008).

Researchers have suggested that two factors mitigate the stress of working in other high intensity health care settings: personal resilience (Gillespie, Chaboyer, Willis, & Grimbeek, 2007; Grafton, Gillespie, & Henderson, 2010; Hart, Brannan, & DeChesnay, 2014; Rushton, Batcheller, Schroeder, & Donohue, 2015) and workplace civility (Brunetto et al., 2013; Hart et al., 2014; Vessey, DeMarco, & DiFazio, 2011). However, no research was found that studied combined associations between these factors and staff retention. Additionally, very little is known about retention for direct care staff, especially in BMH settings (Dailey, Morris, & Hoge, 2015; The Lewin Group, 2008). Traditionally, direct care staff have been neglected in workforce retention studies, but they are important partners in a high-quality health care system (Alliance for Health Reform [AHR], 2012; The Lewin Group, 2008).

There was a need to fill a knowledge gap regarding the relationship between personal resilience, workplace civility, and the intention to remain in practice for registered nurses (RN), licensed practical nurses (LPN), and direct care staff at three southeastern U. S. CSUs. One validated and reliable instrument measured personal resilience and another measured workplace civility. Intention to remain in practice data was obtained through one self-report question. Demographic data was gathered based on associations supported in the literature. Findings were disseminated to the CSU leadership and other CSUs across the state. The aim of this correlation cross-sectional study was to inform BMH workforce retention efforts for a specific population and health care setting: RNs, LPNs, and direct care staff in three CSUs that provide acute BMH care in a public safety net system.

### **Problem Statement**

BMH care in CSUs requires a well-honed skill set that takes time to learn; however, retention of experienced staff is a well-known challenge (Annapolis, 2007; SAMHSA, 2013; The

Lewin Group, 2008). A public safety net service agency with three CSUs was experiencing staff retention difficulties. Agency attrition and retention data was not collected on a regular basis, or compared to national trends, however the leadership had noticed a decrease in retention over a twelve-month period. This lack of systematic data collection is not uncommon in BMH organizations because most funds are directed toward client care (Annapolis, 2007). What was known is that of five new nurse graduates hired last year, only one remained. Many of the direct care staff were new while some had been employed over three years. The CSU director and three nurse managers were eager to implement evidence-based retention strategies, but were uncertain where to begin.

Minimal research has been done on retention of BMH care staff (Itzhaki et al., 2015; Harrison, Hauck, & Hoffman, 2014; Madathil, Heck, & Schuldberg, 2014). However personal resilience (Cleary, Jackson, & Hungerford, 2014; Jackson, Firtko, & Edenborough, 2007; Lee et al., 2015; Rushton, et al., 2015) is thought to influence retention in high intensity specialties, and the lack of workplace civility has a strong correlation with attrition rates and/or intention to leave (Armmer & Ball, 2015; D'Ambra & Andrews, 2014; Vessey et al., 2011). Based on observations and conversations with staff and leadership, personal resilience and workplace civility were thought to be low in all three CSUs and the retention of experienced staff had been a challenge in two facilities. This project used a correlation design to investigate the relationships between personal resilience, workplace civility, and the intention to remain in practice at these CSUs to inform future retention interventions.

### **Background and Significance**

Approximately 9.8 million (4.0%) persons in the United States (U. S.) have serious mental illness, but many have limited or no access to care (Substance Abuse and Mental Health

Services Administration [SAMHSA], 2017). The burden of mental illness on community, family, and individual resources can be devastating (Reeves, 2011). Additionally, over 20 million persons struggle with addictive diseases, and deaths related to alcohol (n = 88,000) and illegal drug use (n = 47,055) have been increasing annually (Murthy, 2016). Persons with these conditions often find themselves without health insurance and end up needing care from the public safety net system (Reeves, 2011). A national effort to decentralize hospital-based BMH care began with good intentions decades ago, but many communities still struggle to provide adequate services for citizens who are challenged to live safely and independently (Hudson, 2016). Recently added health care regulations require states to provide BMH services on par with traditional medical care and these changes created a critical need to retain skilled BMH staff (Center for Consumer Information & Insurance Oversight [CCIIO], 2017; Parity, 2016). Recruitment, training and retention initiatives across the country are seeing some success (Annapolis, n.d.), but in other regions the BMH workforce pipeline is severely underdeveloped and undernourished (Annapolis, 2007; The Lewin Group, 2008).

Georgia is among the latter group and continues under a U. S. Department of Justice court ordered agreement to improve and increase community based services within the next two years (Jones, 2016). The independent investigator's report highlighted an urgent need to correct serious vacancies in the registered nurse and direct care BMH workforce, however exact numbers were not given (Jones, 2016). Additionally, the annual report from the BMH planning board does not specify how this will be accomplished (Georgia Department of Behavioral Health and Developmental Disabilities-Region One [DBHDD-Reg1], 2015). Much work has been done, but a critical need exists to retain current staff so that planned service improvements are sustainable (Georgia Department of Behavioral Health and Developmental Disabilities

[DBHDD], 2016). The Georgia Nursing Leadership Coalition (2016) reports that only 3.5% (2,043) of Georgia RNs reported their primary employment was in psychiatric, mental health, or substance abuse specialties, but no data is available on retention rates, length of service or BMH practice settings. Additionally, Georgia is expected to experience a serious shortfall in the supply of RNs and LPNs related to projected demand over the next eight years (U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis [HRSA], 2014).

Turnover rates for direct care staff are considered a key barrier to providing quality care (Annapolis, 2007; Dailey et al., 2015), however no data is available for BMH direct care staff in Georgia. National attrition and retention data for this group is also scant, but The Lewin Group (2008) estimates that BMH direct care staff attrition is 50% each year. This lack of retention data is not unusual in BMH care organizations that are reluctant to invest funds into infrastructure when persons with BMH have so many unmet needs (Annapolis, 2007, p. 21). Training new staff creates burdensome costs, however, and these funds could be used to provide services (Annapolis, 2007).

**Regional background.** Citizens in Georgia receive BMH public safety net services through Region One of the Department of Behavioral Health and Developmental Disabilities (DBHDD). This government agency funds non-profit community service boards (CSB). The CSB in this study is the state's largest public safety net provider and provides comprehensive BMH services for twelve counties across 4,400-square miles. This agency has a Tier 1 safety net designation with the DBHDD and is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), a sought-after designation. Over 16,000 individuals, families, and veterans receive care each year (DBHDD-Reg1, 2015). Many clients have no

health insurance, employment, or reliable shelter, and some have limited education and transportation.

Since the closing of the regional hospital in 2011, experienced BMH care teams are urgently needed to provide services in outpatient centers, residential treatment programs, adolescent clubhouses, schools, client homes, and three crisis stabilization units. Counties covered by this agency include Bartow, Cherokee, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, and Whitfield. Health care access is limited, and disparity is severe in some counties. Per the US Health and Human Services Administration health shortage maps, eight of these counties are rated as medically underserved, ten have health professional shortages, and eleven lack adequate mental health services (Health Resources & Services Administration [HRSA], n.d.). Interestingly, the DBHDD employment opportunity website lists positions only for state hospitals and not for CSBs (Georgia Department of Behavioral Health and Developmental Disabilities [DBHDD], n.d.) so persons interested in community BMH work must search regionally. However, the Region One annual report does not mention workforce development for its proposed expansion of comprehensive services (DBHDD-Reg1, 2015) and leaves recruiting to the CSBs. Furthermore, the report describes CSUs as an expensive default service when prevention and early treatment fails, therefore more attention is being given to preventive services (DBHDD-Reg1, 2015).

Although a public safety net system is in place, an inadequate nurse and direct care staff workforce would jeopardize the health and safety of a vulnerable population (Annapolis, 2007; The Lewin Group, 2008). The burden of mental illness can be substantial and is frequently a cause of disability that strains community resources (Murthy, 2016; Office of Disease Prevention and Health Promotion [ODPHP], 2016; Reeves, 2011). Costs associated with

chronic attrition can be substantial (Duffield, Roche, Homer, Buchan, & Dimitrelis, 2014) and these funds are needed to provide BMH services. Therefore, retention of nurses and direct care staff who thrive in BMH settings a crucial public health concern. The optimal time for an assessment of BHM CSU workforce retention factors is now.

**CSU significance.** According to the CSU director, three nurse managers, and the human resources coordinator, retention of experienced BMH nurses and direct care staff is a challenge for these public safety net CSUs. Optimal care for persons needing acute BMH care requires staff with experience and the ability to skillfully manage disruptive behaviors and serious mental illness episodes (Itzhaki, et al., 2015; Lim, 2011; Van Bogaert, Wouters, Willems, Mondelaers, & Clark, 2012). It takes time to learn the nuances of evidence-based psychiatric interventions (Annapolis, 2007; SAMHSA, 2013; The Lewin Group, 2008). Therefore, it is vital that staff retention factors are assessed so that targeted interventions can be implemented. Researchers suggest that skills training in personal resilience (Mealer et al., 2014; Sinclair & Britt, 2013) and workplace civility (Ceravolo, Schwartz, Foltz-Ramos, & Castner, 2012) could reduce attrition rates. However, an assessment was needed to determine whether personal resilience and workplace civility were associated with intention to continue working in these CSUs.

### **Purpose of the Study**

The primary purpose of this correlation study was to investigate associations between personal resilience, workplace civility, and the intention to continue working in the CSUs for RNs, LPNs, and direct care staff. Several researchers have called for studies that investigate the relationships between retention and personal resilience or workplace civility, but this has not been done in BMH CSUs. Therefore, this study was designed to test whether these associations

hold true for essential BMH care staff and fill a knowledge gap to inform much needed retention initiatives.

### **Research Question and Hypotheses**

The study question asked: “For behavioral/mental health nurses and direct care staff what is the relationship between personal resilience, workplace civility, and the intention to continue working in the crisis stabilization units?” Based on calls for research to fill the knowledge gap, a non-directional hypothesis was chosen to explore all associations. The study was guided by Neuman’s Systems Model (2011) which states that internal (resilience) and external (civility) environments affect each other and either direction is possible. Therefore, the null hypothesis stated there is no relationship between personal resilience, workplace civility, and the intention to continue working in CSUs for nurses and direct care staff. The study hypothesis suggested that there is a relationship between personal resilience, workplace civility, and the intention to continue working in CSUs for nurses and direct care staff. All relationships were explored between descriptive variables and personal resilience, workplace civility, and the intention to continue working in CSUs. Specific questions were:

1. What are the relationships between descriptive variables and intention to continue working in the CSU (dependent variable)?
2. What are the relationships between descriptive variables and personal resilience scores (independent variable)?
3. What are the relationships between descriptive variables and workplace civility scores (independent variable)?
4. What are the relationships between personal resilience scores and intention to continue working at the CSU?



5. What are the relationships between workplace civility scores and intention to continue working at the CSU?
6. What are the relationships between personal resilience scores and workplace civility scores?

The null hypothesis was accepted since no relationships were found between the independent and dependent variables, however, relationships between the descriptive variables were found.

### **Concepts and Definitions**

Concepts and definitions for study variables are briefly described here and further explained in the literature review.

**Subjects.** The term “nurse” in this study indicates all RNs and LPNs who work in three CSUs, excluding the three RN nurse managers. The term direct care staff refers to unlicensed persons who care directly for individuals receiving treatment in the CSUs (The Lewin Group, 2008). These employees are trained on the job through facility-sponsored BMH orientation sessions with required annual updates. Direct care staff work with all nurses, but are supervised on the day or night shift by a clinical coordinator. Clinical coordinators are RNs who work closely with direct care staff to ensure high quality BMH care. These nurses were included in the study.

**Independent variables.** Personal resilience was defined in this study as successful adaptation after experiences with adversity or the ability to “bounce back” from extreme stress (Grafton et al., 2010; Hart et al., 2014; Kumpfer, 1999; Richardson, 2002). Workplace civility was defined as an authentic respect for others and sincere intention to find common ground (Clark and Carnosso, 2008). Further descriptions of variables are provided in Chapter Two.

**Dependent variable.** In this study retention was operationalized as the self-reported length of time that subjects intend to continue working in the CSU. The relationship between personal resilience, workplace civility, and the intention to remain in practice was the study focus with a non-directional design so that all associations could be observed.

### **Significance to Advanced Nursing Practice**

The American Nurses Association has called nurses to action regarding four principles for health system transformation: access, cost, quality, and workforce (American Nurses Association [ANA], 2016). Doctor of nursing practice (DNP) program graduates are transforming health care by translating research into practice settings where problems can block achievement of desired population health outcomes (American Association of Colleges of Nursing [AACN], 2006). This DNP project addressed all four ANA principles by investigating relationships between personal resilience, workplace civility, and the intention to continue working in CSUs for nurses and direct care staff. When workforce attrition is high, health care access and quality suffer, and expenses increase due to training costs. According to the Annapolis Coalition on Behavioral Health Workforce (2007), funds and human resources are not often used to study staff retention issues due to the many unmet needs of the vulnerable and underserved BMH population. But this lack of investment in the BMH workforce leads to healthcare access disparities (Annapolis, 2007). A growing body of evidence suggests that personal resilience (Cleary et al., 2014; Gillespie et al., 2007; Lee et al., 2015) and the ways in which nurses work together (Armmer & Ball, 2015; Brunetto et al., 2013; Budin, Brewer, Chao, & Kovner, 2013; Ceravolo et al., 2012; D'Ambra & Andrews, 2014; Evans, 2017; Harrison et al., 2014) are important factors in retaining nurses who thrive in modern day health care settings. However, little is known about factors that influence retention of direct care staff (Dailey et al.,

2015). Determining whether these CSU staff were experiencing a lack of resilience and civility was an important first step in planning effective retention strategies. Filling this knowledge gap benefits a larger audience since other CSUs must also retain experienced BMH staff who can skillfully provide optimal care to persons with acute mental illness conditions (Ceravolo et al., 2012; D'Ambra et al., 2014; Evans et al., 2017; Vessey et al., 2011).

### **Feasibility and Limits**

The CSU leadership of a southeastern U. S. public safety net agency was eager to retain experienced nurses and direct care staff. The CSU director agreed to the study and served on the project committee. The three CSU nurse managers supported the study and expressed eagerness to use findings to bolster nurse and direct care staff retention strategies. A preliminary assessment with nurse managers and the director indicated a disconnected interaction pattern and limited team work between nurses and direct care staff (Appendix A). Workplace civility appeared to need attention in at least two CSUs as evidenced by comments from the nurses and direct care staff (Appendix A). The human resources coordinator confirmed that team dynamics between nurses and direct care staff were a common complaint during exit interviews, but no data was formally collected regarding reasons for leaving the CSUs. There was no evidence to support or refute personal resilience concerns. Annual attrition data was not available; however anecdotal information from CSU leadership aligned with national calls to strengthen the BMH workforce. The researcher, having trained, worked, and taught nursing students within this system, noticed that staff were demonstrating symptoms of low-to-high personal resilience and that each unit was exhibiting different levels of incivility-civility. This preliminary assessment supported the need for a formal evaluation of these factors in this population.

Due to the lack of available evidence, a correlation design was chosen with a convenience purposive sample to study retention factors in this small, specialized population. Generalizability is limited; however, baseline data was established. This project was focused and manageable and provides a noteworthy contribution to less explored aspects of workforce retention for BMH CSU staff. Chapter Three describes the methodology, Chapter Four reports data analysis procedures, and Chapter Five discusses results and evaluation of the project.

### **Benefit to Clinical Setting**

This project was designed to benefit the service agency and the clients they serve by filling a knowledge gap regarding CSU nurse and direct care staff retention. BMH care is a significant part of medical care, but until recently, uninsured citizens throughout the United states had limited access to such care (Murthy, 2016; National Conference of State Legislators [NCSL], 2017). DBHDD is working on a plan to improve and increase BMH services through six regional planning boards (DBHDD, 2016). In a resource-limited public safety net system, substantial training costs could be saved through effective retention efforts (Duffield et al., 2014). This project informs those efforts by bringing attention to workforce retention needs.

Programs to foster personal resilience (Mealer et al., 2014; Robertson, Cooper, Sarkar, & Curran, 2015) and workplace civility (Ceravolo, et al., 2012; Chipps & McRury, 2012; Oore et al., 2010) are being studied and implemented with some promising results for nurses. Other groups are being recognized for direct care staff training and retention efforts (Dailey et al., 2015). CSU nurses and direct care staff would benefit from these programs and CSU leaders plan to implement evidence-based retention interventions.

This study sought to discover relationships between personal reliance, workplace civility, and staff retention. Associations were found between age groups and civility scores with

Millennials scoring lower than other generations, and differences were found in resilience scores with direct care staff scoring lower than nurses. No significant associations were found regarding retention; however, this project raised awareness regarding the need to promote and sustain personal resilience and workplace civility in challenging BMH care settings. CSU nurses and direct care staff are crucial partners in meeting the needs of persons with acute BMH conditions and more research is greatly needed to support their work.

## **Chapter Two:**

### **Theoretical Framework and Review of Literature**

Caring for individuals with acute BMH conditions can be challenging and should optimally be provided by experienced staff, but long-term retention of skilled nurses and direct care staff can be problematic (Annapolis, 2007; The Lewin Group, 2008). Personal resilience is thought to influence nurse retention (Lee et al., 2015; Mealer, et al., 2012), and workplace civility (Ceravolo et al., 2012) has been shown to increase nurse retention. However, less is known about direct care staff (Dailey et al., 2015) and no studies were found that explored the relationships between both factors and retention of CSU staff. This chapter describes current knowledge regarding resilience, civility, and retention for nurses and direct care staff and the theoretical frameworks used to guide the project.

#### **Theoretical Frameworks**

Betty Neuman's Systems Model was chosen to guide this study because it has the capacity to embrace concept ambiguities and blends her knowledge of BMH settings with the unique interplay of human interactions (Neuman, 2011). Kurt Lewin's change model was used to inform recommendations based on this study to give nurse leaders a structure for promotion of personal resilience and workplace civility.

Clinical observations by this researcher and nurse leaders in three BMH CSUs noticed that retention of nurses and direct care staff was problematic. Possible causes were discussed, and personal resilience and workplace civility were noted to be lacking in some individuals. This DNP student reviewed the literature and found no evidence regarding the combined relationships between personal resilience, workplace civility, and staff retention. Additionally, personal resilience and workplace civility have been challenging to define. Neuman's model provided a broad and well-organized structure to analyze relationships between factors that influence individual responses and environmental effects (Neuman & Fawcett, 2011). The concepts of internal (personal resilience) and external (workplace civility) stressors guided observation of influences on intention to remain in practice. The model also addresses the constant adaptation that individuals make during challenging situations. For example, as the work environment (field) changes, the person changes (resilience and civility); as stress increases, the demand for adaptation increases (resilience and civility). When stressors are too extreme, and adaptation has not been successful, staff could choose to leave the work setting or linger with less than optimal functioning. However, the concept of reconstitution explains the process whereby individuals regain stability after reacting to stressors (Gehrling, 2011). The definition of reconstitution includes phrases such as "regenerative or reconstructive process," and "a higher level of return to wellness" (Gehrling, 2011, p. 91) which resemble resilience definitions provided later in the literature review.

Additionally, group interactions can be explained through this model (Jajic, Andrews, & Jones, 2011). The co-created environment impacts each person's ability to recover from stress reactions (Neuman & Fawcett, 2011). Thus, the dynamic and challenging relationship between individuals, work teams, and the BMH care environment can be monitored using the model's

whole person, open system, and multi-dimensional approach (Turner & Kaylor, 2015).

Interestingly, Turner and Kaylor (2015) provide a strong argument for studying resilience-building strategies in nurses and recommend the Neuman Systems Model as a good framework for this research. In summary, the model emphasizes that during optimal functioning, a person's internal and external factors work together to balance the ongoing interplay of healthy equilibrium within an ever-changing environment (Neuman & Fawcett, 2011).

Kurt Lewin's change model was used to guide recommendations to nurse leaders because it clarifies complex interactions in work settings (Burnes & Cooke, 2013). The model also explains how work environments can be transformed from counterproductive to productive (Kaminski, 2011) and provides a foundation for understanding the driving and restraining forces that influence individual behaviors within a work environment (Burnes & Cooke, 2013). The model uses action research to observe, influence, and measure behavioral change within work settings. The concepts of freeze, unfreeze, and refreeze are easy to explain and understand and especially appropriate for this project. The unfreezing of habitual work patterns allows staff to gain insights, develop new outlooks, and reestablish more resilient self-care and civil interaction patterns. Lewin's field concept aligns with Neuman's model since it captures the inherent interconnectedness of all persons and the environment in which they work.

In summary, BMH staff must maintain extreme self-mastery while witnessing human crises within a resource-limited health care system and this mastery takes time to develop (Annapolis, 2007; Cleary et al., 2014; Itzhaki et al., 2015; Lim, 2011). Neuman's model provides a strong and fluid framework to explain personal resilience, workplace civility, and intention to continue working in CSU environments. The model can also shift from a focus on problems toward a wellness-promotion paradigm which gives full partnership to the nurse and

direct care staff in claiming resilience, civility, and the intention to remain in practice. Lewin's change model underscores the interconnectedness of individuals with the environment and the influence each has on the other. Based on these models, the researcher asked: if nurses and direct care staff became more aware of inner and outer influences would they nurture personal resilience levels, maintain higher levels of civility with coworkers, and thus choose to continue working in the CSU? Both models effectively guided this inquiry and provided a structure for recommendations to nurse leaders.

### **Appraisal of Evidence**

A comprehensive literature search was performed using Galileo Scholar and Cochrane databases with filters for English, peer reviewed, academic journals, from 2011 to 2016. Initially, key words focused on negative terms which affect staff attrition and/or intention to leave such as bullying, incivility, and attrition in nursing. Various "AND" / "OR" combinations resulted in narrowing the search from over 6,000 articles to 763. As screening continued, a pattern emerged toward positive outcomes: personal resilience, workplace civility, and retention in nursing. Based on reference lists from seven literature reviews, the search was expanded to include evidence from 2000 to 2017. A critical review of those articles yielded 113 relevant sources. Standard research critique methods (Melnik & Fineout-Overholt, 2015) and the PRISMA reporting model (Moher, Liberati, Tetzlaff, & Altman, 2009) provided frameworks for the synthesis of evidence.

### **Literature Review**

This review presents current evidence and identifies knowledge gaps supporting the need for a study which explores associations between personal resilience, workplace civility and intent to continue working in BMH CSUs for nurses and direct care staff. To ensure clarity of intent



for this project, variables were defined using current evidence with a caution that personal resilience and workplace civility (independent variables) exist on fluid continuums that can appear ambiguous. However, reliable and valid instruments objectively operationalized the independent variables, and the researcher-developed questions provided clear answers to the retention question (dependent variable) and demographics. The goal of this project was to examine associations between personal resilience, workplace civility, and intention to continue working in the CSU for RNs, LPNs, and direct care staff.

**Personal resilience.** Simply defined, personal resilience is the ability to bounce back, adapt, and become more resourceful or stronger after an adverse event, major challenge, or tragedy (Earvolino-Ramirez, 2007; Hart et al., 2014). Based on the work of Kumpfer (1999), Luthar, Cicchetti, and Becker (2000), and Richardson, (2002), and an integrative review by Jackson et al. (2007), resilience can be defined as a process, trait, quality, cycle, attribute, hardiness, mental or emotional toughness, and emotional stability. Articles were included in this review if resilience was operationalized using these definitions.

The review by Jackson et al. (2007) evaluated 50 articles from 1996 to 2006 to determine what was known about personal resilience within the nursing profession and to report on effective resilience-building strategies. The authors reported that nurses encounter frequent workplace challenges such as incivility, safety issues, and organizational changes. These stressors impact the willingness to continue working in the healthcare system, however some nurses thrive and succeed in difficult situations. Effective resilience-building strategies were identified: mentoring, life balance, positive emotions, spirituality, and personal growth and reflection. The main challenges for Jackson's review were the lack of consistent definitions and varied research designs, however the emerged themes supported other research that defines

personal resilience as a positive and protective response to adversity. Despite these difficulties, the researchers concluded that development of personal resilience reduces a nurse's vulnerability in challenging health care settings. They called for personal resilience training in nursing education and mentoring programs to lower vulnerability to adversity and increase well-being.

A later review by Grafton et al. (2010) reported that personal resilience may ameliorate workplace stress and can be developed through holistic self-care practices. Sixty-four articles were reviewed from seminal works in a wide range of fields published between 1970-2009. Over the four decades, three chronological themes clarified concepts, and a personal resilience development model was presented. The researchers concluded that workplace stress is inevitable and that nurses must maintain personal resilience to remain fully engaged in practice and prevent burnout. They called for resilience skills education, burnout prevention training, and a study to test the impact of these interventions on retention.

Rudman, Gustavsson, & Hultell (2014) confirmed the impact of burnout on retention rates and called for frequent assessments and early prevention interventions. The researchers performed a prospective study of 1,417 new graduate Swedish nurses to determine if burnout predicted intent to leave the profession within five years. A latent growth modeling methodology was used to capture individual changes over time. Two burnout symptoms were found to be significant predictors of intent to leave: emotional exhaustion ( $b = 0.116 - 0.178, p < .001$ ) and disengagement ( $b = 0.235 - 0.304, p < .001$ ). Disengagement was more strongly associated with intent to leave over time ( $b = 0.067 - 0.121, p < .001$ ). No associations were found with age, gender, or education. Alarmingly these nurses reported strong intentions to leave the profession after one year (27%), three years (45%), and five years (43%) of employment with a cumulative intention of 30% leaving within five years.

Five other studies provide evidence to support the assessment of personal resilience in nurses who work in high-intensity settings. In an early study by Gillespie et al. (2007) 1,430 Australian operating room (OR) nurses were randomly selected and surveyed to examine associations between personal resilience and ten characteristics associated with mitigation of workplace stress. Their goal was to develop a personal resilience model to guide retention strategies for OR nurses. Using a parsimonious regression analysis of independent variables on the Conner-Davidson Resilience Scale (CD-RISC), five variables explained 60% of the variance: hope, self-efficacy, coping, problem solving competence, and sense of control. The most significant association with resilience was hope ( $r = .67, p < .001$ ) followed by self-efficacy ( $r = .63, p < .001$ ) and coping ( $r = .53, p < .001$ ). Two other factors explained resilience at a moderate level: problem solving competence ( $r = .38, p < .001$ ) and a sense of control ( $r = .47, p < .001$ ). The researchers were surprised to find that age ( $M = 46.1, SD = 9.2, \text{range} = 21 - 73$ ), education, cohesion among nurses, peer support, and years of experience ( $M = 24.2, SD = 10.2, \text{range} = 1 - 44$ ) were not associated with higher levels of resilience in this population. The authors called for additional research on the latter five factors due to inconsistencies with prior research. They recommended that the positively correlated variables should inform interventions to enhance resilient adaptation to workplace stress which could retain more OR nurses. The CD-RISC mean score for general populations is 80.4 ( $SD = 12.8$ ) (Conner & Davidson, 2003). However, mean score for this study was 75.9 ( $SD = 11.0$ ) with a Cronbach alpha of .90.

Mealer et al. (2012) surveyed 744 U. S. critical care nurses to determine resilience prevalence and whether this factor is associated with fewer psychological symptoms. The study found that 22% ( $n = 157/725, 95\% \text{ CI } [19, 25]$ ) were highly resilient with scores  $\geq 92$  on the CD-RISC, however, 80% ( $n = 744$ ) had burnout symptoms. Resilience was associated with

increased age ( $M = 43.6$ ,  $SD = 11.0$ ,  $p = .03$ ) and decreased years of experience ( $M = 18$ ,  $SD$  not available,  $p = .05$ ). Four outcome variables (post-traumatic stress disorder, burnout, anxiety, and depression symptoms) were tested using multivariate logistic regression models that adjusted for gender, age, and other factors. High resilience scores were independently associated with the absence of posttraumatic stress disorder symptoms ( $p < .001$ ,  $OR = .27$ , 95% CI [0.13, 0.52]), burnout syndrome ( $p < .001$ ,  $OR = .22$ , 95% CI [0.13, 0.33]), anxiety ( $p = 0.006$ ,  $OR = .26$ , 95% CI [0.11, 0.53]), and depression ( $p = .001$ ,  $OR = .10$ , 95% CI [0.02, 0.31]). Nurses with high resilience scores were also less likely to report problems with work ( $p < .001$ ), household chores ( $p < .001$ ), and maintaining relationships ( $p < .001$ ). The authors concluded that despite high rates of burnout syndrome, some critical care nurses have a personal resilience that allows them to remain in stressful work environments, and to adapt, thrive, and provide better patient outcomes. They also reported on ten psychosocial factors that increase resilience in nurses including a supportive social network and a “resilient role-model or mentor” (Mealer et al., 2012). The CD-RISC Cronbach alpha for this study was .92.

Rushton et al. (2015) used six validated and reliable instruments to test associations between personal resilience, burnout, moral distress, perceived stress, meaning, and hope in 114 U. S. high-intensity unit nurses (oncology, adult critical care, and pediatric/neonatal units). The study demonstrated that greater resilience protected nurses from two characteristics of burnout: emotional exhaustion ( $r = -.31$ ,  $p < .01$ ) and depersonalization ( $r = -.23$ ,  $p < .05$ ) and mitigated perceived stress ( $r = -.44$ ,  $p < .01$ ). Additionally, resilience was associated with hope ( $r = .51$ ,  $p < .01$ ), personal meaning ( $r = .26$ ,  $p < .01$ ), and personal accomplishment ( $r = .59$ ,  $p < .01$ ). Conversely, resilience, as measured by the CD-RISC, was found to be independent from years of experience based on analysis of variance ( $p = .13$ ). Associations between resilience and age,

education, gender and ethnicity were not reported, although these demographics were collected. Participants were recruited from four hospitals within one healthcare system and represented 63% of nurses ( $N = 180$ ) from the six units. The mean resilience score across all units was 74.3 ( $SD = 11.0$ ) which falls at the bottom of the “moderately low” quartile on the CD-RISC (Conner & Davidson, 2003). The units were matched for patient acuity, turnover, and staffing ratios and participant demographics were remarkably similar across the unit groups. Based on past research that indicates associations between nurse burnout and intention to leave practice, these authors called for studies that test correlations between personal resilience and intention to quit, and for interventions to raise resilience in nurses who work in high-intensity specialties.

Hsieh, Hung, Wang, Ma, and Chang (2016) surveyed a convenience sample of 187 Taiwanese emergency department nurses ( $N = 265$ ) who had experienced verbal or physical violence in the last 12 months and who had not had a personal significant life event. Resilience was operationalized by scores on the 29-item Resilience Scale (Friborg, Hjemdal, Rosenvinge, & Martinussen, 2003). One study objective was to examine the effect of peer support on personal resilience after experiencing client violence. Using a hierarchical linear regression analysis, peer support significantly enhanced personal resilience ( $b = 1.738, p < .001, 95\% \text{ CI } [0.78, 2.70]$ ). Age, education, and years of experience were not significantly associated with resilience. This study supports the need for peer support (a form of workplace civility) that fosters personal resilience in clinical settings where violence against staff is common. This study confirms what other research has indicated - that age, education, and years of experience are not associated with personal resilience in nurses.

Lee et al. (2015) surveyed 1,066 staff from 20 U. S. pediatric intensive care units (PICU) to describe the availability, use, and efficacy of resilience-promoting resources. Nurses ( $n =$

893), physicians ( $n = 136$ ), and advance practice professionals ( $n = 37$ ) comprised the 51% response rate. The Resilience Scale-14 (Wagnild, 2009) was used to determine that resilience levels were moderate to moderately high in this population (median 84, IQR [79 – 88]). Individual resilience scores were not associated with profession; however, perceptions of teamwork climate were 7% higher for staff with moderately high or high resilience scores ( $p < .001$ ) and 10% lower for persons with low or very low resilience scores ( $p < .001$ ). Additionally, staff with fewer than seven years' experience in the PICU averaged two points lower on the resilience scale ( $p < .001$ ). The researchers' main conclusion was that one-on-one peer discussions and informal social interactions were the most often used and impactful resources for raising resilience levels across all disciplines. These findings suggest that personal resilience and workplace civility are linked, however, as the researchers caution, these factors are multifaceted making it impossible to assign causation.

Only one study included direct care staff and the results are important. Sull, Harland, & Moore (2015) surveyed 845 healthcare workers in the United Kingdom using the Wagnild 25-item resilience scale (Wagnild, 2009). Ancillary staff scored the lowest when compared to all other clinical staff ( $t = -4.120, p < .006$ ) and management personnel ( $t = -2.956, p < .004$ ). All clinical staff scored lower than administrators and managers in every t-test. Interestingly, working between 18.75 and 37.5 hours per week ( $t(213) = 4.25, p < .05$ ) was associated with higher resilience scores than persons working fewer hours ( $t(606) = 0.26, p < .05$ ). Researchers also found significant associations between resilience and gender with females scoring higher ( $X^2(5) = 18.50, p < .05$ ). No associations were found between resilience and absenteeism.

Three studies examined personal resilience in BMH staff. Itzhaki et al. (2015) found that nurses developed personal resilience through exposure to violence in BMH units and the

phenomenon is an important factor in managing challenging situations. The authors used linear regression to test associations between five factors: life satisfaction, job stress, exposure to violence, posttraumatic growth, and personal resilience. The model was significant ( $F(5,109) = 7.46, p < .0001$ ) with four of the factors accounting for 25.5% of the variance (excluded exposure to violence). The relationship between resilience and life satisfaction was significant ( $r = .19, p < .05$ ), but the other four factors were not significantly associated with resilience. Interestingly, post-traumatic growth was significantly associated with life satisfaction ( $r = .37, p < .0001$ ). Exposure to verbal violence was reported by 88.1% of nurses and 58.4% reported physical violence exposure within 12 months. Only three nurses (2.5%) reported no exposure. Although age, gender, education, and ethnicity data were gathered, no associations with personal resilience were reported. This study used the 10-item CD-RISC to survey 118 BMH nurses ( $N = 230$ ) in one 520 bed hospital in Israel. Mean score was 2.88 ( $SD = 0.64$ ) with a range of 1.5 - 4.00 and many staff (42.7%) reported having resilience often or most of the time. Findings may not be generalizable to nurses in the U. S. However, the authors called for additional studies of resilience in BMH nurses and drew attention to the need for resilience-building programs in these high-stress work settings.

Matos, Neushotz, Griffin, and Fitzpatrick (2010) used a correlational design to examine associations between personal resilience and job satisfaction for 32 U. S. acute care BMH nurses (response rate = 76%). The 25-item Resilience Scale (Wagnild, 2009) provided evidence that a majority of these BMH nurses are resilience with a mean score of 145 ( $SD$  not available) and a range of 44 - 172. However, the association between personal resilience and overall job satisfaction was weak ( $r(30) = .33, p < .10$ ). Interestingly, a positive relationship between

resilience and professional status, a component of the job satisfaction instrument, was significant ( $r = .45, p < .05$ ). The resilience scores increased with higher professional status.

Lim (2011) reported on a systematic review regarding the aftermath of patient aggression toward BMH nurses. This study highlights the need for personal resilience-building strategies for staff who provide direct care to persons with severe mental illness. Best practices were identified for managing the aftermath of the effects of violence and the most effective methods were formal and informal peer support. Most nurses relied on peer support to regain perspective and build inner resources similar to those associated with personal resilience. Nurses who used peer support were less likely to suffer long-term psychological consequences (Lim, 2011, p. 11). This review found that formal training was not as effective as peer support.

Cleary, Horsfall, O'Hara-Aarons, Jackson, and Hunt (2012) reported on Australian BMH nurse perceptions in acute cares settings. The insights were drawn from a national Delphi study on scope of practice. Due to the global decentralization of BMH care from hospital based to community settings, BMH nurses found themselves in new environments without the support of a large network of peers. The perceived loss of professional identity was challenging for individual nurses, the specialty, and the profession. The authors called for immediate action to sustain BMH nursing. Implementation of resilience-building interventions were recommended at the personal, group, and professional levels. Specific initiatives included fostering collegial relationships, mutual respect, and effective communication.

**Personal Resilience Training.** Researchers have also investigated ways in which personal resilience can be taught, observed in behaviors, and nurtured through support from peers and collegial relationships. McDonald, Jackson, Wilkes, and Vickers (2013) used a qualitative design to study resilience training efficacy in 14 nurses and midwives employed by a



large tertiary care hospital in Australia over a six-month period. They found that six personal resilience workshops combined with a supportive mentoring program strengthens this inner characteristic, however, a validated resilience instrument was not used. Rather, interviews focused on participant's perceptions of pre-determined resilience factors. Researchers interviewed participants before, during and after the interventions and used thematic analysis to determine efficacy. Outcomes included enhanced confidence, self-awareness, assertiveness, and self-care that empowered nurses to withstand workplace adversity. Improvements in peer communication, conflict resolution, and collegial relationships were obtained through the personal resilience training. This study supports other research (Cleary et al., 2012; Gillespie et al., 2007; Hsieh et al., 2016; Lee et al., 2015; Lim, 2011; Mealer et al., 2012) that indicates a link between personal resilience and workplace civility factors.

Robertson et al. (2015) reviewed literature from 2004 - 2014 to synthesize evidence regarding efficacy of workplace resilience training for working adults. Fourteen relevant studies with methodological rigor were found (random controlled trials, controlled trials and trials without control groups). The variability in definitions, intervention characteristics, and participant characteristics prevented reporting of firm conclusions; however, the researchers determined that workplace resilience training improves personal resilience, subjective well-being, psychosocial functioning, and performance. To further excellence in resilience research, the authors recommended that consistent definitions and standardized instruments be used.

Sinclair and Britt (2013a) summarized decades of military research regarding the importance of assessing, building, and sustaining personal resilience to overcome adversity during extreme stress. Other military researchers provided valuable insights on organizational factors that foster resilience, models and programs to build resilience, and future implications for

research and practice (Sinclair & Britt, 2013b). The main message from this collection of evidence is that personal resilience can be taught and sustained through effective training programs and peer support (Sinclair & Britt, 2013a, 2013b).

Koen, Van Eeden, Wissing, and Koen (2011) considered the need for personal resilience so important that practice guidelines were developed to foster and sustain it. The authors used theoretical knowledge based on Kumpfer's work (1999) and empirical data from research on healthy work environments and positive organizational practices. Eight guidelines and ten strategies were presented for use in health care facilities to enhance nurse resilience. No studies were found that tested the efficacy of the guidelines, however each strategy had previously been tested and found to be effective.

In summary, personal resilience is important for staff who care for others during extreme hardship and vulnerability (Jackson et al., 2007; Itzhaki et al., 2015; Koen et al., 2011). This phenomenon could be a significant factor in prevention of burnout (Grafton et al., 2010; Mealer et al., 2012; Rushton et al., 2015), but is understudied in BMH settings (Itzhaki et al., 2015). Several researchers called for studies to examine associations between personal resilience and intention to continue working, however no studies were found. Personal resilience and forms of workplace civility (peer support, teamwork, and/or mentoring) are associated (Hsieh et al., 2016; Jackson et al., 2007; Lee et al., 2015; Lim, 2011; McDonald et al., 2013; Mealer et al., 2012; Robertson et al., 2015; and Sinclair and Britt, 2013a, 2013b). This evidence led to a review of workplace civility in health care settings.

**Workplace Civility and Incivility.** Ample research demonstrates that uncivil staff interactions can negatively impact personal resilience and intention to remain in the workplace. However, the concept of civility in healthcare work settings is not studied as often as its opposite

- incivility - and this imbalanced distribution of evidence prevented adequate information to inform this project. Therefore, evidence in this section is provided along a continuum of workplace civility-incivility to provide an acceptable foundation for this study. Articles for this review used workplace incivility terms such as bullying, harassment, horizontal/lateral violence, incivility, uncivil episodes, and verbal abuse. Workplace civility terms included collaboration, collegial relationships, mentoring, peer relationships, peer support, and teamwork.

***Workplace civility.*** Civility is more than politeness, reasonableness, or respectful behaviors, and includes the challenging work of agreeing to disagree so that everyone's voice is heard (Spath & Dahnke, 2016). Clark and Carnosso (2008) define civility as an authentic respect for others during disagreements that requires intention to seek common ground. In BMH settings, client moods and behaviors can be volatile (Itzhaki et al., 2015; Lim, 2011) and BMH team members are required to remain civil so that a therapeutic and safe environment can be maintained (Annapolis, 2007; Hoge, Morris, Laraia, Pomerantz, & Farley, 2014). The art and science of calming a disruptive person is a crucial skill set that takes time to develop, but healthy team dynamics can foster those skills (Hoge et al., 2014; Cleary & Happell, 2005; Dailey et al., 2015; Harrison et al., 2014). Furthermore, previously cited research demonstrated that a characteristic of workplace civility (positive mentoring) can help staff thrive, but incivility can decrease staff intention to continue working in the health care system (Jackson et al., 2007).

***Workplace incivility.*** Vessey et al., (2011) performed a four-decade systematic review to investigate bullying, harassment, and horizontal violence (BHHV) within the nursing profession. This seminal work uncovered several important findings. First, BHHV prevalence rates ranged from 17-76% and increased in high-intensity healthcare settings. Second, multiple negative outcomes resulted from these interactions:

- decreased psychological and physical health, self-esteem, professional mastery
- diminished communication leading to errors and poor patient outcomes
- increased disengagement, absenteeism, and intent to leave

Third, nurses have known for quite some time that a lack of workplace civility is related to these negative outcomes. However, there was limited data on effective interventions to prevent BHHV. These researchers called for prevention strategies at the primary, secondary, and tertiary levels. Targeted initiatives were recommended: awareness raising education, policies, periodic staff assessments, site specific interventions, training, and personnel actions. As will be shown, the nursing profession continues to research the impact of incivility on intention to leave the workplace or profession, and is progressing with research on prevention strategies.

Four recent studies sought to determine whether a lack of civility was associated with staff intention to leave. Armmer and Ball (2015) surveyed a random sample of 104 nurses from one mid-western hospital to examine the association between horizontal violence (HV) and intent to leave within the year. The study found that nurses of all ages and experience had experienced HV (100%) and there was a significant positive relationship between HV and intent to leave ( $r = .214, p = .029$ ). Additionally, younger nurses were more willing to leave than older nurses due to HV ( $r = -.198, p = .05$ ), and nurses with more experience were more likely to have experienced HV ( $r = .227, p = .02$ ).

Brunetto et al. (2013) surveyed 718 nurses from two urban hospitals in Australia to examine relationships between intent to leave, team work, well-being, and supervisor relationships. Variables were measured using regression analyses which determined that intention to leave was negatively correlated ( $p = .001$ ) with teamwork ( $r = -.33$ ), wellbeing ( $r = -.53$ ), commitment to the organization ( $r = -.64$ ), and supervisor relationships ( $r = -0.42$ ). Nearly

half (44%) of nurse's intention to leave was explained by these variables, although the study is limited by reliance on self-report questionnaires. Baby Boomer nurses ( $n = 273$ ) had a lower intent to leave than Generation X ( $n = 193$ ) and Generation Y nurses ( $n = 60$ ) as indicated by means (standard deviations) respectively 1.2 (1.3), 2.8 (1.4), and 2.7 (1.3). The study instruments were adapted from standardized tools to adjust for cultural differences, however an exploratory factor analysis was performed to ensure reliability.

Budin et al. (2013) pulled data from the fourth wave of a U. S. national survey of early career registered nurses ( $n = 1,407$ ) to examine relationships between verbal abuse (VA), demographics, work attitudes, and work attributes. Results indicate significantly ( $p < .001$ ) that nurses who reported "no abuse" were the least likely to have an intention to leave within three years ( $n = 394$ ) and those with moderate VA were also less likely to plan on leaving ( $n = 289$ ). Interestingly, nurses who worked in Magnet designated hospitals reported fewer episodes of VA ( $p = .007$ ): "no abuse" ( $n = 383$ ) and "moderate verbal abuse" ( $n = 288$ ). Contrary to other studies, the intensive care unit nurses were least likely to experience VA ( $p = .036$ ), however, researchers caution this might be due to the separation of verbal abuse source types in this study.

Evans (2017) examined intent to leave and the prevalence and frequency of uncivil behaviors experienced by 170 health professionals in one southeastern U. S. healthcare organization. Nurses (73.68%) reported uncivil episodes more often than other professionals and all participants reported that co-workers were most likely to instigate the bullying. Uncivil episodes were measured using the Negative Acts Questionnaire (Einarsen, Hoel, and Notelaers, 2009). The intention to stay was operationalized using four statements on a Likert scale. Three positively framed items were positively correlated with a lack of exposure to incivility ( $p = .006$ ,  $.0002$ , and  $.0001$ ) and the negatively stated question had a positive correlation with intent to

leave ( $p < .0001$ ). No association was found between uncivil episodes and age, race, unit type, or education.

Other researchers investigated the prevalence of incivility and associations between burnout, post-traumatic stress disorder symptoms, and job satisfaction which have been linked to staff attrition and/or intention to leave. Elmblad, Kodjebacheva, and Lebeck (2014) used a correlation design to explore the prevalence, severity and consequences of incivility in 385 U. S. certified registered nurse anesthetists (CRNA) who were members of a mid-western CRNA association. The response rate was 22.6% ( $N = 1,700$ ). The Nursing Incivility Scale (Guidroz, Burnfield-Geimer, Clark, Schwetschenau, and Jex, 2010) and Copenhagen Burnout Inventory (Kristensen, Borritz, Villadsen, and Christensen, 2005) were used to operationalize the variables. Workplace incivility and burnout were positively correlated ( $p < .0001$ ) using linear regression. No associations were found between burnout and gender, hours worked, and years of experience. The researchers also asked participants to make open-ended recommendations for increasing workplace civility. The top recommendations included team-building workshops, zero tolerance policies, and serving as a role model for civility.

Laschinger and Nosko (2015) surveyed 1,205 Canadian hospital nurses to examine relationships between exposure to workplace bullying (WPB), post-traumatic stress disorder (PTSD) symptoms, and psychological capital (PsyCap). Researchers used a moderated regression analysis which demonstrated that WPB and PTSD were positively correlated at  $p < .05$  for new and experienced nurses ( $r = .55$  and  $r = .60$  respectively). WPB and PsyCap were negatively associated at  $p < .05$  for both groups ( $r = -.32$ ,  $r = -.29$ ). A subcategory of PsyCap (efficacy) provided significant buffering to the WPB-PTSD relationship in experienced nurses ( $b = -0.06$ ,  $p < .0001$ ). Gender was not associated with the variables, however, age (older nurses)

had a weak association with increased PsyCap scores ( $r = .23, p < .05$ ). Experienced nurses reported higher overall PsyCap ( $t(851) = -5.54, p < .0001, M = 4.55$ ), efficacy ( $t(851) = -7.57, p < .0002, M = 4.38$ ), and resilience ( $t(851) = -6.45, p < .0001, M = 4.72$ ). PTSD symptoms are serious consequences of unmitigated WPB. However, efficacy, a component of PsyCap and personal resilience, was shown to lessen PTSD symptoms in nurses who were exposed to WPB. This study indicates that more experience may raise personal resilience as measured by the PsyCap instrument.

D'Ambra and Andrews (2014) reviewed 16 studies from 2002 - 2012 to evaluate the influence of incivility on 13,577 new nurse graduates' experience and intent to leave practice or remain. Incivility was measured through various questionnaires in 14 studies, three of which included open-ended questions, and two studies were face-to-face interviews. Six studies were longitudinal. The lack of consistency in measurement instruments was a challenge for the researchers, however, the integrative review was narrowed by using these search terms: incivility, oppressed group behavior, horizontal violence, lateral violence, and bullying. To measure intention to leave practice or remain, these terms were used: burnout, transition, and retention. Incivility in the workplace was a significant predictor of low job satisfaction and intent to leave. Interestingly, some nurse residency programs (designed to retain new nurses) were contaminated with a culture of incivility which perpetuates the problem.

Chipps, Stelmaschuk, Albert, Bernhard, and Holloman (2013) surveyed 167 perioperative nurses (44.7%), surgical technologists (53.4%), and unlicensed personnel (1.9%) and found that 59% had witnessed coworker bullying at least weekly. Bullying was measured by the Negative Acts Questionnaire-Revised (Einarsen et al., 2009). Emotional exhaustion was significantly associated with bullying frequency ( $r = .56, p < .001$ ) and intensity ( $r = .54, p < .001$ ), and job

satisfaction was negatively associated with bullying frequency ( $r = -.31, p < .001$ ) and intensity ( $r = -.29, p < .001$ ). The facility was a predictor of increased bullying and Caucasian staff members reported higher levels of bullying than non-white staff (26.4%). The researchers emphasized that although only 6% of participants identified as never having been bullied, 34% met the definition of being a target, and nearly 59% reported witnessing bullying episodes. The authors suggest that these findings may indicate incivility is tolerated as a cultural norm. This study did not find associations between bullying and age or years of experience. The authors highlighted past research that correlated bullying with staff intention to leave and called for workplace awareness raising efforts to retain staff.

Purpora, Blegen, and Stotts (2015) surveyed a random sample of 175 California hospital nurses ( $N = 1,271$ ) to describe associations between peer relationships, job satisfaction, and horizontal violence (HV). Peer relationships and job satisfaction were positively correlated ( $r = .614, p < .01$ ) and peer relationships and HV were inversely correlated ( $r = -.641, p < .01$ ). Importantly, peer relationships mediated the relationship between HV and job satisfaction as evidenced by the reduction of HV from 21.3% ( $b = -0.462, p < .001$ ) to 0.94% ( $b = -0.127, p = .109$ ). Age, years of experience, and hours worked were not associated with job satisfaction.

***Civility training.*** Research on the effect of civility training programs and policies is important and an indication that the science of workplace civility is progressing. Ceravolo et al., (2012) tested a civility training program which may have lowered verbal abuse episodes from 90% to 76% and lowered nurse turnover rates from 8.9% to 6.0% over a three-year period. Nurses ( $n = 4,032$ ) in a U. S. five-hospital system attended the trainings and 703 nurses (34%) took the pretest while 485 nurses (23%) took the posttest in the third year. Several factors were analyzed which indicated the healthcare system had improved the previous culture of incivility,



but 76% of nurses were still experiencing some level of verbal abuse. This study is limited because the posttest respondents were not matched to pretest responses. Also, the authors caution that economic factors may have affected the turnover rates.

Oore et al. (2010) tested the effect of workplace civility training on workplace stressors and personal strain using a two-group quasi experimental design over six months. Participants were staff from 17 units of five hospitals in Canada and nurses (61.7%) were the largest sample group. Researchers tested whether naturally occurring incivility episodes moderated the effect of stressors and strain at baseline in one group ( $n = 478$ ; 9 units) and compared the effect of civility training in the second group ( $n = 361$ ; 8 units). Incivility was measured using the Civility, Respect, and Engagement at Work (CREW) survey tools and the intervention followed the standardized CREW training program (U.S. Department of Veterans Affairs, n.d.). Stressors (workload and job control) and strain (mental and physical health symptoms) were measured using three standardized instruments and two abbreviated questionnaires. Incivility and increased stressors and strain were positively correlated ( $p < .0001$ ) in the pre-intervention group. The intervention group reported less work overload and mental health strain ( $p < .05$ ) at six months. The pre- and post-test participants in the intervention group may or may not have been the same persons, however, effects were tested on group norm rather than individuals. This study demonstrated that workplace civility has a buffering effect on mental strain and work overload stress.

***Civility-incivility policies.*** Coursey, Rodriguez, Dieckmann, and Austin (2013) systematically reviewed the literature to determine whether organizational policies against lateral violence were effective. Twelve studies from 1990 - 2012 were reviewed ( $n = 6,069$  nurses, 59 nursing students). Most evidence was from low-level studies; however, researchers determined

that passive dissemination of policies against lateral violence was ineffective. Instead, collaborative implementation strategies that changed behaviors and involved staff and management lead to successful policy implementation. Additionally, the quality of relationships between administrators and staff was found to be crucial in sustaining positive behavior change.

Civility studies in BMH settings were not found, however workplace civility is a vital component of quality care in BMH settings (Annapolis, 2007). Interestingly, a systematic review on violence in health care by Spector, Zhou, and Che (2014) did not include studies on bullying in BMH settings, but did for other specialties. This omission may have been due to a lack of research or exclusion due to poor quality, but it underscores the paucity of evidence regarding BMH workplace civility. The authors appraised 160 articles from 38 countries ( $n = 151,347$  nurses) to establish global prevalence rates of workplace violence. Over 148,000 nurses reported exposure to non-physical violence (66.9%), bullying (39.7%), physical violence (36.4%), injuries related to violence (32.7%) and sexual harassment (25%). Psychiatric facilities were among the most prevalent settings for physical violence ( $n = 8,072$  nurses, 24 articles,  $M = 55.0$ ,  $SD = 26.6$ , range 0.5 - 100), and non-physical abuse was also high ( $n = 2,608$  nurses, 14 articles,  $M = 72.8$ ,  $SD = 24.6$ , range 17.0 - 100). Researchers emphasized the need for personal resilience and peer support to continue working in this high-stress environment.

It is important to end the discussion on workplace civility and incivility by referencing the mandates from the American Nurses Association and The Joint Commission. Both organizations created documents to raise awareness that incivility in healthcare settings has negative consequences. The ANA's "Position Statement on Incivility, Bullying, and Workplace Violence" (2015) clearly states that any form of uncivil behavior is unacceptable and could place nurses and clients at risk for harm. The Joint Commission issued a sentinel alert entitled

“Behaviors that undermine a culture of safety” (The Joint Commission, 2008) and called for immediate and sustained corrective action to improve safety and retain experienced staff. It is imperative that nurse leaders regularly assess workplace civility levels to inform effective workforce retention planning, implementation, and evaluation.

In summary, ample research has been done on incivility in its many forms and the impact on staff intention to leave is clear (Armmer and Ball, 2015; Budin et al., 2013; D’Ambra and Andrews, 2014; Evans, 2017; Vessey et al., 2011). However, very little evidence is available to guide civility-building intervention strategies (Clark, 2013; Coursey et al., 2013; Vessey et al., 2011). Only two studies were found on civility training strategies, but one reported significant positive influences on nurse retention (Ceravolo et al., 2012) and a buffering effect on mental strain and work overload stress in Canadian hospital workers (Oore et al., 2010). No research was found regarding the relationship between workplace civility and retention of staff in BMH settings which emphasized the need for this study.

**Retention.** For this review, the terms attrition, intention/intent to leave, and retention were used to search for factors influencing staff retention. Although retention of experienced nurses and direct care staff is considered a cornerstone of optimal BMH care and is crucial to meeting the needs of individuals with acute conditions (Annapolis, 2007) very little research was found. The well-known global, national, and state nursing shortage (GNLC, 2016) creates a strong argument for transforming work environments where nurses and their direct care co-workers thrive in supportive teams. However, direct care staff have traditionally been neglected in studies of health care professionals (Dailey et al., 2015). Despite their vitally important partnership in BMH care delivery (Annapolis, 2007), their turnover rates are high (The Lewin Group, 2008). Both nurses and direct care staff are needed to ensure quality BMH care,

therefore, factors that influence their intention to remain on the job must be studied so that effective interventions can be implemented. The Annapolis Coalition on the Behavioral Health Workforce suggests that implementation of BMH core competencies in communication, collaboration, team work, and adaptation could improve retention of experienced staff (Hoge et al., 2014).

Retention of BMH staff is an understudied phenomenon in the U. S. but two articles were found that offer helpful insights. Harrison et al. (2014) studied 192 Australian BMH nurses over five months using a brief interview survey and qualitative content analysis. The research question used a positive approach by asking why nurses initially chose BMH and why they remain in the specialty. Among the eight emerged themes, two were related to this study: encouragement from others (influenced decision to choose BMH nursing) and workplace conditions such as camaraderie, teamwork, and a sense of belonging (influenced the intention to remain). Interestingly, researchers also found that the nature of mental health nursing can be intrinsically satisfying to those who choose to remain, and the developed art of therapeutic relationship enables them to better cope with professional and personal stress. The authors emphasized the need for deliberate action with informed strategies to retain BMH nurses in response to the aging nursing workforce.

Research on direct care staff retention is scant, however Dailey et al. (2015) reported on findings from a national U. S. search to identify best practices in workforce development and retention. A call for nominations was sent to all BMH agencies across the U. S. with the goal of systematically studying innovations. Of the 51 respondents, 38 agencies met eligibility requirements. Thirteen judges each reviewed nine or ten applications which allowed for at least two reviewers per application ( $M = 3.2$ ). Site visits were made, case studies were examined, and

five agencies received winning scores. The project team judged each applicant on eight criteria adapted from two program evaluation models. The team found that six principles should inform retention efforts for direct care staff: educational support and career development, increased wages and benefits, workforce development partnerships, evidence-based training with service fidelity assessments, supervision strengthening, and employment of persons in recovery. The authors emphasized that conscious, active investment in direct care staff development was immensely beneficial to organizations, staff, and the clients they served.

### **Summary**

This literature review presented current evidence and addressed knowledge gaps regarding associations between personal resilience, workplace civility, and intent to continue working in BMH CSUs for nurses and direct care staff. Terms were defined using current evidence with a caution that personal resilience and workplace civility (independent variables) exist on continuums that may appear ambiguous. However, studies were selected which used reliable and valid instruments to operationalize these factors, and to guide development of the intention-to-continue-working question (dependent variable).

Evidence indicates that the development and maintenance of personal resilience are important for staff who care for others during extreme hardship and vulnerability (Jackson et al., 2007; Itzhaki et al., 2015; Koen et al., 2011). This characteristic could be a significant factor in prevention of burnout (Grafton et al., 2010; Mealer et al., 2012; Rushton et al., 2015), but is understudied in BMH settings (Itzhaki et al., 2015). Other studies demonstrated that personal resilience has a protective influence on workplace stress and related symptoms (Grafton et al., 2010; Jackson et al., 2007; Rushton et al., 2015). An important finding in one study is that direct care staff have the lowest resilience levels among all other personnel (Sull et al., 2015), however

investment in this employee group reaps ample benefits for organizations, staff, and the clients they serve (Dailey et al., 2015). Several researchers called for studies to examine associations between personal resilience and intention to continue working, however no studies were found. Associations have been found between personal resilience and forms of workplace civility such as peer support, teamwork, and/or mentoring (Hsieh et al., 2016; Jackson et al., 2007; Lee et al., 2015; Lim, 2011; McDonald et al., 2013; Mealer et al., 2012; Robertson et al., 2015; and Sinclair and Britt, 2013a, 2013b). This evidence led to a review of research on workplace civility in health care settings.

No studies were found to link workplace *civility*, personal resilience, and staff retention in healthcare settings. However, ample research demonstrates that *incivility* in its many forms can negatively impact personal resilience and/or intention to continue working (Armmer et al., 2015; Brunetto et al., 2013; Budin et al., 2013; Ceravolo et al., 2012; D’Ambra et al., 2014; Evans et al., 2017; Vessey et al., 2011). Therefore, evidence was gathered along a continuum of workplace civility-incivility and terms were defined based on current research. *Civility training* can reduce turnover rates (Ceravolo et al., 2012) and may have a buffering effect on mental strain and work overload (Oore et al., 2010), however more research is needed to guide these intervention strategies (Clark, 2013; Coursey et al., 2013; Vessey et al., 2011). Magnet status organizations were found to have lower levels of incivility (Budin et al., 2013) and civility was associated with personal resilience in several studies (Hart et al., 2014, Hsieh et al., 2016; Lee et al., 2015; McDonald, 2013; Mealer et al., 2012; Sinclair & Brit, 2013a, 2013b).

Although retention of experienced nurses and direct care staff is considered a cornerstone of optimal BMH care and is crucial to meeting the needs of individuals with acute conditions (Annapolis, 2007) very little research was found on this population. One study emphasized the

need for encouragement from peers, camaraderie, teamwork, and a sense of belonging (Harrison et al., 2014) while another study called for active investment in direct care staff research and development of these vital partners in BMH care (Dailey et al., 2015).

This literature review demonstrates that a growing body of research on personal resilience, workplace civility, and staff retention is emerging, but a chasm exists regarding how these factors work together in the BMH workforce. It is imperative to understand associations between these factors to inform effective strategies. This study was designed to fill the void.

### **Chapter Three:**

#### **Methodology**

This correlation study systematically investigated associations between personal resilience, workplace civility, and the intention to continue working at three southeastern U. S. BMH CSUs for nurses and direct care staff. The expected outcome was a better understanding of factors associated with retention of the workforce in public safety net CSUs. This chapter describes the project design, population, sample, setting, recruitment, instrumentation, data collection, security, analysis, human protection, and expected outcomes.

#### **Design**

A correlation research design was used to study associations between personal resilience, workplace civility, and retention for nurses and direct care staff who work in three southeastern U. S. BMH CSUs. This level of research was selected due to the need for evidence prior to higher level research on BMH workforce retention efforts (Terry, 2015). A non-profit BMH agency approved the study and a memorandum of understanding was signed. The letter of support can be viewed in Appendix B. After IRB approval, participants were recruited internally as described below. Study costs were under budget and the data collection timeframe was

condensed due to rapid attainment of all possible data (95.3% response rate). The project support documents are provided in the appendices: timeline (Appendix C), materials list (Appendix D), budget (Appendix E), recruitment materials (Appendix F), consent form with survey packet (Appendix G), survey administration signs (Appendix H), and study progress and early completion notices (Appendices I and J).

### **Population, Setting, Sample, and Recruitment**

**Population.** BMH staff who work in public safety net CSUs face daily challenges in caring for a vulnerable population. It is important to study factors that influence retention of nurses and direct care staff because chronic attrition is costly and can negatively impact client care. The population selected for this study ( $N = 85$ ) was all RNs, LPNs, and direct care staff employed by a non-profit public safety net BMH agency in the southeastern U. S.

**Setting.** The hosting agency was a community service board which provides BMH crisis stabilization care in three CSUs within one hour of each other. One CSU has 16 beds while the other two have 28 and 30 beds, and all units offer crisis stabilization care for persons with mental illness and substance use disorders. The units are staffed on two 12-hour shifts each day with a minimum of two RNs and two direct care staff and additional personnel when client acuity is higher than usual. Case workers and psychiatrists see clients during normal business hours and a physician assesses each person every day. High census rates are maintained through charge nurses who screen potential clients from the Behavioral Health Line referral system (BehavioralHealthLink.com, n.d.) and through collaboration with local emergency departments and correctional facilities. “Walk-up” clients are also screened by the charge nurses who make recommendations to the admitting physician. Although individuals are screened for medical



conditions and a lack of violent behavior over a 48-hour period, mental illness and substance use acuity is high.

**Sample.** A convenience purposive sample ( $n = 81$ ) allowed for exploration of characteristics in this small, specialized population ( $N = 85$ ) (Melnik & Fineout-Overholt, 2015). The subjects were male and female adults 18 years and older and employed at one of three CSUs. All RNs, LPNs, and direct care staff employed part- or full-time in any position, on any shift, at each CSU were included except the three RN nurse managers. Only one part-time nurse was excluded due to not working during the study period. Three staff declined to participate after the study purpose, anonymity, benefits and risks were explained. Reasons for declining included being “too tired” and “too busy.” The sample size was small which limits generalizability, however, 95.3% of the population participated in the study ( $N = 85, n = 81$ ). Therefore, the confidence interval is:  $95.3\% \pm 1.01\%$  or  $94.29\% - 96.31\%$  (Calculator.net, n.d.).

**A priori.** Based on a priori power analysis of the original population ( $N = 90$ ) at least 59 subjects were needed to test non-directional relationships between the variables when assuming .80 power and .05 alpha (Calculator.net, n.d.), however, the population dropped to 85 when data collection began. The power analysis determined sample size for a Spearman’s rho test. Effect size could be detected at  $r > .31$  or  $-.31$ . For Mann-Whitney U tests, a sample size of six or less was needed for .80 power and .05 alpha. To determine the power needed for the CD-RISC, the mean of 72.59 ( $SD = 18.1$ ) was based on a resilience study by Youssef et al. (2013), and there were no reported means for the CNQ-B. No studies have investigated the combined relationship between personal resilience, workplace civility, and the intention to continue working in CSUs.

**Recruitment.** Participant recruitment began after IRB approval and occurred concurrently with data collection from June 1 through June 18, 2017. Nurse managers

announced the study through email and staff meetings. The researcher placed recruitment flyers with survey administration schedules on staff bulletin boards, and left individual invitations in staff mail boxes. One introductory meeting was provided at each facility on each shift (Appendix F, Figures F1, F2, F3, F4, and F5). Scheduling calls were made periodically to nurse managers and charge nurses to ensure that unit workflow needs were met, and all possible staff were given the opportunity to participate. For populations under 100, researchers should invite participation from the entire population (Sylvia & Terhaar, 2014).

### **Human Protection, Benefits, and Risks**

**Human Protection.** IRB approval was obtained through the GCSU Institutional Review Board (IRB) to ensure that risk of harm was minimized. Prior to survey administration, the researcher reviewed the purpose, benefits, and risks of participation in the study with each participant and written consent was obtained (Appendix G, Figure G1). Participants were volunteers and minimal stress was expected; however, individuals were informed they could stop at any time should stress or discomfort be experienced. No deception was used in this study, and no minors participated. To ensure confidentiality and anonymity during data collection, participants completed the anonymous paper survey in a quiet room at each facility. After completion, participants placed the survey into an envelope, sealed it, and dropped it into the researcher's lock box. The box remained in the presence of the researcher during specified survey administration times and was removed from the facility after each administration period. The researcher's phone and email were provided with an invitation to contact the researcher at any time.

Electronic data will be retained for three years on a password protected, secured and encrypted network at GCSU and paper surveys will be stored securely in a locked file cabinet in

the researcher's office. After three years, the researcher will destroy all paper surveys and request that electronic data be erased through the electronic shredder approved by GCSU. No audio or videotapes were used. No deception was used in this study, and no minors participated.

**Benefits and risks.** Benefits outweighed potential harm. Possible benefits included empowerment regarding high resilience scores, increased self-awareness, improved professional awareness, and desire to learn more about personal resilience and workplace civility. Staff were invited to participate with the goal of exploring the relationship between personal resilience, workplace civility, and the intention to continue working in CSUs (Appendix F, Figures F1 and F2). Recruitment flyers noted that BMH staff possess certain skills that may seem a mystery to health care teams in other specialties and that understanding the relationship between personal resilience, workplace civility, and the intention to continue working in CSUs may help other teams. Snacks were provided during recruitment and survey administration sessions and participants who completed the survey were offered a five-dollar gift card of their choice immediately after placing the survey in the drop box (Appendix F, Figure F2). Staff were told that a report of findings would be provided at lunch-and-learn meetings with an uplifting evidence-based skill-building session and that other BMH care teams could benefit from findings. These incentives were not expected to alter results.

Potential harm could have occurred regarding concern over a low resilience or civility score or increased self-awareness regarding low scores without follow up. However, participants were encouraged to discuss concerns with the researcher, supervisor, or professional (Appendix G, Figure G2). The researcher's phone and email address were provided on the informed consent. After survey completion, two persons asked what they could do to increase personal resilience scores. The researcher provided verbal guidance on three evidence-based techniques

for building resilience: exercise, get adequate quality sleep, and talk with a supportive person.

Both persons stated they would use as least one of the techniques to raise their personal resilience levels. They were also encouraged to talk with the researcher, nurse manager, or professional if ongoing concerns were an issue. Aggregated results were shared with the CSU director and nurse managers with recommendations for interventions known to foster and support increased levels of personal resilience and workplace civility.

### **Instrumentation**

Personal resilience and workplace civility (independent variables) were measured by two reliable and well-validated instruments: the Conner-Davidson Resilience Scale - 25 (CD-RISC) (Conner & Davidson, 2003) and the Civility Norms Questionnaire-Brief (CNQ-B) (Walsh et al., 2012). Retention (dependent variable) was measured via a Likert-scale self-report of intention to continue working in the CSU. Demographics were collected based on associations found in the literature.

**Personal resilience.** This independent variable was operationalized and measured using the 25-item CD-RISC (Appendix G, Figure G3) which has been validated (Conner & Davidson, 2003) and is reliable with recently reported Cronbach alphas of .92 in critical care nurses (Mealer et al., 2012) and .96 in military personnel after combat (Youssef et al., 2013). Original development tested convergent validity and found adequate correlations with hardiness, perceived stress, disability, stress vulnerability, and social support (Conner & Davidson, 2003). Studies included pilot samples from the general population ( $n = 577$ ,  $M = 80.4$ ,  $SD = 12.8$ ), primary care patients ( $n = 139$ ,  $M = 71.8$ ,  $SD = 18.4$ ), and psychiatric patients ( $n = 89$ ,  $M = 68.0$ ,  $SD = 15.3$ ) (Conner & Davidson, 2003). Two systematic reviews gave the CD-RISC high marks when compared to other resilience instruments (Cosco, Kaushal, Richards, Kuh, & Stafford,

2016; Windle, Bennett, & Noyes, 2007). The CD-RISC website lists ongoing reliability reports with recent means ranging from 61.7 ( $SD = 10.60$ ) to 0.83 ( $SD = 13.4$ ) in studies with adult sample sizes from 35 to 10,997 ("CD-RISC," n.d.). Four studies of nurses in high-intensity settings used the tool successfully (Gillespie et al., 2007; Itzhaki et al., 2015; Mealer et al., 2012; Rushton et al., 2015). Rushton et al. (2015) reported a mean of 74.3 ( $SD = 11.3$ ) in nurses who work in high intensity settings. The instrument asks 25 questions with a five-item Likert scale ranging from zero ("not true at all") to four ("true nearly all the time"). Total scores range from zero to 100. According to the CD-RISC manual, (2017) low scores from 0 - 73 represent low resilience, moderately low scores range from 74 - 82, moderately high scores are 83 - 90, and high scores of 91 - 100 indicate highest resilience levels.

The tool asks participants to reply based on experiences over the last month and rate how well they adapt and cope with adversity, whether they are easily discouraged, what they do under pressure, and if they achieve goals despite obstacles. The researchers recommend that the total score be utilized, and a factor analysis not be performed. Factor analysis was calculated during development, and the tool, when used intact, was found to be sensitive enough to measure changes in personal resilience over time. The CD-RISC is a psychometrically sound instrument and adequately quantifies characteristics of personal resilience.

**Workplace civility.** This independent variable was measured by the CNQ-B which was validated in five large working-adult samples with multiple test phases ( $n = 2,711$ ) and was found to be reliable (Walsh et al., 2012). Satisfactory analyses were completed for exploratory principle components, principle axis factors, and confirmatory factors (Walsh et al., 2012). The potential for self-report bias was controlled by collecting data over two timepoints, four months apart. The self-report instrument is brief, but was validated in comparison with ten other

instruments, and coefficient alphas ranged from .70 to .91 (Walsh et al., 2012). In two of the original studies, coefficient alphas were .82 ( $n = 791$ ) and .87 ( $n = 446$ ) (Walsh et al., 2012). No mean scores were reported in the literature. The instrument is a good predictor of intent to quit work, general job satisfaction, and affective organizational commitment as evidenced by the multiple-phased correlation and regression testing (Walsh et al., 2012). The four-item questionnaire uses a seven-point Likert scale to score workplace civility from low to high with a total range from 4 - 28. Participants are asked whether their work group accepts rude behavior, tolerates angry outbursts, and whether all coworkers are treated with respect. The CNQ-B is a concise and psychometrically sound instrument for assessing civility within workgroups. The researchers recommend that the total score be utilized to determine workplace civility levels and that no further factor analysis be performed. The tool can be viewed in Appendix G Figure G4.

**Retention.** The dependent variable (retention) was measured via a five-item Likert-style question on the demographic questionnaire that asked, “How long do you plan to continue working at the CSU?” (Appendix G, Figure G5). This question was tested verbally in one CSU with nurses and direct care staff and provided concise, measurable answers. Participants circled one of five points in time from “one year” through “five years or more.” For purposes of this study, the question was appropriate and provided quantitative data on staff intention to continue working at the CSU.

**Demographics.** Demographic data was collected on age, gender, ethnicity, work hours, licensure status, education level, years of BMH experience, and length of employment at the agency. Questions were researcher developed and validated by the project committee. Responses were quantifiable with rare missing data and are discussed in Data Analysis.

### **Data Collection Process, Data Entry, and Data Security**

Standard research protocols were followed during data collection and entry to ensure accuracy, fidelity, and security of all data (Moran, Burson, & Conrad, 2014; Sylvia & Terhaar, 2014; Terry, 2015). Data was collected via anonymous paper surveys, safeguarded for confidentiality, and transcribed into password protected SPSS software on the Georgia College and State University (GCSU) secure network.

**Data collection process.** The researcher worked closely with nurse managers and charge nurses to ensure that all possible subjects were invited to participate. Study participation progress notices were posted after each administration session to keep staff informed and to encourage ownership in the study (Appendix I). Staff indicated a strong interest in success of the study as evidenced by the encouragement given to peers to participate. No one was pressured to participate, however the naturally occurring peer-to-peer snowball recruitment probably increased the participation rate. Only three persons declined due to being “too busy” or “too tired” and one part-time nurse was not available during the study period. Eighty-one staff participated of a possible 85 subjects (95.3% response rate).

**Timeline.** Survey administration occurred from June 1 through June 18, 2017 during pre-scheduled sessions for each unit. Timing was adjusted to fit the needs of staff and workflow patterns. The data collection phase ended twelve days early because all possible participants were recruited sooner than expected.

**Survey packets.** This study used anonymous paper survey packets as recommended by the CSU leadership. The format is comfortable for staff and customary in this organization to minimize concerns regarding privacy. Ninety stapled packets were prepared and envelopes were color coded for each CSU. A sequential identification number was placed on the instruction

page and then randomized to provide anonymity. Packets remained stapled throughout data collection and analysis and included a cover letter with instructions, three instruments, and a survey completion instruction page (Appendix G, Figures G2, G3, G4, G5, and G6). The instruction page provided information on the purpose of the study, how to participate, and the expected benefits and risks. The body of the packet included three instruments: the 25-item Conner-Davidson Resilience Scale, the four-item Civility Norms Questionnaire-Brief, and a Likert-style demographics page with one additional question to indicate how long participants intended to continue working at the CSU. The final page provided completion instructions.

***Survey administration.*** Before survey administration, the researcher obtained written consent in person after verbally reviewing the consent form with each participant. The consent to participate included the study purpose, volunteer status, inclusion criteria, duration, risks, benefits, rights and responsibilities, confidentiality, financial consideration, and IRB and researcher contact information (Appendix G, Figure G1). No pressure was made to take the survey and individual questions were answered at that time. When participants indicated a readiness to take the survey, they were asked to sign the consent indicating that s/he understood the purpose, benefits, and risks of participation. The signed consent was filed and participants were provided a copy. After consent was obtained, the survey was administered in quiet break rooms where the researcher was located to ensure privacy.

Participants were allowed adequate time to complete the survey which took approximately 10 - 15 minutes. Participants placed completed survey packets into an envelope, sealed it, and dropped it into the researcher's lock box. The lock box remained in possession of the researcher and was transported to the researcher's off-site office after each survey



administration session. Before leaving the survey administration room, participants were offered a five-dollar gift card of their choice (Appendix F, Figure F2).

**Data entry.** The researcher entered data from each paper survey into SPSS 23.0 while giving careful attention to data management procedures that ensured accuracy and fidelity of all data (Moran et al., 2014; Sylvia & Terhaar, 2014). At least three times, each survey was compared with electronic data for accuracy. Different color envelopes were used for each facility so that comparisons could be made during data analysis. A code was written on each instruction page next to the packet identification number when envelopes were opened. Survey packets remained intact throughout survey administration and data entry, however the completion page was removed to save storage space. A systematic approach to data entry ensured fidelity of all transcribed data. One complete final audit was made to ensure accuracy and only one error was found and corrected. Missing data was coded and reviewed with the statistician to ensure fidelity.

**Data security.** Sealed surveys were stored in a locked file cabinet and envelopes were opened in the researcher's office for electronic data transcription into the GCSU secured network. The opened paper surveys were then stored in a locked file cabinet in the researcher's office and kept secure during data entry and analysis. The researcher followed GCSU policy regarding data security and used a dedicated laptop and password encryption. All paper surveys and SPSS raw-data codebook records are stored securely and will be destroyed after three years. The researcher will request that electronic data be destroyed per GCSU policy after three years.

### **Study Limits and Expected Outcomes**

**Limits.** Limits include the correlation study design, self-reported data, and purposive sample selection, but this methodology allows for exploration of retention factors in a specialized

health care team (Melnyk & Fineout-Overholt, 2015). Sample size was small with 81 participants which limits generalizability, however, the 95.3% participation rate strengthens the findings. The a priori power analysis assuming .80 power and .05 alpha, indicated that a minimum sample size of 59 was needed (Calculator.net, n.d.) and this requirement was achieved. The time sensitive demographic questions could have been converted from Likert scale to continuous variables for more precise results and robust models. To minimize limitations during data analysis, tests included Kruskal-Wallis H and the Mann-Whitney U tests.

**Expected outcomes.** Expected outcomes from this study included an understanding of the relationship between personal resilience, workplace civility, and the intention to continue working in CSUs for RNs, LPNs, and direct care staff in a southeastern U. S. BMH public safety net agency. These factors have been studied separately in other health care specialties, but not together in BMH specialty areas and this data was needed to plan evidence-based retention strategies. Maximizing retention of experienced BMH nurses and direct care staff is a critical public health concern and is considered a cornerstone of high quality BMH care for persons with severe mental illness (Annapolis, 2007; SAMHSA, 2013). Data from this study will assist CSU leadership to develop retention strategies based on the needs of this specialized population. The ultimate goal is to sustain a BMH workforce with the capacity to offer high quality care. Staff retention also saves recruiting and training costs which can be used to provide much needed client services (Annapolis, 2007; SAMHSA, 2013).

### **Data Analysis**

Associations between the two independent variables (personal resilience and workplace civility scores), descriptive data, and one dependent variable (intention to continue working in three CSUs) were analyzed in consultation with a statistician who holds a National Institute of

Health certificate for protecting human research subjects. Data analysis was performed from June 20 through July 15, 2017 using standard statistical procedures (Sylvia & Terhaar, 2014) via SPSS version 23.0 located on the secured GCSU network. Every possible effort was made to ensure data accuracy and fidelity. Exploratory tests were run to observe distribution on all data and tests for normality were run for the one continuous variable (age). Audits were conducted for accuracy, and data cleansing was performed using standard statistical procedures. The highest statistical tests possible were used to determine associations. The sample was small with 81 participants; however, this sample is 95.3% of the study population ( $N = 85$ ). Therefore, the confidence interval is:  $95.3\% \pm 1.01\%$  or  $94.29\% - 96.31\%$  (Calculator.net, n.d.).

**Data cleansing.** Data cleansing was performed on all raw data using standard statistical procedures (Sylvia & Terhaar, 2014). Exploratory tests provided a case processing summary and descriptive table which was saved to an encrypted e-file. The mean, median, variance, standard deviation, minimum/maximum, skewness, and kurtosis results were reviewed for outliers. Data was screened and cleaned, but not preened and the original data set was preserved. One data entry error was corrected using the primary source (paper survey) and missing data notations were made. Incomplete data included one omission and six write-in answers that could not be quantified: intent to continue working ( $n = 4$ ), length of employment at the CSU ( $n = 1$ ), age ( $n = 1$ ), and race ( $n = 1$ ). Three persons omitted one answer each on the CD-RISC instrument, so their scores might have been higher had this omission not occurred. Total scores were entered without the answer in every case. No missing data occurred for the CNQ-B, however, two participants entered numbers in columns rather than checking the space provided. The score for the space was used rather than the number in both cases. No deletions were made for the final data set.

**Procedures.** A statistician was consulted regarding all procedures, and all changes were documented and saved in consecutive codebook e-files. Data analysis was performed with precise fidelity to standard statistical procedures (Sylvia & Terhaar, 2014). After exploratory univariate descriptive tests were performed on all descriptive data, non-parametric bivariate tests observed for relationships between the ordinal dependent variable (length of intention to continue working at the CSU) and nominal and ordinal independent variables (personal resilience, workplace civility, and descriptive data). Table 1 lists associations tested for study variables and demographic data. Based on distribution, and due to the small sample size new categories were established within selected variables to protect anonymity (Table 2). For example, the two LPN participants were enfolded with the RNs into a new “nurse” category for the CSU role variable, and the age variable was recoded into three subcategories. Age categories were based on a nurse civility study by Brunetto et al. (2013) and established using the subdivisions provided at The Center for Generational Kinetics (2016). These procedures prevented the jeopardizing of individual privacy.

### **Summary**

This study asked whether relationships exist between personal resilience, workplace civility, and intention to continue working in three southeastern U.S. CSUs for BMH nurses and direct care staff. A correlation research design was chosen to provide evidence prior to research on staff retention efforts at higher levels. The small purposive convenience sample ( $n = 81$ ) was appropriate for this specialized population ( $N = 85$ ). Internal announcements and a naturally occurring snow-ball recruitment resulted in a 95.3% participation rate. Protection of human subjects was assured, risk of harm was minimized, and benefits and risks were explained prior to obtaining consent. The three data collection settings provided quiet privacy and protected the

rights of participants to agree or decline consent. Two well-validated and reliable instruments were used to measure independent variables; however, the time-sensitive demographic questions should have been developed as continuous variables to produce more precise and robust models. Data collection processes adhered rigorously to standards of survey collection management (Melnik & Fineout-Overholt, 2015; Terry, 2015). Data entry, security, and analysis procedures were meticulously followed in consultation with a statistician. Study limitations include the correlation design, the small specialized sample, reliance on self-reported data, and ordinal level demographic data. Chapter Four describes results from this project which include two statistically significant correlations.

## **Chapter Four:**

### **Results**

This chapter describes results for a correlation study that investigated associations between personal resilience, workplace civility, and intention to continue working in three southeastern U. S. CSUs for nurses and direct care staff. Data are reported in aggregate form to protect individual confidentiality due to the small sample size.

### **Demographics**

Univariate descriptive data are summarized in Table 3 and the results are reflective of this CSU population ( $N = 85$ ). Age was the only continuous variable ( $M = 42.74$ ,  $SD = 14.028$ , median 42, mode 59), however, to protect anonymity, age was recoded into categories based on generations (The Center for Generational Kinetics, 2016). Distribution data for age is provided in Table 4 and Figure 1. Millennials ( $n = 38$ , 46.91%) constituted the largest staff group while Generation X ( $n = 20$ , 24.69%) and Baby Boomer/Silent Generation ( $n = 22$ , 27.16%) staff make

up 51.85%. One survey entry for age could not be coded properly (“over 50”) and was therefore entered as missing data.

The nominal and ordinal demographic data are summarized on Table 1. The three CSUs were well represented (29.62%, 34.57%, 35.80%) with a 95.3% response rate. Gender ( $n = 58$ , 71.60% female) and ethnicity ( $n = 62$ , 76.54% Caucasian) are reflective of BMH staff demographics where more males and minorities are employed than in other nursing specialties (Annapolis, 2007). There were similar numbers of nurse ( $n = 41$ , 50.62%) and direct care staff ( $n = 40$ , 49.38) participation, and education (Figure 2) was split between those with a college degree ( $n = 35$ , 43.21%) and those with associate or bachelor degrees ( $n = 46$ , 56.79). Five direct care staff have college degrees, twenty-eight have some college experience, and seven have high school degrees. Thirteen of the 41 nurses (31.7%) have bachelor’s degrees. A comparison between length of employment at the CSU and length of time in the current role demonstrated that some staff changed roles during their tenure (Figure 3). Fifty-four percent ( $n = 44$ ) of staff have worked in the BMH specialty for over five years while 24.69% ( $n = 20$ ) have been working less than 1.5 years in BMH (Figure 4). Those who have less than five and more than 1.5 years’ experience make up the smallest group ( $n = 17$ , 20.99%). Most staff ( $n = 53$ , 65.43%) work full time while part-time persons make up 13.58% ( $n = 11$ ). Over twenty percent of staff ( $n = 17$ ) work 45 hours or more per week.

### **Hypothesis Testing**

The null hypothesis stated there is no relationship between personal resilience, workplace civility, and the intention to continue working in CSUs for nurses and direct care staff and it was accepted. All relationships were explored between the independent, dependent, and descriptive variables. Specific questions were investigated with appropriate tests.

1. What are the relationships between descriptive variables and intention to continue working in the CSU?
2. What are the relationships between descriptive variables and personal resilience scores?
3. What are the relationships between descriptive variables and workplace civility scores?
4. What are the relationships between personal resilience scores and intention to continue working at the CSU?
5. What are the relationships between workplace civility scores and intention to continue working at the CSU?
6. What are the relationships between personal resilience scores and workplace civility scores?

To answer the question whether associations existed between personal resilience, workplace civility, and retention in this population, six relationships were assessed (Table 1). Non-parametric tests were used due to the ordinal dependent variable (Sylvia & Terhaar, 2014). Spearman's rho was used since the sample size was adequate ( $n = 81$ ), and differences between variables were tested with Mann-Whitney U, and Kruskal-Wallis. An ordinal logistic regression was built to identify associations between all the variables. Calculations were made for collinearity diagnostics, tolerance, and the variance inflation factor which indicated the model was invalid. Based on prior research, the only expected confounding variable was CSU role (direct care staff/nurse) (Sull et al., 2015) and this was controlled with the multiple regression analysis. Ancillary staff in that study scored the lowest on the Wagnild (2009) Resilience Scale when compared by t-tests to all other clinical staff ( $t = -4.120, p < .006$ ) and management

personnel ( $t = -2.956, p < .004$ ). In studies of nurses, education was not found to have an influence on personal resilience or workplace civility, however, mixed results were reported for years of experience. Age was associated with resilience in only one of six studies, and was associated with workplace civility in three studies. No prior evidence was found regarding age, education and years of experience for direct care staff which underscored the need for this study.

**Personal resilience.** CD-RISC scores for this sample ( $M = 79.11, SD = 10.13$ ) were only 1.29 ( $SD = 2.67$ ) less than the average mean for the general population ( $M = 80.4, SD = 12.8$ ) ("CD-RISC," 2017), and is higher than found in a study of acute care nurses ( $M = 74.3, SD = 11.3$ ) (Rushton et al., 2015). See Figure 5. This finding is also well within the current means on the CD-RISC website which range from 61.7 ( $SD = 10.60$ ) to 0.83 ( $SD = 13.4$ ) ("CD-RISC," n.d.). The CD-RISC was not significantly associated with age ( $M = 43.5, SD = 15.4$ ), gender, or ethnicity in the original study nor in this sample. Cronbach alpha for this study sample when comparing the CD-RISC and intention to continue working at the CSU was .034.

**Workplace civility.** The CNQ-B mean scores illustrated in Figure 6 were 19.64 ( $SD = 5.185$ ) however no other research is available for comparison. In the second validation study for this instrument, mean age was 41.2 ( $SD = 13.10$ ) and participants worked an average of 41.8 ( $SD = 8.9$ ) hours per week, however, persons were excluded if they worked less than 20 hours per week (Walsh et al., 2012). That sample had worked in current positions an average of 8.7 years ( $SD = 8.7$ ). Cronbach alpha for this study sample when comparing the CNQ-B and intention to continue working at the CSU was .126.

**Retention.** The intention to continue working at the CSU was the dependent variable. Figure 7 illustrates the distribution over five periods provided on the questionnaire. When the distribution is viewed within three categories, 35.80% ( $n = 29$ ) plan to leave within two years



while 46.91% ( $n = 38$ ) plan to stay five years or more. Only 12.35% ( $n = 10$ ) plan to leave between three and four years. Three (3.7%) persons were unsure of their plan to continue working in the CSU and one (1.23%) wrote in how long they had been working at the CSU instead of answering the question.

### **Findings**

Non-parametric bivariate tests were used to investigate relationships between the variables. A Spearman's rank-order correlation was run to assess the relationships between the descriptive variables and the CD-RISC, CNQ-B, and plan to continue working at the CSU. A significant positive correlation was found between age (continuous variable) and the CNQ-B scores,  $r_s(78) = .328, p = .003$ . Preliminary analysis showed the relationship to be monotonic, as assessed by visual inspection of a scatterplot. The correlation is weak, but is statistically significant.

Mann-Whitney U tests were run to determine if there were differences in CSU role, age, education, gender, CD-RISC scores, CNQ-B scores, and plan to continue working between direct care staff and nurses (Table 7). Age and education were treated as categorical data. Differences in CD-RISC scores for direct care staff (mean rank = 35.14) and nurses (mean rank = 46.72) were statistically significant,  $U = 1054, z = 2.217, p = .027$ . Distributions of the scores were not similar, as assessed by visual inspection. A significant difference was also found in CNQ-B scores between Millennials (mean rank = 34.16) and other age groups (mean rank = 46.24),  $U = 1039, z = 2.326, p = .02$ . Distribution of the CNQ-B between the groups were not similar, as assessed by visual inspection.

Two other associations are worth mentioning, but fall just below the .05 confidence level. A Spearman's Rho tested the relationship between the number of hours worked each week at the

CSU and the amount of time participants planned to work at the CSU,  $r_s(75) = .217, p = .058$ .

Preliminary analysis showed the relationship to be monotonic, as assessed by visual inspection of a scatterplot. This weak, positive correlation could be further studied using a larger sample.

Kruskal-Wallis H tests were run to determine if there were differences between the three CSUs and CD-RISC scores, CNQ-B scores, and plan to continue working. Distributions were not similar for all groups, as assessed by visual inspection of boxplots. The distribution of differences was not statistically significant between groups for: CD-RISC ( $\chi^2(2) = 1.864, p = .394$ ), CNQ-B ( $\chi^2(2) = 5.701, p = .058$ ), and plan to continue working ( $\chi^2(2) = 0.538, p = .764$ ).

However, the relationship between CSU location and the CNB-Q might indicate a relationship in larger populations.

An ordinal logistic regression model was built to identify independent relationships between intention to continue working and all other variables. However, 79.7% of the cells had zero frequencies, rendering the model invalid. Therefore, the null hypothesis was rejected. No relationship was found between personal resilience, workplace civility and intention to continue working at the CSU. No other statistically significant associations or differences were found as summarized in Table 6.

### **Summary**

This chapter described results of a correlation study to investigate relationships between personal resilience, workplace civility, and intention to continue working in three southeastern U. S. CSUs for nurses and direct care staff. The null hypothesis was accepted which stated there are no relationships between the variables. However, this study found that differences exist in personal resilience scores between licensed staff (higher scores) and unlicensed staff (lower scores) and that civility scores vary between generations (Millennials scored lower). Differences

were also noted between civility scores and CSU location and between the number of hours worked and intention to continue working in the CSU. A non-directional hypothesis allowed for exploration of associations between variables in a rarely studied population. Two-tailed statistical tests explored whether significant findings could be observed in this small sample. An ordinal logistic regression model was unable to demonstrate associations between the variables. Chapter Five discusses the study and provides recommendations for further research.

### **Chapter Five:**

#### **Discussion, Recommendations, and Conclusions**

This correlation study investigated relationships between personal resilience, workplace civility, and intention to continue working in three southeastern U. S. BMH CSUs for nurses and direct care staff. The null hypothesis was accepted since no significant relationships were found between the variables. However, three associations were identified below the .05 level for descriptive variables. These correlations support other research: direct care staff have lower personal resilience scores (Sull et al., 2015) and younger staff report that workplace civility is lower than other generations perceive it to be (Armmer and Ball, 2015). This chapter provides a discussion of results and offers recommendations for future research.

#### **Discussion**

The number of BMH CSU nurses and direct care staff in this public safety net system is limited and retention of experienced staff has been a challenge. Symptoms of burnout and a “disconnect” between nurses and direct care staff was reported by nurse managers and observed by the researcher. Further investigation into the problem was needed. Prior research suggested that personal resilience and workplace civility may influence nurse retention, but very little was known about associations between factors that retain direct care staff. No studies were found

that explored the combined relationship of personal resilience, workplace civility, and staff intention to remain in practice. Even fewer studies were found regarding BMH staff.

Determining whether these CSU staff experienced a lack of resilience and civility was an important first step in planning effective retention strategies.

**Findings related to personal resilience.** No association was found between personal resilience and intention to continue working in the CSU in this study, and no recent studies were found that tested this relationship. However, it is logical to assume that personal resilience might impact retention, and researchers have urged investigation of this association (Gillespie et al., 2007; McDonald et al., 2013; Mealer et al., 2012; Rushton et al., 2015). Rudman et al. (2014) found a strong association between burnout and intent to quit, but this finding might not indicate a relationship on the opposite end of the continuum. Although, evidence suggests that personal resilience has a protective influence on burnout (Gillespie et al., 2007; Itzhaki et al., 2015; Mealer et al., 2012; Rushton et al., 2015). Other nurse researchers have shown that personal resilience for nurses can be maintained in high intensity health care settings (Itzhaki, 2015; Mealer, 2012) and clinical guidelines were developed to promote and foster personal resilience in health care staff (Koen et al., 2011). Military research indicates that resilience training can foster personal resilience and help individuals regain resilience after experiences with extreme adversity. Robertson et al. (2015) recommended that resilience-building interventions be utilized to improve wellbeing in working adults, and provided ample evidence that training does improve work performance and psychosocial functioning. Personal resilience has been studied in high-intensity healthcare settings where moderately low scores are common (Gillespie et al., 2007; Mealer et al., 2012; Rushton et al., 2015), but little is known about BMH care staff resilience (Cleary et al., 2014; Itzhaki, 2015). Fifty-two (64.19%) CSU staff scored low or moderately low

and 29 (35.8%) scored moderately high and high on the CD-RISC which should prompt an effort to raise these scores.

***Personal resilience, role status, gender, and setting.*** In this study, the differences between personal resilience (CD-RISC scores) and the CSU role status indicated a significant, but weak correlation. Direct care staff (mean rank 35.14) scored lower than nurses (mean rank 46.72) on personal resilience,  $U = 1054$ ,  $z = 2.217$ ,  $p = .027$ . This finding supports similar results reported by Sull et al. (2015) in a study of United Kingdom health care workers. Ancillary staff scored the lowest on the Wagnild (2009) resilience scale when compared by  $t$ -tests to all other clinical staff ( $t = -4.120$ ,  $p < .006$ ) and management personnel ( $t = -2.956$ ,  $p < .004$ ). Interestingly, females in the study by Sull et al. (2015) scored higher, but other researchers have not reported this relationship and no relationship was found in this study regarding differences in gender scores. The moderately low CD-RISC scores in this study ( $M = 79.11$ ,  $SD = 10.13$ ) were comparable to scores in other studies. Moderate to low scores were reported in BMH nurses (Itzhaki et al., 2015), moderately low scores in operating room nurses (Gillespie et al., 2007), and moderately low scores in high-intensity unit nurses (Rushton et al., 2015). Mealer et al. (2012) found that only 22% of intensive care unit nurses reported high resilient CD-RISC scores.

***Personal resilience, education, years of experience, and age.*** No correlation was found in this study between personal resilience and education, years of experience, or age. In other studies of nurses, education was also not found to have an influence on personal resilience (Gillespie et al, 2007; Hart et al., 2014; Hsieh et al., 2016; Rudman et al., 2014); however, mixed results were reported for years of experience. A positive correlation between resilience and years of experience was reported in one study of nurses (Lee et al., 2015); however, Rushton et

al. (2015) and Gillespie et al. (2007) found that resilience in nurses remains constant over time, with a flat correlation between resilience scores and years of experience. Hart et al. (2014) and Hsieh et al. (2016) found no association, and Mealer et al. (2012) found a negative correlation with years of nursing experience. Only one study reported a positive association between personal resilience and age in nurses (Mealer et al., 2012). No evidence was found for direct care staff regarding these variables which underscored the need for this study.

**Findings related to workplace civility.** No association was found between workplace civility, personal resilience, and intention to continue working in the CSU. Although, civility scores differed subtly ( $\chi^2(2) = 5.701, p = .058$ ) between the three units and this supports evidence that the experience of bullying can vary between facilities (Chipps et al., 2013). The impact of workplace incivility on nurse attrition and/or intention to leave is well known (Armmer & Ball, 2015; Brunetto et al., 2013; Budin et al., 2013; Ceravolo et al., 2012; D'Ambra & Andrews, 2014; Evans, 2017; Vessey et al., 2011). However, the relationship between workplace civility and nurse retention is a less studied phenomenon (Clark, 2013). Hart et al. (2014) found through an integrative review that dissonance in the workplace results in diminished personal resilience in nurses. Other researchers report that workplace civility and personal resilience are closely related (Hsieh et al., 2016; Lee et al., 2015; McDonald et al., 2013; Mealer et al., 2012; Sinclair & Britt, 2013; Sull et al., 2015). Very little is known about the experience of direct care staff, especially in the BMH specialty (Dailey et al., 2015; The Lewin Group, 2008). Interestingly, a systematic review found that zero tolerance policies and passive dissemination of information were not effective, but specific collaborative interventions reduced incivility episodes (Coursey et al., 2013). Other studies found that civility training is effective in buffering work related stressors (Oore et al., 2010) and highly effective in raising

awareness and increasing retention (Ceravolo et al., 2012). During the CNQ-B instrument validation studies, peer groups were found to have greater impact than supervisors in the perception of workplace civility (Walsh et al., 2012).

***Workplace civility, age, years of experience, and education.*** A very small relationship was present between the numbers of hours worked in relation to intention to continue working in the CSUs, but this observation was not found in the literature. A significant, but weak, positive correlation was found between age as a continuous variable and the CNQ-B scores,  $r_s(78) = .328, p = .003$ . When age was categorized, a significant difference was found between CNQ-B scores for Millennial generation staff (mean rank = 34.16) and other age groups (mean rank = 46.24),  $U = 1039, z = 2.326, p = .02$ . This finding supports what other researchers have reported about generational differences: Millennial staff view workplace interactions differently (Armmer & Ball, 2015; Brunetto et al., 2013; Laschinger & Nosko, 2015). However, other researchers found no relationship between these variables (Chipps et al., 2013; Evans, 2017; Purpora, Blegen, & Stotts, 2015). In studies of nurses, mixed results were reported regarding workplace civility and years of experience, but no studies were found for direct care staff. No differences were found between workplace civility and education. For now, nurse leaders need to be mindful of potential differences in perception of civility for staff in different age groups and with varied experience. More research is needed to fully understand these differences.

**Findings related to retention.** The dependent variable for this study was retention of nurses and direct care staff who work in three CSUs in the southeastern U. S., however, the regression model failed to demonstrate that CD-RISC and CNQ-B scores were associated with the intention to continue working at the CSU. A weak positive correlation between the number of hours worked each week and the intention to continue working at the CSU ( $r_s(75) = .217, p =$

.058) was not significant at the .05 level, but is worth mentioning because it might indicate a relationship seen in a larger sample. Many researchers have called for studies to investigate associations between resilience and nurse retention, however, no studies were found. The lack of civility and intention to leave have been studied, but no studies were found that tested the relationship between civility and intention to remain.

***Retention and staff development.*** The education survey question provided an interesting finding that relates to retention of direct care staff. Five direct care staff have college degrees, twenty-eight have some college experience, and seven have high school degrees. The Annapolis Coalition on the Behavioral Health Workforce (2007) action plan provides substantial evidence that quality BMH care is dependent on investment in staff who provide direct care. The plan advocates for staff development initiatives to retain a high-quality workforce (Hoge et al., 2014). Another study identified essential components of direct care staff development which include core competencies (Dailey et al., 2015). This study also found that education and promotion opportunities resulted in happier staff, improved services, and substantial cost savings. In BMH, retention of experienced nurses and direct care staff directly impacts the quality of patient care and ensures that vital services are provided to a vulnerable and underserved population (Annapolis, 2007; Annapolis, n.d.; SAMHSA, 2013).

***Other findings.*** The distributions between the three CSUs were not significantly different for: CD-RISC scores ( $\chi^2(2) = 1.864, p = .394$ ), CNQ-B scores ( $\chi^2(2) = 5.701, p = .058$ ), and the plan to continue working at the CSC ( $\chi^2(2) = 0.538, p = .764$ ). This homogeneity may be of interest to CSU leadership and staff development educators.

An informal finding from this study arose from conversations with staff after survey administration sessions and is worth mentioning as it relates to the lack of hope, a component of



personal resilience supported by the literature. Five years ago, many of the nurses and direct care staff in this study experienced the closing of the regional BMH hospital. During data collection, staff commented on the loss of camaraderie and high-quality services rendered by a close community of caregivers. Staff talked fondly of the teamwork, the support from leadership, and the high-quality care provided to the clients (Table 8). A sense of loss and grief was still apparent five years later and was combined with a loss of hope that high quality acute care would return. Cleary et al. (2012) reported similar findings after investigation of a Delphi study of Australian BMH nurses in acute cares settings. Due to the global decentralization of BMH care from hospital-based to community settings, nurses found themselves in new environments without the support of a large network of peers. The perceived loss of professional identity was challenging for individual nurses, the specialty, and the profession. The authors called for immediate action to sustain the BMH specialty with resilience-building interventions at the personal, group, and professional levels. Specific initiatives included fostering collegial relationships, mutual respect, and effective communication. It is important for nurse leaders to be aware of this continued sense of loss and hope in CSU staff.

**A view through Neuman's framework.** These findings can be viewed meaningfully through Neuman's Systems Model. According to Neuman (Neuman & Fawcett, 2011), a person's internal and external environments are interrelated and interdependent. When the normal defensive response is stretched maximally, the person experiences stress in any number of variables including physiological and psychological. Internal lines of defense (personal resilience) can protect a person during extreme stress. Healthy external environments (workplace civility) can provide a structure that promotes wholeness. However, when over-taxed, these lines of defense can weaken and lead to instability, burnout, or illness.

Work in a BMH CSU setting frequently challenges staff defenses both individually and collectively since behaviors and moods can be quite fluid and difficult to manage. Extreme self-mastery is needed to manage responses within this environment. Through Neuman's lens, personal resilience and workplace civility could help staff to function well individually, to thrive within teams, and to choose to remain in practice at CSUs. These factors can fluctuate and are interrelated which creates challenges for researchers. However, this framework effectively guided the planning, implementation, and evaluation phases because of its ability to encompass ambiguous internal and external factors within an open dynamic system (Neuman, 2011).

### **Strengths, Limitations, and Lessons Learned**

Strengths of this study include the careful selection of instruments to measure personal resilience and workplace civility, the use of data collection processes most comfortable for staff, the precision with data analysis, and the relationships built with key project stakeholders. A 95% response rate was achieved due to staff interest in the study and unsolicited peer recruitment.

A significant limitation in this correlation study is the small purposive sample which could result in over-representation of the population. However, the 95.3% response rate provided a detailed description of this unique pre-existing work group. The naturally occurring snowball recruitment most likely increased the participation rate which might not be duplicated in other studies. Data from the three persons who declined to participate could have resulted in different outcomes. The self-report survey data has a well-known bias. Additionally, the time-sensitive demographic questions (hours, years) could have been converted from ordinal to continuous data for more precise results and robust models. Results are not generalizable beyond this population.

Lessons for the researcher included the importance of paying attention to subtleties during data collection. Two persons expressed concern over low resilience scores, however, they were provided evidence-based tools to raise resilience levels and left the survey administration session with a sense of hope and empowerment. Benefits for staff were expected and sometimes surprising as individuals were brought together through peer conversations after survey administration sessions. The project raised awareness regarding the need to attend to personal resilience and workplace civility and provided invaluable opportunities to discuss the internal and external stressors that face BMH staff each day. A final lesson involved the importance of consulting a statistician during demographic instrument development. This step would have enhanced data precision by gathering continuous rather than ordinal level data.

### **Recommendations**

This study was a first step in exploring a highly salient but rarely studied clinical issue. Findings can be used to inform strategies that support BMH staff in CSUs. Four goals for CSU leaders are apparent:

- increased resilience scores in all staff, especially for direct care staff
- improved perception of workplace civility in younger staff
- investigation of the relationship between hours worked and intention to continue working at the CSU
- strategic planning to replace the aging workforce

First, low personal resilience scores and the wide-ranging civility scores should be addressed. The observed differences in personal resilience scores between nurses and unlicensed staff suggest that direct care staff have a greater need for personal resilience training. The variation in workplace civility scores between generations (Millennials scored lower) is a call for

nurse leaders to address the perceptions of younger staff. Just as annual fire drills and skills check offs calibrate staff readiness to perform, annual training and assessments of personal resilience and workplace civility could be performed. Data compared over time would determine if relationships predict intention to quit so that preventive strategies are implemented. A simple tracking of CD-RISC and CNQ-B scores with a seven-minute assessment each year would be compared to scheduled work hours, retention rates, and exit interviews. These initiatives could be performed quickly and would provide short and long-term views for strategic planning.

Lewin's change model could assist nurse managers to track individual and team progress toward increased resilience and civility levels (Burnes & Cooke, 2013). As older staff move toward retirement, recruitment of younger nurses with "unfrozen" work habits will become crucial so that vital public safety net services continue. If younger nurses perceive problems with work place civility, retention could become difficult. Brief teammate assessments could become a part of the work culture prior to shift report and team meetings. Resilience guidelines (Koen et al., 2011) and effective training are available for staff to raise personal resilience (Robertson et al., 2015; Sinclair & Britt, 2013a, 2013b) and workplace civility (Ceravolo et al., 2012; Oore et al., 2010) and these could become annual staff "checkups" to augment orientation. The ultimate goal is to enhance health outcomes for persons requiring acute care BMH services through a resilient and civil workforce.

## **Conclusion**

This study provided a rare glimpse into the experience of CSU nurses and direct care staff, but more could be learned from continued study of this unique population. Researchers called for studies to investigate associations between personal resilience and intention to continue working, however, no association was found in this small, unique sample and no other

studies were found. Perhaps a larger study would demonstrate a relationship, but BMH staff might be unique due to their constant exposure to stressful interactions. More studies are needed, especially regarding direct care staff who provide the bulk of care in acute BMH settings because retention of experienced staff supports access to care for a vulnerable and underserved population. Project evaluation and its contribution to nursing scholarship are discussed in Chapter Six.

### **Chapter Six:**

#### **Project Evaluation**

This DNP project met expected outcomes and was completed on time and under budget. The study adhered to rigorous standards for nursing research (Melnyk & Fineout-Overholt, 2015; Terry, 2015) and statistical analysis (Sylvia & Terhaar, 2014). The researcher partnered with key stakeholders to enhance the delivery of client care by raising awareness regarding the importance of high quality internal (individual) and external (work team) environments in BMH acute care settings. Formative and summative project evaluations followed the nursing process: assess, diagnose, plan, intervene, and evaluate. Selected components of these processes are described next (Moran et al. 2014). The study was funded by the researcher with no outside funds or conflicts of interest.

#### **Expected outcomes**

The project goal was met to translate theory into practice through investigation of relationships between personal resilience, workplace civility, and intention to continue working at CSUs for nurses and direct care staff. This theory-driven population assessment was designed to inform BMH workforce retention efforts so that high quality care can be assured for a vulnerable and severely underserved population. No associations were found between the

variables, but demographic data provided insights into the needs of the CSU staff. Project objectives were also met: to obtain an adequate sample from the small specialized population; minimize workflow interruptions; and raise awareness of the need for personal resilience and workplace civility in this challenging and vitally important health care setting. Maximizing the quality and quantity of BMH staff is a critical public health concern and is considered a cornerstone of BMH care for persons with severe mental illness (Annapolis, 2007; SAMHSA, 2013). Nurse leaders needed baseline data before initiating retention strategies. This project was a first step in exploring a highly salient but rarely studied clinical issue and informs the next step in supporting the vital work of CSU staff.

### **Formative evaluation**

Monitoring the progress of a DNP project is an important component of sound nursing research (Melnyk & Fineout-Overholt, 2015; Moran et al., 2014; Terry, 2015). Formative evaluation included regular assessments to ensure strict adherence to data collection processes and data analysis procedures. Continuous monitoring improved processes and allowed for course corrections to prevent errors and adjust actions as needed. The researcher utilized a project flow chart and data collection fidelity log to track timely completion of each step in the research process (Moran et al., 2014). The flow chart included procedural reminders and deadlines for each task. The data collection phase adhered rigorously to standards of survey collection management while adjusting for CSU workflow needs. Memos regarding schedule changes were made on the data collection fidelity log and posted on the units each day (Melnyk & Fineout-Overholt, 2015; Terry, 2015).

An interesting phenomenon was observed at each survey administration session. Participants often shared thoughts generated by the survey questions. The researcher noticed

common themes on the first day, so a log was kept of frequent phrases. These comments were summarized to protect anonymity and presented to nurse leaders (Table 8). Project committee members were consulted regularly throughout the study and weekly reports were sent to the committee chairperson.

***Communication and relationships.*** Action oriented collaboration was arguably the most important component for minimizing barriers and ensured success of this project. Committee members provided input based on their areas of expertise. A statistician was hired to assist with data analysis to ensure that all statistical procedures and decisions were pristine. Communication with nurse managers and staff was crucial. A team approach to data collection emerged as evidenced by friendly encouragement from peers to participate. Staff indicated a strong interest in success of the study early on and were provided updates on participant numbers at every survey administration session to support ownership of the project. No one was pressured to participate, however, the naturally occurring snowball recruitment most likely increased the participation rate. Only three persons declined, and one part-time nurse was not available during the study period. Eighty-one staff participated of a possible 85 subjects (95.3% response rate) and demographic variables were well represented.

***Project timeline, materials, and budget.*** The project development and approval process were slower than expected, but finalized in time to begin subsequent phases on schedule. The recruitment and data collection timeline of four weeks was more than adequate to introduce the study and administer surveys (Appendix C). Only 16 calendar days were needed to recruit 81 of 85 possible participants. The researcher visited both shifts in each facility on multiple days so that every possible subject had an opportunity to participate. The original schedule was adjusted in response to unit workflow needs and to ensure that part-time staff could participate (Appendix

F). Six weeks were allocated for data entry and analysis, however only four weeks were needed to complete this phase. Ample project materials (Appendix D) were procured early and the project was successfully completed under budget (Appendix E).

**Reporting.** Findings from this study were summarized according to standard research reporting format (SQUIRE, 2015; Sylvia & Terhaar, 2014). Each variable was addressed, and findings were compared to prior research. Suggestions for future research were made and recommendations for nursing scholarship were offered.

**Lessons learned.** The project garnered lessons for the researcher and reaped benefits for the CSU leadership and staff. On day one, the researcher realized the power of paying attention to details and subtleties so that data collection processes were pristine and persons with concerns over low scores were left with a sense of hope and tools to raise resilience levels. The benefits to CSU leaders and staff were expected and sometimes surprising. People were brought together through conversations that underscored the need for addressing BMH staff needs. The project raised awareness about personal resilience, workplace civility, and intention to continue working in the CSU during discussions with peers and the researcher after data collection sessions. These chats were invaluable opportunities to discuss the internal and external stressors that staff face each day and the tools available for building high quality internal and external environments. Another lesson highlighted the need to consult a statistician while designing a demographic instrument. This step would have enhanced data precision by gathering continuous data rather than Likert scale ordinal data.

**Summative evaluation.** This DNP project provided insight into a highly salient but rarely studied clinical issue. Clinical questions were raised for further study that are vitally important to sustaining a BMH public safety net system. The final project evaluation was made



in collaboration with committee members and covered all phases from initiation through completion. Goals and objectives were met. Study procedures followed standard protocols so that results and recommendations were reported with confidence. The final defense was completed satisfactorily. The processes described here outline a comprehensive, well-organized model that could be useful to other DNP students and researchers. Very little research has been conducted on BMH staff and this study demonstrated the feasibility studying a gap in nursing scholarship.

**Dissemination.** Results and recommendations were presented to CSU leadership and staff. Both groups received an audience-specific report with findings and recommendations regarding maintenance of high quality internal (individual) and external (work team) environments. Abstracts were submitted for presentation at professional nursing conferences and publication in a peer reviewed journal.

**Report to CSU leadership.** The researcher met with CSU leadership to discuss results and recommendations for evidence-based retention initiatives. These meetings were guided by Neuman's Systems Model so that the concepts of internal (personal resilience) and external (workplace civility) environments could be understood as interrelated and dynamic factors. Recommendations from the Annapolis Coalition on the Behavioral Health Workforce were presented (Annapolis, 2007; Dailey et al., 2015; Hoge et al., 2014). Preliminary discussions with human resource personnel had indicated that one hour of staff orientation and annual training sessions could be added without a heavy financial burden. Annual skills trainings for fire, corporate compliance, and crisis prevention interventions are required and customary for CSU staff, therefore, adding a brief educational session on the importance of high quality internal and external environments would be feasible. The financial impact of hardiness (resilience)

education was discussed (Henderson, 2015) and the impact of investing in staff retention on health outcomes (Annapolis, 2007) was emphasized. Information from this study highlighted the need to be mindful of generational perceptions of workplace civility and the need to promote personal resilience in nurses and direct care staff. Additionally, a recommendation was made to compare CSU work hours and retention rates over time and monitor civility levels in each unit.

***Report to CSU staff.*** The report to staff was congratulatory and commended them for ownership in the project which made it a success. The 95.3% response rate was outstanding and revealed interest in individual and team health. Based on recommendations from the CSU leadership, an uplifting and encouraging report to CSU staff was offered at one staff meeting. Participants were encouraged to utilize evidence-based integrative health care methods to refresh, renew, and maintain self-mastery (Koen et al., 2011) within the context of Lewin's Change model (Burnes & Cooke, 2013). Clinical guidelines for personal resilience were introduced (Koen et al., 2011) and a brief evidence-based workplace civility training session was offered (PACERS, 2015). Resource notebooks with handouts were provided for each CSU breakroom. The long-term goal is to increase and sustain high levels of personal resilience and workplace civility with periodic well-informed self and team reassessments. Staff were encouraged to "take your personal resilience pulse" daily and to assess workplace civility levels for signs of individual and team fatigue so that early intervention can prevent burnout and incivility. The researcher also recommended that team jargon be developed to enculturate an atmosphere where healthy internal and external environments are promoted and fostered daily.

***Presentations and publication of findings.*** A podium presentation was offered at a professional nursing conference and manuscripts will be submitted to two peer-reviewed journals. All participant information remained confidential and no agency identifier was used.

**Final Comments.** It is hoped this study will spark greater interest in promoting personal resilience and workplace civility for nurses and direct care staff who care for vulnerable and underserved populations. The BMH specialty is challenging and retention of experienced staff in public safety net systems is a critical public health issue because they care for some of society's most disenfranchised populations. These caregivers deserve to work in civil workplaces and have their personal resilience supported and fostered. An inadequate, burned out, and uncivil BMH workforce could jeopardize the health and safety of an at-risk population. Civil interactions with co-workers are crucial for safety and for healthy team dynamics. However, high-level self-mastery in BMH settings takes time to acquire. Retention of experienced, resilient, and civil health care workers who thrive in BMH settings is, therefore, an important component of a sustainable and healthy workforce.

While this study is not generalizable to a wider audience, it made a small but important contribution toward understanding the experience of BMH staff in a public safety net acute care setting. CSU nurse leaders can use the data to raise awareness and continually monitor healthy and unhealthy patterns in the BMH workforce. Despite the unique challenges and high-intensity quality of BMH care (Itzhaki et al., 2015; Lim, 2011), the specialty can be rewarding with adequate investment in staff support and development (Annapolis, 2007; Cleary et al., 2012).

## References

- Alliance for Health Reform. (2012). Direct Care Workers. Retrieved from [http://www.allhealth.org/wp-content/uploads/2017/01/Direct\\_Care\\_Toolkit\\_118.pdf](http://www.allhealth.org/wp-content/uploads/2017/01/Direct_Care_Toolkit_118.pdf)
- American Association of Colleges of Nursing. (2006). The essentials of doctoral education for advanced nursing practice. Retrieved from <http://www.aacn.nche.edu/publications/position/DNPEssentials.pdf>
- American Nurses Association. (2015). American Nurses Association position statement on incivility, bullying, and workplace violence. Retrieved from <http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Nurse/bullyingworkplaceviolence/Incivility-Bullying-and-Workplace-Violence.html>
- American Nurses Association. (2016). ANA's principles for health system transformation 2016. Retrieved from [www.nursingworld.org/principles-healthsystemtransformation](http://www.nursingworld.org/principles-healthsystemtransformation)
- Annapolis Coalition on the Behavioral Health Workforce. (2007). An Action Plan for Behavioral Health Workforce Development. Retrieved from <http://annapoliscoalition.org/wp-content/uploads/2013/11/action-plan-full-report.pdf>
- Annapolis Coalition on the Behavioral Health Workforce. (n.d.). Behavioral health pacesetter award. Retrieved from <http://annapoliscoalition.org/?portfolio=behavioral-health-pacesetter-award>
- Armmer, F., & Ball, C. (2015). Perceptions of horizontal violence in staff nurses and intent to leave. *IOS Press, 51*, 91-97. doi: 10.3233/WOR-152015
- Behavioralhealthlink.com. (n.d.). Behavioral Health Link. Retrieved from <http://behavioralhealthlink.com/crisis/>

- Biomath.info [Measurement instrument]. (n.d.). Unpublished instrument. Retrieved from <http://biomath.info/power/corr.htm>
- Brunetto, Y., Shriberg, A., Farr-Wharton, R., Shacklock, K., Newman, S., & Dienger, J. (2013, April). The importance of supervisor-nurse relationships, teamwork, wellbeing, affective commitment and retention of North American nurses. *Journal of Nursing Management*, *21*, 827-837. doi: 10.1111/jonm.12111
- Budin, W. C., Brewer, C. S., Chao, Y., & Kovner, C. (2013). Verbal abuse from nurse colleagues and work environment of early career registered nurses. *Journal of Nursing Scholarship*, *45*(3), 308-316. doi: 10.1111/jnu.12033
- Burnes, B., & Cooke, B. (2013). Kurt Lewin's Field Theory: A review and re-evaluation. *International Journal of Management Review*, *15*, 408-425. doi: 10.1111/j.1468-2370.2012.00348.x
- Calculator.net. (n.d.). Sample size calculator. Retrieved from <https://www.calculator.net/sample-size-calculator.html?type=2&cl2=95&ss2=81&pc2=95.3&ps2=85&x=54&y=19>
- CD-RISC The Conner-Davidson Resilience Scale User Guide Manual. (2017). Retrieved from personal communication
- CD-RISC: The Conner-Davidson Resilience Scale User Guide. (n.d.). Retrieved from <http://connordavidson-resiliencescale.com/user-guide.php>
- Center for Consumer Information & Insurance Oversight. (2017). The Mental Health Parity and Addiction Equity Act (MHPAEA). Retrieved from [https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea\\_factsheet.html](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html)

- Ceravolo, D. J., Schwartz, D. G., Foltz-Ramos, K. M., & Castner, J. (2012). Strengthening communication to overcome lateral violence. *Journal of Nursing Management, 20*, 599. doi: 10.1111/j.1365-2834.2012.01402x
- Chipps, E. M., & McRury, M. (2012). The development of an educational intervention to address workplace bullying. *Journal for Nurses in Staff Development, 28*(3), 94-98. Retrieved from [www.jnsdonline.com](http://www.jnsdonline.com)
- Chipps, E., Stelmaschuk, S., Albert, N. M., Bernhard, L., & Holloman, C. (2013, November). Workplace bullying in the OR: Results of a descriptive study. *AORN Journal, 98*, 479-493. doi: 10.1016/j.aorn.2013.08.015
- Clark, C. M. (2013). *Creating & sustaining civility in nursing education*. Indianapolis, IN: Sigma Theta Tau International.
- Clark, C. M., & Carnosso, J. (2008, April). Civility: A concept analysis. *Journal of Theory Construction & Testing, 12*(1), 11-15. Retrieved from [https://www.researchgate.net/publication/287821658\\_Civility\\_A\\_concept\\_analysis](https://www.researchgate.net/publication/287821658_Civility_A_concept_analysis)
- Cleary, M., & Happell, B. (2005). Promoting a sustainable mental health nursing workforce: An evaluation of a transition mental health nursing programme. *International Journal of Mental Health Nursing, 14*, 104-116.
- Cleary, M., Horsfall, J., O'Hara-Aarons, M., Jackson, D., & Hunt, G. E. (2012). Mental health nurses' perceptions of good work in an acute setting. *International Journal of Mental Health Nursing, 21*, 471-479. doi: 10.1111/j.1447-0349.2011.00810.x
- Cleary, M., Jackson, D., & Hungerford, C. L. (2014). Mental health nursing in Australia: Resilience as a means of sustaining the specialty. *Issues in Mental Health Nursing, 35*, 33-40. doi: 10.3109/01612840.2013.836261

- Conner, K. M., & Davidson, J. R. (2003). Development of a new resiliency scale: The Conner-Davidson resilience scale (CD-RISC). *Depression and Anxiety, 18*, 76-82. doi: 10.1002/da.10113
- Cosco, T. D., Kaushal, A., Richards, M., Kuh, D., & Stafford, M. (2016). Resilience measurement in later life: A systematic review and psychometric analysis. *BioMed Central, 14*(16), 1-6. doi: 10.1186/s12955-016-0418-6
- Coursey, J. H., Rodriguez, R. E., Dieckmann, L. S., & Austin, P. N. (2013, January). Successful implementation of policies addressing lateral violence. *AORN Journal, 97*(1), 101-109. doi: 10.1016/j.aorn.2012.09.010
- Dailey, W. F., Morris, J. A., & Hoge, M. A. (2015). Workforce development innovations with direct care workers: Better jobs, better services, better business. *Community Mental Health Journal, 51*, 647-653. doi: 10.1007/s10597-014-9798-4
- D'Ambra, A. M., & Andrews, D. R. (2014). Incivility, retention and new graduate nurses: An integrated review of the literature. *Journal of Nursing Management, 22*, 735-742. doi: 10.1111/jonm.12060
- Duffield, C. M., Roche, M. A., Homer, C., Buchan, J., & Dimitrelis, S. (2014). A comparative review of nurse turnover rates and costs across countries. *Journal of Advanced Nursing, 70*(12), 2703-2712. doi: 10.1111/jan.12483
- Earvolino-Ramirez, M. (2007, April-June). Resilience: A concept analysis. *Nursing Forum, 42*(2), 73-82. Retrieved from <http://www.nursingacademy.com/uploads/6/4/8/8/6488931/resilienceaconceptanalysis.pdf>
- Elmblad, R., Kodjebacheva, G., & Lebeck, L. (2014, December). Workplace incivility affecting CRNAs: A study of prevalence, severity, and consequences with proposed interventions.

- American Association of Nurse Anesthetists Journal*, 82(6), 437-445. Retrieved from [www.aana.com/aanajournalonline](http://www.aana.com/aanajournalonline)
- Einarsen, S., Hoel, H., & Notelaers, G. (2009). Measuring exposure to bullying and harassment at work: Validity, factor structure and psychometric properties of the Negative Acts Questionnaire-Revised. *Work & Stress*, 23(1), 24-44. doi: 10.1080/02678370902815673
- Evans, D. (2017). Categorizing the magnitude and frequency of exposure to uncivil behaviors: A new approach for more meaningful interventions. *Journal of Nursing Scholarship*, 49(2), 214-222. doi: 10.1111/jnu.12275
- Friborg, O., Hjemdal, O., Rosenvinge, J. H., & Martinussen, M. (2003). A new rating scale for adult resilience: What are the central protective resources behind healthy adjustment? *International Journal of Methods in Psychiatric Research*, 12(2), 65-76. doi: 10.1002/mpr.143
- Gehrling, K. R. (2011). Reconstitution. In B. Neuman & J. Fawcett (Eds.), *The Neuman systems model* (5th ed., pp. 89-99). Upper Saddle River, NJ: Pearson.
- Georgia Department of Behavioral Health and Developmental Disabilities. (2016). DBHDD access and quality engineering project stakeholder report. Retrieved from <http://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/imported/DBHDD/Home/ASO%20Stakeholder%20Report%202-7-14.pdf>
- Georgia Department of Behavioral Health and Developmental Disabilities. (n.d.). DBHDDJobs.com. Retrieved from <http://www.dbhddjobs.com/default.aspx>
- Georgia Department of Behavioral Health and Developmental Disabilities-Region One. (2015). Region One DBHDD Planning Board 2017 annual plan. Retrieved from



[https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related\\_files/site\\_page/Reg%201%20FY2017%20FULL%20PLAN%20Final.pdf](https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Reg%201%20FY2017%20FULL%20PLAN%20Final.pdf)

Georgia Nursing Leadership Coalition. (2016). Report on the registered nursing workforce in Georgia 2014-2015. Retrieved from

[https://issuu.com/gnlc/docs/gnlc\\_nursing\\_workforce\\_report\\_2014-](https://issuu.com/gnlc/docs/gnlc_nursing_workforce_report_2014-)

Gillespie, B. M., Chaboyer, W., Willis, M., & Grimbeek, P. (2007, April). Resilience in the operating room: Developing and testing of a resilience model. *Journal of Advanced Nursing*, 59(4), 427-438. doi: 10.1111/j.1365-2648.2007.04340.x

Grafton, E., Gillespie, B., & Henderson, S. (2010). Resilience: The power within. *Oncology Nursing Forum*, 37(6), 698-705. Retrieved from

[http://www.academia.edu/2176360/Resilience\\_the\\_power\\_within](http://www.academia.edu/2176360/Resilience_the_power_within)

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 Measures*, 18(3), 176-200. doi: 10.1891/1061-3749.18.3.176

Harrison, C. A., Hauck, Y., & Hoffman, R. (2014). Choosing and remaining in mental health nursing: Perceptions of western Australian nurses. *International Journal of Mental Health Nursing*, 23, 561-569. doi: 10.1111/inm.12094

Hart, P. L., Brannan, J. D., & DeChesnay, M. (2014). Resilience in nurses: An integrative review. *Journal of Nursing Management*, 22, 720-734. doi: 10.1111/j.1365-2834.2012.01485.x

Health Resources & Services Administration. (n.d.). HRSA Data warehouse. Retrieved from

<https://datawarehouse.hrsa.gov/tools/quickmaps.aspx>

- Henderson, J. (2015, July-August). The effect of hardiness education on hardiness and burnout on registered nurses. *Nursing Economics*, 33(4), 204-209.
- Hoge, M., Morris, J. A., Laraia, M., Pomerantz, A., & Farley, T. (2014). Core competencies for integrated behavioral health and primary care. Retrieved from [http://www.integration.samhsa.gov/workforce/Integration\\_Compencies\\_Final.pdf](http://www.integration.samhsa.gov/workforce/Integration_Compencies_Final.pdf)
- Hsieh, H., Hung, Y., Wang, H., Ma, S., & Chang, S. (2016). Factors of resilience in emergency department nurses who have experienced workplace violence in Taiwan. *Journal of Nursing Scholarship*, 48(1), 23-30. doi: 10.1111/jnu.12177
- Hudson, C. G. (2016). A model of deinstitutionalization of psychiatric care across 161 nations: 2001-2014. *International Journal of Mental Health*, 45, 135-153. doi: 10.1080/00207411.2016.1167489
- Itzhaki, M., Peles-Bortz, A., Kostistky, H., Barnoy, D., Filshtinsky, V., & Bluvstein, I. (2015). Exposure of mental health nurses to violence associated with job stress, life satisfaction, staff resilience, and post-traumatic growth. *International Journal of Mental Health Nursing*, 24, 403-412. doi: 10.1111/inm.12151
- Jackson, D., Firtko, A., & Edenborough, M. (2007). Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: A literature review. *Journal of Advanced Nursing*, 60(1), 1-9. doi: 10.1111/j.1365-2648.2007.04412.x
- Jajic, A., Andrews, H., & Jones, C. W. (2011). The client system as family, group, or community. In B. Neuman & J. Fawcett (Eds.), *The Neuman Systems Model* (5th ed., pp. 70-88). Upper Saddle River, NJ: Pearson.
- Jones, E. (2016). *Independent reviewer's report year six: United States v. the State of Georgia* (Civil Action No. 1:10-CV-249-CAP). Retrieved from

- [https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related\\_files/site\\_page/Final%20Year%20Six%20Independent%20Reviewer%20Report%20to%20the%20Court.pdf](https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Final%20Year%20Six%20Independent%20Reviewer%20Report%20to%20the%20Court.pdf)
- Kaminski, J. (2011, Winter). Theory applied to informatics - Lewin's change theory. *Canadian Journal of Nursing Informatics*, 6(1), 1-5. Retrieved from <http://cjni.net/journal/?p=1210>
- Koen, M. P., Van Eeden, C., Wissing, M. P., & Koen, V. (2011). Guidelines with strategies for enhancement of resilience and psycho-social well-being in professional nurses. *Journal of Psychology in Africa*, 21(4), 643-652.
- Kristensen, T. S., Borritz, M., Villadsen, E., and Christensen, K. B. (2005) The Copenhagen Burnout Inventory: A new tool for the assessment of burnout. *Work and Stress*, 19(3), 192-207. doi: 10.1080/02678370500297720
- Kumpfer, K. L. (1999). Factors and processes contributing to resilience: The resilience framework. In M. D. Gantz & J. L. Johnson (Eds.), *Resilience and development: Positive life adaptations* (pp. 179-224). New York, NY: Kluwer Academics.
- Laschinger, S., & Nosko, A. (2015). Exposure to workplace bullying and post-traumatic stress disorder symptomology: The role of protective psychological resources. *Journal of Nursing Management*, 23, 252-262. doi: 10.1111/jonm.12122
- Lee, K. J., Forbes, M. L., Lukasiewicz, G. J., Williams, T., Sheets, A., Fischer, K., & Niedner, M. F. (2015, September). Promoting staff resilience in the pediatric intensive care unit. *American Journal of Critical Care*, 21(4), 643-652. doi: 10.4037/ajcc2015720
- Lim, B. C. (2011, July). A systematic literature review: Managing the aftermath effects of patient's aggression and violence towards nurses. *Singapore Nursing Journal*, 38(3), 6-12. Retrieved from <http://eds.a.ebscohost.com/eds/pdfviewer/pdfviewer?vid=3&sid=af6bea56-0bf2-4ad4-bb37-b8dcf86bca8f%40sessionmgr4007&hid=4108>

- Luthar, S. S., Cicchetti, D., & Becker, B. (2000, May/June). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71*(3), 543-562. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1885202/pdf/nihms-21559.pdf>
- Madathil, R., Heck, N. C., & Schuldberg, D. (2014). Burnout in psychiatric nursing: Examining the interplay of autonomy, leadership style, and depressive symptoms. *Archives of Psychiatric Nursing, 28*, 160-166. doi: 10.1016/j.apnu.2014.01.002
- Matos, P. S., Neushotz, L. A., Griffin, M. T., & Fitzpatrick, J. J. (2010). An exploratory study of resilience and job satisfaction among psychiatric nurses working in inpatient units. *International Journal of Mental Health Nursing, 19*, 307-312. doi: 10.1111/j.1447-0349.2010.00690.x
- McDonald, G., Jackson, D., Wilkes, L., & Vickers, M. H. (2013, August). Personal resilience in nurses and midwives: Effects of a work-based educational intervention. *Contemporary Nurse, 45*(1), 134-143. doi: 10.5172/conu.2013.45.1.134
- Mealer, M., Conrad, D., Evans, J., Jooste, K., Solyntjes, J., Rothbaum, B., & Moss, M. (2014, November). Feasibility and acceptability of a resilience training program for intensive care unit nurses. *American Journal of Critical Care, 23*(6), 97-105. doi: 10.4037/ajcc2014747
- Mealer, M., Jones, J., Newman, J., McFann, K. K., Rothbaum, B., & Moss, M. (2012, March). The presence of resilience is associated with a healthier psychological profile in ICU nurses: Results of a national survey. *International Journal of Nursing Studies, 49*(3), 292-299. doi: 10.1016/j.ijnurstu.2011.09.015

- Melnyk, B. M., & Fineout-Overholt, E. (2015). *Evidence-based practice in nursing & healthcare: A guide to best practice* (3rd ed.). Philadelphia, PA: Wolters Kluwer.
- Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine*, 6(7), e1000097. doi: 10.1371/journal.pmed1000097
- Moran, K., Burson, R., & Conrad, D. (2014). *The doctor of nursing practice scholarly project: A framework for success*. Burlington, MA: Jones & Bartlett Learning.
- Murthy, V. H. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health*. Retrieved from U.S. Department of Health & Human Services website: <https://addiction.surgeongeneral.gov/>
- National Conference of State Legislators. (2017). Mental health benefits: State laws mandating or regulating. Retrieved from <http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx>
- Neuman, B. (2011). Neuman Systems Model. Retrieved from <http://www.neumansystemsmodel.org/>
- Neuman, B., & Fawcett, J. (Eds.). (2011). *The Neuman systems model* (5th ed.). Upper Saddle River, NJ: Pearson.
- Office of Disease Prevention and Health Promotion. (2016). Mental health: Overview and impact. Retrieved from <https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health>
- Oore, D. G., Leblanc, D., Day, A., Leiter, M. P., Spence-Laschinger, H. K., Price, S. L., & Latimer, M. (2010). When respect deteriorates: Incivility as a moderator of the stressor-

- strain relationship among hospital workers. *Journal of Nursing Management*, 18, 878-888. doi: 10.1111/j.1365-2834.2010.01139x
- PACERS. (2015). Civility tool kit. Retrieved from [www.stopthebullyingtoolkit.org](http://www.stopthebullyingtoolkit.org)
- Purpora, C., Blegen, M. A., & Stotts, N. A. (2015). Job satisfaction and horizontal violence in hospital staff registered nurses: The mediating role of peer relationships. *Journal of Clinical Nursing*, 24, 2286-2294. doi: 10.1111/jocn.12818
- Reeves, W. C. (2011). Mental illness surveillance among adults in the United States. Retrieved from [https://www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm?s\\_cid=su6003a1\\_w](https://www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm?s_cid=su6003a1_w)
- Robertson, I. T., Cooper, C. L., Sarkar, M., & Curran, T. (2015). Resilience training in the workplace from 2003 to 2014: A systematic review. *Journal of Occupational and Organizational Psychology*, 88, 533-562. doi: 10.1111/joop.12120
- Rudman, A., Gustavsson, P., & Hultell, D. (2014). A prospective study of nurses' intention to leave the profession during their first five years of practice in Sweden. *International Journal of Nursing Studies*, 51, 612-624. doi: 10.1016/j.ijnurstu.2013.09.012
- Rushton, C. H., Batcheller, J., Schroeder, K., & Donohue, P. (2015, September). Burnout and resilience among nurses practicing in high-intensity settings. *American Journal of Critical Care*, 24, 412-420. doi: 10.4037/ajcc2015291
- Sinclair, R. R., & Britt, T. W. (Eds.). (2013). Personality and psychological resilience in military personnel. *Building psychological resilience in military personnel: Theory and practice* (pp. 21-46). Washington, DC: American Psychological Association.
- Sinclair, R. R., & Britt, T. W. (Eds.). (2013a). Introduction: The meaning and importance of military resilience. *Building psychological resilience in military personnel: Theory and practice* (pp. 3-17). Washington, DC: American Psychological Association.

- Sinclair, R. R., & Britt, T. W. (Eds.). (2013b). *Building psychological resilience in military personnel: Theory and practice* Washington, DC: American Psychological Association
- Spath, T., & Dahnke, C. (2016). What is civility? Retrieved from [www.instituteforcivility.org/who-we-are/what-is-civility/](http://www.instituteforcivility.org/who-we-are/what-is-civility/)
- Spector, P. E., Zhou, Z. E., & Che, X. X. (2014). Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review. *International Journal of Nursing Studies*, *51*, 72-84. doi: 10.1016/j.ijnurstu.2013.01.010
- SQUIRE. (2015). Revised standards for quality improvement reporting excellence SQUIRE 2.0. Retrieved from <http://www.squire-statement.org/index.cfm?fuseaction=page.viewpage&pageid=471>
- Substance Abuse and Mental Health Services Administration. (2013). Report to congress on the nation's substance abuse and mental health workforce issues. Retrieved from <http://store.samhsa.gov/shin/content//PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>
- Substance Abuse and Mental Health Services Administration. (2017). The CBHSQ Report. Retrieved from [https://www.samhsa.gov/data/sites/default/files/report\\_2734/Spotlight-2734.html](https://www.samhsa.gov/data/sites/default/files/report_2734/Spotlight-2734.html)
- Sull, A., Harland, N., & Moore, A. (2015). Resilience of health-care workers in the UK: A cross-sectional survey. *Journal of Occupational Medicine and Toxicology*, *10*(20), 1-8. doi: 10.1186/s12995-015-0061-x
- Sylvia, M. L., & Terhaar, M. F. (2014). *Clinical analytics and data management for the DNP*. New York, NY: Springer.
- Terry, A. J. (2015). *Clinical research for the doctor of nursing practice* (2nd ed.). Burlington, MA: Jones & Bartlett Learning.

- The Center for Generational Kinetics. (2016). An intro to generations. Retrieved from <http://genhq.com/FAQ-info-about-generations/>
- The Joint Commission. (2008). Sentinel event alert issue 40: Behaviors that undermine a culture of safety. Retrieved from [www.jointcommission.org/assets/1/18/sea\\_40](http://www.jointcommission.org/assets/1/18/sea_40)
- The Lewin Group. (2008). A synthesis of direct service workforce demographics and challenges across intellectual/developmental disabilities, aging, physical disabilities, and behavioral health. *Washington, DC*, 1-54. Retrieved from <https://www.medicaid.gov/medicaid/ltss/downloads/workforce/a-synthesis-of-dsw.pdf>
- The Mental Health & Substance Use Disorder Parity Task Force. (2016). Final report. Retrieved from <https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.pdf>
- Turner, S. B., & Kaylor, S. D. (2015, March). Neuman Systems Model as a conceptual framework for nurse resilience. *Nursing Science Quarterly*, 23(3), 213-217. doi: 10.1177/08943184155
- U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. (2014). The future of the nursing workforce: National- and state-level projections, 2012-2025. Retrieved from <http://www.hrsa.gov>
- U.S. Department of Veterans Affairs. (n.d.). Civility, respect, and engagement in the workplace (CREW). National Center for Organizational Development. Retrieved from <https://www.va.gov/NCOD/CREW.asp>
- Van Bogaert, P., Wouters, K., Willems, R., Mondelaers, M., & Clark, S. (2012). Work engagement supports nurse workforce stability and quality of care: Nursing team-level



- analysis in psychiatric hospitals. *Journal of Psychiatric and Mental Health Nursing*, 20, 679-686. doi: 10.1111/jpm.12004
- Vessey, J. A., DeMarco, R., & DiFazio, R. (2011). Bullying, harassment, and horizontal violence in the nursing workforce: The state of the science. In *Annual Review of Nursing Research*, pp. 133-157. Retrieved from <http://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?vid=1&sid=2e2be2ad-9407-4e3d-b991-85e7bc7d9de0%40sessionmgr107&hid=111>
- Wagnild, G. (2009). A review of the Resilience Scale. *Journal of Nursing Measurement*, 17(2), 105-113. doi: 10.1891/1061-3749.17.2.105
- Walsh, B. M., Magley, V. J., Reeves, D. W., Davies-Schrills, K. A., Marmet, M. D., & Gallus, J. A. (2012). Assessing workgroup norms for civility: The development of the Civility Norms Questionnaire-Brief. *Journal of Business Psychology*, 27, 407-420. doi: 10.1007/s10869-011-9251-4
- Windle, G., Bennett, K. M., & Noyes, J. (2007). A methodological review of resilience measurement scales. *BioMed Central*, 9(8), 1-18. doi: 10.1186/1477-7525-9-8
- Youssef, N. A., Green, K. T., Dedert, E. A., Hertzberg, J. S., Calhoun, P. S., Dennis, M. F., & Beckham, J. C. (2013). Exploration of the influence of childhood trauma, combat exposure, and resilience construct on depression and suicidal ideation among U.S. Iraq/Afghanistan era military personnel and veterans. *International Academy for Suicide Research*, 17, 106-122. doi: 10.1080/13811118.2013.776445

## Appendix A

## CSU Needs Assessment Summary

DNP Student Project Needs Assessment - Staff Questionnaire – Spring 2017				
CSU Staff Areas to Improve	█ n=4	█ n=12	█ n=5	Summary of Needs
Communication	0+	37	3	Clarity, privacy, respectful, helpful
Equal treatment	0+	5	5	Pay, interactions, same rules
Recognition	3	5	2	Pay, PTO, awards, game, acknowledgement
Role definition	0+	9	5	Clarity, structure, different ways of working
Team work	0+	19	4	Support, team work, care for each other
Environment	2	2	2	Need a doctor 24/7 [█] Designated [█] HST admission room In-house clinical training [█; █] Higher staff to client ratio
CSR Needs	4	10	4	Connection w/staff; groups, supplies; activities; respect and caring staff
Nurse Managers	All mentioned need to increase team connectedness. Two mentioned respectful communication and need for team work between nurses and techs; Techs feel disconnected from nurses, not mentored; easy to burnout; Nurses to interact more with clients and HSTs. Nurses need staff development to New Behavioral Response Training (BRT) completed for █ (14) and █ (15); plan to train all staff. Raises would be great, but that is decided at a higher level.			
Human Resource Total RN/HST positions: 35 █ 37 █ 28 █ 90 Positions	Ask if HSTs would like to have a “level 2” designation after more training Would a career path with mentoring program be desired? Would HST’s want to become a CPI trainer? Or Case Manager? >RN? >DD Paraprofessional? >HST 2? >Addiction CAC? Techs feel disconnected from nurses, not mentored by them or part of team Confusion with “who is my boss?” RN Clinical Coord? RN charge nurse? Host CSU Nurse Day; CSU HST day; bond the building; mentor; team respect			
Education Director	Only one education person to train all staff; focuses on orientation and annual compliance training; BRT pending in all CSUs; done by DBHDD			
CSU Director	Daily huddles for “what went right today?” Staff training needed: HSTs on medical terms; how to run a group; life skills; huddles; communication; Nurses on mentoring skills and meds Huge potential to develop and retain HSTs Build confidence with psych 101-praise and mentoring			

*Note.* CSU identifying information has been redacted for this publication; CSU = crisis stabilization unit; + = only positive comments made; CSR = consumer or individual receiving treatment.

Selected comments from CSU staff assessment  
regarding personal resilience, workplace civility or staff retention

Communication:

- Communicate more. Communicate better. Techs can say, “I’m covered up. Please help.”
- Address problems with one another in order to solve them rather than...make a situation worse. Less hateful. More work, less drama. Keep talking to each other.
- We do a great job at this, but sometimes we need to just say what is going on.

Equal treatment

- Address deficiencies as needed in individuals, not in meetings...privately [so they know it applies to them]. Everyone follow the rules. More structure. Set rules.
- No more double standards. Hold people accountable. Treated equal.

Recognition

- Consideration should be given to those who have displayed loyalty and longevity; recognition for years of service. Pay raises based on years of service.
- Have “Employee of the month” and have staff vote. [Recognition] game in staff meetings
- Just tell us we are great. Acknowledge us. [Staff need] to know that higher-ups know how awesome we are; to know we are appreciated.

Role definition

- It is hard to know what is expected of me; different [staff] do things differently.
- Hold each employee [to] the same standards. Work ethic expectations: attendance, dress code, attitude, demeanor, phones, tardiness.
- Be on the same page. Everyone follow the rules. [No] passing off responsibilities to other staff. [HSTs] need training on how to do groups. [Nurses] need education on new drugs.
- We’ve got this.

Team work

- Make everyone understand we have to work together to make the job work.
- Treat the techs with a little more respect; find out how to help them and work together.
- Respect for each other. Better teamwork. More supportive of each other. Team bonding.
- Free from rumors, discrimination and harassment. More patience. Helping out.
- This is an awesome pace to work. We are great together. Best place I ever worked. We are like a family.

Environment

- The nurses’ station is not sound proof and consumers can hear what is going on.
- Need space designated for HST admission so we are not on top of one another...more orderly and professional.
- Less time charting; Supplies, activities, interactive projects [for staff-CSR interactions].

Consumer needs

- Golden Rule [respect]. Activities. Groups. Something to fill their minds. Structure, exercise and workshops. More than we can give them.
- Time, energy, and ability to access staff to conversate with staff more. Higher staff-to-CSR ratios for more interaction [with CSRs].

## Appendix B

## Letter of Support

The letter of support has been redacted to protect confidentiality for the host agency. The document addressed permission to complete the following tasks:

- perform anonymous surveys with staff working in the three CSUs
- communication with staff regarding the project
- discussion of the project with CSU leadership, human resources, and others as needed
- collection of dis-identified employee retention/attrition data
- collection of dis-identified data deemed helpful or appropriate by CSU staff and leadership
- perform duties appropriate for a doctoral student project under the supervision of nursing faculty

The letter also addressed:

- protection of all information (confidentiality) upon project completion
- research portion of project was to begin after the Memorandum of Understanding was signed by all parties and the college Institutional Review Board approval was obtained



## Appendix D

## Project Materials List

---

Project Items	Procurement Process
Laptop with GSCU secure network access	Had on hand
SPSS version 23.0	Had on hand
Encrypted e-storage device	Purchased with project escrow funds
Lock box	Purchased with project escrow funds
Paper, ink, copies for survey packets	Purchased with project escrow funds
Pens and pencils for taking the survey	Had on hand
Recruitment meal and snacks	Purchased with project escrow funds
Thank you cards	Had on hand
Gift cards	Purchased with project escrow funds
Travel and meals away	Purchased with project escrow funds
Secure office space with locked file cabinet	Had on hand

---

## Appendix E

## Project Budget and Actual Expenses

<hr/>		
Project funds in escrow		<u>\$4,000</u>
<hr/>		
Costs	Projected Expenses	Actual Expenses
<hr/>		
Encrypted storage devices (2)	\$50	\$36
Lock box	\$100	\$37
USG Statistician	\$750	\$750
Paper, ink, and copies	\$200	\$180
Recruitment snacks	\$500	\$110
Gift cards (81)	\$500	\$405
and food baskets (6)	\$500	\$100
Travel expenses	\$450	\$1098
Total costs	<u>\$3,050</u>	<u>\$2,716</u>
Amount remaining in escrow fund	<u>\$950</u>	<u>\$1,284</u>
<hr/>		

## Appendix F

## Recruitment Materials

Recruitment materials include generic invitations and items specific to each unit:

Figure F1. Invitation Flyer

Figure F2. Invitation Note Card for Staff Mail Boxes

Figure F3. Survey Administration Schedule – [REDACTED] Unit

Figure F4. Survey Administration Schedule – [REDACTED] Unit

Figure F5. Survey Administration Schedule – [REDACTED] Unit

CSU identifying information has been redacted for this publication.



Figure F1. Invitation Flyer

6/1-30/2017

## Invitation to Participate in a Research Project

### **A student project**

Your work in a crisis stabilization unit takes a special kind of person. Many staff in other specialties struggle to do what CSU staff do every day. *This is intensive care* for persons with psychiatric conditions.

I will be conducting a study to explore the relationship between personal resilience, workplace civility, and intention to continue working at the CSU.

Your participation in this study may help increase knowledge about what nurtures CSU staff in such a manner that they want to remain on the job. Information from the study will be presented to staff and CSU leadership this fall so that nurturing retention plans can be made.

I will be on your unit at the dates and times below. You will have the opportunity to take one 20-minute survey and receive a \$5 gift card of your choice.

After completing the survey, you will place it in a sealed envelope and locked box that only Ms. Stover will open. The survey is completely anonymous so that no one will be able to tell who filled out the surveys.

RNs, LPNs, and HSTs at all three [REDACTED] CSUs are invited to help with my study. Participation is completely voluntary. I hope you will join me in this important work.

Thank you for your time and I hope to see you on one of the dates listed below!

Paula Stover, MSN, RN, CNS (DNP Student)  
706-346-6053 ~ paula.stover@bobcats.gcsu.edu

Figure F2. Invitation Note Card for Staff Mail Boxes

## Invitation to Participate in a Research Project

### A student project

You are invited to participate in a research survey. The purpose of this study is to explore the relationship between personal resilience, workplace civility, and the intention to continue working in crisis stabilization units (CSU) for nurses and direct care staff. Resilience and civility have been studied in other specialties, but not together in CSU settings.

Paula Stover, a former nurse at [REDACTED] and a doctor of nursing practice student at Georgia College and State University is conducting this study under the oversight of the college Institutional Review Board. Address questions or concerns to Dr. Tsu-Ming Chiang, GC IRB Chair at [irb@gcus.edu](mailto:irb@gcus.edu); 478-445-0863.

If you are willing to participate in this study, please arrive at the room listed on the attached schedule or the room assigned for that day (ask the charge nurse). Note the times when the survey will be available. You may come to any one of these sessions. The questionnaires will take approximately 20 minutes. After completion of the survey you will receive a \$5 gift card of your choice:

- Starbucks
- Taco Bell
- McDonalds
- Subway
- Kroger
- Walmart

If you would like additional information about this study, please call, text, or email: Paula Stover at 706-346-6053 or email [paula.stover@bobcats.gcsu.edu](mailto:paula.stover@bobcats.gcsu.edu).

My very best regards,  
Paula Stover

Research Survey Administration Times

>>Attached<<

Figure F3. Survey Administration Schedule – CSU A

Research Survey Administration Times  
Name withheld

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<b>June, 2017</b>	<b>Contact:</b> Paula Stover 706-346-6053 Paula.stover@bobcats.gcsu.edu			<b>June 1</b> Time: 12:00 p – 2:00 p Location: Conference Room	<b>June 2</b> Time: 12:00 p – 2:00 p Location: Conference Room	<b>June 3</b> Time: 12:00 p – 2:00 p Location: Conference Room
<b>June 4</b>	<b>June 5</b> Time: 12:00 p – 2:00 p Location: Conference Room	<b>June 6</b> Time: 12:00 p – 2:00 p Location: Conference Room	<b>June 7</b> Time: 12:00 p – 2:00 p Location: Conference Room	<b>June 8</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 9</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 10</b> Time: 4:00 a – 7:00 p Location: Conference Room
<b>June 11</b>	<b>June 12</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 13</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 14</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 15</b> Time: 8:30 a – 10:00 a Location: Conference Room	<b>June 16</b> Time: 8:30 a – 10:00 a Location: Conference Room	<b>June 17</b> Time: 8:30 a – 10:00 a Location: Conference Room
<b>June 18</b>	<b>June 19</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 20</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 21</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 22</b> Time: 12:00 p – 2:00 p Location: Conference Room	<b>June 23</b> Time: 12:00 p – 2:00 p Location: Conference Room	<b>June 24</b> Time: 12:00 p – 2:00 p Location: Conference Room
<b>June 25</b>	<b>June 26</b> Time: 8:30 a – 10:00 a Location: Conference Room	<b>June 27</b> Time: 8:30 a – 10:00 a Location: Conference Room	<b>June 28</b> Time: 8:30 a – 10:00 a Location: Conference Room	<b>June 29</b> Time: 8:30 a – 10:00 a Location: Conference Room	<b>June 30</b> Time: 8:30 a – 10:00 a Location: Conference Room	

Figure F4. Survey Administration Schedule – CSU B

Research Survey Administration Times  
Name withheld

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<b>June, 2017</b>	<b>Contact:</b> Paula Stover 706-346-6053 Paula.stover@bobcats.gcsu.edu			<b>June 1</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 2</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 3</b> Time: 4:00 a – 7:00 a Location: Conference Room
<b>June 4</b>	<b>June 5</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 6</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 7</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 8</b> Time: 12:00p – 2:00p Location: Conference Room	<b>June 9</b> Time: 12:00p – 2:00p Location: Conference Room	<b>June 10</b> Time: 12:00p – 2:00p Location: Conference Room
<b>June 11</b>	<b>June 12</b> Time: 8:30 a – 10:30 a Location: Conference Room	<b>June 13</b> Time: 8:30 a – 10:30 a Location: Conference Room	<b>June 14</b> Time: 8:30 a – 10:30 a Location: Conference Room	<b>June 15</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 16</b> Time: 4:00 a – 7:00 a Location: Conference Room	<b>June 17</b> Time: 4:00 a – 7:00 a Location: Conference Room
<b>June 18</b>	<b>June 19</b> Time: 8:30 a – 10:30 a Location: Conference Room	<b>June 20</b> Time: 8:30 a – 10:30 a Location: Conference Room	<b>June 21</b> Time: 8:30 a – 10:30 a Location: Conference Room	<b>June 22</b> Time: 8:30 a – 10:30 a Location: Conference Room	<b>June 23</b> Time: 8:30 a – 10:30 a Location: Conference Room	<b>June 24</b> Time: 8:30 a – 10:30 a Location: Conference Room
<b>June 25</b>	<b>June 26</b> Time: 12:00p – 2:00p Location: Conference Room	<b>June 27</b> Time: 12:00p – 2:00p Location: Conference Room	<b>June 28</b> Time: 12:00p – 2:00p Location: Conference Room	<b>June 29</b> Time: 12:00p – 2:00p Location: Conference Room	<b>June 30</b> Time: 12:00p – 2:00p Location: Conference Room	

Figure F5. Survey Administration Schedule – CSU C

Research Survey Administration Times  
Name withheld

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<b>June, 2017</b>	<b>Contact:</b> Paula Stover 706-346-6053 Paula.stover@bobcats.gcsu.edu			<b>June 1</b> Time: 8:30 a – 10:00 a Location: Break Room	<b>June 2</b> Time: 8:30 a – 10:00 a Location: Break Room	<b>June 3</b> Time: 8:30 a – 10:00 a Location: Break Room
<b>June 4</b>	<b>June 5</b> Time: 8:30 a – 10:00 a Location: Break Room	<b>June 6</b> Time: 8:30 a – 10:00 a Location: Break Room	<b>June 7</b> Time: 8:30 a – 10:00 a Location: Break Room	<b>June 8</b> Time: 8:30 a – 10:00 a Location: Break Room	<b>June 9</b> Time: 8:30 a – 10:00 a Location: Break Room	<b>June 10</b> Time: 8:30 a – 10:00 a Location: Break Room
<b>June 11</b>	<b>June 12</b> Time: 12:00p – 2:00p Location: Break Room	<b>June 13</b> Time: 12:00p – 2:00p Location: Break Room	<b>June 14</b> Time: 12:00p – 2:00p Location: Break Room	<b>June 15</b> Time: 12:00p – 2:00p Location: Break Room	<b>June 16</b> Time: 12:00p – 2:00p Location: Break Room	<b>June 17</b> Time: 12:00p – 2:00p Location: Break Room
<b>June 18</b>	<b>June 19</b> Time: 12:00 p – 2:00 p Location: Break Room	<b>June 20</b> Time: 12:00 p – 2:00 p Location: Break Room	<b>June 21</b> Time: 12:00 p – 2:00 p Location: Break Room	<b>June 22</b> Time: 4:00 a – 7:00 a Location: Break Room	<b>June 23</b> Time: 4:00 a – 7:00 a Location: Break Room	<b>June 24</b> Time: 4:00 a – 7:00 a Location: Break Room
<b>June 25</b>	<b>June 26</b> Time: 4:00 a – 7:00 a Location: Break Room	<b>June 27</b> Time: 4:00 a – 7:00 a Location: Break Room	<b>June 28</b> Time: 4:00 a – 7:00 a Location: Break Room	<b>June 29</b> Time: 4:00 a – 7:00 a Location: Break Room	<b>June 30</b> Time: 4:00 a – 7:00 a Location: Break Room	

## Appendix G

## Survey Packet

The survey packet includes the following figures:

Figure G1. Consent to Participate

Figure G2. Introductory Cover Letter with Participant Instructions

Figure G3. Conner-Davidson Resilience Scale (CD-RISC) – 25 Item

Figure G4. Civility Norms Questionnaire-Brief (CNQ-B)

Figure G5. Demographic and Length of Intention to Continue Working Questions

Figure G6. Survey Completion Instructions

Figure G1. Consent to Participate

## Informed Consent to Participate in the Personal Resilience, Workplace Civility and Staff Retention Study

### Purpose of Research

You are invited to participate in a research survey. The purpose of this study is to explore the relationship between personal resilience, workplace civility, and the intention to continue working in crisis stabilization units (CSU) for nurses and direct care staff. Resilience and civility have been studied in other specialties, but not together in CSUs. Paula Stover, a former nurse at [REDACTED] and a doctor of nursing practice student at Georgia College and State University is conducting this study under the oversight of the college Institutional Review Board. Address questions or concerns to Dr Tsu-Ming Chiang, GC IRB Chair at [irb@gcus.edu](mailto:irb@gcus.edu); 478-445-0863.

### Voluntary Participation

You have been selected as a possible participant because you are a nurse or direct care staff currently working in a [REDACTED] crisis stabilization unit (CSU). This study is seeking 60 - 100 participants. Your participation is completely voluntary, and you are free to stop at any time. Simply stop taking the survey at any point.

By checking the box at the end of this consent, you are agreeing that you are:

- An adult person over 18 years of age
- Currently working in a [REDACTED] CSU (part or full time)
- Currently a health service tech, LPN, or RN
- Persons will be excluded from the study if they are younger than 18 years old or do not currently work in a [REDACTED] facility.

### Duration, Risks and Benefits of Study

The survey will take approximately 20 minutes and be available between June 1, 2017 and June 30, 2017. You will take the survey in a private area at the CSU. When you are finished, you will place it in a sealed envelope and into the locked box that only Ms. Stover will open. Your name will not be on the survey and only Ms. Stover will have access to the information. Between 60 and 100 staff will participate. Only one survey will be completed by each person. All surveys will be shredded after the project is finished. The results of this study are anonymous, strictly confidential, and for research purposes only. No one will know your identity.

Risks associated with this survey are minimal. Possible effects include increased self-awareness regarding resilience and workplace civility. Concern over low scores may occur and should be addressed by talking with the researcher, supervisor and/or professional counselor.

If you feel discomfort at any time, please stop taking the survey and return the packet to Ms. Stover. The unfinished survey will be shredded on site, placed in the sealed envelope, dropped in the lock box, and disposed off-site by Ms. Stover. You may call or email Ms. Stover at any time to discuss concerns. Contact information: 706-346-6053 / paula.stover@bobcats.gcsu.edu.

The researcher cannot guarantee benefits from this study. However, increased self-awareness may occur regarding personal resilience and workplace civility. You will receive a \$5 gift card after placing the survey in the locked box. Your participation may benefit future nurses and direct care staff by improving knowledge about personal resilience, workplace civility and intention to continue working in CSUs.

### Participant Responsibilities and Rights

- Begin the survey when you have 20 minutes of undisturbed time.
- Please complete the entire survey unless you experience discomfort.
- Be honest and thoughtful with your answers.
- Complete the study between June 1 and June 30, 2017.

You should not feel obligated to participate. Your questions should be answered clearly and to your satisfaction. If you decide not to participate, simply stop taking the survey and follow the steps noted above.

### Financial Consideration

There is no cost to you other than your time which is greatly appreciated.

### Confidentiality

The purpose of this research is to explore relationships between personal resilience, workplace civility, and the intention to remain in practice for nurses and direct care staff in the CSU. The results may be reported in nursing journals, conferences and poster presentations. Your identity will not be known and therefore not disclosed in any manner.

***Do you have any questions at this point?*** Please let Ms. Stover know before you begin.

If you are ready to take the survey, please sign your name on the line below to indicate you have read and understand this informed consent.

>> \_\_\_\_\_ <<

Please give your signed consent form to Ms. Stover and keep your copy.

You may now take the survey.



Figure G2. Introductory Cover Letter with Participant Instructions

## Instructions for the Study Participant # \_\_\_\_\_

Thank you for agreeing to participate in this study regarding the relationship between personal resilience, workplace civility, and the intention to continue working at the crisis stabilization unit (CSU) for nurses and direct care staff.

This survey packet contains three sets of survey questions and instructions on how to submit your answers. *If you have questions, please ask them now.*

Six important tasks are a part of this study:

1. read the “consent to participate” and ask Ms. Stover to answer any questions
2. when you are ready to begin, sign the form indicating that you have read and understand the consent
3. keep your copy of the consent form
4. give the signed consent to Ms. Stover and go to the quiet area per her instructions
5. answer the questions in the survey packet which should take about 20 minutes
6. when finished, place the survey packet in the envelop, seal it, and place it in Ms. Stover’s lock box

Only Ms. Stover will have access to your survey packet and no one will know which packet is yours. Your participation is completely voluntary, and you are free to stop at any time. If you decide not to participate, simply stop taking the survey and return the packet to Ms. Stover. The unfinished survey will be shredded on site, placed into a sealed envelope and the locked box, and disposed of by Ms. Stover in a secure manner. There will be no negative consequence for your decision to not participate.

Items in the packet include:

- ✓ Introductory cover letter with participant instructions (This page)
- ✓ Conner-Davidson Resilience Scale
- ✓ Civility Norms Questionnaire-Brief
- ✓ Demographic information and length of time you plan to continue working at the CSU question
- ✓ Survey completion instructions

Your participation may benefit future nurses and direct care staff by improving knowledge about the relationship between personal resilience, workplace civility and the intention to continue working in CSUs. You will receive a \$5 gift card of your choice after placing the survey in the sealed envelope and into the locked box.

When you are ready to take the survey, please turn the page. >

Figure G3. Conner-Davidson Resilience Scale 25 (CD-RISC)

**Connor-Davidson Resilience Scale 25 (CD-RISC-25) ©**

---

*For each item, please mark an "x" in the box below that best indicates how much you agree with the following statements as they apply to you over the last month. If a particular situation has not occurred recently, answer according to how you think you would have felt.*

	not true at all (0)	rarely true (1)	sometimes true (2)	often true (3)	true nearly all the time (4)
1. I am able to adapt when changes occur.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I have at least one close and secure relationship that helps me when I am stressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. When there are no clear solutions to my problems, sometimes fate or God can help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I can deal with whatever comes my way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Past successes give me confidence in dealing with new challenges and difficulties.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I try to see the humorous side of things when I am faced with problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Having to cope with stress can make me stronger.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I tend to bounce back after illness, injury, or other hardships.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Good or bad, I believe that most things happen for a reason.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I give my best effort no matter what the odds may be.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I believe I can achieve my goals, no matter how many obstacles.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Even when things look hopeless, I never give up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. During times of stress, I know where to turn for help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Under pressure, I remain organized and think clearly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I prefer to take the lead in solving problems rather than letting others make all the decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I am not easily discouraged by failure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I think of myself as a strong person when dealing with life's challenges and difficulties.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I can make unpopular or difficult decisions that affect other people, if it is necessary.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I am able to handle unpleasant or painful feelings like sadness, fear, and anger.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. In dealing with life's problems, sometimes you have to act on a hunch without knowing why.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I have a strong sense of purpose in life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. I feel in control of my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. I like challenges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I work to attain my goals no matter what roadblocks I encounter along the way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I take pride in my achievements.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Add up your score for each column</i>	0	+	+	+	+
<i>Add each of the column totals to obtain CD-RISC score</i>	= _____				

All rights reserved. No part of this document may be reproduced or transmitted in any form without permission in writing from Dr. Davidson at [mail@cd-risc.com](mailto:mail@cd-risc.com). Copyright © 2001, 2017 by Kathryn M. Connor, M.D., and Jonathan R.T. Davidson, M.D.

01-01-17

Figure G4. Civility Norms Questionnaire-Brief (CNQ-B)

**Instructions to crisis stabilization unit (CSU) nurses and direct care staff:**

While completing this portion of the survey, please think about how your workgroup interacts with each other. This survey is about interactions between co-workers, not about interactions with the individuals in the CSU. Thank you.

**The Civility Norms Questionnaire-Brief (CNQ-B)**

	Strongly Disagree 1	Somewhat Disagree 2	Disagree 3	Neutral 4	Agree 5	Somewhat Agree 6	Strongly Agree 7
Rude behavior is not accepted by your coworkers	—	—	—	—	—	—	—
Angry outbursts are not tolerated by anyone in your unit/workgroup	—	—	—	—	—	—	—
Respectful treatment is the norm in your unit/workgroup	—	—	—	—	—	—	—
Your coworkers make sure everyone in your unit/workgroup is treated with respect	—	—	—	—	—	—	—

*Note.* This survey is used with permission from Benjamin M. Walsh, Department of Management, University of Illinois, Springfield, One University Plaza, MS UHB, Springfield, IL 62703-5407, USA. Email: bwals2@uis.edu.

Please turn the page. >

Figure G5. Demographic and Length of Intention to Remain in Practice Questions

**Instructions to crisis stabilization unit (CSU) nurses and direct care staff:**

This part of the survey gathers information about age, gender, education, etc. Since you will place this survey in a locked box without your name on it, I will not be able to tell who you are nor will anyone else be able to tell when I mix all the information together in the study. This information will help with the study, but you can mark "NA" next to any question that makes you feel uncomfortable. Thank you.

---

*Please circle your answers.*

---

How long do you plan to continue working at the CSU?	1 year	2 years	3 years	4 years	5 years or more						
How long have you worked in a [redacted] CSU?	1-6 months	6-12 months	1.5 years	2 years	2.5 years	3 years	3.5 years	4 years	4.5 years	5 years or more	
How long have you worked in behavioral mental health?	1-6 months	6-12 months	1.5 years	2 years	2.5 years	3 years	3.5 years	4 years	4.5 years	5 years or more	
How many hours per week do you work at the CSU?	10 hours	15 hours	20 hours	25 hours	30 hours	35 hours	40 hours	45 hours	50 hours	55 hours or more	
What is your role at the CSU?	Certified HST		LPN		RN						
-For how long?	1-6 months	6-12 months	1.5 years	2 years	2.5 years	3 years	3.5 years	4 years	4.5 years	5 years or more	
How much education have you completed?	GED in Process	GED	High School	College Classes	Associate Degree	Bachelor's Degree	Master's Degree				
How old are you?	_____	<Please write your age.									
Are you male or female?	Female	Male									
What is your race or ethnicity?	African American Black	Asian Pacific Islander	Caucasian White	Hispanic Latino	Mixed or other, please describe:						

---

Please turn the page. >

Figure G6. Survey Completion Instructions

### **Survey Completion Instructions**

Thank you for participating in this study! Now that you are finished, please follow these instructions:

- ✓ place this packet in the envelope and seal it
- ✓ place the sealed envelope in Ms. Stover's lock box
  - no one will be able to tell which survey is yours
- ✓ select your gift card as a thank you

If you have any questions or concerns, Ms. Stover's contact information is on your copy of the consent form. You may call or email her at any time.

Again, thank you for helping to increase knowledge about the relationship between personal resilience, workplace civility, and the intention to continue working at the CSU for nurses and direct care staff. Your participation is a valuable contribution to nursing research.

## Appendix H

## Signage for Survey Administration Room

To ensure privacy during survey administration, a sign was placed on the door outside the room. A second sign was placed on the researcher's table to remind participants that conversations are to be kept focused on the study during survey administration sessions.

Figure H1. Survey Administration in Process Door Signage

Figure H2. Survey Administration in Process Table Signage

Figure H1 Survey Administration in Process Door Signage

# Research Survey in Process

Someone is taking the research project survey.

Please let them finish.

If you need help immediately,  
let Ms. Stover know.

**About this project:**

I am conducting a survey that asks nurses and direct care staff about the relationships between personal resilience, workplace civility, and the intention to continue working at the CSU.

If you are interested in participating, please let Ms. Stover know.

Thank you for your help in making this project a success.

I hope to see you on one of the dates listed below!

Paula Stover, MSN, RN, CNS (DNP Student)  
706-346-6053 ~ paula.stover@bobcats.gcsu.edu

Figure H2. Survey Administration in Process Table Signage

# Research Survey in Process

**Conversations with the researcher:**

Ms. Stover must focus on the study during survey administration times.

Please talk with her after the session about things unrelated to the survey.

If you have any questions about the survey or the research project, feel free to talk with her at any time.

**About this project:**

I am conducting a survey that asks nurses and direct care staff about the relationships between personal resilience, workplace civility, and the intention to continue working at the CSU.

If you are interested in participating, please let Ms. Stover know.

Thank you for your help in making this project a success.

I hope to see you on one of the dates listed below!

Paula Stover, MSN, RN, CNS (DNP Student)  
706-346-6053 ~ paula.stover@bobcats.gcsu.edu



## Appendix I

## Survey Administration Early Completion Notices

<p><b>Great Job So Far!</b></p> <p>We have ____ completed surveys!</p> <p>You are helping to build knowledge about the Behavioral/Mental Health care staff experience.</p> <p>Thanks for helping with this student project!</p> <p><i>Paula Stover</i></p>	<p><b>Great Job So Far!</b></p> <p>We have ____ completed surveys!</p> <p>You are helping to build knowledge about the Behavioral/Mental Health care staff experience.</p> <p>Thanks for helping with this student project!</p> <p><i>Paula Stover</i></p>
<p><b>Great Job So Far!</b></p> <p>We have ____ completed surveys!</p> <p>You are helping to build knowledge about the Behavioral/Mental Health care staff experience.</p> <p>Thanks for helping with this student project!</p> <p><i>Paula Stover</i></p>	<p><b>Great Job So Far!</b></p> <p>We have ____ completed surveys!</p> <p>You are helping to build knowledge about the Behavioral/Mental Health care staff experience.</p> <p>Thanks for helping with this student project!</p> <p><i>Paula Stover</i></p>

Appendix J

Survey Administration Early Completion Notices

<p style="text-align: center;"><b><i>Thank You!</i></b></p> <p style="text-align: center;">We reached over 90% participation in the study!</p> <p style="text-align: center;">If anyone has not participated and wants to, please contact Paula Stover at 706-346-6053 before June 18th.</p> <p style="text-align: center;">I will let you know this fall what your collective voice says about Personal Resilience and Workplace Civility in Behavioral/Mental Health care.</p> <p style="text-align: center;">Thanks for helping with this student project.</p>		<p style="text-align: center;"><b><i>Thank You!</i></b></p> <p style="text-align: center;">We reached over 90% participation in the study!</p> <p style="text-align: center;">If anyone has not participated and wants to, please contact Paula Stover at 706-346-6053 before June 18th.</p> <p style="text-align: center;">I will let you know this fall what your collective voice says about Personal Resilience and Workplace Civility in Behavioral/Mental Health care.</p> <p style="text-align: center;">Thanks for helping with this student project.</p>
<p style="text-align: center;"><b><i>Thank You!</i></b></p> <p style="text-align: center;">We reached over 90% participation in the study!</p> <p style="text-align: center;">If anyone has not participated and wants to, please contact Paula Stover at 706-346-6053 before June 18th.</p> <p style="text-align: center;">I will let you know this fall what your collective voice says about Personal Resilience and Workplace Civility in Behavioral/Mental Health care.</p> <p style="text-align: center;">Thanks for helping with this student project.</p>		<p style="text-align: center;"><b><i>Thank You!</i></b></p> <p style="text-align: center;">We reached over 90% participation in the study!</p> <p style="text-align: center;">If anyone has not participated and wants to, please contact Paula Stover at 706-346-6053 before June 18th.</p> <p style="text-align: center;">I will let you know this fall what your collective voice says about Personal Resilience and Workplace Civility in Behavioral/Mental Health care.</p> <p style="text-align: center;">Thanks for helping with this student project.</p>

Table 1

*Associations Tested*

---

Each descriptive variable and intention to continue working at the CSU

Each descriptive variable and the CD-RISC score

Each descriptive variable and the CNQ-B score

CD-RISC scores and intention to continue working at the CSU

CNQ-B scores and intention to continue working at the CSU

CD-RISC and CNQ-B scores

---

Table 2

*Category Changes for Selected Variables*

Original Variables	New Variables	Recode = 1	Recode = 2	Recode = 3
Intent to continue	Intent to continue 2	1 - 2	3 - 5	
CSU years worked	CSU years worked 2	1 - 3	4 - 9	10
BMH years worked	BMH years worked 2	1 - 9	10	
CSU role	CSU role	NA	2 - 3	
HST, LPN, RN	HST, Nurse			
CSU years in role	CSU years in role	1 - 3	4 - 9	10
Education	Education	1 - 4	5 - 7	
Age	Age 2*	Under 41	≥ 41	
Age	Age 3**	Under 53	≥ 53	
Age	Age 4***	Under 41	41-52	> 52

*Note.* CSU = Crisis Stabilization Unit; HST = Health Service Technician; LPN = Licensed Practical Nurse; RN = Registered Nurse

\* Millennial (GenY) Generation versus everyone else

\*\* Baby Boomers/Silent Generation versus everyone else

\*\*\* Individual categories

Table 3

*Sample Characteristics (n = 81) and Staff Population (N = 85)*

Characteristic	n (%)
Gender	
Female	58 (71.60%)
Male	22 (27.16%)
Missing	1 (1.23%)
Age* Mean (SD) on continuous data	42.74 (14.03)
Millennial (Age 40 and below)	38 (46.91%)
Generation X (Age 41-52)	20 (24.69%)
Baby Boomer/Silent Generation (Age 53 and above)	22 (27.16%)
Missing	1(1.23%)
Ethnicity*	
Caucasian	62 (76.54%)
Non-Caucasian	17 (20.98%)
Missing	2 (2.47%)
Education*	
No college degree	35 (43.21%)
Associate or Bachelor's degrees	46 (56.79%)
Years of experience in BMH*	
Under five years	37 (45.68%)
Five years or more	44 (54.32%)
Years worked in the CSU*	
One month – 1.5 years	31 (38.27%)
Two years – less than five years	20 (24.69%)
Five years or more	30 (37.04%)
Hours working per week*	
Less than 35 hours	11 (13.58%)
35 – 40 hours	53 (65.43%)
More than 40 hours	17 (20.98%)
CSU Role*	
Direct Care Staff (HST/Paraprofessional)	40 (49.38%)
Nurse (LPN/RN)	41 (50.62%)
Length of time in current role*	
One month – 1.5 years	30 (37.04%)
Two years – less than five years	15 (18.52%)
Five years or more	35 (43.21%)
Missing	1 (1.23%)
CSU Location percent of total population (N = 85)	81 (95.29%)
CSU 1 (Missing 1 part-time nurse)	24 (29.62%)
CSU 2 (Missing 2 Nurses “two busy”)	28 (34.57%)
CSU 3 (Missing 1 HST “too tired”)	29 (35.80%)

*Note.* CSU = Crisis stabilization unit; Percentages may not total 100 due to rounding

\* Categories merged for reporting to protect privacy of individuals

Table 4

*Age by Generations (n = 80)*

Generation	Age Range	Frequency	Percent
Millennial	Age 40 and below	38	46.91%
Generation X	41-52 years	20	24.69%
Baby Boomer and Silent Generation	Age 53 and above	22	27.16%
Missing	“over 50” years	1	1.23%

*Note.* Percentages may not add to 100 due to rounding

Table 5

*Frequency and Distribution of Independent and Dependent Variables*

Variable	n (%)
Intent to continue working in the CSU	77 (95.06)
1 year	12 (14.81%)
2 years	17 (20.98%)
3 years	6 (7.41%)
4 years	4 (4.94%)
5 years or more	38 (46.91%)
Unsure*	3 (3.70%)
Missing**	1 (1.23%)
CD-RISC score	81 (100%)
Mean ( <i>SD</i> )	79.11 (10.13)
Median	80.00
Mode	81
Minimum	46
Maximum	98
CNQ-B scores	81 (100%)
Mean ( <i>SD</i> )	19.64 (5.19)
Median	20.00
Mode	20
Minimum	7
Maximum	28

*Note.* Percentages may not total 100 due to rounding

\*Participants wrote in “unsure” or “?”; data treated as missing

\*\* Participant wrote in the number of years employed at the CSU; data treated as missing

Table 6

*Spearman's Rho Correlations between Variables (2-tailed)*

Variable	CD-RISC <i>rs (n)</i>	CNQ-B <i>rs (n)</i>	Intent <i>rs (n)</i>
CD-RISC			
CNQ-B	-0.005 (81)		
Intent	0.002 (77)	0.11 (77)	
BMH years of experience	-0.034 (81)	0.156 (81)	0.094 (77)
CSU years of experience	-0.114 (81)	0.071 (81)	0.058 (77)
CSU hours per week	0.043 (81)	-0.133 (81)	0.217 <sup>b</sup> (77)
CSU length of time in current role	-0.09 (80)	0.158 (80)	0.018 (76)
Age*	0.046 (80)	0.328 <sup>a</sup> (80)	0.085 (77)

*Note.* Intent = intention to continue working at the CSU

\*Age as continuous variable

<sup>a</sup>  $p = .003$

<sup>b</sup>  $p = .058$



Table 7

*Differences between Variables*

<u>Kruskal-Wallis</u>						
Variable	CD-RISC	CNQ-B	Intent			
CSU Location	1.864 (2)	5.701b (2)	0.538 (2)			
df (k-1)						
<u>Mann-Whitney (2-tailed)</u>						
Variable	CD-RISC	CNQ-B	Intent	U	Rank Mean	Rank Mean
CSU Role	2.217a			1054	(D) 35.14	(N) 46.72
CSU Role		0.289		850.5	(D) 40.24	(N) 41.74
CSU Role			0.099	750	(D) 38.77	(N) 39.24
Education	1.517			964	(No) 36.46	(C) 44.46
Education		0.864		895.5	(No) 38.41	(C) 42.97
Education			0.061	736.5	(No) 38.84	(C) 39.13
Gender	-1.13			533.5	(F) 42.30	(M) 35.75
Gender		1.058		736	(F) 38.81	(M) 44.95
Gender			-0.38	574	(F) 39.56	(M) 37.59
Age*	0.178			816.5	(Y) 40.01	(X) 40.94
Age*		2.326a		1039	(Y) 34.16	(X) 46.24
Age*			0.758	807	(Y) 37.08	(X) 40.68

*Note.* C = College degree; D = Direct care staff; F = Female; Intent = intention to continue working at the CSU; M = Male; N = Nurse; No = No college degree; X = Generation X and Baby Boomer generation; Y = Y (Millennial) Generation;

a  $p < .05$

\*Age as generational categories

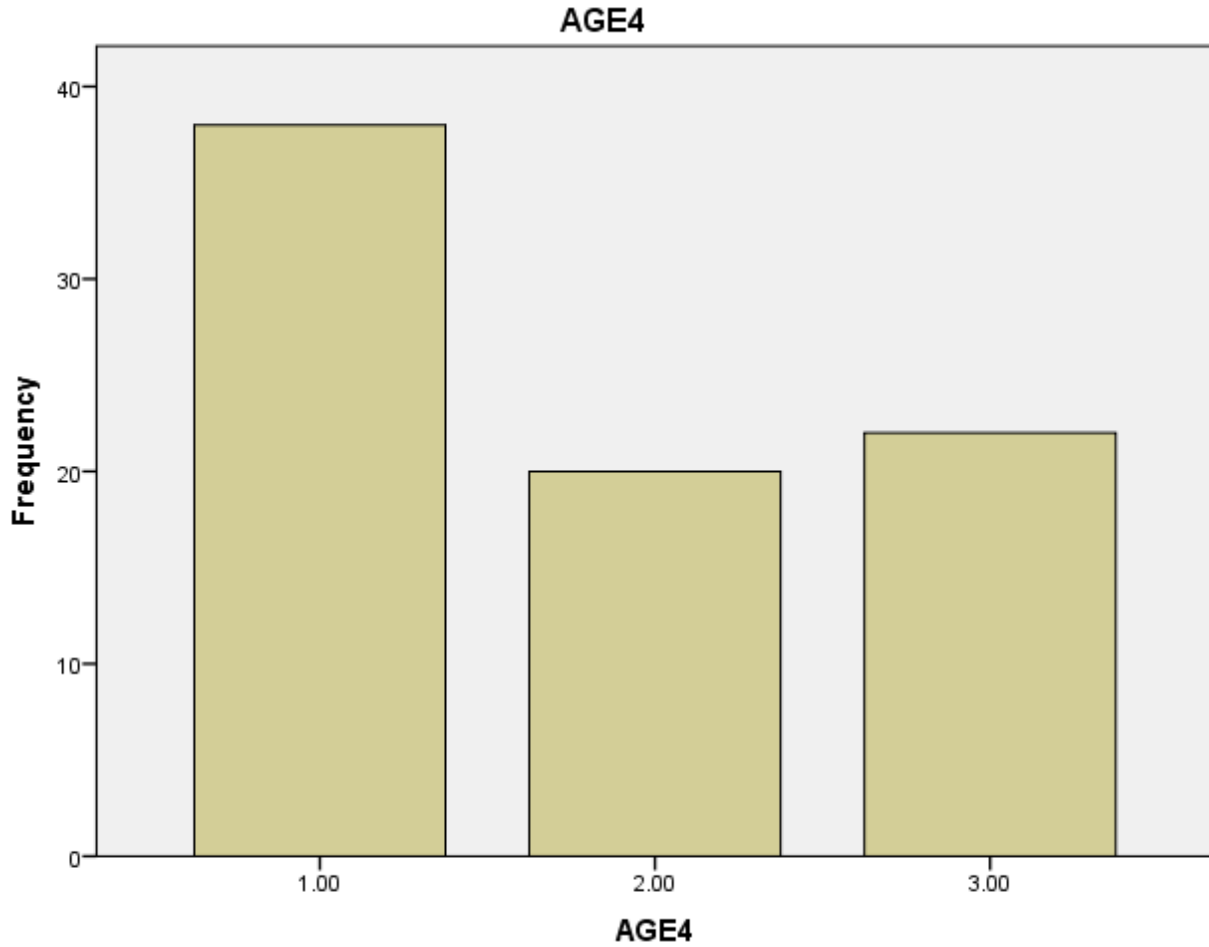
Table 8

*Staff Comments After Survey Administration Sessions*

Comment	Frequency
<u>Retention</u>	3
I am staying right here; Best job ever	
<u>Lack of opportunity</u>	8
There is no way to move up here; this is all there is [HST].	
I'm capped out even after years of service [RN/HST].	
I've been doing this so long, it's time to move [up, out, to school] [HST].	
<u>Work enjoyment</u>	7
I like it here; I love my job [RN/HST].	
This is the best place I ever worked [RN/HST]	
<u>Workplace civility/Teamwork</u>	15
They [Nurses/HSTs] should treat us with more respect. (2/3)	
You have to trust each other in this line of work. (3)	
We are like a family here; We are the dream team. I love my work family. (7)	
We have fun here. You have to keep it light. (4)	
<u>Closure of the regional hospital</u>	5
When they closed the hospital, we lost our community, our family [RN/HST].	
We could depend on each other and could work other units [HST].	
Here it is so closed in and isolated [HST].	
We were respected; everyone knew us and we knew them [HST]. (2)	
We had pride in being a part of something larger [HST]. (2)	
We took better care of the patients. We had more to offer. [RN/HST] (5)	
We aren't recognized here like we were there [HSTs]. (3)	
<u>Safety concern</u>	5
We should prevent interruptions during med set up and med pass [RN].	
We talk about it all the time, but we don't do it [RN].	
<u>Thoughts generated from the survey instruments</u>	8
This made me think; I have some things to think about.	
This was great; I liked it.	
What do you do if you have a low (resilience) score [RN/HST]?	

*Note.* No persons made comments about personal resilience or self-care.

Figure 1

*Age by Generations (n = 80)*

*Figure 1.* Age was categorized into groups from a continuous variable to protect privacy. Age 1.00 = Millennial is age 40 and below ( $n = 38$ ; 46.91%); Age 2.00 = Generation X is 41-52 years ( $n = 20$ ; 24.69%); Age 3.00 = Baby Boomer and Silent Generation are age 53 years and older ( $n = 22$ ; 27.16). One participant wrote in “over 50” which could not be quantified accurately; the data was entered as missing.

Figure 2

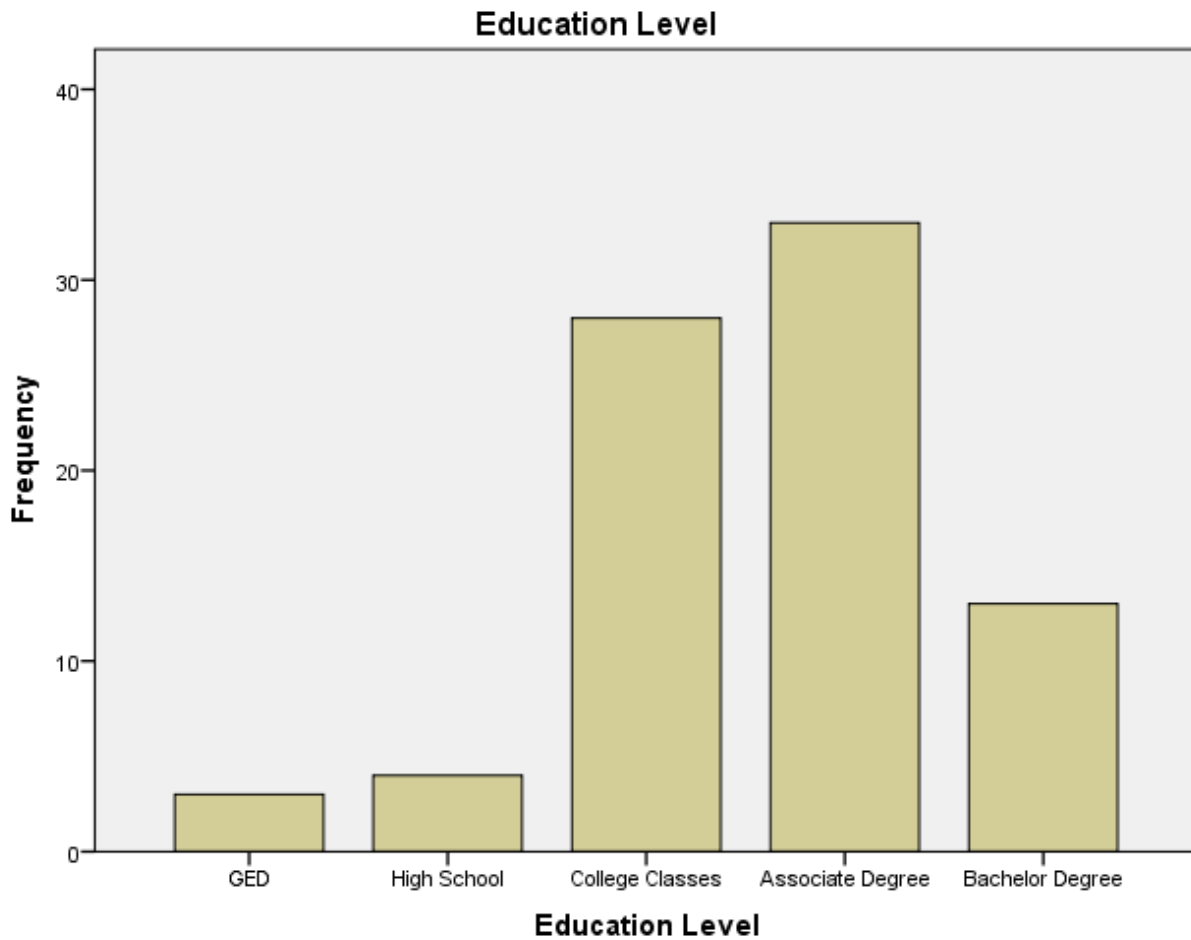
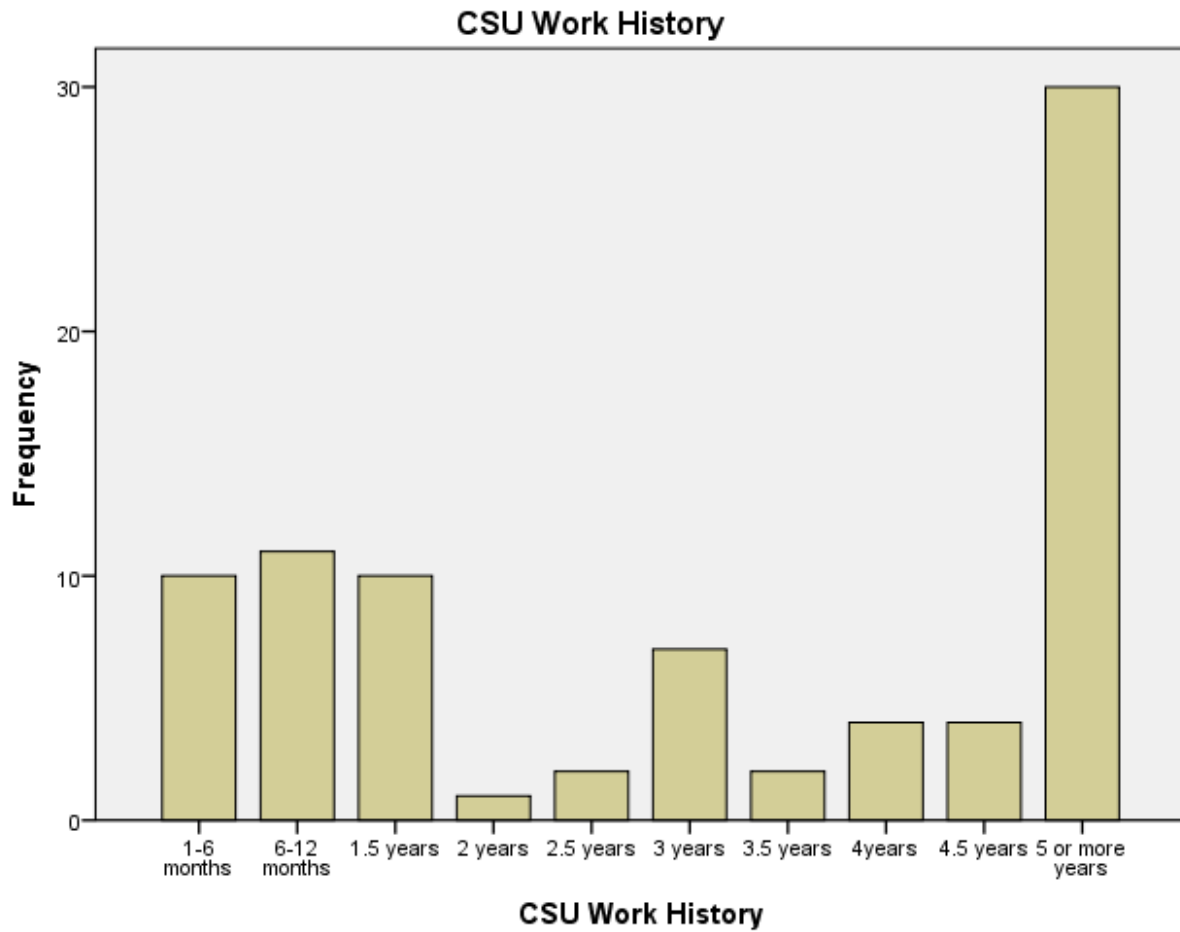
*Education Level (n =81)**Figure 2.* No data adjustments were needed for this variable.

Figure 3

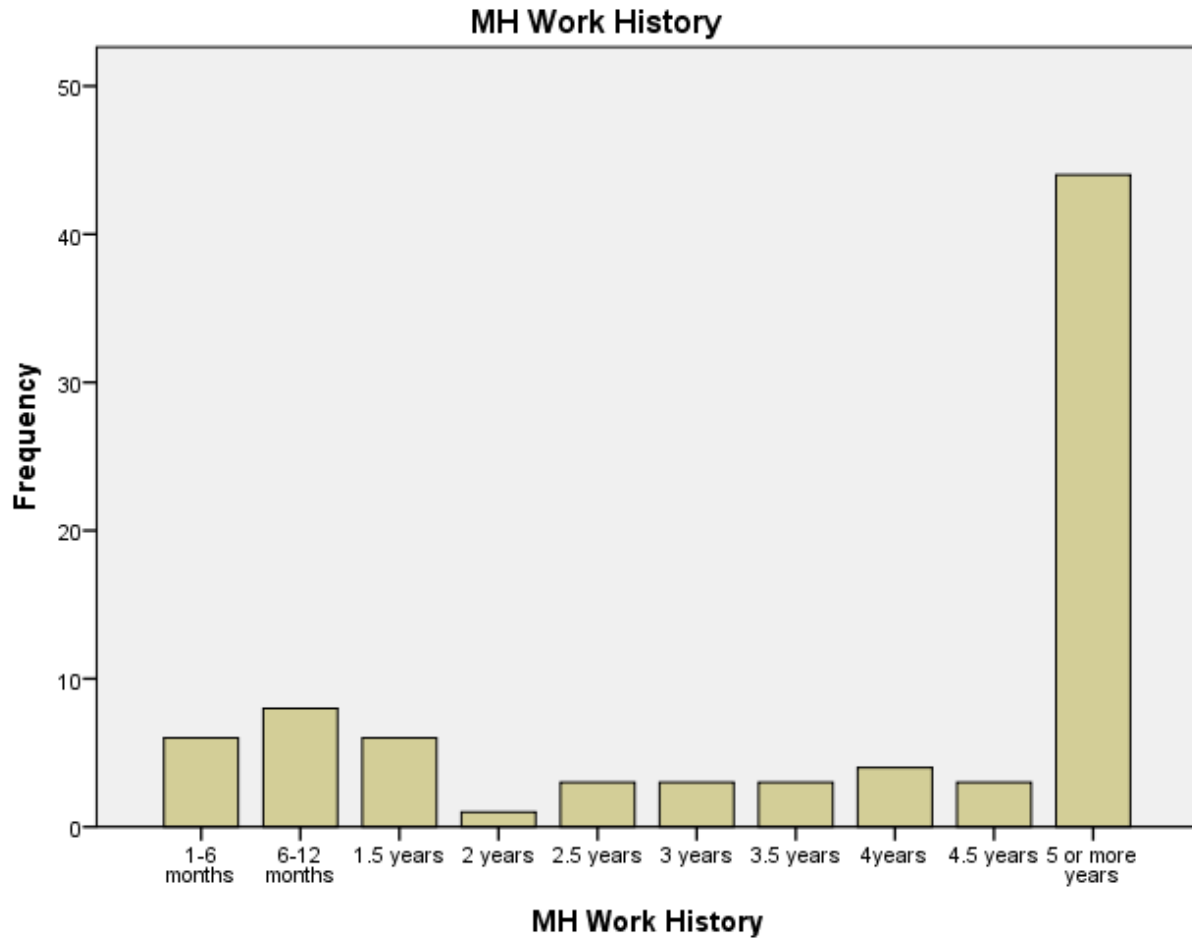
*Years of Experience in the CSU (n = 81)*



*Figure 3.* No data adjustments were needed for this variable.

Figure 4

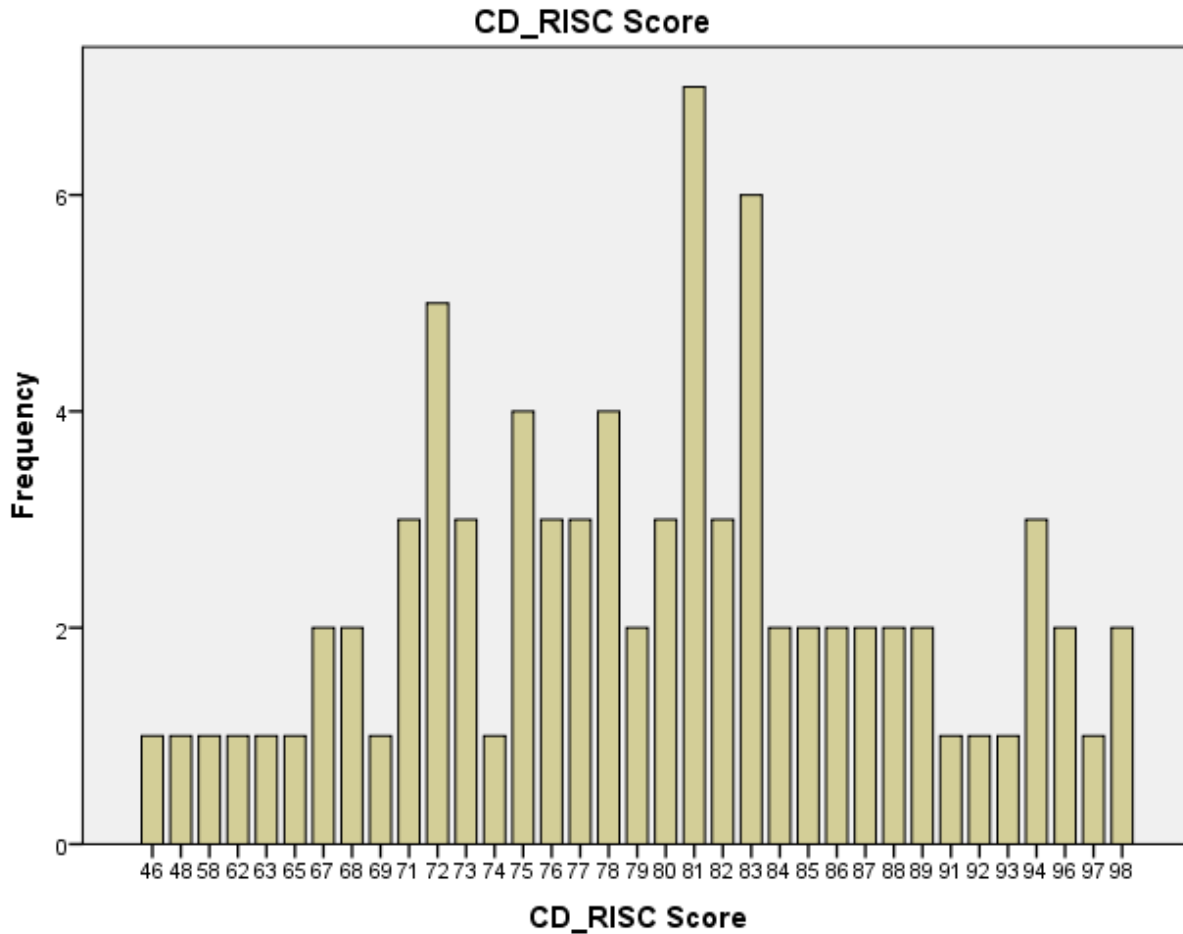
*Years of Experience in BMH (n = 81)*



*Figure 4.* No data adjustments were needed for this variable.

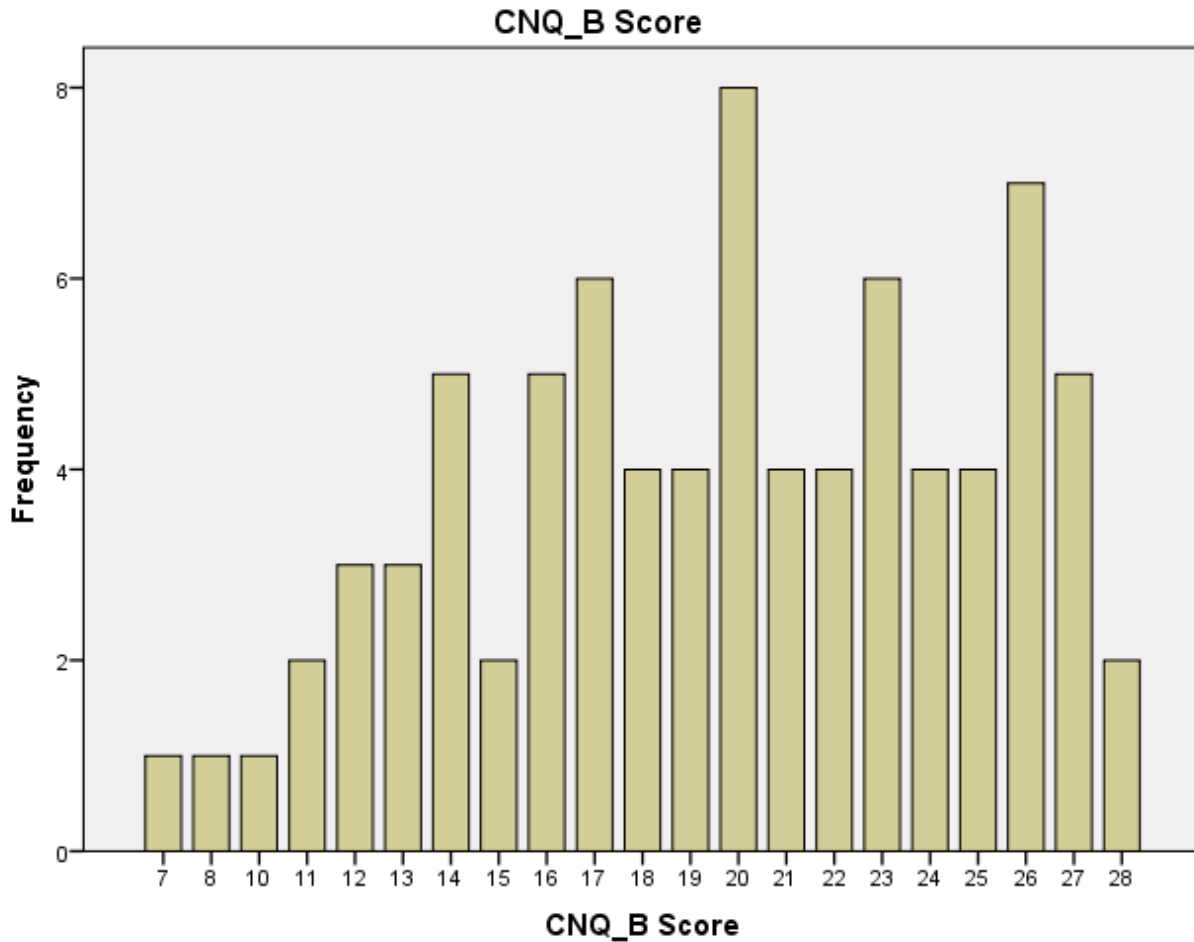
Figure 5

*Personal Resilience Scores (n = 81)*



*Figure 5.* In this study, the mean was 79.11 ( $SD = 10.13$ ), median was 80.00, and mode was 81. Low and Moderately Low scores total 52 (64.19%); Moderately High and High scores total 29 (35.8%). Three persons omitted one answer each on this instrument, so their scores might have been higher had this omission not occurred. Low scores = 0 - 73; moderately low scores = 74 - 82; moderately high scores = 83 - 90; high scores = 91 - 100 ("CD-RISC," 2017).

Figure 6

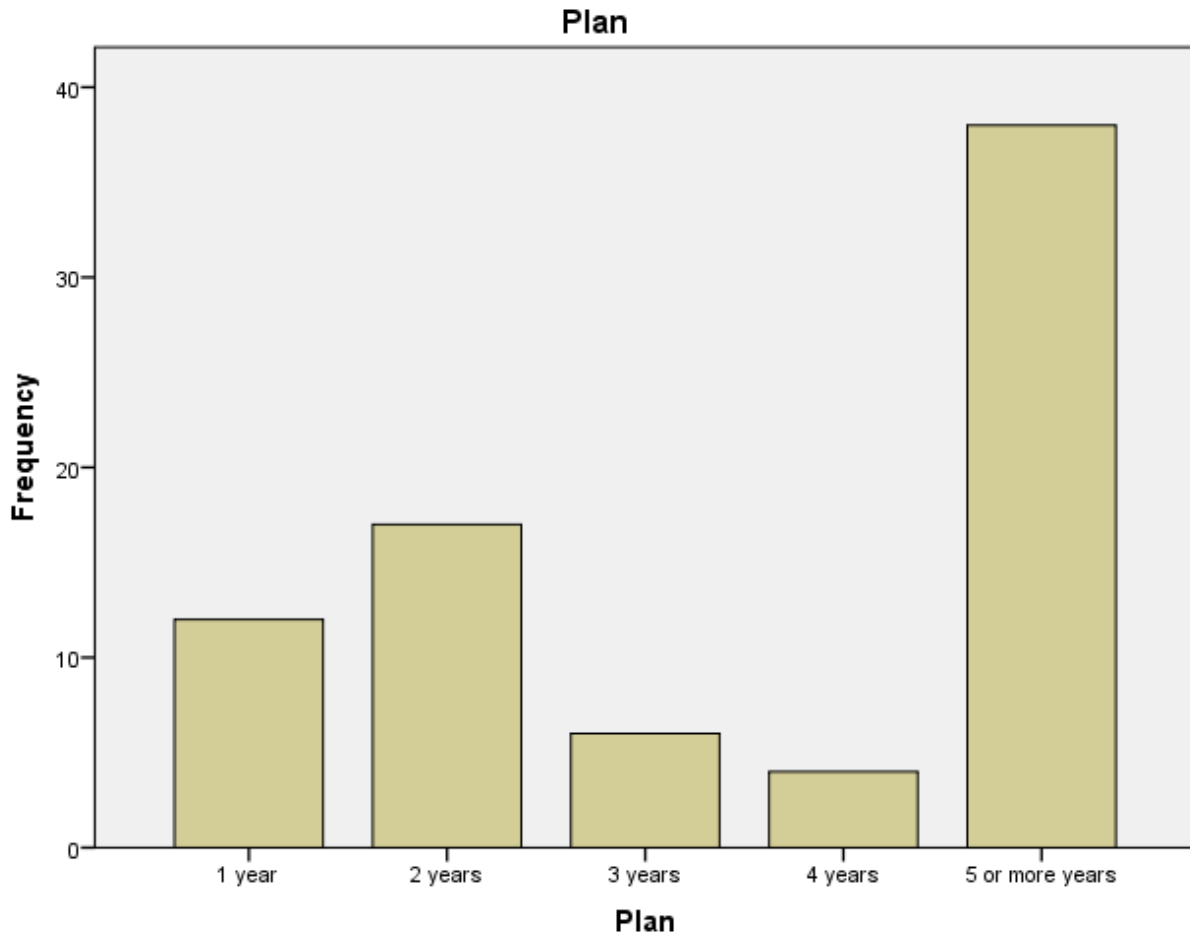
*Workplace Civility Scores (n = 81)*

*Figure 6.* In this study, the mean was 19.64 ( $SD = 5.185$ ), median was 20, and mode was 20. No missing data occurred for this instrument, however, two participants entered numbers in columns rather than checking the space provided. The score for the space was used rather than the number in both cases. There are no established score categories for this instrument (Walsh et al., 2012).



Figure 7

*Intention (Plan) to Continue Working in the CSU (n = 77)*



*Figure 7.* Three persons indicated “unsure” or “?” and one person wrote in the length of time already working in the CSU, therefore, four cases are missing this information.