Nursing Incivility and the Culture of Safety in an Acute Care Facility

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Abstract

Background: Nursing incivility is a problem for the profession of nursing and interferes with the establishment of a culture of safety, placing patient safety at risk. Elements associated with incivility, Jean Watson's nursing Theory of Caring, and transformational leadership contributed to the project's theoretical framework. The aim of this DNP project was to increase the knowledge of nurses regarding incivility, improve respectful communication, and provide support to enforce the expectation of a culture of safety

Methods: A survey of the modified culture of safety (MCSS) with intent to stay and the nursing incivility scale (NIS) was administered prior to a one-hour educational intervention and within 30 days. An incivility policy was created to address uncivil behavior outlining procedure if necessary.

Results: Paired samples t-tests were conducted on data gathered from 52 participant surveys. Five of 12 subscales showed a statistically significant difference suggesting an increased awareness of incivility from the educational intervention.

Conclusion: As organizations strive for a culture of safety for the work environment, the matter of incivility must be addressed. This project increased awareness of the existence of incivility in the project setting.

Keywords: nursing incivility, bullying, lateral and horizontal violence

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Communication is imperative when working in the healthcare environment. Factors such as uncivil behaviors interrupt the communication process and breakdown the effectiveness of the team. According to Evans (2017), uncivil behavior occurs more frequently among nurses than any other health care discipline. Nurses are expected to act in a professional manner by collaborating with others to provide safe patient care. Furthermore, as recounted by Reynolds, Kelly, and Singh-Carlson (2014), the highest incidences of uncivil behavior reported were within the maternal child health (MCH) setting, specifically the labor and delivery (L&D) unit. Uncivil behaviors range from gossiping, rudeness, yelling, ignoring, and backstabbing (Rainford, Wood, McMullen, & Philipsen, 2015). Non-verbal behaviors such as eye-rolling, negative facial expressions, and turning away from someone when speaking are equally uncivil (Reynolds, Kelly, & Singh-Carlson, 2014). Uncivil behaviors negatively influence patient outcomes, the atmosphere of the workplace, and the nurse turnover rate (Evans, 2017). Unit leadership is expected to provide a culture of safety by recognizing and eliminating incivility to promote a healthy workplace environment (Spence Laschinger, Borgogni, & Consiglio, 2015). This paper discusses a doctor of nursing practice (DNP) project focused on increasing awareness of uncivil behaviors through nursing education and policy development to reduce the incidence of incivility in a select MCH department.

Background

In 2015, the American Nurses Association (ANA) published a position statement on incivility, bullying, and workplace violence (American Nurses Association [ANA], 2015). The position statement identifies the incidence and definition of each term, provides three levels of prevention, and suggests ways to combat incivility. For this discussion, incivility is an umbrella

term for bullying, and horizontal and lateral violence. In addition to the ANA, Reynolds et al.

(2014), reported the "Joint Commission issued a sentinel event alert to healthcare organisations

[sic] in an effort to combat disruptive behaviors that undermine the culture of safety and threaten

quality care to patients" (p. 25). The culture of safety and positive patient outcomes are essential

for effective healthcare organizations.

The Agency for Healthcare Research and Quality (AHRQ) developed survey tools

specifically for assessing the culture of safety for organizations (Agency for Healthcare Research

and Quality [AHRQ], 2017). The culture of patient safety corresponds directly to nurses'

perception of a healthy work environment. Hospitals routinely utilize the AHRQ survey tool

regarding issues influencing the work environment. The survey is a qualitative data collection

tool, in a Likert style, to determine whether employees feel safe in their work environment.

Surveying the workforce provides leadership with necessary information for quality

improvement planning related to the work environment. The survey results also serve as a

feedback mechanism for first-line management accountability to higher administration related to

the healthy work environment for which they are responsible.

The project site currently provides the population of interest for this DNP project an

opportunity to complete the AHRQ survey on a biannual basis. The survey was last

administered in May, 2017 to the entire organization. A brief, modified culture of safety survey

(MCSS) of seven questions based on the AHRQ survey will assess the nurses' perception of the

culture of safety within the MCH department (Appendix A). Permission was granted to use

modified items from the AHRQ survey (Appendix B).

Part of a culture of safety is the issue of incivility including possible measurement of

uncivil behavior that is not specifically addressed in the AHRQ survey. However, Guidroz,

Burnfield-Geimer, Clark, Schwetscchenau, and Jex (2010) have developed a nursing incivility

scale (NIS) (Appendix C) to assess nurse perception of incivility in the workplace. The NIS is a

valid and reliable survey to assess hospital nurses' experiences with incivility depending upon

experiences with different populations such as providers, patients, and coworkers (Guidroz,

Burnfield-Geimer, Clark, Schwetscchenau, & Jex, 2010).

The correlation between patient safety and the available numbers of nurses in the

workforce is another consideration. In 2010, the Institute of Medicine (IOM) reported an

impending nursing shortage and identified the need to increase retention of the existing

employed nurse workforce (Rosenfeld & Glassman, 2016). Additionally, the number of nurses

retiring in the same period will only increase this need for more nurses (Spence Laschinger,

Borgogni, & Consiglio, 2015). Nurses who perceive the work environment in a negative light

due to conditions such as incivility often leave their unit (Berry, Gillespie, Fisher, Gormley &

Haynes, 2016). Reports of high numbers of new graduates leaving their first position due to

incivility further impacts the active nursing workforce (Bratt & Felzer, 2011). New nurses are

more likely to be targets of incivility, which can lead to high turnover rates (Evans, 2017).

Incivility is detrimental to the work environment, employee satisfaction, and can reduce the

nurses' intent to stay in clinical positions.

The largest numbers of available nurses for hire are new graduate nurses. MCH is a

specialty area which places the new nurse in a high stress situation on both an educational and

psychological level (Welding, 2011). As Evans (2017) points out, new nurses are more likely to

be the target of incivility during their first year of practice due to learning processes and their

lack of experience. Once uncivil behavior begins, the new nurse may be less likely to consult

experienced nurses for assistance with clinical decision-making, thereby putting the patient at

risk (Reynolds et al., 2014). Read and Lacschinger (2013) note that regardless of experience level, recipients of uncivil behavior often experience distress such as feelings of humiliation, vulnerability, and of being threatened. Consequently, uncivil behavior contributes to lowering of self-confidence levels, increased stress levels, unhealthy work environments, and ultimately compromise of patient safety (Reynolds et al., 2014).

Problem Statement

Rainford et al. (2015) pointed out that when nurses employed on a unit have strained relationships, medical errors and patient safety become significant issues. The lack of a policy to address professional conduct does not support the organizational leadership's ability to expect and enforce collegial and respectful behaviors among the nursing staff. Nursing management is instrumental in directing the nurse workforce to contribute to a healthy work environment and decrease uncivil behavior (Spence Laschinger et al., 2015). Furthermore, data gathered from the safety survey can provide insight to management about the healthfulness of the work environment as well as to administration as a gauge for management performance. Therefore, it is crucial to employ strategies to increase awareness of incivility, decrease the incidence of these behaviors, and nurture the culture of safety. Research suggests the combination of education and recognition of incivility will lead to a decline of these behaviors (Stagg, Sheridan, Jones, & Speroni, 2013). Creating and enforcing a zero-tolerance policy serves to provide a culture of safety for MCH nurses.

Purpose of the Project

The purpose of this project is to design a workplace incivility educational workshop and to generate a zero-tolerance incivility policy for a specific MCH department. The intention of this project is to decrease workplace incivility, foster a positive work atmosphere, increase

employee satisfaction, and indirectly improve patient outcomes. The goal of the incivility

educational workshop is to reduce uncivil behavior, mitigate stress and burnout, improve

retention rates, and improve the MCSS and NIS survey results between the end date of the

educational intervention and 30 days after.

DNP Project Practice Question (PICO)

The lead of this project utilizes the population, intervention, comparison, and outcomes

format to develop the DNP practice question (Moran, Burson, & Conrad, 2017). The population

(P) of interest, are nursing staff employed in a specific MCH department, which include L&D,

two post-partum units, the neonatal intensive care unit (NICU) and high-risk obstetrics unit

(HROB). The intervention (I) is the creation of an incivility educational workshop and policy.

The comparison (C), are the MCSS and NIS survey results before and after the incivility

educational workshop. The outcome (O) of this project is 50 percent increase in positive results

of the MCSS and NIS survey such as the perception of respectful treatment. The timing (T)

involves collection of data from the MCSS and NIS survey administered at the time of the

workshop and a post survey administered within 30 days after the incivility educational

workshop. The project question is: will the creation of a zero tolerance policy and incivility

educational workshop reduce the incidence of nurses experiencing uncivil behaviors from

colleagues and improve the intent to stay employed in the MCH department?

Objectives

The aim of this DNP project is to increase the knowledge of nurses regarding incivility,

improve respectful communication, and provide support to enforce the expectation of a culture of

safety. The result of the project will be a measurable reduction in the occurrence of incivility

and an increased intent to stay employed in the MCH department. The DNP project aim will be

met through the attainment of the following objectives.

Objective 1

Develop an incivility policy to support zero tolerance of uncivil behaviors perpetrated by

the staff members. This policy will assist the management team and nursing staff in recognizing

uncivil behaviors, and implementing strategies listed in the policy. The implementation of this

objective will reduce the incidence of uncivil behaviors within the MCH department after the

policy is reviewed and accepted by the organization.

Objective 2

Design, develop, and evaluate an incivility educational program using evidence-based

strategies such as case studies, discussion, video portrayal of uncivil behaviors, and terminology

and scripting to utilize when incivility occurs (Thompson & George, 2016). The nursing staff of

the MCH department are invited and encouraged to attend the incivility educational workshop

and participate in the activities provided to increase their awareness.

Objective 3

Determine if the incivility educational program improves perceptions of culture of safety

and job satisfaction among nurses. The perception of the culture of safety will be measured by

the pre-post MCSS and NIS surveys.

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Literature Search

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This project lead conducted a comprehensive search of digital databases, ProQuest, Ovid,

EBSCOhost, and CINAHL. The search performed used terms associated with incivility,

bullying, lateral and horizontal violence, and best practices for addressing incivility, bullying,

and lateral and horizontal violence. The Boolean phrases used by this project lead for gathering articles included nursing and incivility, nursing and bullying, nursing and lateral or horizontal violence, as well as nursing and workplace violence. The period for the search was limited to January 2012 through April 2017. The inclusion criteria consisted of English language, full-text, and peer-reviewed, scholarly articles. When over 2000 articles surfaced, there was a need to further narrow the scope of the search. Over 100 articles were appraised with 50 articles selected and considered for this review based on the project lead of the article's definition of terminology. For example, when the search term or phrase included the word violence, many articles included physical violence which resulted in this project lead excluding the article. The same occurred for searches with phrases of lateral, horizontal, and workplace violence. After further inspection, several articles mentioned incivility, horizontal or lateral violence or bullying in a brief manner but did not include a full discussion of the topic, which excluded those articles. The final total of articles considered for this literature review was 35 out of the 50 English language; nursing focused, non-physical violence, peer-reviewed, scholarly articles concerning nursing, incivility, lateral and horizontal violence.

Literature Review

This literature review provides evidence that education of nurses can increase awareness of incivility, influence the perception of nurses' actions, and change the practice of nurses in the clinical area. The majority of evidence supported the provision of education, communication training, and rehearsal to raise awareness and effects of incivility. Additionally, some publications included strategies to increase awareness and prepare nurses to address incivility. Along with education and increasing awareness, numerous articles considered prevention,

leadership and management, and the implementation of a zero-tolerance policy as strategies to decrease or control the pervasiveness of incivility in the work environment.

Nursing literature highlights the need for education and implementation of strategies to address the occurrence of incivility. Reducing incivility in nursing will foster a healthier work environment, which will increase nurse retention and decrease the severity of the impending nursing shortage. Additionally, employing strategies to combat incivility will result in reducing financial strain associated with nurse turnover, improving nurse morale, and lowering stress levels of the nurses working in the MCH department (Berry, Gillespie, Gates, & Schafer, 2012; Rush, Adamack, Gordon, & Janke, 2014; Mellor & Gregoric, 2016).

Nursing is an occupation centered on providing care for diverse individuals. Unfortunately, some nurses treat their colleagues in an uncaring manner as many nurses report being subjected to incivility (Bogossian, Winters-Chang, & Tuckett, 2014; Lux, Hutcheson, & Peden, 2014; Rainford, Wood, McMullen, & Philipsen, 2015). There are several terms used to describe the matter of incivility that occurs at various occupational levels and the degrees of severity or intent. Expressions to describe the phenomenon include lateral or horizontal violence, bullying, disruptive or inappropriate behavior, and incivility. Various research studies have differentiated bullying from incivility by the degree of harm and intended target of behavior. Malcolm and Boyle (2016) discuss being bullied as "a person's perception of repeated negative acts such as harassment, intimidation, exclusion, isolation, hostility, character assassination, and constant criticism" (p. 3). Read and Laschinger (2013) describe incivility as being hard to define such as "low-intensity rude or disrespectful behaviors with an ambiguous intent to harm others" (p. 222). Bullying is also listed in several studies as having a period of

lasting greater than six months (Boyle & Wallis, 2016; Lee, Bernstein, Lee, & Nokes, 2014; Moore, Leahy, Sublett, & Lanig, 2013).

As previously stated, prevention of incivility is a prevailing theme discovered during this literature review for opposing the incidence of incivility in nursing. Over ten of the reviewed articles mention themes of nursing students being nurses' first exposure to uncivil behavior. The addition of incivility awareness training and preparing nursing students to deal with uncivil behavior can influence the future of nursing and the work environment. Smith, Gillespie, Brown, and Grubb (2016) examine themes revealed through interviewing nursing students; and the paramount recommendations that emerged was education in how to moderate uncivil behavior and to teach students how to respond in a professional manner. Smith et al. further describes management influences and the effects of charge nurses in choosing which nurses students are exposed to certain nurses known for incivility during clinical experiences. This idea of education and preparing nursing students can carry over to preparing new graduate nurses during orientation. Preventing the first exposure to incivility is crucial because many nurses who perpetrate incivility report their personal experience with the behavior as a rite of passage as a new nurse (Boyle & Wallis, 2016; Etienne, 2014; Frederick, 2014). Breaking the cycle of past victims becoming future agents of incivility will foster a healthy work environment for healthcare organizations.

The impact of leadership in influencing the work environment to be respectful and safe is invaluable (Spence Laschinger & Read, 2016). The adage of nurses "eating their young" mentioned in another 13 articles suggests the inability to alter this mindset for the better. Moore, Leahy, Sublett, and Lanig (2013) debate active leadership to support a healthy work environment for nurses by providing support, encouragement, and intervention during conflict management as

crucial for promoting a healthy work environment. Major, Abderrahman, and Sweeney (2013) examine the idea of a framework for managers to conduct "crucial conversations" to address conflict management in the workplace (p. 68). Berry, Gillespie, Fisher, Gormley, and Haynes (2016) inspect stress and incivility and found that lack of management involvement can result in perpetuating the atmosphere of being unable to decrease incivility. Conversely, they found leadership that recognized and intercepted inappropriate communication between nurses fostered a more positive environment. Berry et al. (2016) further observed that managers who "move swiftly to resolve escalating conflict" empower the nurses on their unit (Berry, Gillespie, Fisher, Gormley, & Haynes, 2016, p. 7).

Although incivility in the workplace has been an issue since first appearing in nursing literature, there seems to be no lessening of its incidence. Furthermore, the issue is so problematic that accrediting bodies and professional organizations of nursing have addressed the subject to curtail the behavior within the profession. The ANA has a nursing code of conduct in addition to a position statement against bullying and incivility (Becher & Visovsky, 2012; Burgess & Patton Curry, 2014; Evans, 2017; Frederick, 2014; Lachman, 2014; Major, Abderrahman, & Sweeney, 2013). Multiple studies discuss how the Joint Commission classifies incivility as being of high importance for patient safety (Becher & Visovsky, 2012; Burgess & Patton Curry, 2014; Etienne, 2014; Evans, 2017; Lachman, 2014; Moore et al., 2013; Reynolds, Kelly, & Singh-Carlson, 2014; Thompson & George, 2016). The IOM has published reports on the impending nursing shortage and the need to recruit and retain nurses (Frederick, 2014; Spence Laschinger, Leiter, Day, Gilin-Oore, & Mackinnon, 2012).

The mission of the AHRQ is to foster patient safety in a structural manner for health organizations worldwide. The AHRQ endorses the approach of a culture of safety and seeks to

educate about ways to improve the concept of safety in nursing (Griffin & Clark, 2014). According to Ulrich and Kear (2014), the AHRQ strives to increase the body of knowledge for quality improvement concerned with the delivery of healthcare and patient outcomes. The AHRQ collects information from healthcare organizations that use their surveys to create a database. The database serves as a benchmark for organizations to gauge and assess trends in healthcare regarding patient safety to use for comparison. In addition to using these databases for comparison, organizations use the evidence-based information for quality improvement measures within their facility (Ulrich & Kear, 2014).

In addition to collecting information for databases, the AHRQ develops tools for organizations to use to enhance the culture of safety in healthcare organizations (Ulrich & Kear, 2014). The specific tool revealed by the literature review is the concerned, uncomfortable, safety tool (C-U-S), which the AHRQ supports as an example of scripting for communicating during a time of conflict between provider and nurse. As pointed out by Griffin and Clark (2014), the C-U-S tool provides a model for professionally addressing uncivil behavior between nurses. C-U-S stands for terms a nurse can use that serve as a notification to colleagues of the frame of mind of concern, uncomfortableness, and feeling unsafe (Griffin & Clark, 2014). Griffin and Clark (2014) further suggest when a nurse is dealing with an issue of incivility and feels that team discord may negatively impact patient safety, to speak up and use the phrase "Please address me in a respectful way" (p. 541).

A healthy and safe work environment should be an expectation of a professional nurse. Nurses should not have to defend themselves from their colleagues engaging in inappropriate or destructive behavior such as yelling, rude comments, sabotage, or the rolling of eyes (Becher & Visovsky, 2012; Berry et al., 2012; Etienne, 2014). Moore, Leahy, Sublett, and Lanig (2013)

conducted a qualitative study about nurse relationships and the influence of the nursing work environment. Moore et al. (2013) used the open-ended, Nurse-to-Nurse Relationship Questionnaire, to collect data about how the nurses felt regarding their work environment and relationships. This study found several themes influencing the workplace including intention to stay on the nursing unit, occurrence of negative interactions or incivility, managerial role regarding conflict resolution, and the ability of new graduate nurses to fit into the unit (Moore et al., 2013). The study concluded positive relationships within the unit are essential for a healthy work environment. Relationships depend upon positive interactions between nurses of all levels of experience and position (Becher & Visovsky, 2012; Lux, Hutcheson, Peden, 2014; Berry et al., 2012). A lack of positive relationships or healthy work environment leads nurses to consider leaving either the unit or the profession entirely (Moore et al., 2013; Stagg, Sheridan, Jones, & Speroni, 2013).

Interpersonal relationships in nursing were also studied by Spence Laschinger et al. (2012) to determine the effect of an intervention on nurse perceptions of incivility. Spence Laschinger et al. (2012) compared results of a program designed to increase nurse empowerment, trust in management, and evaluate its impact on the incidence of incivility (Spence Laschinger et al., 2012). A quasi-experimental design determined the effects of a workplace intervention, Civility, Respect, and Engagement in the Workforce (CREW) on nurses. Participating units were surveyed about perceptions three months before the intervention. The CREW toolkit was provided, complete with goals and strategies to use for six months. The CREW intervention study results, when compared to a control group, showed greater improvements, thus supporting the hypothesis of the intervention and strategies (Spence

Laschinger et al., 2012). The nurses in the study reported increased trust in management and lower incidence of incivility.

The effects of incivility have been widely studied and range from physical and psychological distress to affecting patient safety and outcomes. Dang, Bae, Karlowicz, and Kim (2016) used a cross-sectional descriptive design to study over 1500 clinicians of various educational levels and job descriptions. The study aim was to discover correlations between disruptive behaviors and negative consequences for both patients and clinicians (Dang, Bae, Karlowicz, & Kim, 2016). For their conclusions, Dang et al. (2016) used descriptive, bivariate, and inferential statistical analyses. Their study ascertained there is an inverse relationship between disruptive behavior and patient safety, specifically errors and near misses (Dang et al., 2016). The authors also note the study's limitations as it was "conducted in only one setting, an urban academic medical center, (and) the results may not be generalizable to community or rural hospitals…" (Dang et al., 2016, p. 121). Despite this limitation, the study is an important one as it makes the correlation between disruptive behaviors, incivility, and patient safety.

Smith et al. (2016) point out that for many nurses, exposure to incivility starts in nursing school. Educating nursing students about incivility and providing them with strategies and ways to respond in a professional manner can help foster a healthy work environment and increase nurse retention (Berry et al., 2012; Rush et al., 2014; Thompson & George, 2016). Tecza, Boots, Clay, Kirkman et al. (2015) further support the importance of examining incivility and nursing students in the clinical environment. Tecza et al. (2015) developed an instrument to measure uncivil types of behaviors in the hospital clinical environment and student nurse perceptions. They developed a reliable and valid tool to examine nursing students' reports of incivility as perpetrated by nurses (Tecza et al., 2015). The study surveyed 490 nursing students; their results

supported the report of high incidence of incivility noted by nursing students. The authors

suggest results of the study can serve to further investigate incivility and implement strategies to

negate its continuance starting with nursing education.

      New graduates struggle with reconciling what they were taught with what they see and

learn in clinical practice during their first clinical position (Read & Laschinger, 2013; Etienne,

2014; Mellor & Gregoric, 2016; Thompson & George, 2016). New graduates, as well as nursing

students, are at highest risk for incivility due to their lack of knowledge and dependence upon

experienced nurses (Berry et al., 2012; Burgess & Patton Curry, 2014; Chang & Cho, 2016;

Missen et al., 2015). Mellor and Gregoric (2016) further support the issue of incivility and

nursing students with their results of a qualitative study. The aim of the qualitative study used

grounded theory to examine approaches new graduate nurses employed to survive during their

first year of employment. The Ways of Being model emerged from the information gleaned

from the interview process. After this realization had surfaced, Mellor and Gregoric (2016)

conducted a literature search and applied the Ways of Being model. Conclusions of this study

consisted of the use and acknowledgment of an emotional factor when providing care for patients

and sought emotional support from others when necessary. Limitations of the study stemmed

from nine new nurses as the cohort. The implications of the study underscore both the

relationships and communication aspects of new graduate nurses as important to their success

while transitioning to a care provider (Mellor & Gregoric, 2016). Preparing nursing students and

new graduates about the expectations of clinical practice and strategies to manage less than ideal

relationships will lessen the incidence of incivility and increase coping for the less experienced

nurse. The significant result will be an increase in retention of nurses and less turnover (Evans,

2017; Etienne, 2014; Lux et al., 2014; Mellor & Gregoric, 2016).

The literature review illustrates the need for incivility prevention, education, and zero-tolerance policies supported by management to an overwhelming extent. The idea of a zero-tolerance policy for a healthy work environment against inappropriate behavior was debated in more than a few articles used for this literature review. The influence of organizational structure and the institution of policies addressing inappropriate and uncivil behavior are necessary for nurses to have the expectation of personal safety in the workplace (Bogossian et al., 2014). Transparency about the incidence of workplace incivility within organizations and policies to address uncivil behavior will nurture a healthy work environment. Leadership surveillance and swift interception in the face of uncivil behavior is necessary for changing a negative work atmosphere. Tezca et al. (2015) concluded addressing, managing, and instituting consequences of uncivil behavior is the responsibility of nurse leaders. Nurse leaders must intervene due to circumstances where nurses are reluctant to intercede when witnessing uncivil behavior (Lachman, 2014; Read & Laschinger, 2013; Stagg et al., 2013). Nurse leaders further promote a healthy work environment by modeling professional communication and deescalating conflict when necessary in the clinical environment (Frederick, 2014; Longo & Hain, 2014; Moore et al., 2013).

The literature supports the observation that incivility in nursing and health care is an important concept affecting patient care, nurse retention, and impedes a healthy work environment. Multiple articles support the idea that education about uncivil behaviors and increasing awareness about incivility can help to reduce its incidence in organizations. A healthy work environment for nurses who strive to provide safe patient care will help recruit and retain new nurses to a profession facing a personnel shortage. Limitations of this literature review include methods to increase both the incidence of reporting incivility and the awareness among

administration about the need for leadership when combating incivility. Multiple studies support the idea of heightened education for nurses regarding communication, uncivil behavior, and the need to eliminate or attempt to control the incidence of this type of behavior in the nursing profession. Furthermore, prevention of uncivil behavior and a zero-tolerance policy enforced by nursing leadership will diminish the prevalence of incivility. Nurses who strive to contribute to a healthy work environment will serve as role models for new nurses and nurses of the future. Civility is a behavior practiced by positive nursing role models.

Theoretical Framework

Nursing is both an art and science with caring being the central theme (Adams, 2016). Incivility is detrimental to interpersonal relationships and interferes with the caring process in the work environment. Building professional nurse relationships includes nurturing and caring behaviors which result in a healthy work environment. Uncivil behavior blocks caring and may cause psychological harm to colleagues and contribute to an unhealthy work environment. A relationship of factors associated with incivility, nursing theory, and transformational leadership contributed to the theoretical framework for this paper. Incivility is manifested through communication and is a barrier for relationship development (Edmonson & Allard, 2013). Caring is also communication based, but is meant to foster relationships and meaningful interactions (Lachman, 2012). Transformational leadership is how this project lead plans to alter the communication culture of the MCH department by implementing caring behaviors through policy and education to foster caring behaviors between nurses.

There are many theories about caring, but Jean Watson's nursing Theory of Caring is used for this DNP project. According to Norman, Rossillo, and Skelton (2016), Watson "first published her theory of caring in 1979, which included the 10 Carative Factors that evolved into

10 Caritas Processes" (p. 401). In addition to the Caritas Processes, the theory also involves the

"transpersonal caring relationship, the caring moment, and the caring-healing modalities"

(Zaccagnini & Waud White, 2014, p. 25).

  Theory, research, and evidence-based practice, are intricately entwined as are nursing and

caring (Lachman, 2012; Moran, Burson, & Conrad, 2017). A theoretical viewpoint provides a

framework for clinical practice. Theory and research combine to create a symbiotic relationship

for producing best practices for nursing (Moran et al., 2017). Theory provides a contextual basis

for an identified problem and helps the nurse to scrutinize approaches to determine the

appropriate theory to utilize. An example of this is using Watson's Theory of Caring within this

writer's incivility program.

  Watson's ten Caritas Processes includes the "(1) practicing of loving-kindness, (2) being

authentically present, (3) cultivating spiritual practices, (4) developing/sustaining helping-

trusting-authentic caring relationships, (5) Supporting the expression of positive and negative

feelings, (6) creative use of self, (7) genuine teaching/learning experiences within the context of

a caring relationship, (8) creating healing environments, (9) respectfully/reverentially assisting

with basic human needs, (10) being opened to miracles" (Watson as cited by Clerico et al., 2013,

p. 56). Besides the factors listed above, the Watson Theory of Caring focuses on the subjective,

intimate experience shared between people who engage in a caring relationship, however brief

the period (Lachman, 2012). Of the above listed Caritas, four are employed for this project, the

first, fourth, fifth, and seventh.

  A review of the literature regarding incivility generated numerous articles utilizing a

caring theoretical framework due to the relationship between nursing and caring. The Watson

Caritas processes that apply to this idea are the first, practicing loving-kindness and the fourth,

developing/sustaining helping-trusting-authentic caring relationships (Clerico et al., 2013). In a profession centered on caring and loving values, the existence of incivility is in direct contrast to the principles of the profession. Incivility negatively impacts relationships which are at the core of the nursing occupation. Multiple studies about incivility in nursing discuss three types of nurse relationships influencing the work environment, such as between nurse colleagues, between nurses and patients, and between nurses and the department leadership (Dudkiewicz, 2014). Watson's Theory of Caring was developed to be directed at the nurse-patient relationship but can be postulated to include a nurse's relationship with self, other nurses, and with leadership (Dudkiewicz, 2014). Uncivil behavior aimed at other nurses achieves the opposite of a healthy work environment. Morin (2015) reminds nurses of the ANA Code of Ethics and the duty to provide a healthy work environment, which allows nurses to function at an optimum level, regardless of nursing occupation or experience. This project lead wants to remind nurses of their ethical duty to engage in caring behaviors, which embodies the first Caritas of Watson's theory.

The combination of interpersonal relationships on the unit directs the atmosphere of the workplace and embodies the fourth Caritas. Berry, Kaylor, Church, and Campbell (2013) point out the relationship between the work environment and patient perception of caring. Nurses who demonstrate lack of caring toward each other have contaminated the atmosphere of the unit. Uncivil behavior increases stress in the work environment, which perpetuates a cycle of negativity (Desmond et al., 2014). According to Watson, nursing care is a way of bringing or providing purposeful care which is not task oriented, but rather an experience meant to be meaningful for both the nurse and the patient (Zaccagnini & Waud White, 2014). Having nurses employ caring behaviors toward other nurses can break the cycle of negativity.

The fifth and seventh Caritas Processes, supporting the expression of positive and negative feelings and providing genuine teaching/learning experiences, can be applied to conflict resolution for working relationships between nurses (Clerico et al., 2013). In a stressful work environment, communication can be abrupt and considered rude under the guise of necessary for patient safety. However, employing Watson's Caritas can help nurses improve respectful communication and strengthen working relationships in highly stressful environments, instead of serving as a barrier. Experienced nurses can express both positive and negative feelings in a respectful manner and act in a teaching or coaching manner for less experienced nurses.

Providing quality care resulting in patient satisfaction provides the nurse with a sense of pride. This concept can be applied to nurse relationships with other professionals. Watson's theory focuses on interpersonal relationships between nurses by the connections made from being present in a shared moment and respecting the uniqueness of individuals (Faber, 2013). Caring behaviors between health care professionals can be as small as listening, holding a hand or touching the individual, making eye contact, and facing the person during interactions (Cossette & Forbes, 2012). For professional nurses, these moments might come in the form of a kind word or shared remembrance of past experiences between nurses. The incidental moments that result in an interpersonal interaction make for a positive experience. Watson's theory reminds nurses to focus on making a connection, however brief, as necessary for recognizing the humanistic aspect of nursing.

When a patient observes incivility between nurses, their perception of caring is decreased. Nursing leaders should be mindful of the environment to decrease the occurrence of uncivil behaviors which also embodies the seventh Caritas, genuine teaching and learning experiences (Adams & Maykut, 2015; Clerico et al., 2013). The leadership team can act as

coaches for nurses and help direct caring relationships by modeling caring behaviors. Conversely, management also can serve as a coach by recognizing and intervening in times when uncivil behaviors are present. It is the duty of leadership to foster a healthy work environment to improve patient outcomes and employee satisfaction. Each individual nurse has the responsibility to foster caring relationships to maintain a safe environment. Nurses working together employing Watson's Caritas will preserve the atmosphere of a safe, healthy work environment.

Changing practice is no easy task, as nurses require stimulation and reasons to motivate changing the status quo (Zaccagnini & Waud White, 2014). Transformational leadership is a way to alter nurse awareness of uncivil behaviors and lead nurses in learning how to use strategies and tools when incivility occurs. Nurses are considered leaders regardless of their official position. Watson's Caring Theory will be utilized to support this DNP project in transforming current nursing practice with the aim to improve nursing relationships and promote a healthy work environment. The purpose of the incivility educational workshop as part of this DNP project is to challenge each nurse to become a transformational leader, as well employ caring ways in their practice.

As discussed by Edmonson and Allard (2013), when uncivil behavior occurs and continues in a nursing unit, the behavior becomes part of the culture. Eliminating the expectation of nurses "eating their young" is up to nursing professionals and department management to institute change (Edmonson & Allard, 2013). Anyone, despite position or status, can be a transformational leader by using empowerment to make change (Zaccagnini & Waud White, 2014). Transformational leadership will promote the nurses in the MCH department to work together to improve this problem and practice one of the fundamental aspects of nursing,

which is caring. Zaccagnini and Waud White (2014) state "Transformational leaders lead with a clear vision and use coaching, inspiring, and mentoring to transform themselves, followers, and organizations" (p. 235). Using principles of transformational leadership, this project lead intends to encourage nurses through education and communication, and increasing their interest by inspiring comradery within the department (Burgess & Patton Curry, 2014). Using the educational workshop to inform, educate, and grab the attention of nurses who may not realize their own pattern of disruptive behavior can act as an incentive to bring change to unprofessional behaviors. Creating a zero-tolerance policy using principles outlined in the educational workshop will enable nurses and management to evaluate interactions and identify the proper procedure to deter incivility. By using the transformational leadership theory, the project lead will remind the nurses there is an expectation of professional conduct, which includes participating in respectful, positive interactions among peers as well as managers. One of the primary goals of the incivility workshop is the provision of evidence-based strategies to prepare nurses how to respond professionally to a colleague or manager who displays uncivil behavior. The caring theoretical framework will help achieve this goal.

The purpose of this DNP project is to increase nurses' awareness of their actions and their propensity to institute caring behaviors into their clinical practice as well as their relationships with their colleagues. Interactions which divert attention away from the patient interrupt the caring process and affect both the patient's satisfaction and the employee's or nurses' satisfaction. Additionally, management must increase their vigilance to become aware of issues of incivility between nurses. The literature clearly suggests that evidence-based communication strategies and caring behaviors foster a healthy work environment for nurses and

patients. This DNP project aims to affect a new cultural norm of civility and caring practices on the MCH department and promote a healthy work environment.

Project Design

The following DNP project is considered quality improvement because it seeks to act on impending delivery of service. The Health Resources and Service Administration (2011) note the quality of care provided by a healthcare system is related to service delivery and "should focus on the systems/processes of care, the patients, the care team, and the use of data to drive change" (as cited by Moran, Burson, & Conrad, 2017, p. 134). Incivility in a nursing unit interferes with teamwork and collaboration leading to increased risk of negative patient safety outcomes (Berry, Gillespie, Fisher, Gormley, & Haynes, 2016). The benefit of the practice-focused doctorate is to enhance knowledge to improve nursing practice and patient outcomes (Moran, Burson, & Conrad, 2017). This project aims to use data to drive change to enhance knowledge and improve the atmosphere of the units. The creation of the zero-tolerance incivility policy will foster civility among the nursing staff, promote a sustainable environment that provides a reduction in turnover improving staff satisfaction, and indirectly improve patient outcomes.

Ahmed, Andrist, Davis, and Fuller (2013) point out that, "Quality Improvement intends to improve systems and processes with the goal of improving outcomes" (p. 150). This project will address appropriate and inappropriate professional communication and the teamwork processes to improve nursing staffs' perception of a culture of safety. Through interventions such as education and policy development, this project will provide a sustainable positive impact within the environment of the MCH department. A pre- and post-survey will attempt to measure the staff nurses' knowledge, skills, and attitudes regarding workplace incivility. The goal of the

incivility and culture of safety project is to increase the knowledge of the nurses and

management regarding the negative impact of incivility and to decrease the prevalence of

incivility in the MCH department. This policy will address uncivil behavior and direct

appropriate action if uncivil behaviors are encountered by the staff.

The framework used for the project, which is also used by the practice site, is the Six

Sigma framework, which emphasizes a define, measure, analyze, improve, and control (DMAIC)

strategy (Moran, Burson, & Conrad, 2017). The problem is defined as the increased incidence of

incivility within the MCH department. The measure will be in the form of the pre and post-

survey, using the MCSS and NIS, before and within 30 days after the educational intervention.

The analysis will be completed after the data is collected from the surveys to ascertain the causes

of incivility, knowledge, skills, and attitudes regarding incivility before and after the

intervention, and intent to stay employed within the MCH department. Improvement will consist

of developing a zero-tolerance policy, educating nursing staff to this policy, and will include

recognizing uncivil behaviors. The goal is to create a policy that holds staff accountable and

results in a sustainable process to maintain a culture of safety.

There were three tools used for this project. Data from the MCSS and NIS surveys were

collected pre-, and 30 days after, the educational intervention. Another tool was a self-

evaluation of the educational intervention including questions regarding the nurse's intent to use

the provided tools and scripting phrases learned during the education intervention. Nurses using

the provided scripting for responding to uncivil behavior will help sustain a positive work

environment.

The plan for project data collection was to gather information via survey administered the

day of the intervention using the MCSS and NIS and a second survey within 30 days after the

intervention. The educational intervention lasted approximately 45 minutes to 1 hour in length and included the definitions, types of incivility, suggested scripting for nurses to employ after recognition of uncivil behavior, and appropriate channels for reporting repeated acts of uncivil behavior as delineated in the zero-tolerance policy. The intervention centered on a PowerPoint presentation (Appendix D) and cue cards with suggested scripted phrases while enhanced with a role-playing activity and videos. Permission was granted to use cue cards developed by Griffin (2004) was granted (Appendix E). A continuing education provider sponsored the presentation for awarding credit after attending the entire activity. The intervention provided education to effect change and measure the difference in the perception of the culture of safety within the MCH department. The data will support the institution of the incivility policy (Appendix F) regarding uncivil behavior. The combination of the two interventions will nurture the culture of safety and create sustainable change for the future of the unit.

Population of Interest

The population of interest included the nurses of the MCH department of a select health care organization in the state of New Jersey with an anticipated participation of minimum sample of 30 MCH nurses. Most intended participants are female, with one possible exception from the NICU. The education levels of the nursing participants range from an associate degree to a bachelor of science in nursing (BSN) degree with a notable concession of one nurse who has recently earned her doctorate. The leadership of the MCH department consists of assistant nurse managers (ANM) who hold BSN degrees and nursing directors (ND) who hold either BSN or masters of science in nursing (MSN) degrees. The ages of the potential participants range from 20 to 64 years of age, depending on attendance and participation in the intervention. Another

variable for the population of interest is the years of experience in nursing which ranges from six

months to 45 years.

Setting

The setting for the project is the MCH department within a 398 bed-acute care facility in

the state of New Jersey, accredited through the Joint Commission. The MCH department

delivers the highest number of babies in the region, at just over 5,500 each year and is a regional,

level III, perinatal center providing care for women of childbearing age from diverse socio-

economic backgrounds. The department is comprised of an eight bed obstetric triage, a 17-bed

L&D unit, a 15-bed HROB unit, two post-partum units of 25 beds each, and a 46 bed NICU.

The number of employees for the MCH department is 400 nurses and an additional 40 ancillary

staff.

Stakeholders

The project lead included the input of stakeholders who were vital to the success of this

DNP project. Stakeholders provided input into the importance of a project as well as the

direction of interventions for meeting goals and objectives. The stakeholders for this project

were numerous, varied, and included the nursing staff, management, and upper-level leadership

for the maternal child health department. This group of individuals were considered stakeholders

due to the potential influence in transforming the departmental culture. In addition, this project

has the potential to positively influence the culture of surrounding units. Nursing leaders in

charge of the various MCH units have demonstrated full support for the incivility educational

workshop. They have granted permission for the project lead to host and invite MCH nurses to

the educational workshop. The project lead met with the director of the labor and delivery unit

as well as union representatives to discuss designating the project as mandatory education for the

nursing staff. Due to budgetary and contract concerns, the feasibility of mandatory education was in question and the project participation remained voluntary in nature.

There is a wide variety of experience levels among the nursing staff providing care. The propensity for uncivil behavior grows when patient safety and acuity are an issue (Rainford, Wood, McMullen, & Philipsen, 2015). Transferring patients and hand off reporting of patient information are constantly taking place between nurses of the six separate units within the MCH department.

Another stakeholder considered is the potential pool of nurses to attract as future staff to the MCH department. New graduate nurses and new to MCH nurses should be welcomed to a positive work environment. A positive work environment will potentially increase the intent of these nurses to stay employed within this department. Indirect stakeholders for this project are the MCH patients who deserve the utmost of concern for a culture of safety from those providing care. Nurses practicing in an environment that fosters a culture of safety means the nurse will be able to focus on providing excellent patient care.

The last stakeholder in the project included is the human resources department, which is responsible for the updating and upholding of policies of conduct for staff throughout the organization. The topic of incivility is not formally addressed but is alluded to within the harassment policy, and professionalism is mentioned as part of the values of the organization. One of the objectives for this project was to create the zero-tolerance policy for professional conduct and provide a pathway for recourse if uncivil behavior occurs.

Recruitment Methods

The project lead used convenience-sampling techniques for recruitment of staff nurses employed in the MCH department. A convenience sample was indicated in this project because

the nurses were easily accessible and in close proximity to the project lead. Nurses employed in other departments of the acute care hospital were excluded. Involvement in this project did not affect the participants' employment status.

Recruitment methods involved using the existing resources such as the placement of posters at the nurses' station and changing area, use of the units' shared governance committees for endorsement, and invitations extended to nursing staff during unit huddles, or brief meetings. As part of the communication network used by the organization, employees are contacted through their email address. An email requesting participation in the project ensured all employees of the department were directly contacted. The project lead provided a brief synopsis of information about the topic, location, and time details.

The month before the planned intervention, the chairs of each shared governance committee were contacted to add the project information to their meeting agenda. Another possibility was to address the committees individually to obtain endorsement from the attending members. All meeting minutes sent via employee email to the staff helped communicate the information promoting attendance to the activity. Furthermore, for those staff members who do not routinely read emails, posters detailing the topic of interest, time, and location were posted in all allowable areas of the MCH department.

Additionally, members of the nursing profession in the State of New Jersey are required to complete 15 hours of continuing education units (CEU) every year for a total of 30 credits for licensure renewal every other year (New Jersey Division of Consumer Affairs, 2015). The organization is a provider of CEUs, which facilitated the plan for this educational intervention to offer the free CEU for the nurses who attend the intervention. Another factor for attracting interest and participation in this intervention was to keep the timing to 45 minutes as nurses tend

to have limited attention spans. The location considered for this intervention is a conference

room located on the first floor of the facility, which will be perfect for the presentation. The

conference room had the necessary audio-visual equipment, chairs, tables, and the central

location necessary to attract the nurses working for either the day or night shift as well as those

who were not working were able to attend the intervention. Furthermore, while not advertised as

being present, the project lead had refreshments available at the intervention as a means of

obtaining and keeping the attention of the audience. This educational intervention was offered

twice a day during four days for eight opportunities. The times planned were at five in the

afternoon to be available for night shift nurses prior to work and eight at night to be available to

day shift nurses after the end of the day shift. Additionally, nurses were invited to attend on their

day off.

The last part of the recruitment plan included an electronic sign up process for planning

purposes. With the permission of the practice site, the project lead created an electronic sign up

in the practice site's intranet for participants. The sessions remained open and available for

nursing staff to attend with the electronic sign up process facilitating the planning process for the

possible number of participants. The project lead was able to send surveys to the registered

participants prior to attendance to the educational intervention.

Tools/Instrumentation

Three tools were used to implement this DNP project, a pre-post-survey, and a post

education intervention evaluation. The survey tools selected for this intervention were a MCSS

based on the AHRQ safety survey including two intent to stay items and the NIS survey on

incivility in nursing, a 43-item survey in a Likert-style agreement scale. Permission to use the

NIS survey was granted by Dr. Ashley Guidroz (Appendix G) for this project. The third tool was a post-educational intervention evaluation.

Incivility Policy

A draft of the incivility policy (Appendix F) was brought to the Human Resources director for review. Upon acceptance, the appropriate committee for further evaluation will review the policy. Once this policy draft is finalized, it will be reviewed and voted on for approval by the appropriate human resources policy and procedure committee. This process could take up to two years.

Modified Culture of Safety Survey and Intent to Stay

The MCSS consists of seven questions regarding the nurses' perception of feeling safe, supported, and include two items of the intent to stay employed within their current department. Permission was obtained for the two intent to stay items from Dr. Alsaqri (Appendix H). The MCSS seven item survey was developed and modified from the evidence gathered from the AHRQ culture of safety survey. For future reference, MCSS included the two intent to stay items and underwent the process for determining content validity as each item was rated according to relevance by a panel of ten nurse educators and one physical therapist educator who are all doctorally prepared. The content validity was computed by the relevant ratings for each item being divided by the number of experts, which is the proportion in agreement about relevance. Content validity of items provide information to direct the project lead in "revising, deleting, or substituting items" (Polit & Beck, 2006, p. 483). The content validity index (CVI) of each item of the MCSS was computed and with a mean CVI of 0.93 (Appendix I).

Nursing Incivility Scale

The NIS is a 43-item survey that poses questions about nurses' perception of incivility experienced from five different sources of incivility: general, coworkers, direct supervisor, providers, and patients and visitors (Guidroz, Burnfield-Geimer, Clark, Schwetscchenau, & Jex, 2010). Each group of questions is categorized as source of incivility and includes subscales. For the general incivility section, there are nine items with three questions in each of the following subscales: hostile climate, inappropriate jokes and inappropriate behavior. For the section of incivility experienced by other nurses, there are ten items, three items of hostile climate, four items of gossiping and rumors, and three items of free-riding. The section regarding the supervisor as source has seven items with four pertaining to abusive supervision and three related to lack of respect. The third section of the survey is related to incivility from physicians containing seven items, four regarding abusive supervision and three related to lack of respect. The final section of the survey is regarding patients and visitors with ten items, six refer to lack of respect, and four refer to displaced frustration (Guidroz et al., 2010).

The NIS survey is a reliable tool for assessing incivility in nursing from various sources. According to Guidroz, Burnfield-Geimer, Clark, Schwetscchenau, and Jex (2010), "All values ranged from 0.81 to 0.94, which is well above the minimum of 0.70 recommended" (p. 10). Cronbach's alpha coefficient was the statistical process used for determining reliability (Gray, Grove, & Sutherland, 2017). Gray, Grove, and Sutherland (2017) report the coefficient is, "used for calculating internal consistency for interval and ratio level data" (p.373). Reliability coefficients lower than 0.60 are less than desirable and indicate a lower level of reliability (Gray, Grove, & Sutherland, 2017). The tool also demonstrates good internal consistency as described by Guidroz, et. al., (2010) as the "average item-total correlations for all items was 0.76" (p.10).

Estimate of the NIS validity is described by Warrner, Sommers, Zappa, and Thornlow (2016) as displaying a "demonstrated distinction from each other, having only moderate intercorrelations (r = 0.11 to 0.57)" (p. 26).

The NIS survey was the tool used for the pre and post-survey assessment. Furthermore, the survey included questions related to demographics such as age, work unit, years of experience, and level of education. The intervention materials listed the objectives for the educational intervention. A pre and post-survey is a direct way to measure differences between the two surveys and perceived attainment of the listed objectives.

Educational Workshop Evaluation

The third tool was a post-educational evaluation assessment (Appendix J) requesting participants to rate the relevance of the incivility educational workshop and the value of the information regarding personal practice. The post-survey evaluation included questions of the participants' intent to use the communication tools and scripting provided during the intervention in clinical practice. The project lead hopes to see a reported improvement or increase in the ability to acknowledge and respond to uncivil behavior using the tools and scripting learned as measure by survey results.

The tools utilized had minimal financial implications as the resources for the creation of the education intervention were owned by the project designer and practice site. Additional tools with minimal financial implications included the PowerPoint presentation, survey tools, policy, cue cards with scripting, role-play activity, and videos. The project should have a positive impact on the knowledge of incivility and uncivil behavior within the MCH department and improve the work atmosphere and intent to stay employed within the department. The MCSS

and NIS pre and post survey measures this improvement. An unintended, positive effect may be a reduction in work absences and increase in employee satisfaction.

Data Collection Procedures

The project lead administered the MCSS and NIS survey in two forms, a paper survey format on the day of the educational intervention, and an electronic tool such as Survey Monkey was used to administer the survey electronically after the intervention. The survey link was sent through employee email, approximately 30 days after the educational workshop for participants to respond, on a voluntary, confidential basis. Attendance to the workshop was monitored with sign-in sheets which included a place for the attendees to provide their email address. This list was used as the guide for the second administration of the survey within 30 days after the educational intervention. The week after the electronic survey was sent to participants; the project lead contacted and delivered in paper survey packets to the participants who did not complete the electronic survey. The project lead matched all of the original participants by numerical code and paired the pre- and post-survey results. This method was chosen as the manner for data collection due to the existence and usage of the staff, easy access, and ability to maintain confidentiality.

Two statistical tests were conducted for this project. The project lead used descriptive statistics to present the variables of age, years of experience, and education level, with respect to the knowledge and attitudes regarding incivility. The intent was to gather the information via surveys administered before and after the intervention for data comparison. Paired-sample t-tests were used for comparing means of the first and second survey, or different times. According to Pallant (2013), a paired-samples t-test is "used when you want to compare the mean scores for the same group of people on two different occasions, or when you have matched pairs" (p. 247).

For this intervention, the population is the MCH nursing staff with the goal of a minimum of 30 participants. However, the paired-samples t-test are only utilized if the same nurses who attend the educational intervention take both the pre- and post-survey to compare means of the same samples at two different times. For this reason, the project lead over sampled, or obtained more than 30 nurses, to increase the chance that the sample will result in at least 30 nurses completing both the pre and post survey. The non-parametric alternative to be used to the paired t-test is the Wilcoxon Signed Rank Test if the assumptions for parametric testing are not met (Pallant, 2013).

After performing statistical analysis, the project lead used descriptive statistics to categorize the participants with respect to age, experience, and education level. More in-depth statistical analysis discusses the difference in mean scores between the two survey administration times. Examining the data collected may have the most interesting effects possibly mirroring the results of the study by Nikstaitis & Simko (2014). According to the authors of the study, the reporting of acts of incivility increased due to the growing awareness of uncivil behavior (Nikstaitis & Simko, 2014). The data will be utilized to support incivility education and policy to foster the culture of safety.

Intervention/Project Timeline

The timeline for this project (Appendix K) is approximately eight weeks. Implementation began the second week in November 2017. Permission was granted from department leadership and unit management to invite the nursing workforce of the MCH department to participate in this project. The MCSS and NIS survey was available in paper form on the date of the educational intervention along with the presentation in PowerPoint format. The room was reserved for the date and times for the planned intervention after securing permission from the scheduler for the organization. The project lead collected the surveys at the

time of the intervention with the information held exclusively by the project lead and entered

into a codebook for statistical analysis. Institutional review board (IRB) documents were

submitted to both Touro University Nevada and the organization by the end of September, 2017.

The recruitment efforts started by the end of September with 'save the date' flyers posted on the

various units. Application for the continuing education credit from the hospital organization was

completed by the end of September 2017. The survey monkey was created by the middle of

September. The post intervention educational survey was emailed to participants by November

27, 2017, with one reminder email sent after a week. The expectation was low for return rate of

electronic survey with the second week of December dedicated to following up with paper and

pencil surveys for participants who have not completed the electronic survey.

Number of Tasks	Week(s) to Accomplish Task	Activity
1	**Week(s) to Accomplish Task**	Complete application for Institutional Review Board and email to Organization's Research Council Chair
2	Week of August 21, 2017 to August 25, 2017 2 hours	Complete application for Continuing Education Credit and email to Director of Continuing Education at organization of interest.
3	Week of September 18, 2017 to September 22, 2017 4-6 hours	Email the person in charge of conference rooms for confirmation of conference rooms and times for educational intervention
4	Week of October 2, 2017 30 minutes Possible 6 hours if approved to attend Shared Governance meetings	Email all nursing staff of the MCH department nurses with the information for educational intervention and post flyers with information about educational intervention Email the five Chairs of Shared Governance for inclusion and to attend meetings to discuss project

5	Week of October 23, 2017 to November 5, 2017 1 hour	Have packets of surveys and sign-in sheet ready (Make copies of survey packets) for the following week Email the six Nursing Directors for inclusion of educational intervention in daily huddles and email blast
6	Week of November 13, 2017 to November 17, 2017 25 hours	Eight sessions of educational intervention or until minimum sample of 30 is obtained
7	Week of November 27, 2017 to November 30, 2017	Email participants the post-educational survey link
8	Week of November 30, 2017 to December 3, 2017 One hour	Hand packets to participants who do not complete electronic survey via link
9	Weeks of December 6, 2017 to January 4, 2018 or until all participants have completed the second survey for the project. 5-6 hours planned but possibly more	Complete codebook, input data into SPSS, consult statistician for analysis
10	Weeks of January 8, 2018 to January 22, 2018 10-20 hours but possibly more	Evaluation of data results
11	Weeks of February 12, 2018 to February 26, 2017	Dissemination of results

Protection of Human Subjects

This DNP project is based on a convenience sample of available nurses working in a large MCH department. Participation and completion of surveys and attendance at the educational intervention are completely voluntary. The IRB documents for both the hospital organization and Touro University Nevada were completed. The project lead believed this quality improvement project is exempt due to the use of surveys and does not require IRB approval but completed the official documentation from both organizations. Moran, et al. (2017), notes that no formal IRB review is required for projects that "use surveys, noninvasive procedures, secondary documents, or methods in which the data are deidentified" (p. 210).

This project protected participants by not requesting personal data, rather only demographic information such as age, experience, work unit, and education level. No

identifiable data was collected. Participants were not coerced or threatened to participate in the

educational intervention. The pre-survey was collected at the time of the intervention with the

information held exclusively by the project lead and kept in a locked box in the sole possession

of the project lead.

The pre-surveys from participants were placed in an envelope and labeled with the

number next to their name on the sign-in sheet. All of the pre-surveys had the added letter of 'A'

next to the number to signify the pre-survey. The post surveys were initially administered via

Survey Monkey link to the email provided by the participant on the sign-in sheet. The email

containing the link also included the code number for the participant to add to the first question

of survey monkey link. Electronic information was printed and labeled with the number from

the survey results and the letter 'B' added. The post-survey was added to the numbered

envelope. All participants who did not complete the electronic survey were contacted and

provided with a paper post-survey. The matched, pre- and post-surveys, were placed in folders

labeled with the number from the sign-in sheet. The sign-in sheet was the document that was

used to pair the pre- and post-surveys with the participants. This paper sign-in sheet was kept at

all times in the lock box and was destroyed by shredding after the post survey information was

collected, matched with the pre-survey from the participant, and the data imported into the

codebook. All data gathered was only accessible by the project lead, the course instructor, and

the project mentor, with the survey monkey results stored on the student's password protected

computer. All electronic information was stored on the password-protected computer of the

project lead.

Information regarding the educational intervention was listed on the front page of the

survey packet and included the purpose of the DNP project information such as the risks,

benefits, and possible discomforts, and included the lack of financial incentive. Additionally,

confidentiality of survey results was delineated in the consent for voluntary participation for the

survey pre- and second survey post. Benefits of participating in the educational intervention

centered on personal knowledge and insight of the topic of incivility. Potential benefits also

included the participant learning information for responding to uncivil behavior in addition to the

corrective course for reporting such behavior if necessary. Voluntary participation was

emphasized. A paper with the information for how to obtain continuing education credit was

provided at the end of the workshop. The project lead included personal contact information

providing all participants the opportunity to ask questions at any time and a later date if

requested. All information gathered through survey and evaluation was kept confidential

through numerical coding. After data was exported for statistical analysis, all surveys and sign-

in sheets were be kept in a lock file in a locked cabinet in the home of the project lead and

shredded at the conclusion of the project. Any electronic data was stored in the project lead's

password protected computer and deleted at the conclusion of the project.

Plan for Analysis

The plan for analysis for this DNP project is to use the Statistical Package for the Social

Sciences (SPSS) program for data analysis (Pallant, 2013).

Demographics

To evaluate the demographics of the participants, descriptive statistics and measures of

central tendency were used. According to Gray, Grove, and Sutherland (2017), "A basic yet

important way to begin describing a sample is to create a frequency distribution of the variable or

variables being studied" (p. 523). The project lead analyzed, with the assistance of a statistician,

the years of experience, level of education, age of participants, and work units of the participants.

Modified Culture of Safety Intent to Stay Survey

To evaluate the change in the perception of the culture of safety including the intent to stay employed, a two-tailed paired-samples t-test was performed. A two-tailed paired samples t-test, or repeated measures design, is used for comparing means of the first and second survey, or different times. According to Pallant (2013), a paired-samples t-test is "used when you want to compare the mean scores for the same group of people on two different occasions, or when you have matched pairs" (p. 247).

Nursing Incivility Scale

To evaluate the change in the perception of nursing incivility, a two-tailed paired samples t-test was performed. A two-tailed paired samples tailed t-test, or repeated measures design, is used for comparing means of the first and second survey, or different times. According to Pallant (2013), a paired-samples t-test is "used when you want to compare the mean scores for the same group of people on two different occasions, or when you have matched pairs" (p. 247).

Once the data is gathered, the responses was transposed to the designated Excel spreadsheet and grouped by variable information (Moran, et al., 2017). The project lead consulted to a statistician employed by the organization for discussion regarding the analysis of the data collected during the project. After the data was collected, coded, and exported into the SPSS system, the project lead used descriptive statistics to describe the data. Tests to determine normal distribution were conducted. If the data was found to be normally distributed, parametric testing (paired samples t-tests) was used (Pallant, 2013). Data that was not normally distributed requires non-parametric analysis (Wilcoxon paired signed rank) (Pallant, 2013). Survey items that entered into the codebook facilitated extrapolation to parametric, two-tailed t-test. Analysis was performed through collaboration with the statistical expert.

Significance/Implications for Nursing

There is tremendous potential for the impact of this DNP project. Currently, the perception of the project lead is that the morale on the unit is not at an optimum level. There have been emails from the leadership reminding nurses to lower voices, keep discussion at the nurses' station on a professional level. Additionally, in the past years, there has been significant turnover. Members of the nursing workforce expressed interest in this DNP project and willingness to attend the educational intervention. Incivility among nurses interferes with teamwork putting patient safety at risk (Dudkiewicz, 2014). Education devoted to identifying uncivil behavior and giving nurses the chance to practice phrases for responding to incivility can help decrease the prevalence of inappropriate behavior (Griffin & Clark, 2014).

The effects of workplace incivility on patient safety, job satisfaction, retention, a healthy work environment, along with what is defined as uncivil behavior is not common knowledge in this MCH department. Nurse retention and nurse morale will improve with the learned communication skills provided within the incivility educational workshop (Evans, 2017). The education along with the implementation of the incivility policy will empower nurses to use assertive communication to foster a culture of safety within the work environment (Etienne, 2014). The incivility policy will provide nurses with the direction for reporting uncivil behavior without repercussions to the position in the department. The creation of an incivility policy and educational workshop promotes professionalism, collegiality, mentorship, and a safe work environment for all nurses. This DNP project is sustainable and can be transferred to a MCH department in any acute care organization.

Financial Implications

Financial implications for this project include the potential to retain the many new nurses who leave less than three years after orientation. A lack of feeling supported, and possibly the victim of uncivil behavior results in many new graduates leaving their first clinical position (Cochran, 2017). The turnover and continual orientation of new nurses negatively affects the budgets of the nursing unit and the MCH department (Trepanier, Early, Ulrich, & Cherry, 2012). Reducing turnover positively affects the unit's financial expenditures as well as increasing the morale of the unit. Nurses new to the department will have the skills to respond to others who purport uncivil behavior. Providing education and a policy to increase civility among coworkers and supervisors will help the department nurture new nurses and retain the existing workforce. Fostering and maintaining a culture of safety will help to maintain a stable workforce and promote a healthy work environment.

This project may provide impetus for nurse empowerment in the MCH department, which will to contribute to fostering professionalism in this specialty area. The future implications for this quality improvement project could extend to other departments. Caring behaviors between coworkers foster a healthy work environment reducing risk to patient safety.

<div align="center">

Analysis of Results

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Analysis of the collected data was completed utilizing statistical package for the social sciences (SPSS) version 24. Responses from the 56 pre-survey data and 52 post-survey data were entered into the statistical system for analysis. The mean scores of the modified culture of safety survey (MCSS), and the sub scales of the nursing incivility scale (NIS) were calculated after conducting tests of normality or Shapiro-Wilk (Pallant, 2013). Paired sample t-tests were

used to compare the means of subscales found to be normal and Wilcoxon Signed Rank test were

used for data found to be non-normal (Gray, Grove, & Sutherland, 2017).

In preparing the data for analysis, the project lead examined the data for missing

responses and items necessitating reverse scoring (Gray et al., 2017). There was no pattern

recognized for missing data and were presumed to be omitted by error or lack of answer on the

part of the participant. All blank data cells were treated equally by the using mean of the column

for the item omitted (Gray et al., 2017). The second item of the MCSS required reverse coding,

which the project lead took into account with data entry.

The percentages for the intent to stay and intent to leave data are as listed. Of the

participants surveyed, 99 % (n=55) of the nurses reported the intent to stay employed on their

unit for as long as possible, with one participant responding neither agree nor disagree. Of the

intent to leave as soon as possible, 11 % (n=6) answered neither agree nor disagree with the

remaining participants (n=49) responding disagree or strongly disagree.

Sample

Of the 56 participants, the greatest number, 54 % (n=27) were employed in the labor and

delivery unit, with 22 % (n=44) of nurses holding a BSN (Table 1). Largest number of nurses,

34 % (n=17) were in the 40-49 age range, with 26 % (n=14) having 20-29 years of nursing

experience.

Table 1

Demographic Statistics		
Unit Employed	n	%
L&D	27	54
NICU	4	8
MB3	4	8
MB4	15	30
Highest Nursing Degree	n	%
Diploma	4	8

ADN	18	36
BSN	22	44
MSN	5	10
PhD	1	2
DNP	0	0
Age	n	5
20-29	6	12
30-39	7	14
40-49	17	34
50-59	14	28
60-69	6	12
Years of Experience	n	%
Less than 5	6	12
5-9	6	12
10-19	12	24
20-29	14	26
30-39	11	22
More than 40	2	4

Normal Distribution of Data

The project lead conducted tests of normality to assess meeting the assumptions of

parametric testing. Three subscales met the assumptions for parametric testing, resulting in the

project lead conducting two-tailed paired samples t-test for those subscales. For all of the nine

other subscales not meeting the assumptions of parametric testing, the project lead performed the

non-parametric equivalent, or Wilcoxon Signed Rank Test.

Comparison of Measures of Central Tendency-Parametric and Non-Parametric

The decision to use a certain type of statistical testing for comparison of means is based

on the whether or not the data is determined to have met the assumptions of parametric testing

(Pallant, 2013). For this data set, three of the sub scales were found to be distributed normally

using the Shapiro-Wilk test for normality with $p > 0.05$, and $n > 30$ participants. The three

subscales are the MCSS, Hostile climate, and Doctor abusive supervision.

Paired Sample t-tests

For the three subscales with normal distribution, a two-tailed paired sample t-test was conducted to evaluate the impact of the education intervention on the perception of safety (MCSS), Hostile climate, and Doctor abusive supervision. Each of the three subscales scored a $p < 0.05$, meaning there is a significant difference between the pre- and post survey data gathered. Upon examination of the paired samples statistics, the compared means were examined for the direction of the difference. The MCSS safety pre- and post data comparison of means shows a difference in the direction of the pre-survey data meaning the participants reported a significant decrease in feeling safe from MEANSAFETYPRE (M = 3.98, SD = 0.46) to MeanSAFETYPost (M =3.78, SD 0.55), $p < 0.05$. The mean decrease is 0.2 with a 95% interval ranging from 0.07 to 0.34. When examining the data for the Hostile climate subscale, the opposite is true and there is a significant difference in the perception of a hostile climate from MeanHCPRE (M = 2.6, SD = 0.91) to MEANHCBPOST (M=2.39, SD = 0.75), $p < 0.05$. The mean decreased is 0.2 with a 95% interval ranging from 0.02 to 0.39. When inspecting the means of the Doctor abusive supervision subscale, there was a decrease in the perception of abuse from doctor supervision between MEANDRASPRE (M = 2.72, SD = 0.96) to MEANDRASBPOST (M = 2.5, SD 0.85), $p < 0.05$. The mean decrease is 0.2 with a 95% interval ranging from 0.03 to 0.41.

Wilcoxon Signed Rank Test

For data not normally distributed, the nonparametric, Wilcoxon Signed Rank Test is utilized for comparison of median measure of central tendencies (Gray, et al., 2017). According to Pallant (2013), the Wilcoxon Signed Rank Test is "the nonparametric alternative to the repeated measures t-test, but instead of comparing means the Wilcoxon converts scores to ranks and compares them at Time 1 and Time 2" (p. 238). Seven subscales revealed no statistically

significant change between the pre- and post-survey administrations. For the Inappropriate jokes subscale, $p > 0.05$ (0.108). The median score on the Inappropriate jokes subscale decreased from pre-survey (Md = 2.14) to post-survey (Md = 2.00). When inspecting the Gossip and rumor subscale, $p > 0.05$ (0.061). The median score for the Gossip and rumor subscales decreased from pre-survey (Md = 3.63) to post-survey (Md = 3.5). A similar result is true for the Registered nurse (RN) abusive supervision pre- and post-surveys, $p > 0.05$ (0.60), with median scores increasing from pre-survey (Md = 2.0) to post-survey (Md = 2.25). A comparable result occurred with the RN lack of respect subscale, $p > 0.05$ (0.98), with median scores increasing pre-survey from (Md = 2.0) to post-survey (Md = 2.33). The same result was found for the Doctor lack of respect subscale with $p > 0.05$, and pre-survey median scores remaining constant (Md = 2.33).

The last two subscales concern to the patient and visitors. For the Patient and visitor lack of respect subscale, $p > 0.05$ (0.65), with median scores increasing from pre-survey (Md = 2.17) to post-survey (Md = 2.33). The same result occurred for the Patient and visitor displaced frustration subscale with $p > 0.05$ (0.91). The median scores for the last subscale examined remained constant from pre-survey to post-survey at 3.13.

Two subscales showed a significant change between the two survey administrations, Inappropriate behavior and Free loading. When inspecting the Inappropriate behavior subscale, the Wilcoxon discovered a significant change between pre-and post-surveys $p < 0.05$ (0.002). The median score on the Inappropriate behavior subscale decreased from pre-survey (Md = 3.33) to post-survey (Md = 3.0). When examining the Freeloading subscale, the results were significant as evidenced by $p < 0.05$ (0.004).

Table 2 Comparison of Measures of Central Tendency Listed in Descending Order

Subscale	Central Tendency Pre	Central Tendency Post	P-Value
MCSS	3.98*	3.78*	0.004
Gossip and Rumors	3.63	3.50	0.061
Inappropriate Behavior	3.33	3.00	0.002
Patient/Visitor Displaced Frustration	3.13	3.13	0.907
Doctor Abusive Supervision	2.72*	2.50*	0.026
Hostile Climate	2.59*	2.39*	0.028
Doctor Lack of Respect	2.33	2.33	0.644
Freeloading Behavior	2.33	2.00	0.004
Patient/Visitor Lack of Respect	2.17	2.33	0.649
Inappropriate Jokes	2.14	2.00	0.108
RN Abusive Supervision	2.00	2.25	0.603
RN Supervisor Lack of Respect	2.00	1.33	0.975

*Mean score from paired samples t-test

Discussion of Findings and Significance for Nursing

The one-hour education intervention made a difference in the scores of the participants'
responses for some of the subscales and no difference for several other subscales. These results
meet the project objective of determining if the education intervention improves the awareness of
perception of safety and incivility. Of the 12 survey subscales five (MCSS, Inappropriate
behavior, and Doctor (DR) abusive supervision, Hostile climate, and Freeloading behavior)
measures of central tendency decreased with statistically significant differences. The statistically
significant decrease of scores suggests that the participants' perception of feelings of Safety

(MCSS), Inappropriate behavior, DR abusive supervision, Hostile climate, and Freeloading behavior, increased between the two survey administrations. These results support the findings by previous studies, which have established that education regarding incivility may result in an increase in reporting of uncivil behavior due to heightened awareness (Nikstaitis & Simko, 2014).

Three subscale scores, Gossip and rumors, Inappropriate jokes, and RN supervisor lack of respect, were not statistically significant and decreased between the two survey administrations. An insignificant decrease in the median scores suggests that the educational intervention made little change in the perception of gossiping and inappropriate joking behavior of the nurses. This also suggests there was no perceived change in the level of respect felt by participants, good or bad, from the direct nurse supervisor of the participants. For these subscales, no statistically significant change was noted. This finding is not surprising due to the expectation that a one-hour, voluntary participation, educational workshop will not change ingrained behavior of adult nurses. A more comprehensive program directed at education and practicing communication techniques is needed to shift the culture of behavior over a longer period (Spence Laschinger, et al., 2012).

Two of the subscales, RN abusive supervision and Patient and visitor lack of respect, the scores increased although were not statistically significant, suggesting a slight rise in awareness of uncivil behavior among the participants from these two sources. Two subscales whose means were not statistically significant and stayed the same are the Patient and visitor displaced frustration and DR Lack of respect suggesting that the participants' perception of incivility from these two sources were not affected by the educational intervention.

Approximately two weeks after the educational interventions were completed and survey collection concluded, several nurses contacted the project lead. The nurses were from one of the mother baby units and expressed concern about social media posts and uncivil incidents occurring in the department. The project lead referred them to the suggested phrases and suggested speaking directly to the person perpetrating the behavior. Furthermore, management emailed the project lead requesting an additional educational intervention. The project lead reminded management, the session cannot be made mandatory, nor could any nurse be forced to attend, only invited as a suggestion. Despite this occurrence, the project lead was happy at the prospect that the educational intervention was still being discussed on at least one of the participating units. The complaints suggested that some nurses were feeling empowered by the educational intervention and were taking some form of action to decrease uncivil behavior in their unit. Contact initiated by management caused the project lead to suspect that the inclusion of management intervention and policy into the educational intervention made an impact on participants, an idea also supported by the literature reviewed concerning incivility (Etienne, 2014).

The increased reporting of uncivil behavior to management supports themes found in literature concerning incivility in nursing. Nikstaitis and Simko (2014) found that education regarding incivility lead to more nurses reporting uncivil behavior which is what occurred at this practice site. The involvement of management also is supported by the literature in that management was forced to employ their own communication techniques to address the behavior, which is also discussed in an article by Major et al. (2013). Once nurses increase their communication and report uncivil behavior, management support and intervention will

strengthen and empower nurses fostering a more civil work environment, a finding also published by Berry et al. (2016), Major et al. (2013) and Evans (2017).

An added aspect noted by the project lead is the high percent of nurses with the intent to stay and high percent of disagreement with the plan to leave as soon as possible items. No participants responded affirmatively to either item regarding leaving the unit. These responses are interesting considering the amount of incivility reported for both administrations of the survey. The findings of this DNP project regarding intent to stay are in opposition of some literature that highlights higher turnover intent to leave for nurses when faced with incivility (Evans, 2017). The idea that nurses continue to work in an environment that they may consider less than ideal due to experience and the attitude or expectation of uncivil behavior as something to be tolerated, which the previous reviewed literature supports (Longo & Hain, 2014).

The answer to the project question "Will the creation of a zero-tolerance policy and incivility educational workshop reduce the incidence of nurses experiencing uncivil behavior from colleagues and improve the intent to stay employed in the MCH department?" is not a simple answer. The implementation of a zero-tolerance policy is in progress after the conclusion of the educational intervention sessions and may take an extended time for organizational review and acceptance. The participants' level of intent to stay employed in the MCH department was high from the start of the project. The most noteworthy difference made by the project is the heightened level of awareness concerning incivility in the MCH department. Further education at this practice site would continue the momentum started by the educational interventions of this project. This finding reflects literature that supports the idea of education to increase awareness of incivility (Moore, et al., 2013). More education and workshops can sustain the effects of this

project and shift the change in culture of the MCH department to a culture of civility and reduced

risk to patient safety.

Significance to the Nursing Profession

This project is significant to the profession of nursing because uncivil behavior between

professional nurses sends a negative message to the public and other professions within

healthcare (Evans, 2017). Nursing is a female dominated profession and the perception exists

that women are malevolent toward each other and are more interested in perpetuating a hostile

work environment than taking care of their patients (Edmonson & Allard, 2013). Nurses work in

teams and should be able to communicate clearly and effectively with colleagues to provide the

safest care possible and minimize risk to the patient (Lux, et al., 2013). Incivility interrupts this

process and should be identified and eliminated at all cost (Longo & Hain, 2014). This project

raised awareness of the problem of incivility as a start towards shifting the culture of the MCH

department to a civil environment. The short, one-hour educational interventions and provision

of scripted phrases empowered nurses to address and report incidents of incivility, which is

consistent with current literature on the subject (Burgess & Patton Curry, 2014). Griffin and

Clark's (2014) outcomes echo this project's findings of practicing scripted phrases results of

"being well-prepared, speaking with confidence, and using respectful expressions to address

incivility can empower nurses to break the silence of incivility and oppression" (p. 541).

Additionally, the significance of management intervention to address uncivil behavior

further increased the civility of the work environment and empowerment of the workforce

(Longo & Hain, 2014). "Zero-tolerance policies alone are not enough, organizations must have

clear non-retaliation standards that define reporting pathways, structures of support, and

protections offered to those who report" (Edmonson & Allard, 2013). This finding by Edmonson

and Allard (2013) supports the events following the implementation of this project. Education

increased awareness and more nurses complained about incidents occurring within the

department. Management reached out to the project lead for further education on the topic

instead of following the policy of the organization, suggesting a lack of knowledge by

management. The two existing policies at the practice site related to incivility and detailed the

reporting procedure for workplace violence and harassment, which is the same procedure for

incivility. The need for a specific policy addressing incivility was highlighted by the practice

site response to the DNP project.

A more comprehensive program to increase civility within the work environment would

sustain the efforts of this project. This idea is supported by the findings of a study conducted by

Spence Laschinger, et al. (2012) where an educational program was contributory to increasing

awareness and organizational efforts to address nurse empowerment, increase civility, and

support from management. The DNP project findings are also supported by an article by

Edmonson and Allard (2013) where "Sixty-two medical–surgical nurses completed a before and

after bullying survey instrument after receiving an intervention of Cognitive Rehearsal Training

program consisting of bullying concepts, behaviors, consequences, action, policy support, and

cognitive rehearsal intervention (CRI)" (p. 136). This study supports the recurring themes that

education and practice scripting for nurses increased awareness of incivility and empowered

nurses as well as management intervention increased trust between leadership and the workforce

(Stagg, et al., 2013).

Limitations

There are several limitations of this project concerning location, self-reporting, timing of

the project, the culture of the MCH department, and the reluctance of the human resources

department to change policies related to unprofessional conduct. Furthermore, limitations

concerning project design, recruitment, data collection, and data analysis are also examined.

Study limitations are necessary to identify for interpretation of results, illuminating potential bias

and opportunities for improvement (Moran, et al., 2017). Gray et al. (2017) note the "limitations

of a study decrease the generalizability of the findings" (p. 591). Recognizing limitations helps

the project lead to direct future study efforts toward reducing limitations, increasing the nursing

body of knowledge (Moran, et al., 2017).

One of the paramount limits of this project was the lack of response of the human

resources department of the organization. The contact person for the human resources

department believes that the workplace violence and general harassment policies encompass

uncivil behavior and a separate policy in unwarranted. Future areas of concern and increased

sustainability efforts will concentrate on policy institution and the resulting effect on reported

incidents of incivility.

Project Design

The project design confined the project focus to two times, three weeks apart, limiting the

time frame of the project. When looking for a change in perception brought on by education, a

three-week period of time may not be optimal. An increase in time between survey

administrations might elicit a greater difference in more subscales and possibly an increased

statistical significance. An added data collection method including personal interviews to

identify themes surrounding incivility in the workplace may elicit more information for review

(Gray, et al., 2017). The project focused on perceptions, which are qualitative in nature, and did

not control for extraneous events such as current mood or positive or negative interactions that

may have occurred, influencing participant responses to the questionnaire (Gray, et al., 2017).

This project was based on self-reporting of perceptions of uncivil behavior for survey responses. The project lead maintained confidentiality of survey responses throughout the project to decrease bias and social influence (Gray, et al., 2017). The theme for the project was to change the culture of the MCH department to increase civil behavior. A one-hour educational intervention with two survey administrations is not sufficient to make a substantial culture change for an entire MCH department. Although this DNP project is a good start and resulted in increased awareness of incivility, a more comprehensive program would have the potential for a greater impact (Spence Laschinger, et al., 2012). Along with more educational workshops, and increased opportunity to practice combating uncivil behaviors, the institution of a human resources policy specifically addressing uncivil behavior needs to occur (Moore, et al., 2013).

Data Recruitment and Collection Methods

There are several limitations noted in the methods utilized for data collection and recruitment. This project lead would like to begin this discussion with the recruitment process and choosing the population of interest for the project. The project restricted the participants to the nursing staff, which eliminated attendance from medical providers and ancillary staff.

One of the greatest limitations for the project was the voluntary, convenience of the sampling of nurses. A sample of 56 out of 400 eligible nurses who attended and participated in the educational workshop was a good foundation. Future projects should focus on increasing the numbers of participants, which will contribute to a cultural shift in civility within the MCH department. It is possible that nurses who attended are interested in gaining education and are attracted to reducing uncivil behavior (Spence Laschinger, et al., 2012). The voluntary nature of the project proposes that nurses interested in learning about incivility and how to respond

attended the workshop. Conversely, the nurses either uninterested or less aware of civility and its impact on the atmosphere of the MCH units did not attend the workshops.

An added consideration affecting the results of the project is the location of the project. The project was confined to one facility in an organization containing two MCH departments. Further dissemination of this project would include completing future projects comparing the differences in data collected between the two departments within the same organization.

Furthermore, in the geographical region there are several other MCH departments of competing organizations operating under different conditions with a more diverse population of nurses. The sample population of the project was largely homogenous with 99% of the nurses Caucasian with one African American female participant. The gender of the participants was 99% female with one male working in the NICU clinical area. The findings of this project may not be generalizable to other departments or organizations with more diverse clinicians. An area for future replication and sustainability of this project would be to conduct this project within the same organization in the medical-surgical nursing departments.

Moreover, the project lead addressed completion concerns of the pre-survey and computer illiteracy of some of the participants by providing paper, pre-surveys. A limitation with this type of collection is that some nurses missed questions and the project lead is not sure if omissions where deliberate or due to accidentally skipping questions. This limitation was addressed by inserting the mean for the item into the blank areas to decrease effect of omission (Gray, et al., 2017).

Limitations with data collection were not restricted to the pre-survey but extended to the post-survey. With 56 participants completing the pre-survey, the project lead sought to reach as many participants as possible to complete the post-survey. Post-survey collection started with

individual emails containing the subject identification number and the electronic link.

Subsequent contact with participants was through private messages through social media,

followed by text messages to participants. Data recruitment and collection methods were kept to

a two-week collection period.

A last limitation concerning the data collection related to the fact that the project lead was

well known and considered a peer to the targeted population (Gray, et al., 2017). The project

lead is an employee of the practice site organization and interacts with staff outside of work

hours. This may have elicited participants who might not have attended the educational

intervention if they were not acquainted with the project lead. Furthermore, the project lead

offered several incentives to attend the educational intervention such as food, giveaways, and a

continuing education credit, which may have influenced participation independent of participant

survey completion (Gray, et al., 2017).

Data Analysis

Limitations with data analysis stem from the voluntary sample size, the matching of

participants' pre- and post-surveys, and the use of the SPSS program for data analysis. All pre-

survey data was held by the project lead in the locked box and was not a limitation. There was

the potential for a limitation due to access for data gathered from the electronic, post-survey but

this was eliminated by printing the electronically obtained data. Once the post-survey data was

printed, the pre- and post-surveys were paired in the labeled envelopes and stored in the locked

box. In this manner, the project lead's data analysis was not limited to availability of access.

The use of SPSS program was another potential limitation for data analysis for the project

lead due to lack of confidence and familiarity with the program. This limitation was diminished

by collaborations with several individuals familiar with SPSS and DNP projects with interest in nursing research.

Dissemination

Dissemination efforts of the DNP project focus on stakeholders involved in clinical practice sites and nursing school employers of the project lead. The DNP project dissemination will occur by poster board and PowerPoint presentation created for the both the practice site and the project lead's school of nursing, as well as a nursing advisory committee. Additionally, the project lead will present the project to Touro University Nevada colleagues and faculty as well as a doctoral forum for the practice site, a group of nurses who have either completed, or are in progress of completing, the requirements of a doctoral degree.

Efforts to sustain the project would include the inclusion of the presentation topic to new hire orientation for the department. The continuing education credit and educational intervention brought the topic to the surface. Inclusion of the topic for orientation will help to recognize the unspoken concern of nurses being uncivil to new employees, and each other (Moore, et al., 2013). The inclusion of this information about incivility and policy to combat unprofessional behavior will help foster the culture of safety for employees new to the department (Spence Laschinger, et al., 2012). Furthermore, the project lead is attempting to have the topic added to the annual online mandatory competencies for the entire organization.

The majority of dissemination efforts focus on the practice site and stakeholders familiar to the project lead. Both employers of the project lead expressed interest in the results and findings of the project. This led to the creation of both a poster board and a presentation for dissemination. In addition to the planned dissemination efforts, the project lead intends to investigate presenting the poster board at conferences interested in incivility in nursing at the

national level. Contacting organizations such as Sigma Theta Tau International at www.stti.org or the Doctors of Nursing Practice Conference at www.doctorsofnursingpractice.org would be a priority for the project lead. The project lead will also submit the project abstract and poster board to prospective leadership conferences in the region to further disseminate the results of the project using the poster board. Additionally, the practice site has hosted research conferences in the past and the project lead will complete the application for the poster board for submission. This added dissemination effort would add to the sustainability of the project.

Conclusion

Within health care, there has recently been more attention to the highly important concept of the culture of safety with respect to incivility. As organizations strive to expand professional opportunities and increase patient safety, the manner of which colleagues communicate must be addressed. This project brought to the surface the unrealized existing matter of incivility in the MCH department. Nurses participating in this project learned the definition of incivility and were provided scripted phrases to combat uncivil behavior. Furthermore, the nurses were afforded a brief opportunity to use these phrases and examples with their colleagues. Nurses working in teams should carefully consider the effects of uncivil behavior and the importance of empowerment with communication on job satisfaction and patient safety. This project resulted in an increased awareness of an existing, and an ignored problem in the chosen practice site. This project provides a baseline assessment of concern that will continue to be an issue without policy institution and management intervention to support a culture shift to one of more civility. The nursing profession is focused on providing safe patient care and all actions should concentrate on ways to improve collaborative efforts and teamwork to enforce a culture of safety.

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    Learning.

Appendix A

Modified Culture of Safety Survey (MCSS) modified with permission from AHRQ

1. I feel safe when I am working in my position providing care for patients.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

2. I feel like my mistakes are held against me.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

3. I feel supported by my coworkers when caring for patients.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

4. I feel like the people I work with treat each other with respect.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

5. If I need help, my coworkers will provide assistance when asked, without question.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

6. I feel free to question the decisions or actions of providers and/or my coworkers.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

7. I feel as though the units within the maternal child health setting communicate and work well together to provide safe patient care.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

Intent to Stay Items

8. I plan to leave my department as soon as possible.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

9. I plan to stay in my department as long as possible.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

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Appendix B Modified Culture of Safety Permission from AHRQ

9/15/2017   RE: Safety Culture Survey modified for small DNP project request permission: *ref#24-80471 - dnp18a.gina.galosi@nv.touro.edu - Tour

SafetyCultureSurveys@westat.com   Sep 13 (2 days ago)
to me

Hi Gina Galosi,

Thank you for following up with us.

As you proceed with creating your survey, please be sure to appropriately attribute the items you use from Surveys on Patient Safety Culture™ by noting that the questionnaire or items have been "adapted from" or "modified from" the AHRQ Hospital Survey on Patient Safety Culture™. As a reminder, if you have any questions about our trademark and what is and isn't allowed, you can find more information here: https://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/usingsops.html.

Please feel free to contact me with any further questions.

Thanks,

Miranda

Miranda Baxter | AHRQ Surveys on Patient Safety Culture™ Technical Assistance
Westat | 1700 Research Blvd | Rockville, MD 20850
phone: 1-888-324-9749 | fax: 1-888-852-8277 | email: SafetyCultureSurveys@westat.com

Sign up for SOPS updates, news, and events and select "Surveys on Patient Safety Culture" under Quality and Safety topics: https://public.govdelivery.com/accounts/USAHRQ/subscriber/new?

++

Good morning, Miranda. I am still unsure as to how to proceed with my survey and request your guidance. If I create my own 7 item survey and conduct content validity with several experts, renaming my survey a Modified Culture of Safety Survey, is this the correct way to proceed with my project? Following your provided guidelines, I think this would not be considered a SOPS survey and would not be used for comparison to other facilities, which is not the aim of my project.

I am unsure and want to be correct going forward with my project. I thank you for your assistance.
Gina Galosi

On Mon, Sep 11, 2017 at 1:11 PM, <SafetyCultureSurveys@westat.com> wrote:
Hi Gina Galosi,

Thanks for your interest in the Surveys on Patient Safety Culture™. If you are administering a patient safety culture survey that is based on a SOPS survey or uses items from a SOPS survey, please refer to the guidelines on modifying and naming SOPS surveys in Using the AHRQ Surveys on Patient Safety Culture™ (https://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/usingsops.html). Some organizations use a subset of SOPS survey items as starting points for a modified questionnaire. Changes to the core survey would include any of the following:

- Changing the wording of the items or response options.
- Changing the order of the items or response options.
- Deleting one or more items.
- Adding supplemental or custom questions among the core items within the survey.

If these kinds of changes are made, the survey is no longer considered a SOPS survey. In addition, the results of your survey are not comparable to other organizations in the SOPS Databases. The successful use of SOPS surveys depends on everyone administering the same items in the same order.

Thank you,
Miranda

Miranda Baxter | AHRQ Surveys on Patient Safety Culture™ Technical Assistance
Westat | 1700 Research Blvd | Rockville, MD 20850
phone: 1-888-324-9749 | fax: 1-888-852-8277 | email: SafetyCultureSurveys@westat.com

Sign up for SOPS updates, news, and events and select "Surveys on Patient Safety Culture" under Quality and Safety topics: https://public.govdelivery.com/accounts/USAHRQ/subscriber/new?

+++

Good Afternoon. I am a nursing instructor, labor and delivery nurse and doctor of nursing practice (DNP) student who is conducted a quality improvement project.

My project is related to incivility and the impact on the culture of safety.

My organization currently uses your survey for the entire workforce which is why I am familiar with your safety survey.

I have received permission to use the nursing incivility scale to survey my participants but would also like to add some of the questions pertaining to safety from your survey. I have searched your website and read about the surveys and noticed that your FAQs section says the items should not be modified or deleted because the results will not be able to be compared to other facilities. I only wish to use a select few of your items and will only use them for this project of a potential sample of (hopefully) 30 nurses for statistical analysis purposes.

I am hoping that i can speak to someone about this matter and look forward to the conversation and possible ideas for my project.

I thank you in advance for the consideration and appreciate the importance of your organization.

Gina Galosi
856-770-4238 (cell)

Appendix C

Nursing Incivility Scale

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

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

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

$$1 = \text{Strongly Disagree}$$
$$2 = \text{Disagree}$$
$$3 = \text{Neither Agree nor Disagree}$$
$$4 = \text{Agree}$$
$$5 = \text{Strongly Agree}$$

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

1 HC Hospital employees raise their voices when they get frustrated.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

2 HC People blame others for their mistakes or offenses.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

3 HC Basic disagreements turn into personal verbal attacks on other employees.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

4 IJ People make jokes about minority groups.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

5 IJ People make jokes about religious groups.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

6 IJ Employees make inappropriate remarks about one's race or gender.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

7 IB Some people take things without asking.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

8 IB Employees don't stick to an appropriate noise level (e.g. talking too loudly).

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

9 IB Employees display offensive body language (e.g., crossed arms, body posture).

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

The following describe your interactions with other nurses. Other nurses on my unit…

1 HC…argue with each other frequently.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

2 HC…have violent outbursts or heated arguments in the workplace.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

3 HC…scream at other employees.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

4 GR…gossip about one another.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

5 GR…gossip about their supervisor at work.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

6 GR…bad-mouth others in the workplace.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

7 GR…spread bad rumors around here.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

8 FR…make little contribution to a project but expect to receive credit for working on it.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

9 FR…claim credit for my work.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

10 FR…take credit for work they did not do.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

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

My direct supervisor…

1 AS…is verbally abusive.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

2 AS…yells at me about matters that are not important.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

3 AS…shouts or yells at me for making mistakes.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

4 AS…takes his/her feelings out on me (e.g., stress, anger, "blowing off steam").

1   Strongly Disagree 2 Disagree   3 Neither Agree nor Disagree 4 Agree 5 Strongly Agree

5 LR…does not respond to my concerns in a timely manner.

1 Strongly Disagree 2 Disagree   3 Neither Agree nor Disagree 4 Agree   5 Strongly Agree

6 LR…is condescending to me.

1   Strongly Disagree 2 Disagree   3 Neither Agree nor Disagree 4 Agree   5 Strongly Agree

7 LR…factors gossip and personal information into personnel decisions.

1 Strongly Disagree 2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

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

1 AS Some physicians are verbally abusive.
1 Strongly Disagree 2 Disagree   3 Neither Agree nor Disagree   4 Agree 5 Strongly Agree

2 AS Physicians yell at nurses about matters that are not important.
1 Strongly Disagree 2 Disagree   3 Neither Agree nor Disagree   4 Agree 5 Strongly Agree

3 AS Physicians shout or yell at me for making mistakes.
1 Strongly Disagree 2 Disagree   3 Neither Agree nor Disagree   4 Agree 5 Strongly Agree

4 AS Physicians take their feelings out on me (e.g., stress, anger, "blowing off steam")
1 Strongly Disagree 2 Disagree   3 Neither Agree nor Disagree   4 Agree 5 Strongly Agree

5 LR Physicians do not respond to my concerns in a timely manner.
1 Strongly Disagree 2 Disagree   3 Neither Agree nor Disagree   4 Agree 5 Strongly Agree

6 LR I am treated as though my time is not important.
1 Strongly Disagree 2 Disagree   3 Neither Agree nor Disagree   4 Agree 5 Strongly Agree

7 LR Physicians are condescending to me.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

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

1 LR…do not trust the information I give them and ask to speak with someone of higher authority.
1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

2 LR…are condescending to me.
1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

3 LR…make comments that question the competence of nurses.
1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

4 LR…criticize my job performance.
1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

5 LR…make personal verbal attacks against me.
1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

6 LR…pose unreasonable demands.
1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

7 DF…have taken out their frustrations on nurses.
1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

8 DF…make insulting comments to nurses.
1   Strongly Disagree 2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

9 DF…treat nurses as if they were inferior or stupid.
1   Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

10 DF...show that they are irritated or impatient.
1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

Thank you for your participation!

Guidroz, A. M., Burnfield-Geimer, J. L., Clark, O., Schwetscchenau, H. M., & Jex, S. M. (2010).

The nursing incivility scale: Development and validation of an occupation-specific

measure. *Journal of Nursing Measurement*, *18*(3), 176-200. Retrieved from

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Appendix D

Nursing Incivility and the Culture of Safety in an Acute Care Facility

Gina Galosi
ggalosi@virtua.org

Appendix E Cue Card Permission and Sample Cue Card

Cue Cards to be attached to Nurse's Identification Badge		
Side 1	**Side 2**	**Single Card Attached to ID**
Nonverbal innuendo (raising of eyebrow, face-making). -I sense (I see from your facial expression) that there may be something you wanted to say to me. It's okay to speak directly to me. Verbal affront (covert or overt, snide remarks, lack of openness, abrupt responses). -The individuals I learn the most from are clearer in their directions and feedback. Is there some way we can structure this type of situation? Undermining activities (turning away, not available). -When something happens that is 'different' or 'contrary' to what I thought or understood, it leaves me with questions. Help me understand how this situation may have happened. Withholding information (practice or patient). -It is my understanding that there was (is) more information available regarding this situation and I believe if I had known that (more), it would (will) affect how I learn or need to know.	Sabotage (deliberately setting up a negative situation). -There is more to this situation than meets the eye. Could 'you and I' (whatever, whoever) meet in private and explore what happened? Infighting (bickering with peers). Nothing is more unprofessional than a contentious discussion in non-private places. *Always* avoid. -This is not the time or the place. Please stop (physically walk away or move to a neutral spot). Scapegoating (attributing all that goes wrong to one individual). Rarely is one individual, one incident, or one situation the cause for all that goes wrong. Scapegoating is an easy route to travel, but rarely solves problems. -I don't think that's the right connection. Backstabbing (complaining to others about an individual and not speaking directly to that individual). -I don't feel right talking about him/her/situation when I wasn't there, or don't know the facts. Have you spoken to him/her? Failure to respect privacy. -It bothers me to talk about that without his/her/their permission. -I only overheard that. It shouldn't be repeated. Broken confidences -Wasn't that said in confidence? -That sounds like information that should remain confidential. -He/she asked me to keep that confidential.	-Accept one's fair share of the work-load. -Respect the privacy of others. -Be cooperative with regard to the shared physical working conditions (e.g. light, temperature, noise). -Be willing to help when requested. -Keep confidences. -Work cooperatively despite feelings of dislike. -Don't denigrate to superiors (e.g. speak negatively about, have a pet name for). -Do address coworkers by their first name, ask for help and advice when necessary. -Look coworkers in the eye when having a conversation. -Don't be too overly inquisitive about each other' lives. -Do repay debts, favors, and compliments, no matter how small. -Don't engage in conversations about a coworker with another coworker. -Stand-up for the "absent member" in a conversation when he/she is not present -Don't criticize publicly.

Griffin, M., & Clark, C.M. (2014). Revisiting Cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later. *The Journal of Continuing Education in Nursing, 45*(12), 535-542. http://dx.doi.org/10.3928/00220124-20141122-02

8/7/2017   Touro University Nevada Mail - Cue Cards from Cognitive Rehearsal

Touro University Nevada

Gina Galosi <dnp18a.gina.galosi@nv.touro.edu>

Cue Cards from Cognitive Rehearsal
3 messages

Gina Galosi <dnp18a.gina.galosi@nv.touro.edu>   Mon, Aug 7, 2017 at 11:46 AM
To: marthagriffin123@gmail.com

Dear Dr. Griffin. I am a DNP student at Touro University Nevada and am conducting my DNP project on incivility on a labor and delivery unit. During my literature research, I came across your article with Dr Clark on revisiting cognitive rehearsal and your original article from 2004.

I am writing to you to ask permission to use the cue cards because I think they are fabulous. I am wondering why it took me so long to find them.

I thank you in advance for your consideration of this email and any assistance you may have for me.

Gina Galosi
dnp18a.gina.galosi@nv.touro.edu
cell-856-770-4238

Martha Griffin <marthagriffin123@gmail.com>   Mon, Aug 7, 2017 at 12:43 PM
To: Gina Galosi <dnp18a.gina.galosi@nv.touro.edu>

Hi Gina, Yes you absolutely have my permission to use the cards. Dr Clark's work on incivility is outstanding and she is one of the nicest people you could ever meet! If you send me your address I will send you a sample cueing card and also a new book (The Dauntless Nurse) that a colleague and I just published and I think you would enjoy it. Let me know, and good luck with your DNP! Martha

[Quoted text hidden]

Gina Galosi <dnp18a.gina.galosi@nv.touro.edu>   Mon, Aug 7, 2017 at 1:14 PM
To: Martha Griffin <marthagriffin123@gmail.com>
Cc: cclark@boisestate.edu

Wow! Thank you so much and I really appreciate it. Both you and Dr Clark have been exceedingly helpful beyond my wildest expectations.

My address is 229 east Madison Avenue
Collingswood NJ
08108

Thank you more than you could possibly know

Gina Galosi
[Quoted text hidden]

Appendix F

INCIVILITY POLICY

The organization is committed to providing a work environment in which productivity, interpersonal relations and behavior are promoted in a safe, fair and professional manner. It is the policy of the organization to set reasonable, professional standards for conduct while providing care and while interacting with patients and families, visitors, and other personnel within all facilities. Professional dress, language, and all forms of communication must be adhered to while on any of the organization campus or attending any the organization's function.

The organization highly values the principles of Relationship Based Care for all interactions within the organization. Relationship Based Care focuses on building a caring relationship between self, patients and families, and with fellow employees. Respectful communication fostering teamwork is highly valued for promoting a culture of safety for all employees of the organization. This policy reaffirms the organization's commitment that all employees should be able to enjoy a safe work environment free from disrespect, uncivil behavior, and/or bullying.

SCOPE OF POLICY

This policy covers all employees of the organization as well as physicians and others doing business with the organization and visitors, patients and family members. The organization will not condone or allow unprofessional or uncivil behavior, whether engaged in by fellow employees, supervisors, or non-employee's supervisors, or non-employees (including medical staff) who conduct business with the organization. The organization encourages reporting of all incidents of incivility and any behavior that threatens fostering a culture of safety within the organization, whomever the offender may be.

PROCEDURE:

Definitions:

A. Safe work environment is one in which personnel can function at their optimum level providing quality, safe patient care.
B. Incivility in the workplace is defined as actions and/or communication considered rude or disruptive that result in psychological or physiological distress for those involved may be verbal or non-verbal. The behavior is also defined as low-intensity rude or disrespectful behaviors with an ambiguous intent to harm others.
C. A definition of workplace bullying is repeated offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions that make recipients upset and feel humiliated, vulnerable, or threatened, creating stress and undermining their self-confidence. Some actions considered incivility may include, but are not limited to:
   1. Verbal:
       a. Yelling
       b. Gossiping

        c. Blaming

        d. Put downs

        e. Name calling

        f. Scapegoating

        g. Infighting

        h. Backstabbing

2. Non-Verbal:

        a. Rudeness

        b. Eye-rolling

        c. Ignoring

        d. Withholding information

        e. Intimidation

D.

1. May include actions taken and actions not taken

        a. Witnessing uncivil behavior without action is supporting it

        b. Not reporting inappropriate behavior or bullying

E. Employees who believe they are being subjected to either uncivil behavior, bullying, or any behavior that threatens a culture of safety on the unit should follow the following procedure:

Enforcement Guidelines

A. Managers are responsible for maintaining a work environment free of harassment.

1. Managers are expected to act pro-actively to maintain compliance by all employees and others within the workplace, and to take appropriate corrective action in the event of non-compliance maintaining a culture of safety.

2. Employees are responsible for respecting the rights of their co-workers and fostering a culture of safety.

Reporting Guidelines for Employees

A. Any employee who believes he/she is being subjected to uncivil or bullying behavior is encourage to firmly and promptly notify the individual(s) involved that the behavior is unwelcome.

B. If a discussion is not possible due to the relationship between the employee and the offender(s), or if the employee is uncomfortable with raising the issue with the offender or is not satisfied with the resolution of the problem, the following steps must be followed:

1. The employee must notify Human Resources Management immediately.

2. If the employee is uncomfortable in notifying Human Resources Management or is not satisfied with the action or resolution after notifying Human Resources Management, he/she should notify the next level of Human Resources Management.

       3. Any questions regarding the policy or possible incivility, bullying, or unprofessional behavior can also be brought to the attention of the employee's direct supervisor.

   C. Employees are encouraged to report all incidents of incivility, bullying, and/or unprofessional behavior regardless of who the offender may be.

   D. Employees also always have the option of reporting issues/concerns to the organization's Corporate Compliance Hotline: 800-268-0502.

INVESTIGATION GUIDELINES

   A. Managers are to report all complaints to their local Human Resources Management who will coordinate the investigation, based upon the circumstances presented.

   B. All complaints of harassment are to be investigated appropriately and promptly, in an impartial and in as confidential a manner as possible by the supervisor and Human Resources Management with the understanding that some disclosure may be necessary for the purpose of an investigation or resolution.

   C. The investigation will include obtaining documents of the objectionable behavior or misconduct and the interview of the witnesses to the conduct, including the complainant and alleged person conducting uncivil behavior or bullying, whenever possible.

RESOLUTION OF THE COMPLAINT

   A. If a complaint of incivility or bullying is found to be substantiated, appropriate, prompt corrective action will be taken. The appropriate corrective action will depend upon the particular facts and circumstances of the situation, as identified in the investigation. Corrective action may include counseling up to and including termination of the employee engaging in inappropriate, unprofessional, uncivil behavior reducing the culture of safety of the work environment.

   B. If the investigation results in a finding that the complainant had knowingly filed a false accusation or made such accusations in a malicious manner, the accusing employee will be subject to counseling, up to and including termination of employment.

   C. Employees who are dissatisfied with the resolution of the incivility, bullying, not fostering a culture of safety complaint may file a dispute in accordance with the Dispute Resolution Policy.

   D. There shall be no retaliation against any individual because the employee complained about incivility, bullying, or a decline in the culture of safety of the unit. Any employee found to have engage in retaliation against another individual for complaining about incivility, bullying, or unprofessional behavior will be subject to counseling, up to and including termination of employment.

CURRENT EVIDENCE/REFERENCE:

American Nurses Association. (2015). Position Statement: "Incivility, Bullying, and Workplace Violence" Retrieved from http://nursingworld.org/DocumentVault/Position-Statements/Practice/Position-Statement-on-Incivility-Bullying-and-Workplace-Violence.pdf

Griffin, M., & Clark, C.M. (2014). Revisiting Cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later. *The Journal of Continuing Education in Nursing, 45*(12), 535-542. http://dx.doi.org/10.3928/00220124-20141122-02

Appendix G Permission for NIS

From: Ashley Guidroz <amguidroz@gmail.com<mailto:amguidroz@gmail.com>>
Date: August 31, 2017 at 11:27:29 AM EDT
To: Gina Galosi <dnp18a.gina.galosi@nv.touro.edu<mailto:dnp18a.gina.galosi@nv.touro.edu>>
Subject: Re: NIS Survey

Hi Gina,

Thank you for your interest in the NIS. You have my permission to use the tool for your research. Please let me know if you have any additional questions.

Best of luck in your research!

Ashley

On Wed, Aug 30, 2017 at 9:56 PM, Gina Galosi <dnp18a.gina.galosi@nv.touro.edu<mailto:dnp18a.gina.galosi@nv.touro.edu>> wrote:

Dear Dr. Guidroz,

I am a nursing instructor and labor and delivery nurse in New Jersey in addition to being a doctor of nursing practice (DNP) student. Where I work, clinically, we have a lot of women with strong personalities and uncivil behavior. As a DNP student I have been working on a project where I want to measure uncivil behavior and the nurses' perception of incivility. During my literature search and review of available tools, I came across your nursing incivility scale and would love to administer this tool to my participant population. I plan on a pre and post administration of the tool with a continuing education unit in between. I have asked and received permission from Dr Martha Griffin to use her scripting cue cards and will provide them to the nurses who attend my inservice.

This email is to formally and respectfully ask your permission to use your survey tool as I feel it is the best survey to administer to the participants of my quality improvement project. I thank you in advance for any and all consideration regarding this matter. I really respect the research you have conducted and the findings you have provided.

Sincerely

Gina Galosi MSN Ed., RNC, CNE

Instructor 1

Rowan College @ Gloucester County

1400 Tanyard Road

Sewell NJ 08080

ggalosi@rcgc.edu<mailto:ggalosi@rcgc.edu>

Ashley Guidroz
to me   12:27 PM (2 hours ago)

You are so welcome! I hope everything goes well!

Appendix H Permission for two Item Intent to Stay

31/2017   Doctoral Project, Job stress, Intent to stay and a request for your permission - dnp18a.gina.galosi@nv.touro.edu - Touro University Nevada Ma

Gina Galosi <dnp18a.gina.galosi@nv.touro.edu>   Aug 28 (3 days ago)
to s3260396, ksa_77

Dear Dr Alsaqri.
I am a nursing instructor and labor and delivery nurse in New Jersey in addition to being a doctor of nursing practice (DNP)
student. Where I work, clinically, we have a lot of women with strong personalities and uncivil behavior. As a DNP student I
have been working on a project where I want to measure uncivil behavior and the nurses' perception of incivility as well as
intent to stay employed. During my literature search and review of available tools, I came across your tool and would love to
administer part of this tool to my participant population.

I plan on a pre and post administration of the tool with a continuing education unit in between.

I am very interested in the part of your tool regarding intent to stay and job satisfaction. Is it possible you use part of your
survey? Specifically these 8 questions? As I am sure you know, there are not many tools related to intent to stay employed.
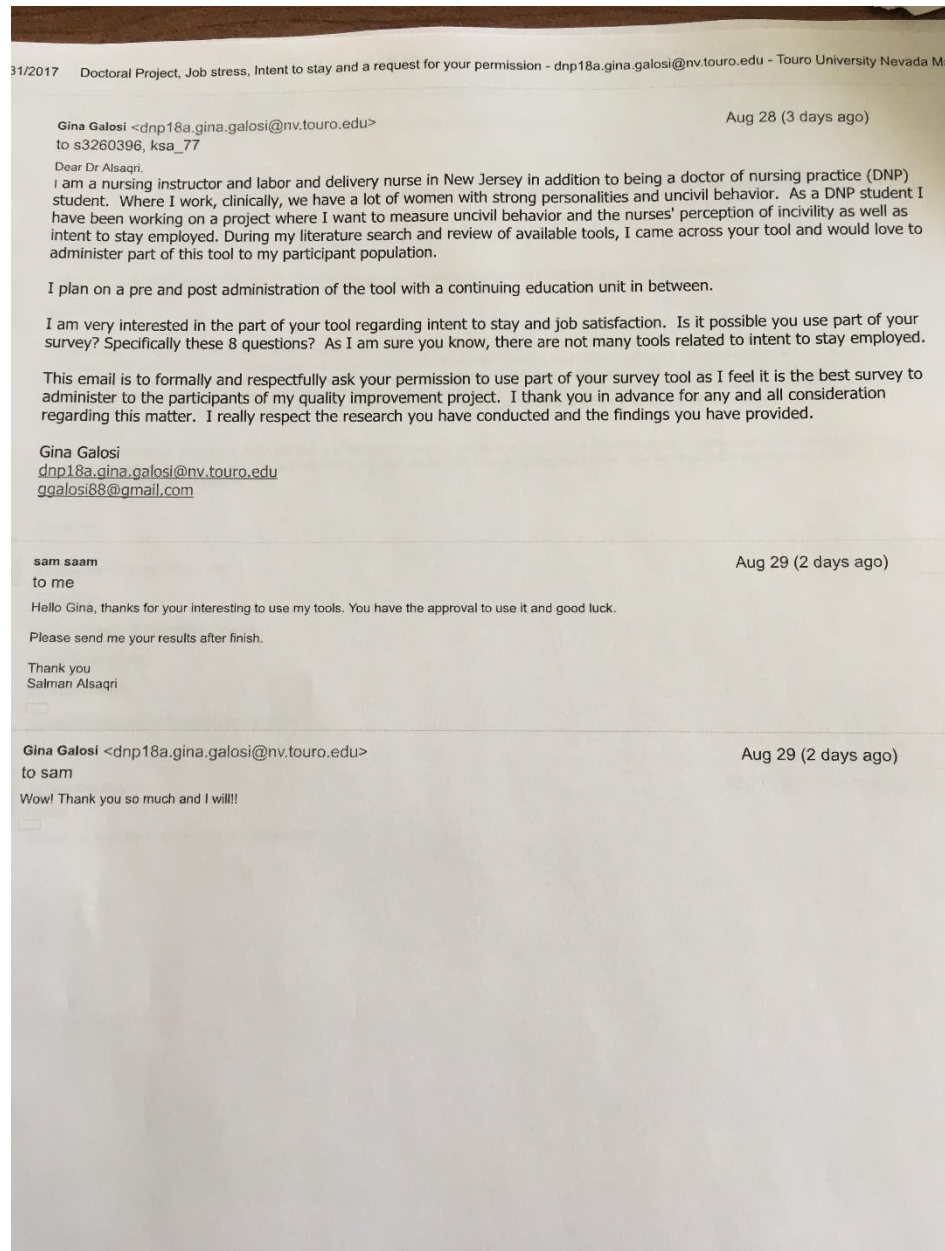
This email is to formally and respectfully ask your permission to use part of your survey tool as I feel it is the best survey to
administer to the participants of my quality improvement project. I thank you in advance for any and all consideration
regarding this matter. I really respect the research you have conducted and the findings you have provided.

Gina Galosi
dnp18a.gina.galosi@nv.touro.edu
ggalosi88@gmail.com

sam saam   Aug 29 (2 days ago)
to me

Hello Gina, thanks for your interesting to use my tools. You have the approval to use it and good luck.

Please send me your results after finish.

Thank you
Salman Alsaqri

Gina Galosi <dnp18a.gina.galosi@nv.touro.edu>   Aug 29 (2 days ago)
to sam

Wow! Thank you so much and I will!!

Appendix I Content Validity Index Table for Modified Culture of Safety Intent to Stay Items

Item	Expert 1	Expert 2	Expert 3	Expert 4	Expert 5	Expert 6	Expert 7	Expert 8	Expert 9	Expert 10	Mean	CVR
1	4	3	3	4	4	4	4	4	4	4	3.8	1
2	3	4	3	4	2	4	4	4	4	4	3.6	0.8
3	4	3	4	4	4	4	4	4	4	4	3.9	1
4	2	4	3	4	4	4	4	4	4	4	3.7	0.8
5	4	3	4	4	2	4	4	4	4	4	3.7	0.8
6	4	4	4	4	4	4	3	4	4	4	3.9	1
7	3	4	4	4	3	4	4	4	4	4	3.8	1
8	4	4	3	4	4	4	4	4	4	4	3.9	1
9	4	4	3	4	4	4	4	4	4	4	3.9	1
										Item CVI Mean= 0.93		
										Universal Agreement 0.78%		
										7 out 9 items were rated 3or 4 by all experts		

The content validity index is calculated using the following formula:

CVR = [(E-(N/2)) / (N/2)] with E representing the number of judges who rated the item as essential and N being the total number of judges.

1. Item 1 [(10-(10/2)/ (10/2)]=1
2. Item 2 [(9-(10/2)/ (10/2)]= 0.8
3. Item 3 [10-(10/2)/ (10/2)]=1
4. Item 4 [(9-(10/2)/ (10/2)]=0.8
5. Item 5 [(9-(10/2)/ (10/2)]=0.8
6. Item 6 [(10-(10/2)/ (10/2)]=1
7. Item 7 [(10-(10/2)/ (10/2)]=1
8. Item 8 [(10-(10/2)/ (10/2)]=1
9. Item 9 [(10-(10/2)/ (10/2)]=1

The mean total of all of the means was 3.8 indicating that all of the questions were essential.

Appendix J Post Educational Intervention Evaluation

1. The content was appropriate for the purpose and objectives.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

2. The listed objectives were met.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

3. The teaching/learning methods (Pre/post-test, questions, role play activity, videos) were effective and appropriate for the subject matter.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

4. The presenter was effective, presented well, and had clarity.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

5. The content and educational materials were useful and added to my knowledge.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

6. How much did you learn from this presentation?

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

7. Participating in this educational activity will assist me to enhance my skills with my professional practice.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

8. Participating in this educational activity will assist me to enhance my skills with caring for patients.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

9. Do you believe that you will employ at least some of the scripting presented during this educational intervention?

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

10. This program was presented in a fair and unbiased manner.

1 Strongly Disagree   2 Disagree   3 Neither Agree nor Disagree   4 Agree   5 Strongly Agree

11. Additional comments:

Appendix K Timeline

Number of Tasks	Week(s) to Accomplish Task	Activity
1	**Week(s) to Accomplish Task**	Complete application for Institutional Review Board and email to Organization's Research Council Chair
2	Week of August 21, 2017 to August 25, 2017 2 hours	Complete application for Continuing Education Credit and email to Director of Continuing Education at organization of interest.
3	Week of September 18, 2017 to September 22, 2017 4-6 hours	Email the person in charge of conference rooms for confirmation of conference rooms and times for educational intervention
4	Week of October 2, 2017 30 minutes Possible 6 hours if approved to attend Shared Governance meetings	Email all nursing staff of the MCH department nurses with the information for educational intervention and post flyers with information about educational intervention Email the five Chairs of Shared Governance for inclusion and to attend meetings to discuss project
5	Week of October 23, 2017 to November 5, 2017 1 hour	Have packets of surveys and sign-in sheet ready (Make copies of survey packets) for the following week Email the six Nursing Directors for inclusion of educational intervention in daily huddles and email blast
6	Week of November 13, 2017 to November 17, 2017 25 hours	Eight sessions of educational intervention or until minimum sample of 30 is obtained
7	Week of November 27, 2017 to November 30, 2017	Email participants the post- educational survey link
8	Week of November 30, 2017 to December 3, 2017 One hour	Hand packets to participants who do not complete electronic survey via link
9	Weeks of December 6, 2017 to January 4, 2018 or until all participants have completed the second survey for the project. 5-6 hours planned but possibly more	Complete codebook, input data into SPSS, consult statistician for analysis
10	Weeks of January 8, 2018 to January 22, 2018 10-20 hours but possibly more	Evaluation of data results
11	Weeks of February 12, 2018 to February 26, 2017	Dissemination of results