A Quality Improvement Project Measuring the Effect of an Evidence-Based Civility Training Program on Nursing Workplace Incivility in a Rural Hospital Using Quantitative Methods

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Abstract

Workplace incivility is a well-documented issue in nursing. It has the potential to cause emotional and physical distress in victims, and potentially affect the quality of care provided. Research in acute care settings found that facilitated educational training sessions related to workplace incivility, in combination with experiential learning activities, assisted nurses in improving their understanding of workplace incivility and their communication skills. It has also been found to reduce workplace incivility. The purpose of this quality improvement project was to see if implementation of a civility training program would: a) increase the staff nurses' ability to recognize workplace incivility, b) reduce workplace incivility on a nursing unit, and c) increase confidence in the staff nurses' ability to respond to workplace incivility when it occurs. The project design involved implementing a civility training program that included education about incivility through facilitated discussions, as well as teambuilding exercises and experiential learning activities involving practice in responding to incivility in a safe environment. The project was implemented in a medically-focused medical-surgical unit at a rural Kentucky hospital with a sample of nine registered nurses. The findings of the project included no significant changes in

the frequency of the nurses' experiences with incivility in their unit. It did result in statistically significant increases in the nurses' self-assessed ability to recognize workplace incivility and confidence in the nurses' ability to respond to workplace incivility when it occurs. It was concluded that implementing this type of intervention in other rural nursing settings might help nurses have greater confidence in their ability to recognize and respond to workplace incivility.

Keywords: Incivility, Nursing, Experiential learning

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Workplace incivility, or bullying, is a behavioral issue that can occur in the healthcare setting. Anderson and Pearson (1999) defined workplace incivility as low-intensity, deviant behaviors that are intended to harm the victim and demonstrate a lack of mutual respect. Incivility seems to occur as the result of poor communication and discourteous attitudes that fall outside of expected work norms. Rural areas are not immune to nursing incivility. Fairchild et al. (2013) interviewed 40 nurse administrators from rural communities. The administrators reported workplace civility education as a specific area of need. Some of the interviewed administrators described periodically having to mediate with employees for both overt and covert acts of workplace incivility, such as name-calling, intimidation, and sabotaging behaviors. This quality improvement project was implemented at a rural hospital in Kentucky. The community containing the hospital is defined as rural, because the county has a population of less than 50,000 people (OMB, 2010).

Background and Significance

Multiple studies have linked incivility to patient safety and the quality of patient care. Wright and Khatri (2014) queried 1,078 nurses working for a Midwest hospital system about workplace bullying and medical errors, and found a significant, positive relationship between being a victim of workplace bullying and the perception of the bullied nurses' risk of committing medical errors (β weight = .370, p < .001). Laschinger (2014) questioned 336 Canadian acute care nurses about their exposures to workplace incivility, and the perceived effects of workplace incivility on patient safety and the quality of care they provided. A significant correlation (R^2 = 0.03-0.06, p = .000) was discovered between workplace incivility experiences and the nurses' perceptions about decreased quality of care provided, increased adverse events, and higher patient safety risks. Hutchison and Jackson (2013) completed a mixed-methods systematic review of literature related to the effect of hostile nursing work environments on patient care. They discovered ten studies related to nurses bullying fellow nurses. Five of the studies found that nurses reporting exposures to workplace bullying frequently felt overwhelmed and at increased risk for errors in patient care. In four of the studies, nurses reported that workplace incivility prevented requests for assistance from coworkers when dealing with complex clinical situations or where patient safety was at risk. The evidence supports the need to improve nursing workplace communication and civility behaviors to maintain a safe, effective care environment for patients.

Nursing incivility can affect hospital finances as well. Laschinger, Leiter, Day, and Gilin (2009) surveyed 612 staff nurses from five Canadian hospital systems about incivility. They found that empowerment, incivility, and burnout were correlated with job satisfaction, organizational

commitment, and turnover intentions of nurses. High nursing turnover rates increase the frequency, and therefore cost, of training and orienting new nurses. Ortega, Christensen, Hogh, Rugulies, and Borg (2010) surveyed 9949 Danish nurses working in the elder-care setting about bullying in the workplace and monitored long-term, sickness-related absences over a one-year period. A long-term sickness absence was defined as over six consecutive weeks of absence related to ill health. Of the nurses reporting occasional exposure to workplace bullying, long-term sickness absences were more common than those not exposed to bullying. Nurses who were frequently exposed to bullying were at a 92% higher risk of experiencing a long-term sickness absence. The replacement of nurses who require long absences increases the overall cost of providing effective patient care.

Incivility has been identified in multiple studies as a problem experienced by nurses in the workplace. Edward, Ousey, Warelow, and Lui (2014) completed a systematic review of the literature involving violence against nurses. Of the 137 articles reviewed, 31 focused on workplace aggression between nurses, and between nurses and other healthcare professionals, with five surveying nurses about exposures to workplace incivility. High levels of reported collegial aggression were found in the reviewed studies, with 21% to 90% of the nurses surveyed from the studies reporting exposures to workplace bullying within the last year. Smith, Andrusyszyn, and Laschinger (2010) surveyed 117 novice Canadian nurses about workplace incivility. Of those responding, 90.4% reported that they had experienced at least some form of co-worker incivility. Many nurses experience workplace incivility. As the available evidence has demonstrated, the consequences of dealing with incivility can be costly for nurses, employers, and patients.

The purpose of this quality improvement project was to implement a civility training program that included education about incivility, teambuilding exercises, and experiential learning

activities. Implementation of the civility training program was expected to: a) increase the staff nurses' ability to recognize workplace incivility, b) reduce workplace incivility on a nursing unit, and c) increase confidence in the staff nurses' ability to respond to workplace incivility when it occurs. The plan was based on the best available evidence, with a focus on its suitability for the participating agency. The plan included education about workplace incivility, teambuilding exercises, and an experiential learning exercise that allowed for practice in responding to workplace incivility scenarios in a safe environment. A quality improvement framework was used to guide the project.

Theoretical Framework

Benner (2001) theorized that nurses transform information into knowledge through experiential learning. In her seminal work, Benner (2001) detailed her philosophy of how basic knowledge is transferred from superficial to deep understanding through the practice of nursing, as a nurse goes through the five major stages of nursing experience. Nurses at the novice level, are beginning learners. They have a basic knowledge of nursing practice through rote memorization of facts and some classroom application, but they have not experienced learning through actual interactions with nurses and patients, or have very limited experience.

Once a nurse has had a fair amount of clinical experience, he or she moves to the advanced beginner stage (Benner, 2001). Through experience, the advanced beginner can demonstrate some understanding beyond the basic level. The advanced beginner can begin to prioritize care, but still needs supervision and guidance in decision-making and in the management of care. The next stage of nursing is the competent stage, which occurs after the nurse has two to three years of experience (Benner, 2001). The knowledge that the competent nurse applies to practice is objective, as well

as abstract and analytical. The competent nurse has enough experience to effectively cope with the management of patients. However, he or she may lack the speed or flexibility of the expert nurse.

According to Benner (2001), the final two stages of nursing knowledge development are proficient and expert. The proficient nurse's knowledge allows for an understanding of the whole situation, rather than isolated parts. Subtle patient needs or issues are detected more readily by the proficient nurse, as compared to the competent one. The proficient nurse can perceive a situation and the flexibility to respond, if the situation changes. The expert nurse is no longer thinking or perceiving based primarily on previous training or education, but knowledge from experience (Benner, 2001).

Benner's (2001) philosophy of nursing knowledge development can be useful in assisting nurses in dealing with workplace incivility, because it provides a framework for nursing staff education. Using Benner's philosophy, the project leader was able to guide nurses in recalling their previous experiences as they progressed through the different stages of personal and professional development as a nurse. The project leader also assisted the nurses in discovering their current expertise levels, and help them to better understand and assist other nurses with less experience. Benner's philosophy also encourages the use of experiential learning in moving learned information, such as interpersonal communication techniques, into deeper understanding for actual utilization in practice. According to Benner (2001), for nurses to truly learn, they must be exposed to situations, through actual or simulated practice, in order to transfer superficially understood information into true knowledge and understanding. Once true understanding takes place, learned skills can be fully used in practice.

Review of Literature

There are four major categories of available evidence related to interventions aimed at helping nurses manage workplace incivility. There are studies that involved non-interactive, or non-facilitated, educational sessions about workplace incivility with experiential learning exercises. Facilitated training refers to learning sessions that are interactive and involve group discussion, rather than traditional one-way teaching methods. Some of the studies have facilitated educational sessions, but no experiential learning exercises. Studies were found that included educational sessions only, with no facilitation or experiential learning exercises. Finally, there were studies that focused on a combination of facilitated educational sessions about workplace incivility with experiential learning exercises involving practice in responding to bullying behaviors effectively.

Non-facilitated Education and Experiential Learning Exercises

Mallette, Duff, McPhee, Pollex, and Wood (2011) used a randomized controlled trial to study effective formats for training nurses in managing nursing incivility. The purpose of the study was to evaluate the effectiveness of traditional educational methods versus a virtual world-based experiential learning program in helping nurses successfully deal with horizontal violence, or incivility, in the workplace. The study was conducted in one Canadian hospital using a convenience sample of 164 nurses who were past their probationary periods, and who worked in tertiary care. The participants were randomly divided into five groups. One group completed a workbook about incivility and how to respond to it. Another group did a self-directed e-learning module. A third group participated in a virtual world training program, using the Second Life format, to role-play, practice, and receive feedback on responding to incivility in the virtual

workplace. A fourth group completed both the e-learning module and the virtual world training program. The final group was a control group with no training provided.

Mallette et al. (2011) found that all forms of educational training resulted in high satisfaction rates, with the highest being given to the combined e-learning module ($M = 6.43$, $SD = 0.60$) and virtual world training sessions ($M = 6.12$, $SD = 0.51$) on a 7-point Likert-type scale. There was overwhelmingly positive feedback given by those using the Second Life virtual world program. All types of educational training formats resulted in increased knowledge about horizontal violence, comparing the pretest to the posttest, except the group using the virtual world training alone. The participants' ability to respond to horizontal violence with a trained actor was not significantly different for any of the groups, including the control group. However, all the intervention groups showed improvement in self-efficacy and confidence, especially in their confidence in their ability to respond to incivility.

Dahlby and Harrick (2014) studied the use of an educational program about lateral violence, or incivility, in the workplace and cognitive rehearsal of appropriate responses to lateral violence in improving nurses understanding of lateral violence and frequency of experiences with lateral violence in the workplace. The study involved 46 RNs from two medical-surgical units in one healthcare organization in the United States. While there were positive increases in the nurses demonstrated understanding of lateral violence and its potential negative consequences in the workplace when comparing the pretest and posttest, the results were not statistically significant. There was qualitative data from a manager from one of the assessed units stating that she had seen nurses discussing how to respond to a situation involving lateral violence, based on the training they received.

Ceravolo et al. (2012) evaluated a program to improve communication in response to incivility, or lateral violence, and to improve the workplace culture in one healthcare system. Over a three-year period, 4,032 practicing RNs at a five-hospital, integrated healthcare organization in the northeastern United States participated in a 60-to-90-minute training workshop. Findings indicated a decrease in verbal abuse at work from 90% (n = 633) to 76% (n = 369) following the interventions. The nurses reported an increased ability to problem-solve in the post-intervention survey. There was also a reduction in the vacancy and turnover rate for nurses.

Facilitated Educational Sessions with no Experiential Learning Exercises

Clark, Ahten, and Macy (2013) studied the effects of educating senior nursing students about nursing incivility and using observed role play in the academic setting involving incivility in the nursing workplace. In this study, the researchers used problem-based learning, in which the participants were given preparatory readings about nursing incivility, and how to respond to it, prior to the training. The researchers lead the 65 student participants in a one-hour, interactive class discussion. The students then observed role play by actors, who were not students, acting out a scenario involving nursing incivility. After the training session, the senior nursing students had small-group debriefing sessions and provided written feedback about the perceived effectiveness of the training. The feedback from the students about the effectiveness of the training was generally positive, although some students were disturbed by the realistic nature of the scenario.

Clark et al. (2014) then completed a 10-month follow-up qualitative study with the students, who were now working in the practice setting as licensed RNs. The 18 participating novice RNs reported that the training they received in the classroom setting had prepared them to better recognize and respond to nursing incivility when it occurs. They also named several barriers to

truly responding to incivility effectively, such as being a new nurse and intimidation. In this study, the researchers did not have the participants actively practice responses to incivility. Rather, they observed role play and discussed appropriate responses to the instigator.

Grenyer et al. (2004) also used an incivility educational training program containing facilitated training, but without experiential exercises. The researchers developed modules pertaining to aggression and violence minimization that were used to train workers in managing incivility in nursing. The healthcare workers received education about workplace incivility and used training exercises with the objective of communicating effectively in response to aggression. The training was divided into two eight-hour modules, one four-hour module, and one two-hour module. Mean scores were significantly higher on the post-test ($M = 4.03$, $SD = .59$, $t = 3.23$, $p = .00$) when compared to the pre-test scores ($M = 3.63$, $SD = .79$) for the nurses perceived ability to management incivility. There were some complaints about the length of the training sessions.

Barrett et al. (2009) evaluated the role that a teambuilding and lateral violence training program had on improving group cohesion and job satisfaction in nurses. Surveys were sent to RNs in an inpatient surgical unit, a critical care unit, an emergency department, and an inpatient operating room at a Rhode Island Magnet hospital two months prior to and three months after the training. The teambuilding and lateral violence prevention training involved two 2-hour team training sessions with facilitated learning in small groups. The median pre-score (540) was significantly lower than the postscore (612, p = .037). The median score ($Md = 540$) for group cohesion had a statistically significant improvement after the intervention ($Md = 612$, $p = .037$). There was also an improvement in the nurses reported job satisfaction.

Educational Sessions Only

Dimarino (2011) researched the use of an evidence-based intervention with the purpose of combating lateral violence in the workplace. A convenience sample of all employees at a Maryland surgery center was used. The intervention involved three major steps, including the development of a workplace code of conduct that focused on caring, communication, and respect in the workplace. Employees were required to sign a pledge that they would adhere to the code of conduct. Another component of the intervention was that the managers in this facility were instructed to maintain an open-door policy in response to employee complaints of incivility in the workplace. They were required to counsel perpetrators of incivility and respond to interpersonal conflicts promptly. Persistent incivility would result in the loss of employment. The policy involved all employees, including healthcare providers and managers. The final intervention involved the use of a training program that was developed to educate the staff about lateral violence in the workplace and its effects. The program transitioned into a mandatory yearly in-service for all employees. The researchers performed a follow-up assessment one year after training completion. They found that there had been zero staff turnover and no reported incidences of lateral violence in the period following training completion. The staff offered qualitative feedback about the positive impact the program had on the work environment.

Chipps and McRury (2012) developed a pilot study to address workplace bullying in nursing. The purpose of the study was to examine the effect of an educational program on workplace bullying in nursing in a hospital setting. The intervention involved a three-month training program aimed at providing education about workplace bullying, establishing a learning community, allowing for personal reflection about their role in workplace civility, and assisting healthcare

workers in developing effective conflict management skills. A questionnaire was administered prior to the intervention and four months after completion of the educational sessions. Participants also kept a logbook of any observed or personally experienced bullying behaviors in the workplace. The intervention resulted in a decrease in from 37.5% (n = 6) to 6.3% (n = 1) participants reporting personal experiences with bullying. Unit managers also reported observing the nurses using conflict management skills more frequently after the training program was completed. However, the job satisfaction scores of the group were unchanged from pre-intervention to post-intervention. There was a non-significant increase in overall experiences with workplace bullying, including observed acts, following the training. The researchers attributed this increase in bullying behaviors to the small size of the sample for the pilot study. Greater success at reducing bullying behaviors was discovered in studies that used facilitated educational sessions, along with experiential learning exercises.

Facilitated Educational Sessions with Experiential Learning Exercises

There are several studies that support the use of facilitated training sessions with experiential learning activities in improving nursing workplace incivility and related outcomes. Griffin (2004) developed a program in which cognitive rehearsal, a form of mental practice, was used to train nurses to respond effectively to bullying through education and practice in using preset responses to bullying in a non-threatening setting. This is a seminal work in developing effective interventions to reduce incivility in the nursing workplace. Twenty-six newly licensed nurses hired at a New England hospital were selected to participate in the study. They were taught about incivility in nursing and given cue cards with assertive responses to common forms of bullying behaviors in the nursing workplace. The novice nurses were then guided in cognitive

rehearsal to practice mentally responding to those behaviors using the hints on the cue card. One year after the training, post-intervention interviews revealed a 100% (n = 26) stoppage of bullying behaviors on the units in which the nurses worked. The novice nurses reported that either they experienced no bullying after training or that their use of assertive responses to bullying behaviors resulted in no repeated bullying experiences.

Oostrom and Mierlo (2008) researched the use of an assertiveness training program with healthcare workers in the Netherlands. The training program included three four-hour training sessions with each session offered two to three weeks apart. In part one of the training program, participants engaged in exercises related to assertiveness and communication training. Part two involved exercises dealing with conflict management in the workplace, including the use of role play. The third part of the program allowed the participants to practice their newly-learned behaviors in a safe environment. This intervention resulted in the participants reporting that they gained insight in understanding aggressive and assertive behaviors and were better able to cope with an adverse work environment

Stagg, Sheridan, Jones, and Speroni (2011) researched the use of a two-hour training session for 15 medical-surgical nurses at two rural community hospitals to improve nursing civility and communication.   The training involved education about appropriate communication techniques in response to bullying behaviors and included time to actively rehearse those techniques in a safe, non-threatening environment. The nurses were given small cue cards that could attach to their work badges, as a reminder of the techniques they learned for application in future situations. The intervention resulted in increased understanding of workplace bullying and the ability to recognize effective responses to bullying behaviors.

Stagg, Sheridan, Jones, and Speroni (2013) sent an electronic follow-up survey to the 15 participants in the pilot study of the previously discussed research by Stagg et al. (2011). Ten nurses responded to the survey. The follow-up survey was given six months after the two-hour cognitive rehearsal training session to test for exposure to bullying and ability to respond to bullying behaviors. Seventy percent ($n = 7$) of the respondents stated that they felt able to respond to incivility after the training.   However, of the six participants who had observed bullying behaviors since the training session, 83% ($n = 5$) stated that they did not respond to the observed bullying, primarily due to fear.

Nicotera, Mahon, and Wright (2014) developed a study with the purpose of measuring the effect of the Transformation for Nurses program on workplace communication and bullying behaviors in nurses. The training involved education about conflict, structural divergence, and conflict management techniques with an aim toward creating common ground during conflict. The term structural divergence refers to when cultural, social, and structural norms are viewed differently by different individuals, creating conflict. Communication and conflict management techniques were practiced using experiential exercises in each of the small groups. The intervention resulted in reduced feelings of persecution and better relational effects in the intervention group. Qualitative feedback from the participants was overwhelmingly positive from the experimental groups. Substantial improvements in appropriate communication and reductions in destructive communication were reported in the experimental group.

Nikstaitis and Simko (2014) piloted the use of a 60-minute training program using education about incivility in the workplace, case studies, and discussion of past experiences with incivility to reduce incivility in the workplace. Twenty-one nurses participated in the study. There

was a slight increase in measured perceived incivility after the educational sessions. The researchers hypothesized that this likely occurred due to increased awareness of what actions by others are defined as incivility.

Leiter et al. (2011) completed a study to discoverg whether the CREW (Civility, Respect, and Empowerment in the Workplace) program could improve civility and social relationships, and thereby improve worker burnout, turnover intentions, job commitment, absenteeism, trust in management, and job satisfaction. The sample included healthcare workers, including nurses, employed in acute care hospitals in Nova Scotia, Canada. There were eight intervention units and 33 control units with 181 workers in the intervention group and 726 in the control group.

The intervention was the CREW training program, which was developed by the United States Department of Veterans Affairs. The CREW program involves facilitated, small-group training sessions with active learning exercises (United States Department of Veterans Affairs, 2017). The foci of the program are to teach about workplace incivility and its effects, to train nurses how to respond to incivility when it occurs, and to improve group cohesion thorough teambuilding exercises aimed at improvements in respect and communication. The experiential learning exercises help the workers to practice new communication techniques and responses to bullying behaviors in a safe environment, so that they are better prepared to use those skills in a real situation in the workplace.

Following CREW training, there was a significant decrease in feelings of burnout and job turnover intentions. Job satisfaction and trust in management had a greater improvement in the intervention group were improved in the intervention group. Absenteeism for the intervention group dropped by more than one-third, while the control group's absence rate remained static.

Study findings indicated improvements in the intervention groups in all major areas studied, including workplace civility.

Laschinger, Leiter, Day, Gilin-Oore, and Mackinnon (2012) implemented the previously mentioned CREW program with RNs working at five hospitals in Nova Scotia, Canada, with eight intervention units and 33 control units. The intervention resulted in significant increases in trust in management and significant decreases in supervisor incivility. Oore et al., (2010) evaluated 361 health care team members, in a subset of the Laschinger et al. (2012) study. The surveys were used to evaluate the role incivility plays in the stressor-strain relationship. The CREW training program was found to have improved the nurses' physical and mental responsiveness to stressors in the workplace, especially related to workload strains.

Overall, the evidence demonstrates that the use of facilitated training about incivility and how to respond to it, with experiential learning activities, such as cognitive rehearsal, can help reduce workplace incivility and help nurses be better prepared to respond to workplace incivility when it occurs. There was a lack of consistency with the type of education provided. Although most of the provided training focused on education about incivility and how to respond in an assertive manner, a variety of programs were used. Also, there was a lack of consistency in the type of instrument and the outcomes measured in the studies. However, the literature consistently demonstrated that the combination of education about incivility, facilitated training sessions on how to respond to incivility effectively using assertive responses, and active practice in responding to bullying behaviors in the workplace produced positive outcomes in reducing workplace bullying, improving understanding of incivility, and increasing nurses' confidence in responding to incivility effectively. The CREW program contains the components of training that were found

to be effective in helping nurses better understand and respond to workplace incivility, as well as reducing unit incivility.

Agency Description

The hospital is a non-profit, public hospital. The hospital holds two medical-surgical floors. One of the medical-surgical units (MS-1) primarily focuses on surgical recovery, while the other unit is medically-focused (MS-2). The implementation involves an intervention with the evening shift nurses on MS-2 medical-surgical unit. The unit holds 28 patient beds and primarily admits elderly patients and young pediatric patients. Routinely this unit has multiple admissions and discharges during the two primary 12-hour shifts.

The target population for this project was evening shift nurses on MS-2. The evening shift on the unit had eight registered nurses (RNs). At the time of the project, the unit also had several RNs from a recently closed wound care floor routinely working on the evening shift. All the nurses on this shift and on this unit, were females and the majority were Caucasian. Usually four RNs worked on the unit on a given night. They generally did not use unit clerks, but they occasionally had nursing assistants on this shift. Travel nurses were not generally utilized on this shift, but as-needed workers were sometimes used. The unit was recommended to the project leader by the unit manager and was selected because they did not have major reported issues with incivility. The intervention was developed for work environments that are not experiencing extreme problems with incivility. Even though there were no major incivility problems on MS-2, the nursing staff reported experiences with routine workplace tensions and conflict, such as occasional irritation at the behavior of coworkers. Issues that put the nurses at risk for workplace incivility included nursing staff attrition and administrative changes. In recent months, some nurses left

their positions on this shift, and new nurses were employed to take their place. Also, the primary charge nurse had recently accepted a new position. The recently appointed primary charge nurse was new to the fulltime leadership role. With the recent turnover, several novice or advanced beginner nurses were hired to work on the unit on the evening shift within the last year, often without the opportunity to work with more experienced nurses. There were also variety of age groups represented in the nurses working on the evening shift, from college-aged to middle-aged. This was a potential source of workplace conflict. The intervention was completed during the shift at a time when the nurses typically experienced downtime, to avoid overtime and to increase participation.

Project Design

Model for Improvement

The Model for Improvement (MFI) by Langley et al. (1996) was used to guide the proposed intervention. The model includes the fundamental questions: What are we trying to accomplish? How will we know that a change is an improvement? What change can we make that will result in an improvement (Langley et al., 1996)? These questions are posed to allow for the setting of aims, establishing measures, selecting changes, and testing changes. The model emphasizes the importance of including the right team members in the plan. It also includes the Plan-Do-Study-Act (PDSA) cycle to guide each step in the process of developing and implementing a quality improvement project.

The beginning step of using the MFI (Langley et al., 1996) involves deciding on the goal, or aim, of the project. The primary goals of the quality improvement project were to increase the nurses' ability to recognize workplace incivility, reduce unit incivility, and assist nurses in better

responding to workplace incivility in a medically-focused unit at a rural hospital in Kentucky. The next step would be to establish measurement plans for the project. The measurement of the nurses' ability to recognize workplace incivility, exposures to nursing incivility on the unit, and the nurses' ability to respond to incivility were established using evidence-based instruments.

The next step in the MFI is to select an evidence-based intervention for the project. In the case of nursing incivility, the literature reviewed supported the use of facilitated training sessions with education about incivility, teambuilding exercises, and experiential learning activities, as the most evidence-supported interventions in assisting nursing in managing incivility in the workplace. The MFI also encourages including the right people in the process improvement team to improve the chances of implementing a successful intervention. Along with members of the Capstone Advisory Committee, key personnel of the agency were identified to ensure that all stakeholders are involved in the process.

In the action phase of the MFI (Langley et al., 1996), the PDSA framework is used to guide each step of the implementation process. The beginning step in preparing for actual implementation of the quality improvement project proposal is planning. An agency review was completed to establish contact with the appropriate people involved in the implementation of the proposed incivility intervention. This included the hospital's Chief Executive Officer, the Vice President of Patient Care Services, the unit manager, and the quality improvement project faculty advisor. Upon the advice of the unit manager, the timeframe for implementation was set at eight weeks in the fall of 2015 on the evening shift at the hospital.

The second element of the framework cycle is the doing phase and involves completion of the planned interventions. This involved training sessions every week for four weeks with the

nurses on the evening shift on the medical-focused unit. The facilitated training sessions lasted 20-30 minutes and included teambuilding activities, education about incivility, and experiential activities to practice responding to incivility in a safe environment. The third step in the cycle is the study phase and involves studying the results of the quantitative data measurement. Measurement instruments were used to measure the nurses' ability to recognize workplace incivility, their self-assessed ability to respond to incivility, and an assessment of current incivility on their unit using the pretest-posttest method of measurement. The final step in the process is to act. The project leader takes the results of the project to determine what changes need to be made based on the results of the intervention in the pilot group. Based on the results of the project, a recommendation can be made to stakeholders about whether to establish a program to perform this intervention throughout the facility.

Project Methods

Description of Evidence-based Intervention

The CREW program was the intervention in this project. CREW focuses on developing a culture of civility, respect, and engagement in the workplace (USDVA, 2017). In CREW, a trained facilitator meets with a small group of employees from one unit with a plan to direct teambuilding exercises, discuss improvement to the work environment, and encourage problem-solving. Experiential learning exercises are included in the plan to develop communication skills and improve group cohesiveness. The CREW plan is geared toward bi-weekly meetings for a six-month time period. However, the CREW program allows for flexibility in its implementation, with the facilitator choosing which activities to include in the training program. The plan is individualized for each group, based on their needs and group dynamics.

The timeframe for implementation on MS-2 was developed at the recommendation of the unit manager and primary charge nurse. While the number of training sessions was lessened to four, the CREW format and CREW concepts of civility education, facilitated learning, teambuilding, and experiential learning were used. The project leader received training to become a CREW facilitator during summer 2014 prior to implementing the intervention. The training occurred at the Minneapolis Veterans Affairs Medical Center, over two eight-hour days. The training included, education about the CREW program, instruction and practice performing meeting facilitation, and training in using program interventions. The project leader conducted the meetings and exercises with the evening shift registered nurses on the MS-2 unit.

This intervention was for four weeks, with one meeting per week. Day one and day two of the intervention involved icebreaker-type activities. The day one session included the Anything Anytime tool. Anything Anytime involves providing a generic subject and discussing how it is viewed differently by different members of the group. The group then participates in a facilitated discussion about what surprised them, commonalities, and differences, followed by a debriefing session about how the activity relates to workplace civility. The Day two session involved the tool Geometry of Work Styles. Geometry of Work Styles involves participants selecting from four geometric shapes that relate to a personality type. Participants choose the shape that best fits their work style. The facilitator discusses the work styles that the shapes represent. The facilitator leads a discussion about how the work styles are different and similar, and how this relates to a civil workplace. The focus for each of these activities is recognizing that each person is unique and has different ways of viewing life, but they also have common interests, such as providing excellent

patient care. The goal is teambuilding. Each facilitated discussion concludes with a discussion on how a civil workplace can be achieved, despite individual differences.

Day three included a facilitated discussion about the definition, characteristics of incivility and how to respond to incivility effectively. The group facilitator providing insights from nursing research, which included talking to the bully in private and respond in an assertive, objective manner to the situation. On day four, the group facilitator reminded the participants about effective responses to incivility, as discussed in the previous week's session. The participants practiced actively responding to incivility scenarios provided by the project leader in a safe, but interactive environment. Each participant provided responses to the scenarios in the small group setting.

Procedures

IRB submission. Because the rural hospital does not have an Institutional Review Board, they granted permission for the proposed project based on the approval of the Eastern Kentucky University IRB. Eastern Kentucky University IRB approval was received prior to the project. Exemption status was granted (Institutional Review Board IRB00002836, DHHS FWA00003332).

Measures and instruments. The level of exposure to workplace incivility on the nursing unit was measured using the Workplace Incivility Scale (Cortina et al., 2001). This instrument was used in three of the reviewed studies (Leiter et al, 2011; Laschinger, et al, 2012; Oore, et al, 2010). This scale contains seven items related to the frequency of incidents of personally experienced incivility in the workplace, such as rude and exclusionary behaviors. The items are 6-point Likert-style questions, with answers that range from 1 (never) to 6 (daily). Higher scores indicate a greater frequency of experiences with workplace incivility. Leiter et al. (2011) found

the internal reliability to be between .84 and .86. Cortina et al. (2001) found strong reliability of the scale with a Cronbach's alpha coefficient of .89. They also found that the scale had positive convergent validity with another standardized scale for incivility. The original scale asked about incivility in the past five years. However, it has been modified previously to measure incivility in the previous month. The revised version was used in the quality improvement project.

The participants' ability to recognize incivility and confidence in their ability to respond to incivility was measured using the Confidence Scale developed by Mallette et al. (2011). The Confidence Scale is domain specific to incivility. In the instrument, a 100-point scale is used to measure confidence in ability to respond to incivility, to recognize incivility when it occurs, and to modify the response to a situation related to incivility. The strength of efficacy is measured on a scale that uses 10-point increments, ranging from no confidence (0 points) to high certainty in the ability to respond (100). There is no psychometric analysis of this instrument available at this time. However, no other instrument was found for measuring self-efficacy related to nursing incivility with psychometric testing.

Implementation

One month before the implementation of the intervention, the project leader met with the charge nurse of MS-2 to discuss the project, project objectives and implementation plan. The primary charge nurse assisted by acting as a change agent during the implementation process. The project leader remained in contact with the primary charge nurse during the preparation phase of the project, as well as during the implementation. The unit manager was the primary contact person during the preparation and implementation phases of the quality improvement project. The

unit manager assisted the project leader in contacting potential participant emails and accessing RN staff schedules.

Recruitment activities included a unit presentation, emails, and a flyer. The project leader met with the participants in three separate small groups prior to the beginning of the intervention for an informational session to briefly explain the project, the reasoning behind the training, and answer any questions potential participants had about the quality improvement project. An emphasis was placed on improving workplace communications, rather than reducing incivility, to reduce a perception of the unit being problematic. The members of the group were assured of confidentiality of any content discussed at the training sessions. They were also assured that all data collected during the implementation would be maintained without participant identifiers, and reported in the aggregate. An informational email, with a copy of the cover letter attached, was sent to the participants via email two weeks and one week prior to the intervention. During the informational sessions, a copy of the cover letter was provided to the participants and reviewed by the project leader. An informational flyer was posted in two areas of the unit, designated by the unit manager, one week prior to the intervention, as a reminder of the upcoming project.

The pilot project was open to all registered nurses, with an active license, hired to work on the evening shift on MS-2. This included nurses from the closed wound care unit. The training sessions were completed on the evening shift during an unscheduled break period, due to the anticipated difficulty of getting the nurses to return to the facility on days that they are not scheduled to work. This break period did not replace the nurses' normally scheduled work breaks. The project leader duplicated each training session multiple times each week, until all participants attended each training session.

The participants completed a paper and pen questionnaire containing the ten questions from the Workplace Incivility Scale and the Confidence Scale during the informational session. The questionnaire generally took three to five minutes to complete. The questionnaire was given a second time two weeks following the completion of the training program. There were a variety of timeframes for evaluating program effectiveness in the literature, from immediately following the training to six months after training was completed. The data collection timeframe did not appear to effect the study outcomes. Two weeks was selected because it allowed for some distance from the training sessions. Individual participant questionnaires were coded by the participant, using two close family member's dates of birth, so that they could be paired for data entry. Demographic data, including sex, age, race, and work experience were collected on a separate form during the informational sessions. The demographic information was collected in a separate envelope to avoid participant identifiers from being attached to the questionnaires. The participants were asked to sit at a distance far enough from each other to avoid being able to see other participants' responses when completing the questionnaires and the demographic data.

The data from the questionnaires and demographic form were entered into a SPSS (version 21) file developed and coded for the project. Descriptive analysis, including mean and standard deviation, of the pretest and posttest questionnaires was performed. A paired two-tailed t-test was used to analyze the difference in mean scores for the items on the pretest and posttest. The level of significance was .05. The effect size was also calculated. Data entry was performed by the project leader. The items from the two questionnaires used in the quality improvement project were analyzed separately.

Results

Demographic data were collected from each participant. Nine participants completed the quality improvement project in its entirety. All the participants were female, ranging from 24 to 56 years of age, with a mean age of 38. Eight of the nurses were Caucasian. One participant was Asian. The mean years of experience as a registered nurse was 3.65 years ($SD = 6.18$), with the majority of the nurses having three or less years of experience as an RN. The median years of experience working on this nursing unit was two years.

Workplace Incivility Scale

A paired t-test was performed to compare the pretest and posttest means for each of the seven items from the Workplace Incivility Scale.

Table 1

Paired t-test Comparison of Workplace Incivility Scale Means

Item	Means ± SD	t	df	p
How often does someone put you down or condescend to you? (n = 9)	-.333 ± 1.12	-.894	8	.397
How often does someone pay little attention to your statement or opinion? (n = 9)	-.333 ± 1.23	-.816	8	.438
How often does someone make mean or derogatory remarks to you? (n = 9)	-.222 ± .44	-1.512	8	.169
How often does someone address you in unprofessional terms? (n = 9)	.111 ± 1.05	.316	8	.760
How often does someone ignore or exclude you from professional camaraderie? (n = 9)	-.111 ± 1.05	-.316	8	.760
How often does someone doubt your judgement? (n = 9)	-.222 ± .83	-.800	8	.447
How often does someone make unwanted attempts to discuss personal matters? (n = 9)	.000 ± 1.00	.000	8	1.000

There were no statistically significant differences in the mean scores for any of the seven items on

the scale (Table 1). None of the posttest items of the Workplace Incivility Scale had statistically

significant differences when compared with the pretest (Table 2).

Table 2

Workplace Incivility Scale Pretest and Posttest Means

Item	Pretest Means ± SD	Posttest Means ± SD
How often does someone put you down or condescend to you? (n = 9)	2.11 ± 1.27	2.44 ± 1.51
How often does someone pay little attention to your statement or opinion? (n = 9)	2.22 ± .97	2.56 ± .88
How often does someone make mean or derogatory remarks to you? (n = 9)	1.78 ± 1.30	2.00 ± 1.66
How often does someone address you in unprofessional terms? (n = 9)	1.78 ± 1.56	1.67 ± 1.00
How often does someone ignore or exclude you from professional camaraderie? (n = 9)	2.00 ± 1.23	2.11 ± 1.05
How often does someone doubt your judgement? (n = 9)	2.22 ± 1.20	2.44 ± 1.74
How often does someone make unwanted attempts to discuss personal matters? (n = 9)	1.89 ± 1.17	1.89 ± 1.36

Confidence Scale

A paired t-test was performed to compare the pretest and posttest mean scores for each of

the three items from the Confidence Scale (Table 3). The analysis revealed a statistically

significant increase in the posttest mean scores for each item on the instrument, when compared

to the mean scores on the pretest. On the item related to the participants' ability to recognize

incivility when it occurs, there was a statistically significant increase in the mean score on the posttest (M = 93.33, SD =8.66, t (8) = -2.871, p =.021), when compared to the pretest mean score (M = 78.89, *SD* = 17.64). Effect size was calculated for this item, with the eta squared statistic (.51) indicating a large effect size. On the item related to the participants' confidence in their ability to respond to situations involving incivility, there was a statistically significant improvement in the posttest mean score (M = 85.56, SD =20.07, t (8) = -4.667, p =.002), when compared to the pretest mean score (M = 62.22, *SD* = 18.56). The eta squared statistic (.95) for this item indicated a large effect size. On the item related to the participants' confidence in their ability to modify their response to situations involving incivility, there was a statistically significant improvement in the posttest mean score (M = 86.67, SD = 19.37, t (8) = -4.40, p =.002), when compared to the pretest mean score (M = 62.22, *SD* = 22.79). The eta squared statistic (.95) for this item indicated a large effect size.

Table 3

Paired t-test Comparison of Mean Confidence Scale Scores

Item	Means ± SD	t	df	P
How certain are you that you can recognize horizontal violence? (n = 9)	-14.444 ± 15.09	-2.871	8	.021
How certain are you that you can respond to a situation involving horizontal violence? (n = 9)	-.23.333± 15.000	-4.667	8	.002
How certain are you that you can effectively modify your response to horizontal violence as the situation changes? (n = 9)	-.24.444± .16.667	-4.400	8	.002

Discussion

In this project, a modified version of the CREW program was used as an intervention to analyze the program's effect on nursing workplace incivility on one medically-focused medical-

surgical unit in a rural Kentucky hospital. The program included facilitated educational discussions about workplace, teambuilding exercises, and experiential learning activities. The project resulted in no significant changes in the nurses' experiences with incivility on their unit. In fact, in five out of seven of the items on the Workplace Incivility Scale, there were slight increases the frequency of the nurses' encounters with workplace incivility. However, this occurred in one of the studies that used a program like CREW (Nikstaitis & Simko, 2014). The researchers in that study suggested that the participants' increased understanding and recognition of workplace incivility may have been the cause of the small increase in the frequency of experienced incivility following the civility training program. This may have occurred in this project, as well. Based on the Confidence Scale results, there was a statistically significant increase in the nurses' self-reported ability to recognize incivility in the workplace. Similarly, the weekly discussions of workplace incivility may have increased the nurses' sensitivity in detecting workplace bullying behaviors.

It was also revealed in the facilitated discussions on the unit that most of the nurses' experiences with incivility did not occur with their fellow participants. Their incivility experiences in their current workplace tended to occur with persons from other units or shifts. The most common complaint involved uncivil behaviors by registered nurses on the day shift, including gossiping or backbiting behaviors. Since the project only involved a small group of the individuals in which they interact in the workplace, there was a decreased likelihood that the project would greatly change their workplace exposures to incivility. As well, the mean pretest scores on the Workplace Incivility Scale items reflected low frequencies of exposures to incivility, with most of

the mean scores equated to "never" and "once or twice a year." Thus, there was not a great deal of room for improvement.

Following the intervention, there were statistically significant increases in the nurses' self-assessed ability to effectively recognize, respond to, and modify their reactions to workplace incivility. This outcome was replicated in other studies that used similar programs (Stagg et al., 2011; Oostrom and Mierlo, 2008). Being able to actively practice responses to incivility in a safe setting, appeared to help increase the nurses' confidence in their ability to respond to bullying behaviors effectively. Although, qualitative data were not collected in this project, the project leader observed a general desire to discuss workplace incivility by the nurses involved in the training sessions. Once the training sessions were completed, the nurses frequently continued to casually discuss their experiences with workplace incivility and the effect that those experiences had on their nursing careers. The participants appeared to be fully engaged in the training process and eager to discuss workplace incivility in the small group setting.

There were several limitations to this project. There was a small number of participants, with nine participants completing the project. This limits the project leader's ability to extrapolate the results in evaluating the potential use of the program facility-wide. The conditions of the implementation were less than ideal. The project leader met with the participants during down times of their work shift. So, the full group of participants were never present at the same time. As well, there were occasional distractions and disruptions during the training sessions, as patient and worker needs were always prioritized over the training sessions. These limitations may have reduced the effectiveness of training sessions that aimed at improving group communication and teambuilding within the entire group. Another limitation of the training program is that it was

shortened from the original CREW program. While there is flexibility in the implementation and content of the CREW program, it preferred that the training sessions occur every other week over a six-month period. This project only evaluated the effectiveness of the shortened program format. Another limitation of this study was the project leader's decision to only include registered nurses in the project. It would have been preferable to include all unit workers, not just registered nurses. However, time and logistical constraints made it difficult to include part-time and as-needed staff.

Implications

The use of civility training sessions that include teambuilding exercises, facilitated discussions that focus on better understanding workplace incivility, and experiential learning exercises may have helped nurses on the MS-2 unit increase their confidence in their ability to recognize and respond to workplace incivility effectively. These outcomes were consistent throughout the literature reviewed, specific to the use of the CREW program. This type of program may be helpful to nurses throughout the facility and on all shifts. To truly improve workplace incivility, it would be helpful to include workers throughout the facility in the training. It might also be helpful to include the program in the orientation plan for nurses newly hired to work at the facility, as new or inexperienced nurses might be more vulnerable to workplace incivility, due to their inexperience. Implementing the modified version of the program on a yearly basis for all nurses could be useful, to maintain program results. If the program were implemented throughout the facility, it would be recommended that the training sessions be completed away from the nursing unit or department, so that there are fewer distractions and more department members could participate at the same time.

Long-term evaluation of this project could be completed to include administration of the Workplace Incivility Scale and Confidence Scale after additional time has elapsed following the initial training of the participants. Evaluating patient outcomes, such as medication errors and patient satisfaction, could also be helpful in the future. Further study is needed to support the use of CREW in combating workplace incivility in rural nursing settings. Addision and Luparell (2014) surveyed 55 rural nurses in Montana about workplace disruptions caused by other healthcare workers. Eighteen percent of those surveyed reported that they had observed nursing colleagues demonstrating disruptive behaviors daily.   The researchers concluded that the familiarity between coworkers that occurs at rural hospitals might increase incivility, due to a reduced perception of the need to maintain personal courtesy in workplace relationships. The available research, along with this quality improvement project, indicates the need to provide routine educational programs that train employees in how to recognize and manage incivility in all healthcare settings, particular so in rural healthcare settings.

Summary/Conclusion

Nursing workplace incivility has the potential to cause detrimental effects to the quality of care provided by nurses. Workplace incivility may also cause emotional and physical distress to those exposed to it on a routine basis. Some research suggests that rural healthcare environments may be more prone to workplace incivility than urban ones (Addision & Luparell, 2014). The effects of workplace incivility, such as nursing turnover, may be more difficult for rural facilities to overcome, due to potentially reduced opportunities to recruit quality nurses (Bragg & Bonner, 2014). Therefore, it is essential that rural healthcare facilities address workplace incivility. A modified version of the CREW program was used in this quality improvement project to help

nurses on one medical-surgical unit in a rural Kentucky hospital learn about workplace incivility. The modified CREW program included teambuilding exercises, facilitated discussions about workplace incivility, and experiential learning activities. This included practicing responding to workplace bullying scenarios in a safe environment. There were no significant differences in the frequency of the nurses' exposure to workplace incivility following their participation in the program. However, there were statistically significant improvements in the nurses' self-assessed ability to recognize, respond to, and modify their responses to workplace incivility, following the CREW program intervention. The results suggest that this type of program may be suitable for use in other rural settings to address nursing workplace incivility.

Supporting Agency

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