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# The Effect of a Facilitated Educational Program and Experiential Learning on Nursing Workplace Incivility

Nancy E. Armstrong

Eastern Kentucky University, [nancy\\_armstrong6@mymail.eku.edu](mailto:nancy_armstrong6@mymail.eku.edu)

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The Effect of a Facilitated Educational Program and Experiential Learning on Nursing  
Workplace Incivility

Submitted in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice  
at Eastern Kentucky University

By

Nancy E. Armstrong, DNP Student

Richmond, Kentucky

2015

### 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 Capstone Project was to implement 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. Implementation of the civility training program resulted in 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.

*Keywords:* incivility, nursing, experiential learning

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By

Nancy E. Armstrong, DNP Student

\_\_\_\_\_  
Capstone Advisor Date

\_\_\_\_\_  
Capstone Project Committee Member Date

\_\_\_\_\_  
Capstone Project Committee Member Date

\_\_\_\_\_  
DNP Coordinator Date

\_\_\_\_\_  
Dept. of Baccalaureate & Graduate Nursing Date

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The Effect of a Facilitated Educational Program and Experiential Learning on Nursing  
Workplace Incivility

Workplace incivility, or bullying, is a behavioral issue that can occur in the healthcare setting. Exposure to workplace incivility has the potential to influence a nurse's emotional state and work performance. 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.

### **Background and Significance**

Nursing workplace incivility can affect the quality of care provided to patients. Vessey, Demarco, Gaffney, and Budin (2009) surveyed 303 nurses about workplace bullying. They found that 49% of the nurses declaring that they were experiencing workplace incivility also reported that they had lost interest in their jobs due to bullying. Wright and Khatri (2014) queried 1,078 nurses working for a Midwest hospital system about workplace bullying and medical errors, and found a highly significant, positive relationship between being a victim of workplace bullying and the perception of the bullied nurses' risk of committing medical errors.

Multiple studies have linked incivility to patient safety and the quality of patient care. 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 evaluated nurses' perceptions of the effect of hostile work environments on the quality of patient care. The other five studies were qualitative, involving interviews with nurses about their experiences with workplace bullying by 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 in order 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. In a survey of 303 American nurses, Vessey et al. (2009) found that 76% of the respondents had experienced incivility in their career. Incivility is experienced by many nurses and the consequences of dealing with incivility can be costly for employers and patients.

The purpose of this Capstone 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 is able to 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 has the ability to 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. 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**

Some studies used a combination of education about incivility, with no facilitated training sessions, and experiential learning exercises to test ways to improve nursing workplace incivility. 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 nurses were required to speak English and have basic computer literacy skills. The nurses volunteered to participate in the program. 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.

Prior to the training, all participants were given a researcher-created horizontal violence knowledge pretest, a demographic questionnaire, and a self-efficacy questionnaire to complete (Mallette et al, 2011). After the training was completed, only the four groups receiving training were given a posttest questionnaire about horizontal violence knowledge and self-efficacy. They were also asked about learner satisfaction with educational format used in their group. The groups using virtual world training were given a debriefing questionnaire. All participants, including the control group, were then asked to act out a scenario involving nursing incivility in

the workplace with a trained actor. The scenario was observed by raters, who used the Global Rating Scale to measure the appropriateness of their responses.

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. The descriptors for the scaling were not provided by the researchers. A score of seven correlated with the highest level of satisfaction. 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 of 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 Lateral and Vertical Violence in Nursing Survey (Stanley, Martin, Michel, Welton, & Nemeth, 2007) was used to measure workplace incivility. The pretest-posttest method of evaluation was utilized. 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. A survey was given prior to and after the three-year training period had ended. Survey items were adapted from the Verbal Abuse Survey (Cox, Araujo, & Sofield, 2007). Pre-intervention, 703 nurses responded to the survey; 485 post-intervention responses were received. The intervention involved training on communication, lateral violence, and conflict resolution with experiential learning exercises and memory aids. 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**

Research was uncovered that involved facilitated educational sessions, without 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. The participants completed the Attitudes Toward Aggressive Behaviour Questionnaire (Collins, 1994) prior to and after the training sessions. The Attitudes Toward Aggressive Behavior Questionnaire consists of eight statements related to attitudes toward workplace incivility. Responses are recorded using a 5-item Likert scale (1= strongly disagree, 5 = strongly agree) with higher scores indicating an effective attitude toward incivility. 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 ( $M = 4.03$ ,  $SD = .59$ ,  $t = 3.23$ ,  $p = .00$ ). However, there were some complaints about the length of the training sessions. Barrett, Piatek, Korber, and Padula (2009) used a similar program format in their study, but with fewer and shorter 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 145 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. Fifty-nine of the surveys were returned pre-intervention and 45 were returned post-intervention. Units scoring low on a nurse satisfaction survey were chosen for study, with managers selecting RNs identified as leaders, bullies, and victims of bullying as participants. The teambuilding and lateral violence prevention training involved two 2-hour team training sessions with facilitated learning in small groups. Group cohesion was measured using the Group Cohesion Scale (Price & Mueller, 1986). The Group Cohesion Scale is a 6-item instrument with a 7-point Likert-type response scale. The descriptors for the scaling were not provided by the researchers. The researchers used SigmaStat, the Mann-Whitney rank sum test, to examine the difference in the values of the scores. The median prescore (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, based on the survey results three months after the training sessions using the National Database of Nursing Quality Indicators (NDNQI) Adapted Index of Work Satisfaction (Stamps, 1997).

**Educational Sessions Only**

Some of the research focused on education about incivility without facilitation or experiential learning exercises. 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. There was no data provided about the sample size or demographics. 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 (Dimarino, 2011). 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 time period following training completion. The staff offered qualitative feedback about the positive impact the program had on the work environment. This study is limited by the lack of statistical data. Chipps and McRury (2012) developed an educational program aimed at reducing workplace bullying that provided some statistical data to support the use of incivility education in nursing.

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. A convenience sample of 16 nurses was used in this pilot study. The participants were the staff on two rehabilitation units, including nurses, unit clerks, and unlicensed assistive personnel. The design of the study was quasi-experimental with no control group. Attendance in the program was mandatory for the employees of the two units. 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.

Chipps and McRury (2012) measured the impact of the intervention using an incivility questionnaire, the Negative Acts Questionnaire (Einarsen, Hoel, & Notelaers, 2009). The Negative Acts Questionnaire-Revised (NAQ-R) was developed to measure perceived exposure to workplace incivility, the frequency and intensity of the acts of incivility, and workplace outcomes, such as job satisfaction. The NAQ-R is a 22-item instrument that asks respondents how often they have experienced 22 negative behavioral acts related to incivility in the past six months (never, occasionally, monthly, weekly, and daily). The 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.

Ostrom 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. The researchers developed a questionnaire to evaluate the intervention. The questionnaire contained 24 items statements related to assertiveness and aggression management. Responses were provided using a 5-point Likert-type scale ranging from 1 (*totally disagree*) to 5 (*totally agree*). A higher score represents more knowledge of or insight into the measured variables. This intervention resulted in the participants reporting that they gained insight in understanding aggressive and assertive behaviors ( $F[2,20] = 5.67, p = .10$ ) and were better able to cope with an adverse work environment ( $F[2,22] = 22.82, p < .01$ ).

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 nurses completed an assessment test, developed by the researchers, prior to and after the training session using the same exam in both instances. The test included questions about their understanding of bullying behaviors, effective responses to workplace bullying, their personal attitude toward bullying, and their ability to respond to bullying. There was total of 21 points possible on the test. Higher scores related to increased understanding of workplace bullying and effective responses to bullying behaviors. Mean test scores prior to the intervention ( $M = 15.47, SD = 1.06$ ) were significantly improved after the intervention ( $M =$

19.73,  $SD = 1.10$ ,  $t(14) = 12.911$ ,  $p < .05$ ). The study was based in a hospital setting with registered nurses as participants, so it matches the proposed study. It also provides an active learning communication training technique, cognitive rehearsal, which produced significant results. Cognitive rehearsal may be an effective technique to use in a training program to help nurses respond to incivility in an assertive manner.

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. The researchers created The Workplace Bullying Follow-Up Survey, based on the previously cited work of Griffin (2004). The survey contained of 14 questions, ten questions requiring yes/no responses and six open response questions. Six months after the study, nurses reported increased knowledge about, and ability to respond to, incivility. 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. This survey is valuable in guiding the proposed intervention, because it demonstrated that nurses retain some knowledge and confidence in their ability to respond to incivility, after the intervention

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 study used a convenience sample of 24 nurses from a major metropolitan area. The participants were required to be actively working fulltime for at least one

year prior to the study. A control group of 47 nurses from other states who were completing graduate course work at the time of the study was used for comparison. The experimental group participants were divided into five small groups with each group attending six 90-minute educational sessions. 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.

Pre and post-test data were collected via the Transformation for Nurses Assessment Transformation for Nurses Assessment (Nicotera et al, 2014). The Transformation Nursing Assessment was developed by the researchers as a compilation of multiple instruments, measuring items such as role conflict, burnout, bullying, and conflict management styles. The researchers did not provide detailed information about of the instruments. They also did not provide a description of how instrument items were scored. The posttest mean scores for feelings of persecution were significantly lower ( $M = 13.42, SD = 3.89, t(64) = -2.40, p < .05$ ) in the intervention group when compared to the pretest mean scores ( $M = 15.76, SD = 4.46$ ). Posttest mean scores for negative relational effects ( $M = 12.88, SD = 3.67, t(61) = 4.43, p < .01$ ) in the intervention group decreased significantly when compared to the posttest mean scores ( $M = 16.03, SD = 3.58$ ). The posttest mean scores for positive relational effects ( $M = 25.58, SD = 4.27, t(64) = 8.83, p < .001$ ) for the intervention group were significantly increased when compared to the pretest means scores ( $M = 22.21, SD = 5.40$ ). The control group scored higher than the intervention group on feelings of persecution and negative relational effects, while scoring lower than the intervention group on positive relational effects, when comparing posttest

results. 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 as a means to reduce incivility in the workplace. Twenty-one nurses participated in the study. The researchers measured workplace incivility exposures three weeks prior to the training session and three weeks after it was completed, using the Nursing Incivility Scale (Guidroz, Burnfield-Geimer, Clark, Schwetschenau, & Jex, 2010). The Nursing Incivility Scale is a 43-item scale grouping incivility by source, such as coworker or supervisor. There were no statistically significant differences between the two assessments. 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. This training program had a limited amount of experiential learning compared to similar programs, such as that used by Leiter, Laschinger, Day, and Oore (2011).

Leiter et al. (2011) completed a study with the purpose of discovering 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. They used several instruments to measure workplace civility and related outcomes, including the CREW Civility Scale (Meterko, Osatuke, Mohr, Warren, & Dyrenforth, 2007) and the Workplace Incivility Scale (Cortina, Magley, Williams, & Langhout, 2001). The researchers used a quasi-experimental design with a control group. 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 researchers used the pretest-posttest method of analysis with a multifaceted questionnaire that was administered prior to the intervention and six months after the training was completed (Leiter et al., 2011). 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, 2012). 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.

Burnout was measured using the Emotional Exhaustion and Cynicism subscales of the Maslach Burnout Inventory-General Survey developed by Maslach, Jackson, and Leiter (1996). Participants used a 6-point Likert scale (0 = never, 6 = everyday) to rate the extent to which they experience exhaustion and cynicism at work. The mean scores for feelings of burnout in the intervention group following CREW training ( $M = 2.76$ ,  $SD = 1.49$ ,  $t(39) = -2.86$ ,  $p < .05$ ) were significantly decreased as compared to the pretest mean scores ( $M = 3.21$ ,  $SD = 1.57$ ). Job turnover intentions were measured using three items from the Turnover Intentions instrument developed by Kelloway, Gottlieb, and Barham (1999). The instrument was used to assess the intention of the nurse to resign from the workplace. The researchers modified the items into

statements such as, “I plan on leaving my job within the next year.” Each item was rated on a 5-point Likert scale (1 strongly disagree, 5 = strongly agree). The mean scores for turnover intentions in the intervention group following CREW training ( $M = 2.18$ ,  $SD = .94$ ,  $t(39) = -2.15$ ,  $p < .05$ ) were significantly decreased as compared to the pretest mean scores ( $M = 2.44$ ,  $SD = 1.00$ ).

Job satisfaction was measured using five questions developed by the researchers using concepts from instruments with high reliability in measuring job satisfaction, The Job Diagnostic Survey (Hackman & Oldham, 1975) and The Job Satisfaction Index (Tsui, Egan & O’Reilly, 1992). Participants were asked to rate their level of satisfaction with different aspects of the workplace, such as coworkers and supervisors. The ratings were measured on a 7-point Likert scale (1 = very dissatisfied, 7 = very satisfied). The mean scores for job satisfaction in the intervention group following CREW training ( $M = 5.62$ ,  $SD = .89$ ,  $t(39) = 6.23$ ,  $p < .05$ ) improved when compared to the pretest mean scores ( $M = 5.06$ ,  $SD = 1.07$ ), with the control group showing no significant improvements (Leiter et al., 2011). Trust in management had a greater improvement in the intervention group, as compared to the control group. Absenteeism for the intervention group dropped by more than one-third, while the control group’s absence rate remained fairly 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 researchers used a questionnaire containing several instruments three months prior to the intervention and six months after CREW training was completed. Structural empowerment was measured using four subscales of the Conditions

for Work Effectiveness Questionnaire-II (Laschinger, Finegan, Shamian, & Wilk, 2001). Using a 5-point Likert-type scale (1 = none, 5 = a lot), participants indicated the extent to which they had access to support, resources, opportunity, and information. The intervention group's pre-intervention mean scores for total empowerment ( $M = 2.91$ ,  $SD = .55$ ) increased significantly post-intervention ( $M = 3.13$ ,  $SD = .58$ ,  $t(265) = 1.90$ ,  $p < .05$ ).

Trust in Management was measured using six items from Cook and Wall's (1980) Interpersonal Trust at Work Scale. Participants rated statements related to their confidence in the sincerity of their immediate supervisor and trust in receiving their supervisor's support in the workplace using a 5-point Likert-type scale (1 = strongly disagree, 5 = strongly agree). The mean post-intervention scores the intervention group for trust in management ( $M = 3.19$ ,  $SD = 0.88$ ,  $t(265) = 2.70$ ,  $p < .05$ ) ( $M = 2.77$ ,  $SD = 0.94$ ) increased significantly when compared to the pre-intervention mean scores ( $M = 2.77$ ,  $SD = 0.94$ ). Workplace incivility was measured using the Workplace Incivility Scale (Cortina et al., 2001). Participants rated the frequency of their personal experiences with workplace incivility with their supervisors and their coworkers using a 7-point Likert-type scale (0 = never, 6 = daily). Pretest mean scores for supervisor incivility ( $M = .79$ ,  $SD = .99$ ) were significantly decreased for the intervention group on the posttest ( $M = .52$ ,  $SD = 0.81$ ,  $t(265) = 2.87$ ,  $p < .05$ ). No significant improvements were seen in the control group. The CREW program involves facilitated, experiential learning activities, and may be appropriate to use in the proposed program. The outcome of the study demonstrated positive improvements in supervisor incivility which further supports its use in developing the proposed intervention.

Oore et al., (2010) evaluated 361 health care team members, in a subset of the Laschinger et al. (2012) study, by using surveys three months prior to the intervention and following the six month CREW training. The surveys were used to evaluate the role incivility plays in the

stressor-strain relationship. Workplace incivility was measured using the Workplace Incivility Scale (Cortina et al., 2001). The Workplace Incivility Scale is a 7-item instrument that assesses for the frequency of incidents of personal experiences with incivility in the workplace, such as eye rolling or exclusionary behaviors. The items consist of 6-point Likert-style questions, with answers that range from 1 (never) to 6 (daily). Higher scores indicate an increased frequency of experiences with workplace incivility.

The Mental Health Inventory (MHI-5), developed by Ware and Shelbourne (1992), was used to measure mental health stressors. The MHI-5 is a 36-item health survey with 6-point Likert-style items. Higher scores indicate greater mental health. Physical health was measured using an unnamed 6-item general health index covering the frequency of physical strains and symptoms, such as headaches or back strain. Higher scores indicate more frequent physical Perceived workload was measured using the 3-item subscale of the Areas of Worklife Scale (Leiter & Maslach 2006). Higher scores indicate better job fit for the individual, or lower workload. The presence of consistent incivility in the workplace was correlated with the stressor-strain relationship ( $r = .33-.41$ ,  $p < .0001$ ), the relationship between stressors and mental health & physical health scores. 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 ( $B = 0.17$ ,  $AR_2 = 0.014$ ,  $F_{1,352} = 5.70$ ,  $p < 0.05$ ).

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 Capstone Project was implemented at a rural hospital in Kentucky. The Murray-Calloway County Hospital is a non-profit, public hospital that was established in 1910. The hospital service area includes Calloway, Marshall, Graves and Trigg counties in Kentucky, as well as Henry County, Tennessee. The hospital, and the long-term care unit it manages, has over 1,000 employees. The hospital has 152 private rooms and holds two medical-surgical floors, with pediatrics included, a critical and progressive care floor, an obstetrical floor, an inpatient rehabilitation unit, and a wound care floor. 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 (7:00 p.m. – 7:00 a.m.) on MS-2 medical-surgical unit. The unit holds 28 patient beds. The primary diagnoses are pneumonia, congestive heart failure, and chronic obstructive pulmonary disease. The respiratory syncytial virus and gastroenteritis are common admitting diagnoses for pediatric patients, occurring sporadically. The unit primarily admits elderly patients and young pediatric patients.

This unit routinely 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 of the nurses on this shift and on this unit were females. 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. This unit 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.

The Capstone Project was congruent with the hospital's mission, strategic plan, and goals. The hospital's mission states the desire to be a leading partner in improving the wellbeing of the people they serve (Murray-Calloway County Hospital, 2014). The hospital vision states that Murray-Calloway County Hospital would like to be a center for healthcare excellence with a focus on high quality care and patient safety, along with compassionate care that is patient centered (Murray-Calloway County Hospital, 2014). Nursing incivility has been linked to an increase in medical errors (Wright & Khatri, 2014) and disengaged nurses (Vessey et al., 2009). A civility training program has the potential to help this facility strive towards the vision of high quality, patient-centered care.

Strategic plan goals for the agency included improving the financial solvency of the organization and increasing the retention of employees (Murray-Calloway, 2015). Nursing civility and communication improvements have been shown to reduce absenteeism and job turnover rates in healthcare facilities (Leiter et al., 2011). This reduction in absenteeism and turnover rates could reduce the costs of replacing missing workers and training replacement nurses, therefore this plan was congruent with both the goal of improving the retention of employees and the goal of maintaining financial stability.

This facility is accredited by The Joint Commission and one of the goals of the facility is to maintain that accreditation. One of The Joint Commission's patient safety goals for hospitals in 2014 is to improve staff communication (The Joint Commission, 2014). Nursing incivility can interfere with workplace communication. The proposed project may assist this medical-focused unit in maintaining effective staff communication, helping to meet this goal of The Joint

Commission and aid the hospital in maintaining its accreditation. Based on a review of the mission, vision, and goals of the agency in the proposed Capstone Project, an intervention to help nurses manage incivility in the workplace was found to be congruent with the goals and objectives of the facility.

## **Project Design**

### **Model for Improvement**

The Model for Improvement by Langley et al. (2009) 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., 2009)? 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 Model for Improvement (Langley et al., 2009) involves deciding on the goal, or aim, of the project. The primary goals of the Capstone 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, to the degree that those instruments were available.



The next step in the Model for improvement is to select an evidence-based intervention or 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 Model for Improvement 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 Model for Improvement (Langley et al., 2009), the PDSA framework is used to guide each step of the implementation process. The beginning step in preparing for actual implementation of the Capstone 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 Capstone 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 Murray-Calloway County 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 (United States Department of Veterans Affairs, 2009). 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 (Appendix A) 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 (Appendix B). 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 and characteristics of incivility (Appendix C). Following this, a discussion occurred involving how to respond to incivility effectively, with 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 (Appendix D). 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 Murray-Calloway County 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 (Appendix E). Eastern Kentucky University IRB approval was received prior to the project (Appendix F). Exemption status was granted.

**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). Permission to use the scale was granted by Dr. Cortina (Appendix G). This scale contains seven items related to the frequency of incidents of personally experienced incivility in the workplace, such as rude and exclusionary behaviors (Appendix H). 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 Capstone 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). Permission to use the scale was granted by Dr. Mallette (Appendix I). The Confidence Scale is domain specific to incivility (Appendix J). 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. This instrument was developed by Dr. Mallette and has not been used in other studies.

**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 Capstone Project. The unit manager assisted the project leader in contacting potential participant emails and accessing RN staff schedules. The project leader met with the Vice President of Patient Care services to explain the intervention, obtain permission to perform the intervention in their facility, and complete a Statement of Mutual Agreement form

prior to the beginning of the study (Appendix K). The project leader also corresponded with the facility CEO via email prior to project implementation to explain the project and obtain permission to complete the project at Murray-Calloway County Hospital (Appendix E).

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 Capstone Project. An emphasis was placed on improving workplace communications, rather than reducing incivility, in order 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 (Appendix L), with a copy of the cover letter (Appendix M) 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 (Appendix N) 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 Capstone Project were analyzed separately.

## Results

Demographic data were collected from each participant. Nine participants completed the Capstone Project in its entirety. All of 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 particular 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. 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 1

#### *Paired t-test Comparison of Workplace Incivility Scale Means*

Item	Means $\pm$ SD	<i>t</i>	<i>df</i>	<i>p</i>
How often does someone put you down or condescend to you? (n = 9)	-.333 $\pm$ 1.12	-.894	8	.397
How often does someone pay little attention to your statement or opinion? (n = 9)	-.333 $\pm$ 1.23	-.816	8	.438
How often does someone make mean or derogatory remarks to you? (n = 9)	-.222 $\pm$ .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

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 $\pm$ SD	<i>t</i>	<i>df</i>	<i>P</i>
How certain are you that you can recognize horizontal violence? (n = 9)	-14.444 $\pm$ 15.09	-2.871	8	.021
How certain are you that you can respond to a situation involving horizontal violence? (n = 9)	-.23.333 $\pm$ 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 $\pm$ .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. 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 similar to 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. 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." As a result, 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 of time. 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. In order 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. It may also be helpful to implement the modified version of the program on a yearly basis for all nurses, in order to maintain program results. If the program is 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 less distractions and more department members could participate at the same time. Also, the program could potentially be expanded to a longer length to better match the original intent of the program. Long term evaluation of this project could be completed to include the Workplace Incivility Scale and Confidence Scale after a period of time has elapsed following the initial training with the current group of participants. The project could also be evaluated in the future for its effects on turnover rates, absenteeism, patient satisfaction, and worker satisfaction.

### **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 those exposed to it on a routine basis. A modified version of the CREW program was used to help nurses on one medical-surgical unit 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.

## References

- Anderson, L. & Pearson, C.M. (1999). Tit for tat? The spiraling effect of incivility in the workplace. *Academy of Management Review*, 24, 242.
- Barrett, A., Piateck, C., Korber, S., & Padula, C. (2009). Lessons learned from a lateral violence and team-building intervention. *Nursing Administration Quarterly*, 33, 342-351.  
doi:10.1097/NAQ.0b013e3181b9de0b
- Benner, P. (2001) *From novice to expert: Excellence and power in clinical nursing practice* (commemorative ed.). Prentice Hall: Upper Saddle River, N.J.
- Centers for Medicare and Medicaid Services (2015). Hospital compare. Retrieved from <https://www.medicare.gov/hospitalcompare/profile.html#profTab=1&ID=180027&cmprID=180027&dist=50&lat=36.6189712&lng=-88.3044908&loc=42071&cmprDist=1.0&Distn=1.0>
- Ceravolo, D. J., Schwartz, D. G., Foltz-Ramos, K. M., & Castner, J. (2012). Strengthening communication to overcome lateral violence. *Journal of Nursing Management*, 20, 599-606. doi:10.1111/j.1365-2834.2012.01402.x
- Chipps, E.M. & McRury, M.M. (2012). The development of an educational intervention to address workplace bullying. *Journal for Nurses in Staff Development*, 28, 94-98.
- Clark, C. M., Ahten, S. M., & Macy, R. (2014). Nursing graduates' ability to address incivility: Kirkpatrick's level-3 evaluation. *Clinical Simulation in Nursing*, 10, 425-431.  
doi:10.1016/j.ecns.2014.04.005
- Clark, C. M., Ahten, S. M., & Macy, R. (2013). Using problem-based learning scenarios to prepare nursing students to address incivility. *Clinical Simulation in Nursing*, 9, 75-83.  
doi:10.1016/j.ecns.2011.10.003



- Collins J. (1994). Nurses attitudes towards aggressive behavior following attendance at ‘the prevention and management of aggressive behaviour programme.’ *Journal of Advanced Nursing* 20, 117–131.
- Cook, J., & Wall, T. (1980). New work attitude measures of trust, organizational commitment and personal need non-fulfillment. *Journal of Occupational Psychology*, 53, 39-52.
- Cortina, L.M., Magley, V.J., Williams, J.H., & Langhout, R.D. (2001). Incivility in the workplace: Incidences and impact. *Journal of Occupational Health Psychology*, 6, 64-80.
- Cox, H.C., Araujo, S. & Sofield, L. (2007) Verbal Abuse Survey. Retrieved from <https://home/comcast.net/~laura08723/vsurvey.htm>.
- Dahlby, M. A., & Herrick, L. M. (2014). Evaluating an educational intervention on lateral violence. *Journal of Continuing Education in Nursing*, 45, 344-352.  
doi:10.3928/00220124-20140724-15
- Dimarino, T. (2011). Eliminating lateral violence in the ambulatory setting: One center’s strategies. *AORN Journal*, 93, 583-588.
- Duffield, C.M., Roche, M.A., Homer, C., Buchan, J., & Dimitrelis, S. (2014). A comparative review of nurse turnover rates and costs across the country. *Journal of Advanced Nursing*, 70, 2703-2712. doi: 10.1111/jan.12483
- Edward, K., Ousey, K., Warelow, P., & Lui, S. (2014). Nursing and aggression in the workplace: a systematic review. *British Journal of Nursing*, 23, 653-659.  
doi:10.12968/bjon.2014.23.12.653

- Einarsen, S., Hoel, H., & Notelaers, G. (2009). Measuring exposure to bullying and harassment at work: Validity, factor structure and psychometric properties of the Negative Acts Questionnaire-Revised. *Work & Stress, 23*, 24-44. doi:10.1080/02678370902815673
- Expedia.com. (2014). Retrieved from
- Hutchison, M. & Jackson, D. (2013). Hostile clinician behaviours in the nursing work environment and implications for patient care: A mixed-methods systematic review. *BioMed Central Nursing, 12*, doi:10.1186/1472-6955-12-25
- Grenyer, B., Ilkiw-Lavalle, O., Biro, P., Middleby-Clements, J., Comminos, A., & Coleman, M. (2004). Safer at work: Development and evaluation of an aggression and violence minimization program. *Australian and New Zealand Journal of Psychiatry, 38*, 804-810.
- Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *The Journal of Continuing Education in Nursing, 35*, 257-263.
- Guidroz, A.M., Burnfield-Geimer, J.L., Clark, O., Schwetschenau, H.M., & Jex, S.M. (2010). The nursing incivility scale: Development and validation of an occupation-specific measure. *Journal of Nursing Measurement, 18*, 176–200.
- Hackman, J. R., & Oldham, G. R. (1975). Development of the Job Diagnostic Survey. *Journal of Applied Psychology, 60*, 159 –170. doi:10.1037/h0076546
- Kelloway, E. K., Gottlieb, B. H., & Barham, L. (1999). The source, nature, and direction of work and family conflict: A longitudinal investigation. *Journal of Occupational Health Psychology, 4*, 337–346. doi:10.1037/1076-8998.4.4.337


- Kentucky Hospital Association. (2009) *Kentucky hospital statistics*. Retrieved from <http://chfs.ky.gov/NR/rdonlyres/F5A3C9DB-E94D-4425-9A15-8E5B8DA62BC2/0/KYHospitalStatistics2009.pdf>
- Langley, G., Moen, R., Nolan, K., Nolan, T., Norman, C., & Provost, L. (1996). *The improvement guide: A practical approach to enhancing organizational performance*. San Francisco: Jossey-Bass.
- Laschinger, H.K.S. (2014). Impact of workplace mistreatment on patient safety risk and nurse-assessed patient outcomes. *The Journal of Nursing administration*, *44*, 284-290.
- Laschinger, H. K. S., Finegan, J., & Shamian, J. (2001). Promoting nurses' health: Effect of empowerment on job strain and work satisfaction. *Nursing Economics*, *19*, 42-52.
- Laschinger, H.K.S., Leiter, M., Day, A., & Gilin, D. (2009). Workplace empowerment, incivility, and burnout: impact on staff nurse recruitment and retention outcomes. *Journal of Nursing Management*, *17*, 302-311. doi:10.1111/j.1365-2834.2009.00999.x
- Laschinger, H. K. S., Leiter, M. P., Day, A., Gilin-Oore, D., & Mackinnon, S. P. (2012). Building empowering work environments that foster civility and organizational trust: Testing an intervention. *Nursing Research*, *61*, 316-325. doi:10.1097/NNR.0b013e318265a58d
- Leiter, M.P., Laschinger, H.K.S., Day, A., & Oore, D.G. (2011). The impact of civility interventions on employee social behavior, distress, and attitudes. *Journal of Applied Psychology*, *96*, 1258-1274.
- Leiter M.P. & Maslach C. (2006). *Areas of Worklife Scale Manual* (4th ed.). Wolfville, NS: Centre for Organizational Research & Development, Acadia University.

- Lynch, M.F., Plant, R.W., & Ryan, R.M. (2005). Psychological needs and threat to safety: Implications for staff and patients in a psychiatric hospital for youth. *Professional Psychology Research and Practice*, 36, 415-425.
- Malette, C., Duff, M., McPhee, C., Pollex, H., & Wood, A. (2011). Workbooks to virtual worlds: A pilot study comparing educational tools to foster a culture of safety and respect in Ontario. *Canadian Journal of Nursing Leadership*, 24, 44-64.
- Maslach, C., Schaufeli, W. B., Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, 52, 397–422. doi:10.1146/annurev.psych.52.1.397
- Meterko, M., Osatuke, K., Mohr, D., Warren, N., & Dyrenforth, S. (2007, August). *Civility: The development and psychometric assessment of a survey measure*. Paper presented at the Academy of Management, Philadelphia, PA.
- Murray-Calloway County Hospital. (2014, June 25). Retrieved from <http://www.murrayhospital.org/about.htm>
- Murray-Calloway County Hospital Strategic Planning Team. (2015). *Murray-Calloway County Hospital strategic plan*.
- Nicotera, A.M., Mahon, M.M., & Wright, K.B. (2014). Communication that builds teams: Assessing a nursing conflict intervention. *Nursing Administration Quarterly*, 38, 248-260.
- Nikstaitis, T., & Coletta Simko, L. (2014). Incivility among intensive care nurses. *Dimensions of Critical Care Nursing*, 33, 293-301. doi:10.1097/DCC.0000000000000061
- Office Depot (2014) Retrieved from <http://www.officedepot.com/a/browse/office-supplies/N=5+1676/>


- Oore, D., Leblanc, D., Day, A., Leiter, M., Laschinger, H., Price, S., & Latimer, M. (2010). When respect deteriorates: incivility as a moderator of the stressor-strain relationship among hospital workers. *Journal of Nursing Management*, 18, 878-888. doi:10.1111/j.1365-2834.2010.01139.x
- Oostrom, J. & Mierlo, H. (2008). An evaluation of an aggression management training program to cope with workplace violence in the healthcare sector. *Nursing in Research & Health*, 31, 320-328.
- Ortega, A., Christensen, K. B., Hogh, A., Rugulies, R., & Borg, V. (2011). One-year prospective study on the effect of workplace bullying on long-term sickness absence. *Journal of Nursing Management*, 19, 752-759. doi:10.1111/j.1365-2834.2010.01179.x
- Price, J.L. & Mueller, C.B., 1986. *Handbook of organizational measurement*. Marshfield, MA: Pitman.
- Smith, L., Andrusyszyn, M., & Laschinger, H. (2010). Effects of workplace incivility and empowerment on newly-graduated nurses' organizational commitment. *Journal of Nursing Management*, 18, 1004-1015. doi:10.1111/j.1365-2834.2010.01165.x
- Stagg, S. J., Sheridan, D. J., Jones, R. A., & Speroni, K. (2013). Workplace bullying. *Workplace Health & Safety*, 61, 333-338. doi:10.3928/21650799-20130716-03
- Stagg, S.J., Sheridan, D., Jones, R.A., & Speroni, K.G. (2011). Evaluation of a workplace bullying cognitive rehearsal program in a hospital setting. *Journal of Continuing Education in Nursing*, 42, 395-401. doi:10.3928/00220124-20110823-22
- Stamps P. (1997) *Nurses and Work Satisfaction: An Index for Measurement*. Chicago, IL: Health Administration Press.

- Stanley, K.M., Martin, M.M., Michel, Y., Welton, J.M., & Nemeth L.S. (2007). Examining lateral violence in the nursing workforce. *Issues in Mental Health Nursing*, 28, 1247 - 1265. 10.1080/01612840701651470
- Tsui, A. S., Egan, T. D., & O'Reilly, C. A. (1992). Being different: Relational demography and organizational attachment. *Administrative Science Quarterly*, 37, 549–579.  
doi:10.2307/2393472
- United States Department of Veterans Affairs. (April, 2012). *Civility, respect, and engagement in the workplace (CREW)*. Retrieved from <http://www.va.gov/ncod/crew.asp>
- U.S. News & World Report. (2014). *Murray-Calloway County Hospital stats & services*. Retrieved from <http://health.usnews.com/best-hospitals/area/ky/murray-calloway-county-hospital-6510750/details>
- Vessey, J.A., DeMarco, R.F., Gaffney, D.A., & Budin, W.C. (2009). Bullying of staff registered nurses in the workplace: A preliminary study for developing personal and organizational strategies for the transformation of hostile to healthy workplace environments. *Journal of Professional Nursing*, 25, 299-306.
- Ware J.E. Jr & Sherbourne C.D. (1992) The MOS 36-item short form health survey (SF-36) I. Conceptual framework and item selection. *Medical Care* 30, 473–483.
- Wright, W. & Khatri, N. (2014). Bullying among nursing staff: Relationship with psychological/behavioral responses of nurses and medical. *Health Care Management Review*, 0, 1-9. doi: 10.1097/HMR.0000-0000.2014.00015.x

## Appendix A.



## ANYTHING ANYTIME



**TYPE**

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CREWcial Connection Tool for an accelerated teambuilding experience.

**PURPOSE**

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The intent is to help the group become better acquainted with each other, learn new things about each other, spark conversation, and explore the diversity of the group members. Individuals are asked to share something about themselves, which can increase familiarity in the group and help to build trust.

**TIMING AND RESOURCE CONSIDERATIONS**

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- **Time Required:** 10 – 20 minutes; depends on the group size (figure about 1 - 2 minutes per person)
- **Resources:** A flipchart, markers, pens, and paper may be useful in capturing all of the ideas on paper.

**CONSIDERATIONS FOR USE**

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- **When to Use:** This icebreaker can be used anytime throughout the wave. It can be a nice icebreaker to use early in the group because it is a relatively non-threatening activity.
- **What Type of Group:** It is appropriate for all types of groups.

**APPLICATION**

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- The facilitators should ask the group to think of the first (one, two, three or however many needed) object, place, candy, music group etc. that comes to mind and discuss those things within their group. (Targeted topical suggestions may be more applicable depending on group's progress and the subject matter the group is discussing. See below for topic ideas.)
- The facilitators can provide instructions similar to this: "Clear your mind as much as possible. I am going to say something, and as I say it, write down the first thing that comes to your mind. OK, ready...(give them the topic, such as ice cream, music, travel, exotic, etc.)"
- Once everyone has identified the specified number of thoughts, facilitators can ask participants to share, one-by-one, and give a short narrative about their thoughts.
- Finally, discuss with the group about the similarities and differences in the thoughts, especially those that stand out.
  - Examples might include multiple thoughts of the same candy bar, vacation destinations, and/or major events currently taking place. Thoughts could be related to childhood memories, experiences, and interests.
- **Additional Applications:**
  - Another application is for the facilitator to ask the group to write down whatever they are thinking about at the present moment.

**POSSIBLE DEBRIEF QUESTIONS**

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Below are potential debrief questions that can be asked by a facilitator upon completion of this activity:

1. What surprised you about this activity?
2. What was it like sharing your responses with the group members?





## ANYTHING ANYTIME



3. Were there any commonalities that you share with your colleagues that you were unaware of before this activity? If so, how might this exercise be helpful in improving your workgroup/team?  
Has this changed your perspective of your coworkers? And, if so, how?
4. How do you think getting to know each other will impact your workplace?
5. Did you notice that group members interpreted the activity in different ways? How so?
6. How does this activity relate to group diversity? How was this apparent in your thoughts? (e.g., geographic diversity, values, personality styles that emerge, personal challenges etc.)
7. We gave you all the same exact topic, but the responses were so diverse – how do you think this plays out in your work environment? (e.g., they might be given the same information or experience the same event, but interpret it/understand it in very different ways)
8. How do the personal contexts and values of group members' impact group cohesion or performance?
9. What are the advantages of having so much diversity of worldviews, opinions, etc. within a team?



## Appendix B.

3 | The Geometry of Work Styles

**TYPE**

In-Session Activity

**PURPOSE**

The *Geometry of Work Styles* activity allows for the application of CREW principles through increasing group members' self-awareness as well as appreciating the strengths, weaknesses, and differences of each individual in their group. This activity is designed to foster a safe and nonjudgmental environment for discussion of personal styles and interpersonal behaviors. Utilization of this activity and subsequent discussion should lead to (1) increased insight into each individual's work style, (2) awareness of how each individual might act in times of stress, and (3) new perspectives on what strengths (and weaknesses) each brings to group activities/interactions. As team members learn more about their own styles as well as those of their coworkers, group members can understand how to tailor their interactions to others' preferences. Group members will gain a better understanding of how others view their behaviors. Group members will also be better able to adapt their behaviors during times of stress once they have an awareness of how they may be prone to behaving.

**TIMING AND RESOURCE CONSIDERATIONS**

**TIME REQUIRED**

This activity can vary in time required depending on how many people are participating and how deeply you want to process the shapes and their potential meanings. The initial selection of shapes takes less than a minute but the subsequent discussions can last much longer. Typically, groups of 10 are able to have meaningful conversations about the shapes and their styles in 30 - 45 minutes.

**MATERIALS NEEDED**

Four sheets of large, flip chart paper with individual shapes drawn on each sheet. Additional materials depend on if the session will include a complementary activity.

**CONSIDERATIONS FOR USE**

**WHEN TO USE**

This inventory can be utilized anytime after the first meeting based on the progression of the group. For some groups, this activity can provide a non-threatening way of discussing individual differences and ways to adapt individual styles to work together better. For groups that are struggling in team functioning, this activity can shed light on potential reasons for such problems.

**WHAT TYPE OF GROUP**

This activity is appropriate for all workgroups, but can be especially effective with groups that are struggling with "personality" conflicts, communication, or experiencing breakdowns of processes in completing group tasks. Even

#### 4 | The Geometry of Work Styles

for groups that are not experiencing any overt problems, this activity can be used to give a new perspective on how each member of the team operates and to increase understanding of individual differences.

#### APPLICATION SUGGESTIONS

#### STRATEGIES FOR IMPLEMENTATION

This activity can be conducted in its entirety during a CREW meeting and can be the basis for ongoing reflection and processing. This activity and the resulting information can be valuable for increasing self-awareness and improving understanding between coworkers early in the CREW process. An advantage of using it early is it provides a shared language and understanding that facilitators can use throughout the CREW process and connections can be made to these styles when the group is engaging in future activities and discussions.

#### INSTRUCTIONS TO PARTICIPANTS

- Facilitators should draw four shapes – a square, triangle, circle, and squiggle - on four separate pieces of flipchart paper and hang them around the room so that there is enough space for group participants to stand around them.
- Facilitators then tell participants to simply go and stand by the shape they prefer. The facilitator might say: “Look at the shapes around the room...go with your initial gut instinct and choose the one that you are most attracted to.”
- When people have chosen their shapes, the facilitator can say: “Believe it or not, 80% of the time people choose the one that actually ‘fits’ their style. There are no right shapes or good shapes and there are no wrong shapes or bad shapes. Each one is different and describes how individuals might approach tasks and communications with others.”
- The facilitator then shares the description of each shape with the group. It is important to stress the positives of each shape more than the “negatives” so that participants do not feel as anyone has selected the wrong shape. After reading the descriptions to the group, allow people to move to a different shape if they feel it is a better fit with their style.
- Be sure to stress that all shapes are necessary and bring something unique to the table. Help the group members to see the importance of having all shapes represented to have a strong, productive, high-functioning team.
- Facilitators can also discuss the idea of “strengths and weaknesses”: All characteristics can be either a strength or a weakness; it is not necessarily the characteristic itself, but the match between the characteristic and the demands of the situation. If a characteristic is used too much, is applied too intensely, or is used at a time that is not appropriate to the situation, it will be a weakness. Facilitators can ask the group – is there ever a time that someone can be “too nice?” Is there a time that being “aggressive” is a good thing? Etc.
- Finally, lead a debrief discussion about the styles and how they impact each individual and the team.

#### POSSIBLE DEBRIEF QUESTIONS

The following are examples of questions that can be posed to the group after the instrument has been completed and the individuals know their styles. The purpose is to facilitate discussion and help individual participants to further learn from the information.



## 5 | The Geometry of Work Styles

1. How easy was it for you to choose a shape?
2. What surprised you about the results?
3. Is there someone whose style/shape surprises you based on how you have interacted with them in the past?
4. What about the results was most true for you?
5. What felt least true?
6. How can the information learned through this activity help you in your job?
7. What changes might you make now that you understand that some of your coworkers have a different style/shape than yours?
8. What changes might you make in the way you communicate with certain others at work?
9. What important contributions to the group do you think you make with your style/shape?
10. Can you think of a time when your behavior exemplified your style/shape and was successful? Would feel comfortable asking someone else in the group to share a time that they experienced your style/shape behavior as being successful?
11. Can you think of a time when your behavior exemplified your style/shape behavior and was unsuccessful? Would feel comfortable asking someone else in the group to share a time that they experienced your style/shape behavior as being unsuccessful?
12. How has your style/shape contributed to your successes and failures overall in the workplace?
13. Based on what the description of your shape says about your behavioral preferences, what roles/responsibilities/activities do you think you are well suited for that you are not currently engaging in?
14. What style/shape is overrepresented in your group? Underrepresented? How could this influence the way your group performs?
15. Why is it important for the team to have Squares on it? How about Circles? Triangles? Squiggles?
16. How would you like to use this information moving forward?

## CONSIDERATIONS

It is important to emphasize that all styles/shapes are valuable in a workgroup and there is no one "right" style/shape. Diversity in the workgroup adds to the tools the team has available to make the team more successful, and the most highly effective teams utilize the strengths of each of the styles. Each style brings something important to the team: triangles bring leadership and decisiveness, squiggles bring ideas and enthusiasm, squares remind the group about important details and get the work done, and circles to keep harmony. Strong, high-functioning teams tend to have all shapes represented and leverage their respective strengths. Taking the approach of no right or wrong style/shape should open the discussion for people to admit where their style has been both effective and ineffective.

## COMPLEMENTARY ACTIVITIES

1. *Tower Building* is an example of activity in which the group might participate to reinforce the *Geometry of Work Styles* concepts. This activity asks group members to work together on a task that they have never attempted together before. This decreases the potential that people's assumptions about a particular task come into play and increases the potential that they are acting in line with their natural behavioral styles. Depending on the group, the activity could be used either before or after completing the assessment.
  - o *Doing the activity before the assessment allows discussion to explain what happened during the group activity – the facilitator can make note of how people interacted and ask them to reflect upon that or other observations they made in terms of the styles/shapes.*

## Appendix C.

## Capstone Project Training Session Day 3

## Responding to Incivility – Facilitated Discussion

These questions will be used to guide a facilitated discussion on responding effectively to incivility. The participants should answer the questions, rather than the facilitator supply the answers. I have included expected responses. I will help the group members with any missing information.

1. What behaviors would you describe as incivility, or bullying, in the workplace?

(Talking about you behind your back, rude behaviors and verbal responses or muttering, eye rolling and other nonverbal behaviors, sabotage or undermining behaviors, not providing you with information needed to perform your job effectively, lying about you or trying to paint you in a negative light, abnormal expectations)

2. What is the difference between workplace incivility and having a “bad day?”

(The behavior is not rare or mild to be labeled bullying or incivility)

3. What can happen if these behaviors are allowed to persist?

(Nurses will leave, may have poor concentration, increased absences, poor care quality, patient safety risks)

4. If you have experienced incivility or bullying in the workplace in the past, how have you responded to it?

(They will supply)

5. What are ineffective ways to respond?

(Aggression, passive)

6. What effective ways to respond? (assertive, deal with it directly, but in private)

7. How should you respond to these specific situations (Stagg et al., 2013)?

- a. Someone frequently rolls their eyes or sighs

(Direct, calm confrontation, but in private – “I noticed you seemed upset when I asked for your help turning the patient. I like to deal with things directly, so why don’t you let me know what upset you?”)

- b. Someone withholds information or sabotages you

(Direct confrontation - “There is more to this situation than I am aware. Could we meet privately to discuss what happened?” or “When something happens that is different from what I understood, it leaves me with questions. Help me understand how this happened.”)

- c. Someone frequently talks negatively about someone else behind their back

(Direct confrontation – “Not having been there, I do not feel comfortable talking about Stephanie. Have you talked to her about it?”)

- d. Rude verbal behavior, such as anger when being asked for help -

(Direct confrontation - I learn best when I understand the directions and feedback given. Can we create this type of situation?)

If all interventions fail and the behavior persists, it needs to be reported to your manager.

## Appendix D.

## Capstone Project Training Session Day 4

## Responding to Incivility – Facilitated Discussion

These questions will be used to guide a facilitated discussion on responding effectively to incivility (Stagg et al., 2013). The participants should answer the questions, rather than the facilitator supply the answers. I have included expected responses. I will help the group members with any missing information.

Today we are going to be practicing responding effectively to workplace incivility, so it will hopefully help you respond to it effectively, if it occurs to you or your coworkers. The available research shows that practice in responding to incivility in a safe setting increases a nurses' confidence in their ability to respond in a real life event. I am going to provide a scenario and let you take turns providing effective responses.

## Scenarios (with appropriate responses)

1. You mention to a coworker that you need to make rounds to check on your patients. The coworker states, "I need to do that, too. Steve probably won't make rounds tonight. He is the most incompetent nurse here!"

("I have not noticed Steve's work being inadequate. I am not comfortable talking about him. Have you spoken with him directly about your concerns?")

2. Target: "I am having problem figuring out how to use the new patient lift. Can you help me?"

Bully: Rolls her eyes to another nurse standing near you.

("I can see you have something you want to say. You can just say it.")

3. Target: "Sally, I have a patient that needs to be turned. Can you help me?"

Bully: "I have my own patients to take care of!!!" Storms off.

("I understand that you are busy. But, sometimes it is not safe to work alone. Can we work as a team?")

4. A family member of one of your patients asks if she can bring her child to visit a patient. You tell the family member no and explain that the visitation restrictions are the result of the current influenza outbreak. The family member then asks another nurse if she can bring her daughter. The other nurse says yes, knowing you have already told her no.

“I understood that we were not allowing visits to limit influenza spread. Help me understand why this does not apply to this patient.”

5. You are assigned to work with a coworker on a project to implement the use of new computerized documentation system. Your coworker is dominating processes; what little work she does give you, she complains that it is all wrong and that she will have to redo it. She tells your manager that you refused to help and what little you do is terrible. Today, she sent an e-mail to the unit staff, stating someone relatively new to the templates (obviously you, but never named outright) had made so many mistakes that she was going to have to redo parts of the project. This will delay the program implementation until the next week. Now everyone is mad at you. But, it is her word against yours.

“There is more to this situation than I am aware. Could we meet privately to discuss what happened?”

If your responses do not improve the situation, it needs to be reported to the manager.

## Appendix E.



June 23, 2015

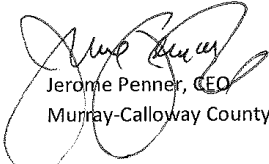
To Whom It May Concern:

Please let this letter serve as permission for Nancy Armstrong, RN, MSN who is working on her Doctorate in Nursing Practice at Eastern Kentucky University to complete her Capstone Project at Murray-Calloway County Hospital. Ms. Armstrong's project will focus on reducing nursing incivility or bullying in the workplace. The program will focus on teambuilding and teaching nurses how to respond in an assertive manner when bullying occurs.

Since Murray-Calloway County Hospital does not have an Institutional Review Board for research projects, we will accept Eastern Kentucky University's IRB's permission to complete the project.

If I can be of further assistance, feel free to call me at 270.762.1101.

Sincerely,



Jerome Penner, CEO  
Murray-Calloway County Hospital

/hm



## Appendix F.



EASTERN KENTUCKY UNIVERSITY  
*Serving Kentuckians Since 1906*

Graduate Education and Research  
 Division of Sponsored Programs  
 Institutional Review Board

Jones 414, Coates CPO 20  
 521 Lancaster Avenue  
 Richmond, Kentucky 40475-3102  
 (859) 622-3636; Fax (859) 622-6610  
<http://www.sponsoredprograms.eku.edu>

**NOTICE OF IRB EXEMPTION STATUS**

**Protocol Number: 16-022**

Institutional Review Board IRB00002836, DHHS FWA00003332

Principal Investigator: **Nancy Armstrong** Faculty Advisor: **Dr. Donna Corley**  
 Project Title: **The Effect of a Facilitated Educational Program and Experiential Learning on Nursing Workplace Incivility**  
 Exemption Date: **08/28/15**  
 Approved by: **Dr. Pat Litzelfelner, IRB Member**

This document confirms that the Institutional Review Board (IRB) has granted exempt status for the above referenced research project as outlined in the application submitted for IRB review with an immediate effective date. Exempt status means that your research is exempt from further review for a period of three years from the original notification date if no changes are made to the original protocol. If you plan to continue the project beyond three years, you are required to reapply for exemption.

**Principal Investigator Responsibilities:** It is the responsibility of the principal investigator to ensure that all investigators and staff associated with this study meet the training requirements for conducting research involving human subjects and follow the approved protocol.

**Adverse Events:** Any adverse or unexpected events that occur in conjunction with this study must be reported to the IRB within ten calendar days of the occurrence.

**Changes to Approved Research Protocol:** If changes to the approved research protocol become necessary, a description of those changes must be submitted for IRB review and approval prior to implementation. If the changes result in a change in your project's exempt status, you will be required to submit an application for expedited or full IRB review. Changes include, but are not limited to, those involving study personnel, subjects, and procedures.

**Other Provisions of Approval, if applicable:** None

Please contact Sponsored Programs at 859-622-3636 or send email to [tiffany.hamblin@eku.edu](mailto:tiffany.hamblin@eku.edu) or [lisa.royalty@eku.edu](mailto:lisa.royalty@eku.edu) with questions.



Eastern Kentucky University is an Equal Opportunity/Affirmative Action Employer and Educational Institution

## Appendix G.



Nancy Armstrong <narmstrong1@murraystate.edu>

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**Permission to use the Workplace Incivility Scale**

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Lilia Cortina <lilia@umich.edu>  
To: Nancy Armstrong <narmstrong1@murraystate.edu>

Mon, Mar 16, 2015 at 8:20 PM

Hello,

The Workplace Incivility Scale (WIS) is freely available for use via its publication in a copyrighted journal. All authors on that journal article support the use of this scale in scientific research (not for profit).

To view the published article containing the WIS, please visit my lab website:  
<http://www.lsa.umich.edu/psych/lilia-cortina-lab/>

All best,  
Lilia Cortina  
[Quoted text hidden]

—  
**Lilia M Cortina, PhD**  
Professor of Psychology  
Professor & Graduate Director of Women's Studies  
University of Michigan

Web: <http://www.lsa.umich.edu/psych/lilia-cortina-lab/>

Psychology Office: 3270 East Hall  
Women's Studies Office: 2110 Lane Hall  
Tel: 734.647.3956  
Fax: 734.647.0440

Mailing Address: Department of Psychology, 530 Church St, Ann Arbor, MI 48109-1043

Appendix H.

*Workplace Incivility Items and Factor Loadings*

Item	Factor loading
"During the PAST FIVE YEARS while employed by the Eighth Circuit courts, have you been in a situation where any of your superiors or coworkers":	
Put you down or was condescending to you?	.84
Paid little attention to your statement or showed little interest in your opinion?	.79
Made demeaning or derogatory remarks about you?	.74
Addressed you in unprofessional terms, either publicly or privately?	.73
Ignored or excluded you from professional camaraderie?	.72
Doubted your judgment on a matter over which you have responsibility?	.71
Made unwanted attempts to draw you into a discussion of personal matters?	.58

## Appendix I.



Nancy Armstrong <narmstrong1@murraystate.edu>

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**Permission to use Incivility Tools**

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Claire Mallette <cmallett@yorku.ca>  
To: Nancy Armstrong <narmstrong1@murraystate.edu>

Wed, Apr 15, 2015 at 1:24 PM

Hello Nancy

My sincere apologies for the delay in getting back to you. Thank you for your interest in our study. Please find attached the two tools.

Best wishes

Claire Mallette

Claire Mallette RN, PhD  
Director,  
School of Nursing  
York University  
Rm 313, HNES  
4700 Keele Street  
Toronto, ON, M3J 1 P3  
416-736-2100, ext. 44541  
Fax: 416-736-5714  
cmallett@yorku.ca




---

From: Nancy Armstrong <narmstrong1@murraystate.edu>  
To: cmallett@yorku.ca,  
Date: 03/25/2015 10:53 PM  
Subject: Permission to use Incivility Tools

---

[Quoted text hidden]

**3 attachments**

-  **Knowledge Pre & Post Test Feb09\_2010.docx**  
55K
-  **Confidence Questionnaire Feb09\_2010.docx**  
77K
-  **Confidence Questionnaire Call back.docx**  
53K



## Appendix K.



Eastern Kentucky University

Department of Baccalaureate and Graduate Nursing

**Statement of Mutual Agreement for Capstone Project**

The purpose of a Statement of Mutual Agreement is to describe the agreement between a designated clinical agency and the DNP student regarding the student's Capstone Project.

**I. General Information**

Student Name: Nancy Armstrong RN, MSN, DNP Student  
 Project Title: Using Evidenced-based Strategies to Manage Nursing Incivility  
 Agency: Murray-Calloway County Hospital  
 Agency Contact: Lisa Ray, Vice President of Patient Care Services

**II. Brief description of the project**

- Evidence-based intervention

The program will be the CREW (Civility, Respect, and Empowerment in the Workplace) training program that was developed by the United States Department of Veterans Affairs (USDVA). The CREW program focuses on developing a culture of civility, respect, and engagement in the workplace (United States Department of Veterans Affairs, 2009). In CREW, a trained facilitator comes to each meeting with a plan to direct teambuilding exercises and discussions about improving the work environment and encouraging problem-solving, with the use experiential learning exercises to develop communication skills and improve group cohesiveness.

- Expected project outcomes (products, documents, etc.)

It is hoped that the CREW intervention will result in the nurses having a greater understanding of workplace incivility, decreased unit incivility, and increased confidence in their ability to respond to workplace incivility when it occurs. The DNP student will attempt to have the results of the study published and will present the results of the study, as a requirement for obtaining a Doctor of Nursing Practice degree. There are no expected products to come from this study.

- On-site Activities (DNP student role, required meetings, access to agency records, non-disclosure expectations)

The DNP student will act as the primary investigator and meeting facilitator. Emails will be sent to the potential participants one month and one week before the project begins, detailing the project's plan and noting that participation is voluntary. The DNP student will speak at a unit meeting, using a script, just prior to the project implementation to fully explain the project and reiterate that participation is voluntary. The participants will be given an informed consent form after the informational session is completed. Participants will be assured via email and in the unit meeting, of confidentiality in the handling of any collected data, and that the data will be reported in the aggregate with no personal identifiers on any collected documents.



Eastern Kentucky University

Department of Baccalaureate and Graduate Nursing

The planned intervention will involve 20-30 minute meetings every other week with the evening shift nursing staff on a medical-surgical unit for eight weeks. The meetings will involve educational training sessions about incivility, experiential learning activities, and teambuilding exercises.

Data will be collected using a questionnaire containing questions about the nurses' understanding of incivility, the frequency and severity of incivility exposures that the nurses have recently experienced, and their confidence in their ability to respond to incivility when it occurs. The questionnaire will be given within one week prior to the beginning of the training program and within one week following the completion of the training program. The results of the pretest and posttest questionnaires will be compiled in the aggregate.

- Products resulting from DNP Capstone Project with potential market value. Any products produced from collaboration with the agency must be discussed with the student, Capstone Advisor, and appropriate agency representative. The ownership of intellectual property rights must be determined prior to the implementation of the project.

The CREW training program was developed and is the property of the USDVA. The DNP student, Nancy Armstrong, owns the intellectual property rights to any products that result from this project.



Eastern Kentucky University  
Department of Baccalaureate and Graduate Nursing

Student Name: Nancy Armstrong

Project Title: Using Evidenced-based Strategies to Manage Nursing Incivility

**III. Agreement of written and oral communication**

- Reference to clinical agency in student’s academic work, publications, and presentations

In the DNP student’s academic work, the name of the agency, agency employees, and activities may be used. However, in publications and presentations outside of academic work, the agency’s name and employee names will not be used. Project participant names will never be used in academic work, publications, or presentations.

- Restrictions on discussion of any project or agency details

In the DNP student’s academic work, project and agency details may be used. However, in publications and presentations outside of academic work, the agency’s name and employee names will not be used. Generic agency details and details about the project may be used in academic work, publications, and presentations.

- Formal agency approval needed for any publicly shared findings

Formal Agency approval is required in order to publish or present the project findings in which the facility is named. No formal agency approval is required to present or publish the findings without identifying the agency or participants by name.

---

**IV. Required Signatures:**

<u>Nancy Armstrong</u>	<u>4/13/15</u>
Student	Date

<u>c</u>	_____
Capstone Advisor	Date

<u>X Lisa Ray</u>	<u>4/15/15</u>
Agency Representative	Date



## Appendix L.

Verbal and Email Script for Recruitment  
The Effect of a Facilitated Educational Program and Experiential Learning on Nursing  
Workplace Incivility  
Nancy Armstrong, RN, MSN  
Eastern Kentucky University  
Department of Baccalaureate and Graduate Nursing

Dear Nurse,

I am Nancy Armstrong, a Doctor of Nursing Practice (DNP) student at Eastern Kentucky University in Richmond, Kentucky. As part of my graduation requirements, I am completing a pilot study aimed at helping to improve nursing civility in the workplace. I would like to invite you to participate in this study. Your unit was selected because you do not have a major problem with incivility and generally work well together. This intervention is geared for workers without severe incivility problems.

The best available research has demonstrated that the use of small group civility educational sessions, with teambuilding exercises and practice in responding to incivility in a safe environment, help to reduce unit incivility and improve nurses' understanding and confidence in responding to incivility. As part of my project, I would like to conduct four short training sessions with the evening shift nurses on fourth floor, during work hours, using these techniques to see if they help nurses to better understand nursing incivility, reduce unit incivility, and increase nurses' confidence in their ability to respond to incivility when it occurs.

Questionnaire will be given prior to and after the four training sessions to measure the knowledge of incivility, unit incivility, and confidence in ability to respond to incivility when it occurs. The questionnaires are anonymous. Only group (aggregate) data with no personal identifiers will be used in written or oral presentations of the study results. The study is voluntary and withdrawal from the project is permitted at any time. There will be no penalty for non-participation. This study poses no foreseeable risks to you or your position within this institution. Your participation will be greatly appreciated!

If you have questions or concerns about the project, you may contact me by telephone at (270) 809-4576 or by email at [nancy\\_armstrong@mymail.eku.edu](mailto:nancy_armstrong@mymail.eku.edu). You may also contact the faculty advisor for the pilot project Dr. Donna J. Corley, PhD, by telephone at (859-622-6316) or by email at [Donna.Corley@eku.edu](mailto:Donna.Corley@eku.edu).

Respectfully,

Nancy Armstrong, RN, DNP Student Eastern Kentucky University

Appendix M.

Cover Letter

The Effect of a Facilitated Educational Program & Experiential Learning on Nursing Workplace Incivility

Nancy Armstrong, RN, MSN

Eastern Kentucky University: Department of Baccalaureate & Graduate Nursing

Dear Nurse,

I am a Doctor of Nursing Practice Student in the Department of Baccalaureate and Graduate Nursing at Eastern Kentucky University in Richmond, Kentucky. You are invited to participate in a project as a fulfillment of the requirements for my completion of the program. The purpose of the project is to determine if a civility training program that includes education about incivility, teambuilding exercises, and experiential learning activities can: 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 involves no foreseeable risks or harm to you or position within the organization. The project is made up of four 20-30 meetings on your nursing unit in small groups where we complete teambuilding exercises, learn about nursing incivility, and how to respond to nursing incivility effectively through small group discussions.

You will be asked to provide demographic information and complete a short, 10-item questionnaire about your experiences with nursing incivility. The questionnaire will be given prior to the training sessions and after the training sessions are completed. I will act as the leader of the training sessions. The questionnaires and demographic information will be anonymous and the results will be reported only in aggregate in the final manuscript to be submitted to my faculty advisor as part of my coursework.

Your participation in this project is voluntary. You are under no obligation to participate and you may withdraw from the project at any time.

If I have questions or concerns about the project or my participation in it, I may contact the project leader, Nancy Armstrong, RN, MSN, by telephone at (270) 809-4576 or by email at [nancy\\_armstrong@mymail.eku.edu](mailto:nancy_armstrong@mymail.eku.edu). I may also contact the faculty advisor for the pilot project at my discretion, Dr. Donna J. Corley, PhD, by telephone at (859-622-6316) or by email at [Donna.Corley@eku.edu](mailto:Donna.Corley@eku.edu). Questions or concerns about your rights as a study participant may be directed to Sponsored Programs, Jones 414/Coats CPO 20, Eastern Kentucky University.

Respectfully,

Nancy Armstrong, MSN, RN, Eastern Kentucky University DNP Student

Appendix N.

The Effect of a Facilitated Educational Program and Experiential Learning on Nursing Workplace Incivility



# CREW Training

## For Evening Shift Nurses



Starting August 2015