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Exploring Workplace Incivility and Bullying in Healthcare Workers in a South Florida Community Hospital

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ABSTRACT

Introduction: Workplace incivility and bullying are concerning issues in healthcare with detrimental consequences for healthcare workers (HCW) and healthcare organizations. Organizational leaders' recognition of incivility/bullying within healthcare organizations, and their sources, is imperative to prevent and/or address issues by creating "zero tolerance" work environments. The purpose of this cross-sectional, descriptive study was to explore HCWs' experiences with incivility and bullying at a South Florida community hospital.

Methods: A convenience sample of HCWs at a South Florida community hospital were recruited to voluntarily complete the Nursing Incivility Scale.

Results: A sample of 325 HCWs responded to the survey. The results showed general incivility as the highest source across all HCWs, with certified nursing assistants having the highest level of incivility across all sources (general, nurse, supervisor, physician, and patients). Correlative analysis showed statistically significant relationships between a) several sources of incivility (general, supervisor, physician, and patient; $r = .250$ to $.390$) for those reporting past experiences with incivility/bullying, and b) healthcare role and physician incivility ($r = -.224$). Independent t tests and one-way ANOVA showed statistically significant differences. Of note, compared to other HCW roles, registered nurses reported physicians as their highest source of incivility.

Discussion: Workplace incivility/bullying is a serious issue in healthcare across all disciplines and roles, requiring healthcare organization leaders' awareness and subsequent interventions to prevent and address its occurrence. The results of this study provide necessary insight for hospital organization leaders as they endeavor to create and nurture "zero tolerance" work environments.

Keywords: Workplace incivility, workplace bullying, workplace violence, zero tolerance

INTRODUCTION

Workplace incivility and bullying are concerning issues in healthcare, spanning across all disciplines and roles, with detrimental consequences for healthcare workers (HCW) and healthcare organizations at large (Bloom, 2018; Butler et al., 2018; Difazio et al., 2018; Johnson, 2018; Liaqat et al., 2021). Incivility and bullying are part of the broader construct of workplace violence. The Joint Commission (TJC, 2021) defines workplace violence as "an act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors" (p. 1). The consequences of workplace violence (i.e., incivility and bullying) include: a) increases in job dissatisfaction, absenteeism, burnout, turnover intention and costs, b) a negative impact on the well-being of HCWs and their

work performance, and indirectly jeopardizing of patient safety and quality of care (Al Muharraq et al., 2022; Ajoudani et al., 2019; Arnetz et al., 2020; Durmus et al., 2018; Cengiz et al., 2018; Kang et al., 2017; Fang et al., 2020; TJC, 2022; Kanitha & Poonam, 2020; King et al., 2021; Liaqat et al., 2021; Ma et al., 2021; Shorey & Wong, 2021;Yang & Zhou, 2021).

Workplace Incivility and Bullying

While related, incivility and bullying are two separate constructs with distinct definitions, with incivility being generalized unprofessional behaviors and "less severe" than bullying and bullying characterized as repetitive intentional behaviors and/or actions targeted towards an individual or particular group of individuals (Cooke & Baumbusch, 2021; Sarwar et al., 2019; Schoville & Aebersold, 2020). The American Nurses Association (ANA, 2015) defines incivility and bullying as follows:

a) Incivility is one or more rude, discourteous, or disrespectful actions that may or may not have a negative intent behind them, and

b) Bullying is "repeated, unwanted, harmful actions intended to humiliate, offend, and cause distress in the recipient" (2015, p. 3).

The manifestation of workplace incivility and bullying is multifaceted, potentially presenting as: unprofessional behaviors, gossip/rumors, written or verbal abuse, exclusion of individuals or groups, hostility, silence, oppression, threats, intimidation, limited opportunities for career growth, damaged reputation, devaluation, taking credit for another's work, and even physical aggression (Bambi et al., 2018; Choi & Park, 2019; Guidroz et al., 2010; Ma et al., 2021; Shorey & Wong, 2021).

Furthermore, incivility and bullying have historically affected the nursing profession, aligning with the belief that "nurses eat their young" which may begin as early as during the formative years of nursing education transferring into professional practice (Johnson, 2018; Rahm et al., 2019). In recognition of these issues in nursing, ANA (2015) released a position statement to encourage healthcare professionals and stakeholders to "create and sustain a safe and healthy interprofessional work environment" (p.3), highlighting the requirement for all professional nurses to "create an ethical environment and culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect" (ANA, n.d. para. 4). As such, "effective workplace violence prevention systems with leadership oversight, policies and procedures, reporting systems, data collection and analysis, post-incident strategies, training, and education to decrease workplace violence" (TJC, 2021, p.1).

Recent literature has revealed several effective strategies for preventing and addressing behaviors associated with incivility and bullying within organizations, which include increasing staff awareness through educational sessions, establishing and upholding policies and procedures, developing a culture of "zero tolerance", and a positive leadership model that cultivates and fosters a positive environment and healthy interpersonal relationships between team members (Al Muharraq et al., 2022; Armstrong, 2018; Bambi et al., 2018; Crawford et al., 2019; Durmus et al., 2018; Fang et al., 2021; Fontes et al., 2018; Homayuni et al., 2021; Howard & Embree, 2020; Islam et al., 2018; Kang et al., 2017; Johnson, 2018; Kanitha & Poonam, 2020; Kim, 2020; King et al., 2021). However, investigation of the presence and prevalence of incivility and bullying within organizations is needed prior to planning and implementing these strategies. Therefore, the purpose of this study was to explore HCWs' experiences with incivility and bullying at a South Florida community hospital. The organization's leaders will use the results of this study to increase awareness and aide development of source-specific strategies for mitigating and preventing incivility and bullying among its HCWs. The researchers used the following research questions to guide the study's methods:

a) What are the hospital healthcare workers' experiences related to incivility and bullying at the workplace?

b) What are the source-specific incivility behaviors?

METHODS

Design, Sample, and Setting

The researchers conducted this study following a quantitative descriptive-comparative research design. The target population was HCWs employed at a South Florida community hospital. The researchers used convenience sampling to recruit a minimum sample size of 300 participants; the researchers conducted an a priori power

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analysis to determine the minimum sample size. Inclusion criteria consisted of full-time, part-time, and per diem employees working at a South Florida community hospital, which is part of a large healthcare system. Exclusion criteria consisted of HCWs employed at other hospitals or outpatient centers within the healthcare system.

Variables

The dependent variable for this study was workplace incivility, which was measured using the Nursing Incivility Scale (higher scores indicate higher levels of incivility). Additionally, participants were asked the following questions: a) *Have you ever reported any incidence of bullying or incivility you experienced in the workplace?* (Yes/No), b) *If yes, what kind of support did you receive when reporting the incidence?* (Open-ended), and c) *If no, why not?* (Open-ended). The independent variables were the participants' characteristics, collected by using a demographic survey that included age group by generation, gender, healthcare role, specialty/unit, years working at the hospital organization, and years of experience in their current role.

Nursing Incivility Scale

The Nursing Incivility Scale (NIS) (Guidroz et al., 2010) is a 43-item self-report Likert-type instrument (see Appendix). The NIS's internal consistency [Cronbach's alpha (α) values] ranged from very good to strong (α = .85 to .94), suggesting it is a reliable instrument (Guidroz et al., 2010). The NIS consists of five categories that measure incivility based on its source: general incivility (nine items; α = .85), nurse incivility (10 items, α = .89), supervisor incivility (seven items, α = .94), physician incivility (seven items, α = .94), and patient incivility (10 items, α = .91). The NIS also measures incivility based on item-specific subscale constructs: Hostile Climate (HC), Inappropriate Jokes (IJ), Inconsiderate Behavior (IB), Gossip/Rumors (GR), Free-Riding (FR), Abusive Supervision (AS), Lack of Respect (LR), and Displaced Frustration (DF) (Table 1). Participants rate the NIS items using a five-point

Table 1

NIS Source Categories: Score Ranges and Subscale-Item Alignment

Source Category	Items *n*	Score Range	Subscale (Items)
General Incivility	9	9 – 45	HC (1,2,3) IJ (4,5,6) IB (7,8,9)
Nurse Incivility	10	10 – 50	HC (1,2,3) GR (4,5,6,7) FR (8,9,10)
Supervisor Incivility	7	7 – 35	AS (1,2,3,4) LR (5,6,7)
Physician Incivility	7	7 – 35	AS (1,2,3,4) LR (5,6,7)
Patient Incivility	10	10 – 50	LR (1,2,3,4,5,6) DF (7,8,9,10)

Note: HC=Hostile Climate, IJ=Inappropriate Jokes, IB=Inconsiderate Behavior, GR=Gossip/Rumors, FR=Free-Riding, AS=Abusive Supervision, LR=Lack of Respect, DF=Displaced Frustration

Likert-type agreement scale (1-Strongly Disagree; 2-Disagree; 3-Neither Agree nor Disagree; 4-Agree; 5-Strongly Agree). Scores are calculated by summing and averaging the scores based on the source category (above) or by subscale-based related items (Table 1). Higher source category averages indicate higher levels of incivility based on the source (general, nurse, supervisor, physician, and/or patient). Higher subscale averages indicate higher levels of incivility based on the subscale construct. For this study, the source categories were used to calculate incivility scores (Table 1). The researchers obtained the author's permission to use the instrument.

Ethical Considerations

The healthcare system's Institutional Review Board (IRB) approved the study in January 2020 (IRBNet ID 1502815).

Data Collection / Procedures

Following IRB approval, data collection was open from March 2021 through May 2021. Participant recruitment consisted of sending a hospital-wide recruitment email every two weeks for three months. The email contained a brief description of the study and the Research Data Capture (REDCap) universal resource locator (URL) link. The web-based REDCap platform provided a means for relaying study information (study purpose, voluntary participation, right to withdraw without penalty, risks/benefits, confidentiality, etc.) and collecting participant demographic information and NIS responses. The survey's design allowed participants to bypass any questions/ items they did not wish to answer. Additionally, participants were not required to respond to NIS source categories that were not pertinent to their healthcare roles. The estimated time to complete the survey was 15 to 20 minutes.

Data Analysis

Data were analyzed using SPSS version 25. Descriptive analyses were used for reporting demographic data (means and frequencies) and averages for the NIS instrument averages by item, source category, healthcare role, and overall totals. Inferential analyses included Pearson's correlation coefficient, independent *t* tests, Mann-Whitney U, and one-way analysis of variance (ANOVA). The researchers reviewed the open-ended responses and categorized them based on similarity as follows:

a) Reason Incident Not Reported: "fear of retaliation", "no action would be taken/no resolution", "general fear or discomfort", "desire to avoid conflict", "issue directly addressed/ resolved with aggressor", "unawareness of reporting process or the opportunity to report", and "provided miscellaneous responses".

b) Type of Support Received after Reporting the Incident: "no support received", "received some support", 'received support but without actions taken", "received full support", "responded with answers incongruent with the question", and "did not provide a comment".

Lastly, reliability analyses were conducted to examine the NIS's internal consistency based on the following criteria: 1) all participants (nurses and non-nurses), b) nurses only, and c) non-nurses only.

RESULTS

Participants

Three hundred and twenty-five HCWs voluntarily participated in the study; however, only 313 responses were retained after removal of grossly incomplete responses. The majority of the participants were female (80%, n = 250), male, 19% (n = 60), and 1% (n = 3) did not provide a response. Participants' generational stratification was Baby Boomers, 40% (n = 126); Generation X, 39% (n = 123); and Generation Y (Millennials), 21% (n = 64). Participant healthcare roles were 19% staff registered nurses (RN) (n = 60); certified nursing assistants (CNA), 7% (n = 21); clinical leaders 22% (n = 67), non-clinical leaders 15% (n = 47); and other role, 37% (n = 117) (Table 2). Participants' reported years of employment were "0 to 5 years", 39% (n = 122); "6 to 10 years", 18% (n = 55); "10 to 15 years", 15% (n = 48); "16 to 20 years", 8% (n = 24); and "greater than 20 years", 20% (n = 64). Participants also reported their areas of specialty as follows: critical care units, 2% (n = 7); emergency department, 3% (n = 9); medical-surgical/observation units, 18% (n = 56); postpartum/labor and delivery, 7% (n = 21); neonatal intensive care unit, 4% (n = 12); perioperative unit, 8% (n = 25); and other specialty, 58% (n = 183).

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Table 2

"Other" Roles as Reported by Participants

Other Role	*n*	Other Role	*n*
Non-Clinical	11	Support	2
Administrator Senior Leadership	8	Charge Auditor	1
Administrative Assistance	7	Clerk	1
Clinical Educator	6	Communications	1
Patient Financial Representative	5	Exercise Physiologist/Wellness	1
Advanced Practice Registered Nurse	4	Concierge Services	1
Technician	4	Laboratory	1
Human Resources	3	Lead Person	1
Patient Experience Advisor	3	Linen Attendant	1
Medical Technician	3	Occupational therapist	1
Security	3	Radiographer	1
Supervisor	3	Radiology Technician	1
Mechanic	2	Risk Management Coordinator	1
Nurse Scientist	2	Respiratory Therapist	1
Patient Advocate	2	Sanitizer Technician	1
Sonographer	2		

Descriptive Statistics

Experienced/Witnessed Incivility or Bullying

The results of the study showed 44% of the participants (n = 138) reported they experienced or witnessed incivility or bullying with only 49% (n = 67) of those having reported the incident. The reasons given for not reporting the incident (51%, n = 71) are as follows:

a) Fear of retaliation, 31% (n = 22),

b) No action would be taken/no resolution, 24% (n = 17),

c) General fear or discomfort, 7% (n = 5),

d) Desire to avoid conflict, 4% (n = 3),

e) Issue directly addressed with the aggressor, 7% (n = 5),

f) Unawareness of reporting process or the opportunity to report, 6% (n = 4), and

g) 21% (n = 15) provided miscellaneous responses.

For the 49% of those who reported bullying, 39% (n = 22) reported receiving no support, 30% (n = 17) received some support, 9% (n = 5) received support but without actions taken, 5% (n = 3) received full support, 9% (n = 5) responded with answers incongruent with the question, and 7% (n = 4) did not provide a comment.

NIS: Sources of Incivility

The results revealed general incivility (56%) as the highest reported source of incivility for all HCWs, sequentially followed by nurse incivility (52%), physician incivility (50%), patient incivility (46%), and supervisor incivility (37%) (Figure 1). Figure 2 shows the source of incivility percentage averages stratified by healthcare role. These results revealed that CNAs had the highest levels of incivility across all sources.

Inferential Analyses of NIS Source Categories

Correlative Analyses

Correlative analyses were conducted to examine relationships between study variables. Pear-

Figure 1

NIS Percent Averages by Healthcare Role and Source of Incivility

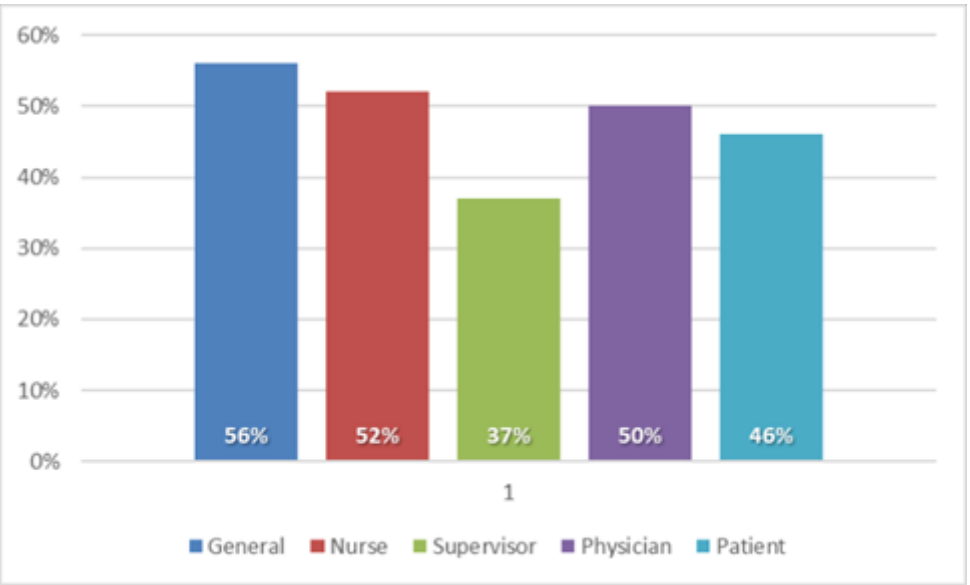
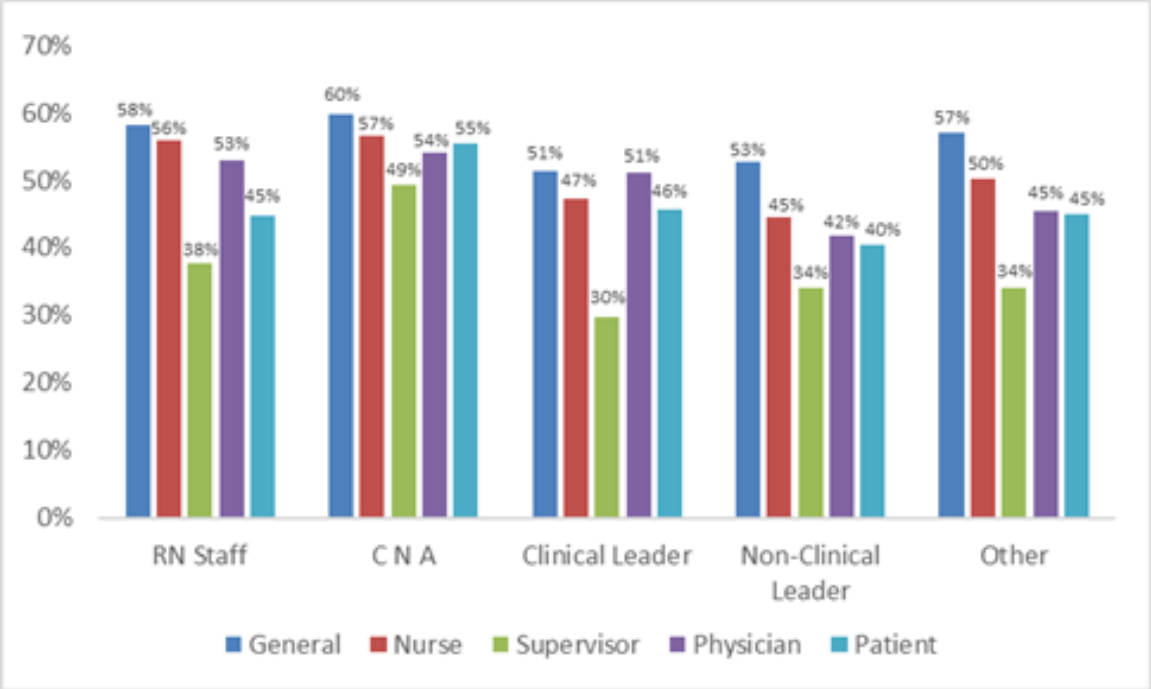


Figure 2

NIS Source of Incivility Percent Averages by Healthcare Role



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son's correlation coefficient showed statistically significant relationships between the following variables.

Participant Demographics and NIS Source Category. A moderately strong positive relationship was shown between the experience/ witness of incivility/bullying and the Nurse Incivility source category ($r = .469$, $p < .001$). Low to moderate positive relationships were found between experience of incivility/bullying and general incivility ($r = .390$, $p < .001$), experience of incivility/bullying and supervisor incivility scores ($r = .250$, $p < .001$), experience of incivility/bullying and physician incivility scores ($r = .251$, $p = .002$), healthcare role and physician incivility ($r = -.224$, $p = .002$), and experience of incivility/bullying and patient incivility ($r = .255$, $p < .001$). Weak relationships were revealed between generation and physician incivility ($r = .147$, $p = .041$) and years at the hospital organization and physician incivility ($r = -.112$, $p = .041$).

Participant Characteristics and Experience with and Reporting of Incivility/Bullying. A low to moderate negative relationship was shown between gender and experience of bullying ($r = -.212$, $p < .001$). Low to no relationships were found between generation and reporting of bullying ($r = -.140$, $p = .013$) and years at the hospital organization and reporting of bullying ($r = .126$, $p = .026$).

Independent t *Test, Mann-Whitney U Test, and One-Way ANOVA*

Independent *t* test, Mann-Whitney U test, and one-way ANOVA were used to examine differences based on the correlation results. Independent *t* test, used for variables with dichotomous groups, showed no statistical differences in source category averages and NIS total averages between genders.

One-Way ANOVA results for source category averages did not show statistically significant differences between generations. However, a statistically significant difference in source category averages between healthcare roles and physician incivility was revealed [$F(df) = 2.635$ (4, 194), $p = .027$] with RNs experiencing the highest level of physician incivility [$M = 19.26$ (55%), $SD = 8.20$]. One-Way ANOVA results also showed statistically significant differences between specialties related to physician incivility [$F(df) = 2.706$ (6, 188), $p = .015$, $M = 22.56$] with perioperative RNs experiencing the highest level [$M = 22.56$ (65%), $SD = 7.10$]. Lastly, one-way ANOVA results showed statistically significant differences in source category averages and length of employment at the hospital organization with higher general incivility averages for 11 to 15 years [$F(df) = 2.688$ (4, 258), $p = .032$, $M = 28.22$], and higher patient incivility averages for 6 to 10 years [$F(df) = 3.174$ (4, 258), $p = .015$, $M = 25.34$]. One-way ANOVA results between NIS total averages and all participants' characteristics were not statistically significant.

Post-Hoc Analyses between Nurse and Non-Nurse Participants

Guidroz et al. (2010) designed the NIS for nurses; therefore, only nurses were included in the testing of the instrument. As such, the researchers of this study provided non-nurse participants with the option of bypassing the physician incivility source category if their roles did not entail interactions with physicians. Eighty-nine non-nurse participants completed the items of the physician incivility source category. Post hoc independent *t* tests were conducted to examine differences of source category averages between nurse and non-nurse participants. There were no statistical differences within the general, nurse, and patient source categories. However, a statistically significant difference was found between nurses ($n = 114$, $M = 11.775$) and non-nurses ($n = 141$, $M = 13.575$) and supervisor incivility source category averages [t (191) = 2.281, $p = .024$, $MD = 2.189$]. There was also a statistically significant difference between nurses ($n = 104$, $M = 18.481$) and non-nurses ($n = 89$, $M = 16.292$) that completed the physician incivility source category [t (191) = 2.281, $p = .024$, $MD = 2.189$]. Both results yielded higher source category averages in nurses.

NIS Internal Consistency: Nurses versus Non-Nurses

The NIS Cronbach's alpha coefficient values ranged from .872 to .960 for the complete sample (nurses and non-nurses), .846 to .962 for nurses only, and .889 to .958 for non-nurses only. Table 3 shows a complete report of results.

DISCUSSION

The results of this study align with previous literature demonstrating the ubiquitous prevalence of workplace incivility and bullying in healthcare

Table 3

Internal Consistency of Source Categories based on the Complete Sample and Nurse Participants versus Non-Nurse Participants

	Cronbach's Alpha Coefficients		
	Complete Sample	Nurses	Non-Nurses
General Incivility	.872	.846	.889
Nurse Incivility	.942	.938	.946
Supervisor Incivility	.960	.962	.958
Physician Incivility	.913	.902	.923
Patient Incivility	.940	.931	.949

across HCW roles (Butler et al., 2018; Johnson, 2018; Liaqat et al., 2021). Furthermore, the results highlighted concerns requiring further examination related to HCWs' encounters with incivility/bullying (related to self or witnessed) regarding reporting the incidents, including whether HCWs received support after reporting the incident and reasons HCWs failed to report the incident. The results also provided further insight into the sources of incivility, as well as relationships and differences between reported experiences with/ reporting of incivility/bullying, sources of incivility, and participant characteristics.

Experiencing and Reporting Incivility/Bullying

Results of the participants' responses to the questions examining experiencing and reporting of incivility/bullying are concerning. The results alarmingly suggest underreporting of incidents due to perceived negative consequences, primarily related to fear of retaliation and discouragement (i.e., the issue would not be addressed appropriately or at all). The results also suggest, to a lesser degree but just as concerning, underreporting of incivility/bullying related to lack of knowledge or awareness of the organization's policy and/or procedure for reporting such incidents. Lastly, the results also suggest inconsistencies in the support received for those who reported the incident, with the majority reporting they did not receive support or received little support after the incident. These findings align with prior research highlighting lack of policy knowledge and lack of institutional support as the main cases for underreporting (Howard & Embree, 2020; Kim, 2020)

Sources of Incivility

Overall, participants scored the highest on the general incivility source category suggesting that incivility did not originate from a specific source group. However, the results also suggested nurses and physicians, respectively, were also sources of incivility for all HCWs. The findings of this study were similar to the results of research studies conducted by Al Muhrraq et al. (2022), Crawford et al. (2019), and Kim (2020). Additionally, when analyzing results based on HCWs' roles, CNAs had the highest scores in all source categories with the highest scores in the general, nurse, and physician source categories suggesting CNAs experienced the highest level of incivility from these specific sources. These findings aligned with Cooke and Baumbusch's (2021) study supporting that CNAs' sources of incivility include multidisciplinary healthcare team members.

Relationships and Differences between Variables

The strongest relationship was between HCWs who experienced/reported incivility/ bullying and the nurse incivility source category, suggesting RNs as the primary source of incivility for those who experienced and/or reported inci-

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dents of incivility/bullying. Results associated with examining differences between groups revealed a significant difference in source category scores based on HCW roles, suggesting RNs experienced the most incivility from physicians, with perioperative RNs experiencing the highest level of physician incivility amongst all RNs. These findings aligned with Lee et al.'s (2021) and Schoville and Aebersold's (2020) research studies related to incivility. Length of employment within the organization suggested that HCWs with 11 to 15 years of employment mostly experienced general incivility, while HCWs with six to 10 years of employment mostly experienced patient incivility. Evidence from similar research studies supported the findings that HCWs with less experience are more susceptible to incivility (Johnson, 2018; Rahm et al., 2019). Lastly, post hoc independent *t* test results suggested nurse participants had higher source levels of physician incivility and supervisor incivility compared to non-nurse participants.

Internal Consistency

Despite the nurse-focused design of the NIS, internal consistency results suggested reliability across all HCWs as shown in the results of the complete sample (Cronbach's alpha .872 to .960), and separately in nurses (Cronbach's alpha .846 to .962) versus non-nurses (Cronbach's alpha .889 to .958).

Recommendations for Practice

In light of these results, the researchers recommend that hospital leaders and administrators use this insight for designing, developing, and implementing strategies to create, maintain, and/or sustain "zero tolerance" healthcare environments and promote reporting of incivility/bullying incidents. Another recommendation is transparent communication of actions taken to address reported incidents, without crossing privacy and confidentiality boundaries. Onboarding and ongoing education for HCWs should include information regarding policies and procedures related to incivility/bullying to ensure HCWs throughout the organization understand and adhere to them, inclusive of the process for reporting the incidents, should they occur. Lastly, special considerations and unique strategies may be required related to preventing and addressing workplace incivility/bullying among CNAs and RNs, focusing on general, nurse, and physician incivility for CNAs and supervisor and physician incivility for RNs.

Limitations and Recommendations for Research

As with all research studies, several limitations were associated with this study. Firstly, results are not generalizable because this was a single-site study using a convenience sampling technique, therefore, the sample was not representative of the larger population. The researchers recommend replication of the study within other hospital organizations to yield site-specific results and add more evidence to the existing body of knowledge. A significant limitation of this study was the use of a nursing-specific instrument to measure incivility in non-nurse HCWs. However, in anticipation of this limitation, the researchers designed the study so that participants were able to skip sections that were not pertinent to their roles. However, this design may have led to misleading lower scores in non-nurse HCW roles. A post hoc independent *t* test showed no significant differences in general, nurse, and patient source category averages between nurses and non-nurses. However, significant differences were found in the supervisor and physician source categories. These differences may be attributed to use of the NIS in non-nurses, potential differences for time/frequency of interactions, as well as potential hierarchical role differences of the nurses and non-nurses. Further examination of these factors is needed.

Several uncontrollable variables may have also affected the results of this study. Data were collected during the Delta surge of the COVID-19 pandemic; therefore, incidences of incivility/bullying may have been higher during this unprecedented time compared to before or after the surge and reported less due to time constraints and other challenges faced by HCWs during the pandemic. Another limitation of the study was, while the NIS provided a method for assessing sources of incivility (or types of incivility), the instrument did not provide a method for assessing frequency or severity of the incidences. The researchers recommend post-COVID-19 assessment of incivility/bullying with assessment of frequency and severity using an instrument designed for all HCWs. Due to the self-report nature of the study and efforts made to avoid "forced responses", missing data, while minimal, was another limitation. Lastly, although participation was voluntary and anonymous, social desirability bias may have influenced participants to respond to items based on how they believe others would like them to respond even though it may have

differed from their genuinely desired response, thus potentially skewing the results.

CONCLUSION

Workplace incivility and bullying are serious issues in healthcare across all disciplines and roles. As such, it is advisable that hospital leaders acquaint themselves with the occurrence of incivility and bullying within their hospital organizations and implement recommended evidence-based strategies for preventing and addressing these issues. The results of this research study were shared with its hospital's senior leaders, including directors, managers, and supervisors, as well as the hospital organization's Workplace Violence Council (WVC). Subsequently, the WVC mandated its membership complete the Center for Disease Control (CDC) and the National Institute for Occupational Safety and Health (NIOSH) workplace violence course for all of its members, with recommendations for senior leaders to do likewise. In addition, the WVC developed a procedure, including a debriefing form and sign to post at key points within the hospital to increase awareness of the organization's zero tolerance for incivility and bullying. The healthcare system also integrated a specific category in the incident-reporting program specific to workplace violence to encourage reporting and incidence tracking.

Creating a safe work environment for staff is key to improving the well-being of HCWs as well as improving patient quality outcomes. Leadership awareness and staff support are paramount to addressing incivility/bullying, thus improving retention, and reducing staff turnover rates. With this in mind, hospital organization leaders should strive for a nurturing leadership model that encourages collegiality and a friendly work environment where toleration of incivility and bullying behaviors is nonexistent.

DECLARATION OF INTEREST

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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Appendix

Nursing Incivility Scale: Items by Source Category with Subscale Alignment

General Incivility (Source Category)		
Sub-scale	**Item**	**Statement**
HC	1.	Hospital employees raise their voices when they get frustrated.
HC	2.	People blame others for their mistakes or offenses.
HC	3.	Basic disagreements turn into personal verbal attacks on other employees.
IJ	4.	People make jokes about minority groups.
IJ	5.	People make jokes about religious groups.
IJ	6.	Employees make inappropriate remarks about one's race or gender.
IB	7.	Some people take things without asking.
IB	8.	Employees don't stick to an appropriate noise level (e.g., talking too loudly).
IB	9.	Employees display offensive body language (e.g., crossed arms, body posture).
Nurse Incivility (Source Category)		
Sub-scale	**Item**	**Statement:** Other nurse on my unit…
HC	1.	… argue with each other frequently.
HC	2.	…have violent outbursts or heated arguments in the workplace.
HC	3.	…scream at other employees.
GR	4.	…gossip about one another.
GR	5.	…gossip about their supervisor.
GR	6.	…bad-mouth others in the workplace.
GR	7.	…spread bad rumors around here.
FR	8.	…make little contribution to a project but expect to receive credit for working on it.
FR	9.	…claim credit for my work.
FR	10.	…take credit for work they do not do.
Supervisor Incivility (Source Category)		
Sub-scale	**Item**	**Statement:** My direct supervisor…
AS	1.	…is verbally abusive.
AS	2.	…yells at me about matters that are not important.
AS	3.	…shouts or yells at me for making mistakes.
AS	4.	…takes his/her feelings out on me (e.g., stress, anger, "blowing off steam").
LR	5.	…does not respond to my concerns in a timely manner.
LR	6.	…is condescending to me.
LR	7.	…factors gossip and personal information into personnel decisions.

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Physician Incivility (Source Category)		
Sub-scale	**Item**	**Statement**
AS	1.	Some physicians are verbally abusive.
AS	2.	Physicians yell at nurses about matters that are not important.
AS	3.	Physicians shout or yell at me for making mistakes.
AS	4.	Physicians take feelings out on me (e.g., stress, anger, "blowing off steam").
LR	5.	Physicians do not respond to my concerns in a timely manner.
LR	6.	I am treated as though my time is not important.
LR	7.	Physicians are condescending to me.
Patient Incivility (Source Category)		
Sub-scale	**Item**	**Statement:** Patients/visitors…
LR	1.	… do not trust the information I give them and ask to speak with someone of higher authority.
LR	2.	…are condescending to me.
LR	3.	…make comments that question the competence of nurses.
LR	4.	…criticize my job performance.
LR	5.	…make personal verbal attacks against me.
LR	6.	…pose unreasonable demands.
DF	7.	…have taken out their frustrations on nurses.
DF	8.	…make insulting comments to nurses.
DF	9.	…treat nurses as if they were inferior or stupid.
DF	10.	…show that they are irritated or impatient.

Note: Hostile Climate (HC), Inappropriate Jokes (IJ), Inconsiderate Behavior (IB), Gossip/Rumors (GR), Free-Riding (FR), Abusive Supervision (AS), Lack of Respect (LR), and Displaced Frustration (DF).