EFFECTS OF INCIVILITY TRAINING ON UNLICENSED ASSISTIVE PERSONNEL'S PERCEPTION OF UNCIVIL BEHAVIOR IN THE WORKPLACE

By

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The DNP Project committee for Naomi King certifies that this is the approved version of the following DNP project:

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Abstract

Problem: Incivility is an important issue in nursing because it can negatively impact both workplace relationships and patient care. The healthcare environment is stressful with complex interpersonal relationships. It is a high-stakes environment where people need to make quick decisions that affect others' care in sometimes difficult situations. Tempers can escalate in these stressful situations causing curt, uncivil, and even hurtful remarks between healthcare providers. Incivility in the workplace can lead to unsafe patient care due to poor staff communication and missed care activities. An interprofessional team approach is required to provide safe patient care. All members of the healthcare team, including unlicensed assistive personnel (UAP), should work in an environment free from incivility to provide quality patient care. Since UAP provide direct patient care, the impact of incivility on UAP should be examined. UAP are integral members of the healthcare team who also value healthy working relationships where colleagues treat each other with respect and dignity. However, the impact incivility has on UAP in acute care settings remains relatively unknown in nursing practice.

Project Aim: The aim for this quality improvement project is to determine the effects of incivility training on UAP's perception of uncivil behavior in the workplace.

Project Method: Forty-one UAP employed in the float pool department at an academic medical center were invited to participate. Participation comprised of completing the Nursing Incivility Scale (NIS) instrument, attending an incivility training 2-hour class, and then retaking the Nursing Incivility Scale instrument after the training class. Nineteen UAP completed the NIS instrument, 9 UAP attended an incivility training class, and 8 of the 9 class attendees completed the post-class NIS instrument.

Project Results: UAP perceive incivility in their workplace. They perceive uncivil behavior directed at them and observe incivility between other healthcare providers. Effects of incivility training suggest a slightly better understanding and general awareness of workplace incivility.

Project Conclusion: Incivility continues to be a problem in hospitals; therefore, more investigation is needed to understand UAP perception of incivility, including how incivility training affects their perception. Increasing organizational knowledge of UAP perception of incivility will help to fill this gap in the nursing literature. UAP are integral members of the healthcare team and are vital to promoting a healthy work environment that is free from incivility.

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Incivility is not a new phenomenon or issue in nursing. Lack of civil behavior between healthcare providers has been documented for over a century. In 1909 an article in *The New York Times* portrayed head nurses in hospitals as strict and harsh healthcare providers who abused other nurses (Castronovo, Pullizzi, & Evans, 2016). It is suspected that this article was the premise for the phrase "nurses eating their young" (Castronovo, et al., 2016). The terms incivility and bullying are sometimes used interchangeably. Merriam-Webster defines incivility as "a rude or discourteous act" and defines bullying as "abuse and mistreatment of someone vulnerable by someone stronger, more powerful, etc." (Merriam-Webster, 2018).

Historically, the term bully has had a positive connotation, meaning a person who is strong with wit and tenacity and often admired (Castronovo, et al., 2016). However, this positive connotation is not true for nursing. Healthcare is a high-stakes environment with complex interpersonal relationships. It is an environment where people make quick decisions that affect others' care in stressful situations. Open communication among healthcare providers is imperative in providing excellent healthcare. At times tempers can escalate in these stressful situations causing curt and uncivil remarks between healthcare providers. Incivility in the workplace can lead to unsafe patient care due to poor staff communication and missed care or delay in care. Workplaces must be safe environments for staff to provide quality patient care (De Villers & Cohn, 2017). The Joint Commission has been a leader in decreasing workplace violence through its Sentinel Event Alert policy; and they recommend that organizations actively foster safe work environments where staff is expected to treat each other with respect (Robbins, 2018). A safe work environment is one free of bullying and uncivil behavior. Unfortunately, the majority of nurses have reported some kind of workplace bullying or uncivil behavior either personally or observed. (Griffin & Clark, 2014; Lasater, Mood, Buchwach, & Dieckmann, 2015;

Taylor, 2016; Warrner, Sommers, Zappa & Thornlow, 2016). One survey found that 82% of the respondents reported they had experienced or witnessed behaviors that included belittling or harsh criticism in front of others, complaining about someone to others, eye-rolling, and pretending not to notice a struggling co-worker (Dumont, Meisinger, Whitacre, & Corbin, 2012). Unfortunately, incivility continues to be a pervasive issue in healthcare organizations (Castronovo et al., 2016; De Villers & Cohn, 2017; Dumont et al., 2012; Lachman, 2014; Lasater et al., 2015; Longo & Hain, 2014; Meires, 2018; Schilpzand, De Pater & Erez, 2014; Taylor, 2016; Warrner, et al., 2016).

All members of the healthcare team are needed to provide quality and safe patient care. To accomplish quality care, the work environment should be free from incivility. The impact of incivility on other frontline healthcare providers, such as unlicensed nursing staff, should also be investigated to ensure overall high staff morale, staff satisfaction with work, safe patient care, and patient satisfaction. It is essential that all healthcare providers work as a team to meet patient needs.

Unlicensed assistive personnel (UAP) is the general term for those individuals who are directed and supervised by licensed professional nurses and who assist with direct patient care. UAP are identified by various titles, such as patient care technician, patient care assistant, health care technician, nursing assistant, or nurses' aide. Many are certified nursing assistants who have successfully completed a state-approved training course and passed a test specified by the state (Kansas Department of Aging and Disability Services, n.d.; [U. S. BLS], 2018). United States Bureau of Labor Statistics ([U.S. BLS], 2018) identifies the 1.5 million individuals that provide basic personal care in hospitals and long-term care facilities as nursing assistants. Approximately 354,000 nursing assistants are employed in general medical and surgical

hospitals ([U. S. BLS], 2018) and 21% of the care hospitalized patients receive is from nursing assistants (Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2012). UAP are integral members of the healthcare team who also value healthy working relationships where colleagues treat each other with respect and dignity. However, the impact incivility has on UAP still remains relatively unknown in nursing practice. The purpose of this DNP project is to determine the effects of incivility training on UAP's perception of uncivil behavior in the workplace.

Statement of the Problem

Incivility is an unfortunate common phenomenon in hospitals and workplace bullying continues to be a problem in healthcare. It is a serious problem that needs to be addressed because poor working relationships can negatively impact patient care and staff turnover if uncivil behavior is left ignored. Thus, incivility impacts safe patient care. For example, Felblinger (2008) reports that 53% to 75% of healthcare providers believe there is a strong link between uncivil behaviors and adverse patient outcomes, such as increased medication errors. Spence Laschinger (2014) found that nurses' perceived incivility is associated with poor quality patient care and an increased risk to patient safety. Furthermore, Meires (2018) and Warrner, et al. (2016) agree that 27% to 85% of nurses have experienced some form of incivility; thus, negatively affecting patient safety when nurses fear to ask for help with patient mobility and transfers. Incivility among healthcare providers can also be detrimental to their physical and mental health, job commitment, job satisfaction, and to patient satisfaction (Meires, 2018; Felblinger, 2008; Griffin & Clark, 2014; Warrner, et al., 2016). Incivility can be costly to organizations due to employee unproductivity, absenteeism, high employee turnover, and anxiety and depression treatment for staff (Griffin, et al., 2014; Warrner, et al., 2016). It is estimated that healthcare organizations spend up to $100,000 per year per employee who experiences incivility

(Schilpzand, et al., 2014; Warrner, et al., 2016). Healthcare organizations should be committed to high quality nursing care and safe patient outcomes where staff can provide effective care in a safe environment. Warrner et al. (2016) interviewed stakeholders about their perceived existence of incivility at their organization. These stakeholders agreed that a program to help reduce the frequency of incivility would show the organization's commitment to providing a safe environment for all (Warrner, et al., 2016). Organizations need to have clear policies of actions to take when encountering incivility in the workplace, and nursing staff have reported a desire for zero-tolerance policies to help combat incivility (Castronovo et al., 2016; Elmblad, Kodjebacheva, & Lebeck, 2014, Meires, 2018).

Significance to Nursing

UAP are a major contributor of healthcare who provide direct patient care and these types of jobs are expected to grow 11% from 2016 to 2026 ([U.S. BLS], 2018). UAP have reported psychosocial hazards in the workplace that have included bullying and poor teamwork (Walton & Rogers, 2017). However, the majority of research on UAP and bullying has focused on UAP in long-term care facilities. It is recommended that future research should survey UAP about their concern to reduce workplace hazards that includes a culture of incivility (Walton & Rogers, 2017). UAP need to be included in subject groups of studies investigating incivility, particularly in the acute care setting. Currently there are little data on how UAP are affected by incivility in hospitals. Examining this issue is important for DNP leaders because they can be influential with organizational change that promotes staff satisfaction, job satisfaction, patient safety, and a safe workplace environment. DNP leaders can assist with policy changes by understanding the impact incivility has on patient outcomes and staff satisfaction (Gaffney, DeMarco, Hofmeyer, Vessey, & Budin, 2012). DNP leaders create a culture of civility when they can define expectations for

civil behaviors and role-model respectful behavior (De Villers & Cohn, 2017). When nurse leaders model civil behaviors, then they can advocate for a workplace free from incivility. Mutual respect and positive social norms are then enhanced as part of the organization's culture of teamwork and safe patient care.

Project Aims

This quality improvement (QI) project aims to: 1) Describe UAP experiences of incivility in the workplace at a large academic hospital in the Midwest using the Nursing Incivility Scale; and 2) Implement an incivility educational program to determine the effects of UAP's perception of uncivil behavior in the workplace at a large academic hospital in the Midwest. The Nursing Incivility Scale will be administered pre- and post-education to determine the effects of incivility training on UAP's perception of uncivil behavior in the workplace.

Literature Review and Synthesis

The Project Director of this QI project conducted a review of the literature to understand the gaps in the literature related to incivility and UAP, and to support the need for this project. Databases searched for this project were CINAHL Complete, PubMed, and GoogleScholar. Types of articles included primary research studies, systematic reviews, survey results, and expert commentary. Search terms included incivility, bullying, and unlicensed assistive personnel. Inclusion criteria included nurses, UAP, hospitals, and acute care. Exclusion criteria included nursing students, faculty, academia, and graduate nurses. No results were found in CINAHL Complete when using the three identified search terms. However, 75 articles were found when the search substituted the term nurse for unlicensed assistive personnel; and 196 articles were revealed when only the terms incivility and nurses were used. Again, no results were found using the original three identified terms in PubMed, but 42 results were discovered

when the term unlicensed assistive personnel was replaced with nurses. Since there is abundant literature concerning nursing incivility, the search was limited to the last 5 years, which narrowed the search to 158 articles. The search list was then reviewed for "perceived" or "perception" with the term incivility, which helped to narrow the search to 16 relevant articles. Google Scholar was not used as a primary search, only as a secondary search to confirm the articles found in the primary searches of CINAHL Complete and PubMed.

Multiple studies investigating incivility or bullying in healthcare have been documented in nursing research. These studies explore healthcare workers' perceptions of incivility, bullying, and lateral violence. However, the literature is overwhelmingly focused on nurses, particularly new nurse graduates, not UAP. Interventions to combat incivility include communication training, such as the TeamSTEPPS approach from the Agency for Healthcare Research and Quality that helps to improve communication and teamwork (Ceravolo, Schwartz, Foltz-Ramos, & Castner, 2012; Griffin, et al., 2014). While Griffin, et al. (2014) implemented the TeamSTEPPS approach with newly-licensed nurses and Ceravolo et al. (2012) used the same approach with experienced nurses, both sets of authors found a decrease in perceived incivility among nurses. Other studies of incivility have examined beyond perception, instead examined nurses' actual experiences when confronting incivility or bullying (Etienne, 2014; Gaffney, et al., 2012). In a study by Gaffney et al. (2012), ninety-nine nurses, both new and experienced, were asked to describe a personal bullying situation and how they responded to the situation. These nurses tended to attempt to reach a solution or escalate to a manager. Etienne (2014) asked nurses how often they experience certain negative behaviors. About half of the 95 respondents stated they have been bullied and educational programs were recommended to address bullying behaviors.

Several studies investigating the frequency of incivility have implemented training programs and education, including administering surveys before and after training (Ceravolo, et al., 2012; Lasater, et al., 2015; Warrner, et al., 2014). This training can be in the forms of workshops, classes, or programs. Purposeful training and education has shown to increase awareness of incivility and perceived decrease incidence of incivility (Ceravolo, et al., 2012; Griffin, et al., 2014; Lasater, et al., 2015; Warrner, et al, 2014). Dumont et al., (2012) suggested formal education as a means to decrease the frequency of horizontal violence. Elmblad, et al. (2014) also report that nurses believe hospitals should provide incivility training and education for all staff. Although learning from initial education can be sustained with refresher sessions (Lasater, et al., 2015), the research has shown little mention of any sustainability plans after initial incivility training or education. Warrner, et al. (2014) suggested that nurses need structured time to practice real-life scenarios. Similarly, Griffin, et al. (2014) trained nursing staff to use a technique called cognitive rehearsal. Cognitive rehearsal is an intervention to practice various ways to deal with uncivil situations when the situation occurs. They found that 96% of newly-licensed nurses reported they had witnessed lateral violence and 46% had personally experienced lateral violence. The newly-licensed nurses who used cognitive rehearsal techniques were able to stop acts of lateral violence in their workplace.

Nursing literature has extremely limited data regarding incivility among UAP. No studies have been identified on incivility among UAP in hospitals, but UAP perception of incivility in nursing homes has been investigated. UAP employed in nursing homes report an unsafe work environment that includes verbal and physical assaults from both residents and nurses (Walton & Rogers, 2017). UAP are mentioned in a horizontal violence report (Dumont, et al., 2012). The report was on a survey conducted by *Nursing2011* to identify the frequency nurses experience or

witness horizontal violence. UAP were only mentioned in the findings of this survey as part of a list of perpetrators of horizontal violence behaviors. UAP were scored as the third most frequent perpetrator of horizontal violence, with peer nurses as the most frequent perpetrator (Dumont, et al., 2012). If UAP are identified as perpetrators in nurse surveys on incivility, then they should be included more in incivility research.

There are numerous nursing articles and studies concerning incivility. Researchers have demonstrated that structured and purposeful education and training decreases perceived incivility among nursing staff (Ceravolo, et al., 2012; Dumont et al., 2012; Griffin et al., 2014; Lasater, et al., 2015; Warrner, et al., 2014). However, the nursing literature focuses on nurses' perception of incivility in the workplace. Thus, UAP perception of incivility in the workplace remains a mystery, specifically in hospital settings. This DNP project is needed because there is a lack of incivility research with UAP, who are also frontline healthcare providers and integral members of the healthcare team. Findings from this project can positively impact interprofessional teamwork, overall communication, and improve safe patient care.

Definitions

Unlicensed Assistive Personnel (UAP)

Unlicensed assistive personnel are the umbrella term used in the nursing literature that encompasses those individuals who serve in nursing assistant roles and are supervised by licensed professional nurses (NCSBN, 2016). The American Nurses Association (2012) defines UAP as a job class of individuals who assist with the activities of daily living of persons with physical and mental disabilities under the supervision of professional nurses. UAP work in various healthcare settings, such as hospitals, long-term care facilities, outpatient clinics, and in-home health (ANA, 2012). They assume various job titles, such nurse aide, patient care assistant,

patient care technician, health care assistant, or health care technician. They are instrumental members of the health care team who keep licensed registered nurses informed of changes in patients' conditions. They perform tasks such as obtaining vital signs, measuring intake and output, indwelling catheter care, emptying drains, CHG bathing, changing bed linens, ambulating patients, collecting urine and stool specimens, and turning patients. Many UAP perform point-of-care testing that includes finger-stick blood glucose, hemoccult analysis, and urine pH testing. Some are also trained to perform simple dressing changes, electrocardiogram testing, and phlebotomy (Ballard and Gould, 1997). UAP must be competent in use of equipment that includes total body lifts, beds, and gait belts. They are instrumental in preventing patient falls and hospital acquired pressure injuries (Sewill, Van Sell, S. & Kindred, 2010; Wagner, 2018). Often UAP are required to perform constant observation for suicidal patients, traumatic brain injury patients, confused patients, and those patients with behavioral health needs (Carr, 2013; Laws & Crawford, 2013; Russ, 2016). To document their actions and the patient condition, UAP need to possess basic computer knowledge to record this information in the electronic health record.

Incivility

Conceptually, incivility is behavior that lacks respect, is rude and mean-spirted. It can be viewed as a form of aggression and harassment that originates from a lack of mutual respect (Felblinger, 2008). Examples of incivility include name-calling, yelling, gossiping, spreading rumors, eye-rolling, sarcastic remarks, berating and interrupting others (Felblinger, 2008; Griffin, et al., 2014). Operationally, incivility creates a feeling of discord that can lead to poor collegial relationships. Griffin (2014) agrees that incivility leads to poor team performance.

Bullying

Conceptually, bullying is the act of belittling another person. Bullying is more deliberate than incivility and stems from aggression that usually has a target in mind and is habitual in nature (Felblinger, 2008; Meires, 2018). Operationally, bullying be derived from feelings of insecurity, and negatively affects the self-esteem of the person being bullied due to an imbalance of power, real or perceived. Bullying is a pattern of disruptive behavior over time, not just a one-time incident (Meires, 2018). Examples of bullying include telling jokes at a person's expense, belittling, verbal threats, criticizing, invasion of personal space, unfair patient assignments, and throwing objects (Meires, 2018).

Theoretical Framework

The Institute for Healthcare Improvement (IHI) Model guided the overall project (Langley, Moen, Nolan, Nolan, Norman, & Provost, 2009). The model has successfully been used by international healthcare organizations to improve outcomes and processes (IHI, 2018). It can support improvement efforts including introducing new services for an organization (Langley, et al., 2009). The Model for Improvement is a framework to guide improvement work and has two parts (Appendix A). The first part asks three questions: 1) What are we trying to accomplish?, 2) How will we know that a change is an improvement?, and 3) What change can we make that will result in improvement? (Langley, et al., 2009). The second part is the Plan-Do-Study-Act (PDSA) cycle; and the answers to these three questions define the result that something was improved (Langley, et al., 2009). Forming the right team is critical to a successful improvement process (IHI, 2018). Team members, or stakeholders, included the DNP project committee, the nurse manager of the float pool department, the float pool department educator,

and the health system's Director of Nursing Practice, Research, and Professional Development, and the health system's Chief Nursing Officer for Kansas City operations.

The steps of the model are to set aims, establish measures, and select changes, then use the PDSA cycle to test change (IHI, 2018). First step or aim of this project was to determine the effects of incivility training on UAP's perception of uncivil behavior in the workplace. The goal to reach the aim was providing UAP with incivility education by means of training classes. The measurement plan for this project measured perceived UAP incivility using the Nursing Incivility Scale. The change outcome of interest is a general UAP understanding of uncivil behavior in the workplace. The Plan-Do-Study-Act (PDSA) cycle illustrated and guided the testing change phase of this project (IHI, 2018).

The planning phase of the PDSA cycle consisted of contact with key stakeholders via written and verbal communication of the aims of the project, Internal Review Board (IRB) acceptance, development of the invitation to participate in the project, obtaining permission to use the Nursing Incivility Scale, and a plan for dissemination of the project findings with recommendations for future work in the organization. The plan for dissemination is to submit abstracts for poster or podium presentations to two organizations, Professional Nurse Educator Group and Academy of Medical-Surgical Nurses. The plan also consisted of developing the incivility training curriculum, objectives, and content. The doing phase of the PDSA cycle consisted of recruitment of project participants, incivility training sessions, administration of the Nursing Incivility Scale before and after the training to identified UAP, and periodic written updates to stakeholders of project progress. The third phase of the cycle consisted of studying and analyzing the results of the responses from the Nursing Incivility Scale implementation. Project participants were provided the opportunity to evaluate the incivility educational training.

The acting phase was determination of the effects of the incivility training on UAP's perception of uncivil behavior in the workplace.

Project Methods

Project Design

This is a quality improvement (QI) project to implement professional standards and to use a form of training to implement a change that can improve workplace behaviors (Langley, et al., 2009). This project used the Institute for Healthcare Improvement Model for Improvement to guide the overall project determining the effects of incivility training on UAP's perception of uncivil behavior in the workplace.

Protected Health Information and Project Approval

The QI project proposal was submitted to the University of Kansas Medical Center (KUMC) human subject committee for designation as a QI project as a determination of an intervention to implement professional standards. This DNP project was determined by the KUMC human subjects committee as a QI project (Appendix B). For this project, no physical risks, and no psychological or social risks were anticipated. There were no economic risks for participation in the project; and they were provided with refreshments during the incivility training sessions. There were no direct benefits to participating, other than the opportunity to learn about incivility. Potential participants were given detailed information about the project via email and department newsletter. No adverse events were anticipated; but if any events did occur, the KUMC IRB would have immediately been informed. Formal approval for the project was obtained from Dr. Rachel Pepper, Chief Nursing Officer for The University of Kansas Health System's Kansas City Operations (Appendix C). Dr. Jennifer Williams, Director of Nursing Practice, Research, and Professional Development supported the project (Appendix D).

Project Setting

This QI project occurred at the University of Kansas Health System's Department of Nursing Practice, Research, and Professional Development. The University of Kansas Health System (TUKHS) includes the University of Kansas Hospital (TUKH), an academic medical center located in Kansas City Kansas. TUKH is a recognized Magnet® facility designated by the American Nurses Credentialing Center and is the largest employer in Kansas City, Kansas (Wyandotte Economic Development Council, 2018).

Sample

A convenience sample of UAP was selected from inpatient UAP who are employed at TUKH. Specifically, they were selected from the hospital's current float pool department of 41 UAP. Float pool UAP comprise of patient care assistants who are credentialed certified nursing assistants, and nurse associates who are current nursing students enrolled in a baccalaureate degree nursing program. All 41 float pool UAP were invited to participate in the project. Float pool UAP were the selected sample because they fall under the same job code with the same job description, allowing for a homogenous group of healthcare providers with the same job duties across all in-patient units. Inclusion criteria consisted of float pool UAP employed at any status level: full time, part time, or as needed; and any job title: patient care assistant or nurse associate. Float pool UAP work in many acute-care inpatient areas, such as the adult acute-progressive and critical care units, the maternal and pediatric areas, and the inpatient psychiatric unit. Medical assistants in the ambulatory clinics and procedural areas were excluded to allow focus on the inpatient acute-care setting.

Data Collection Instrument

The Nursing Incivility Scale (NIS) was used as the survey instrument to collect data of perceived incivility among UAP before and after the incivility training classes (Appendix E). The instrument was developed by Dr. Ashley Guidroz to measure hospital nurses' experiences with incivility with physicians, coworkers, patients, and direct supervisors (Guidroz, Burnfield-Geimer, Clark, Schwetschenau, & Jex, 2010). The instrument has been used in multiple studies (Elmblad, et al., 2014; Lasater, et al., 2015; Warrner, et al., 2016) with documented validity (Guidroz, et al., 2010). The NIS has demonstrated acceptable convergent and discriminate validity and has good metric qualities that can be used by hospitals to assess incivility. Furthermore, the NIS can be used to assess baseline incivility. Then a targeted intervention can be implemented to address any concerns found in the baseline assessment, followed by re-administration of the instrument to determine if the perceived prevalence of incivility has declined (Guidroz, et al., 2010).

The NIS consists of 43 items using a 5-point Likert-style scale that allows respondents to choose how much they agree with each statement of uncivil behavior. The choices range from 1 equaling strongly disagree to 5 equaling strongly agree. The NIS is not meant to assess frequency of perceived uncivil behavior so respondents are not required to recall specific events of incivility (Guidroz, et al., 2010). The NIS requires approximately 10 minutes to complete and is written at a secondary level of education. The first part of the instrument inquires level of agreement to interactions of nine specific uncivil behaviors: 1) hospital employees raise their voices when they get frustrated, 2) people blame others for their mistakes or offenses, 3) basic disagreements turn into personal verbal attacks on other employees, 4) people make jokes about minority groups, 5) people make jokes about religious groups, 6) employees make inappropriate

remarks about one's race or gender, 7) some people take things without asking, 8) employees don't stick to an appropriate noise level, and 9) employees display offensive body language. The remaining 34 inquiries are levels of agreement to interactions with nurses, direct supervisors, physicians, and families and visitors of specific uncivil behaviors. Permission to use the Nursing Incivility Scale instrument was granted by Dr. Ashley Guidroz (Appendix F).

Date Collection Procedure

Prior to data collection the Project Director met with the float pool nurse manager and educator to seek allowance for their UAP to attend a training class if they wish to participate in the project. During this meeting, the Project Director reviewed the aims of the project, the projected incivility training content, and the NIS instrument. The float pool nurse manager fully supported the project by allowing any participants to attend a training class at their paid hourly rate. The float pool educator also verbalized support of the project.

The NIS survey was created using the online tool, SurveyMonkey®. SurveyMonkey® software survey tool is available to the Department of Nursing Practice, Research, and Professional Development at TUKHS. SurveyMonkey® designs, sends, and analyzes surveys in real time with the ability to download visual data and export data into Statistical Package for the Social Science (n.d., surveymonkey.com).

An initial invitation to participate e-mail was sent to the UAP who are employed to work in the float pool department (Appendix G). E-mail invitation included the purpose of the project, the SurveyMonkey® link to the NIS online survey, how the project will help UAP, agreement to participate, reminder that responses are anonymous and participation is voluntary, estimated time to complete the survey, information to enroll in an incivility training session, opportunity to complete the NIS online survey approximately three weeks after the incivility training, and

Project Director's contact information. As a QI project, there was no need to obtain informed consent. The float pool unit educator included the information to participate in the project in the department's weekly newsletter. Personal contact via unit rounding on both day and night shifts was also implemented to help with recruitment of potential participants. During this personal rounding, a flyer was distributed with invitation information to participate in the project (Appendix H). Two weeks later a reminder invitation e-mail was sent that included all the information in the initial e-mail, plus a thank-you to those who had completed the NIS online survey and reminder to enroll in an incivility training session, if they had not already done so. The last invitation e-mail was sent to the participants approximately one month after the initial e-mail with the same information.

Incivility training classes were offered beginning one month after the initial invitation e-mail was sent. Dates for the educational programs were based on availability from the Project Director's work schedule. Classrooms were scheduled through the organization's Teaching and Learning Technologies Media department. UAP were given a choice of pre-determined class days to attend an incivility training class. A flyer with dates, times, and classroom locations for the classes was placed in the hospital's nursing resource room and e-mailed to the float pool UAP. Enrollment information was included on the flyer, and enrollment was conducted via e-mail registration. Participants selected from a list of days they would attend a training class, and e-mailed their choices to the Project Director. For the educational program, a series of seven classes were held over a 4-week period. Classes were 2 hours in length and all classes began at 8:00 a.m. Class content included objectives, definitions of key terms (incivility, bullying, workplace violence), and application of Goleman's Emotional Competence Framework (Goleman, 1998) (Appendix I). Teaching strategies included lecture, discussion, story-telling,

and videos. The class was formatted with a PowerPoint presentation. Participants were given the opportunity to evaluate the speaker and class immediately following the end of class (Appendix J). A copy of the incivility training class objectives and class content was provided to the float pool nurse manager before implementation of the classes.

Twenty UAP participated in the pre-training class NIS survey. However, only thirteen UAP enrolled in an incivility training class. Four of the thirteen class enrollees were not able to attend a class due to unexpected illness or child care issues, thus withdrawing from the project. One class was cancelled due to inclement weather, but rescheduled at a time the participants could attend. Via a series of three e-mails, the NIS instrument was re-administered to the nine class attendees approximately 4 weeks after their class attendance based on when they completed the incivility training class. The e-mail sent to the attendees included the SurveyMonkey® link to complete the NIS online survey post incivility training class.

Data Analysis

The project was evaluated by compiling and analyzing the findings from the Survey Monkey® questionnaire results pre- and post-implementation of the incivility training. The results of the post-implementation survey compared perceived incivility to the pre-training survey results. The Project Director conducted the analysis using the Statistical Package for the Social Science (SPSS) data exports and visual imports in the SurveyMonkey® software. Personnel from the University's Department of Biostatistics Student Tutoring Lab were consulted to determine any use of appropriate statistical tests to ensure the integrity and veracity of the analysis.

Twenty participants responded to the pre-incivility training NIS online survey; however, 19 completed the NIS instrument and some respondents skipped answering some of the statements. All twenty participants responded to every demographic question. 95% (19) of the

participants were female, and 5% (1) male. 65% (13) of the participants were between the ages of 20 and 30 years, 20% (4) were between 31 and 39 years of age, and 15% (3) were between 41 and 50 years of age. 40% (8) of the participants self-identified as black/African ethnic group, 15% (3) self-identified as white/European group, 15% (3) self-identified as Hispanic/Latino group, 5% (1) self-identified as Pacific Islander, and 5% (1) self-identified as American Indian/Alaska Native. 10% (2) self-identified as biracial/multiracial and 10% (2) preferred to not answer the racial identity question. Of these same twenty participants, 20% (4) have a high school education and 30% (6) have technical school education. 25% (5) have an associate degree, while 10% (2) have a bachelor's degree. 15% (3) responded "other" education level. Of these twenty participants, 45% (9) have been employed at TUKH between 1 and 3 years, 30% (6) have been employed 4 to 6 years at TUKH, and 10% (2) have been employed at TUKH for 7 to 10 years. 15% (3) have been with the organization for less than 1 year. Finally, 35% (7) of these twenty respondents have been Certified Nursing Assistants (CNAs) between 1 to 3 years, 30% (6) have been CNAs for 4 to 6 years, and 15% (3) have been CNAs for 7 to 10 years. 20% (4) have been CNAs for more than 10 years. The following table summarizes the percentage of respondents who agreed or strongly agreed to each statement of the NIS before implementation of the incivility training. Because some participants did not respond to every statement of the NIS, the number of respondents for each statement is included in the table.

Table 1: Agreement to Nursing Incivility Scale Statements Pre-Training Class

Nursing Incivility Scale Statement	Agree/Strongly Agree Pre-Incivility Training Class	n
Hospital employees raise their voices when they get frustrated.	33.34%	18
People blame others for their mistakes or offenses.	44.44%	18
Basic disagreements turn into personal verbal attacks on other employees.	29.41%	17
People make jokes about minority groups.	35.29%	17

People make jokes about religious groups.	5.56%	18
Employees make inappropriate remarks about one's race or gender.	27.28%	18
Some people take things without asking.	5.88%	17
Employees don't stick to an appropriate noise level (e.g., talking too loudly).	50.00%	18
Employees display offensive body language (e.g., crossed arms, body posture).	42.11%	19
Nurses on my unit…		
…argue with each other frequently.	5.88%	17
…have violent outbursts or heated arguments in the workplace.	5.88%	17
…scream at other employees.	11.11%	18
…gossip about one another.	41.17%	17
…gossip about their supervisor at work.	47.06%	17
…bad-mouth others in the workplace.	47.37%	19
…spread bad rumors around here.	29.41%	17
…make little contribution to a project but expect to receive credit for working on it.	22.23%	18
…claim credit for my work.	26.31%	19
…take credit for work they did not do.	26.31%	19
My direct supervisor…		
…is verbally abusive.	0%	16
…yells at me about matters that are not important.	6.25%	16
…shouts or yells at me for making mistakes.	0%	18
…takes his/her feelings out on me (e.g., stress, anger, "blowing off steam).	11.11%	18
…does not respond to my concerns in a timely manner.	36.85%	19
…is condescending to me.	31.25%	16
…factors gossip and personal information into personnel decisions.	15.79%	19
Some physicians are verbally abusive.	22.22%	18
Physicians yell at nurses about matters that are not important.	17.64%	17
Physicians shout or yell at me for making mistakes.	5.88%	17
Physicians take their feelings out on me (e.g., stress, anger, "blowing off steam").	5.88%	17
Physicians do not respond to my concerns in a timely manner.	11.76%	17
I am treated as though my time is not important.	29.41%	17
Physicians are condescending to me.	15.79%	19

Patients/visitors…		
…do not trust the information I give them and ask to speak with someone in higher authority.	27.78%	18
…treat nurses as if they were inferior or stupid.	55.55%	18
…show that they are irritated or impatient.	89.47%	19
…criticize my job performance.	27.78%	18
…make personal verbal attacks against me.	29.41%	17
…pose unreasonable demands.	21.05%	19
…have taken out their frustration on nurses.	94.11%	17
…make insulting comments to nurses.	77.78%	18
…treat nurses as if they were inferior or stupid.	55.55%	18
…show that they are irritated or impatient.	89.47%	19

Eight of the nine participants who attended an incivility training class completed the NIS instrument after a training class. However, one participant did not respond to the physician behavior domain statements. Gender and racial identity were the demographic data captured post incivility training classes for all nine participants. Eight females and one male attended the incivility training classes. The racial identity of the nine class participants were 45% (4) black/African, 33% (3) white/European, 11% (1) Hispanic/Latino, and 11% (1) American Indian/Alaska native. Only four of the nine class participants responded to other demographic data questions. Three of these four respondents were between the ages of 20 and 30 years. The highest level of education for two of these four respondents was technical school, with one high school graduate and one holding a bachelor's degree. The following table summarizes the percentage of the eight respondents who agreed or strongly agreed to each statement of the NIS.

Table 2: Agreement to Nursing Incivility Scale Statements Post-Training Class

Nursing Incivility Scale Statement	Agree/Strongly Agree Post-training
Hospital employees raise their voices when they get frustrated.	37.50%
People blame others for their mistakes or offenses.	50.00%
Basic disagreements turn into personal verbal attacks on other employees.	50.00%
People make jokes about minority groups.	50.00%
People make jokes about religious groups.	25.00%

Employees make inappropriate remarks about one's race or gender.	25.00%
Some people take things without asking.	50.00%
Employees don't stick to an appropriate noise level (e.g., talking too loudly).	37.50%
Employees display offensive body language (e.g., crossed arms, body posture).	50.00%
Nurses on my unit…	
…argue with each other frequently.	25.00%
…have violent outbursts or heated arguments in the workplace.	12.50%
…scream at other employees.	25.00%
…gossip about one another.	75.00%
…gossip about their supervisor at work.	37.50%
…bad-mouth others in the workplace.	75.00%
…spread bad rumors around here.	25.00%
…make little contribution to a project but expect to receive credit for working on it.	25.00%
…claim credit for my work.	12.50%
…take credit for work they did not do.	25.00%
My direct supervisor…	
…is verbally abusive.	12.50%
…yells at me about matters that are not important.	12.50%
…shouts or yells at me for making mistakes.	12.50%
…takes his/her feelings out on me (e.g., stress, anger, "blowing off steam).	12.50%
…does not respond to my concerns in a timely manner.	25.00%
…is condescending to me.	12.50%
…factors gossip and personal information into personnel decisions.	25.00%
Some physicians are verbally abusive.	28.57%
Physicians yell at nurses about matters that are not important.	14.29%
Physicians shout or yell at me for making mistakes.	14.29%
Physicians take their feelings out on me (e.g., stress, anger, "blowing off steam").	14.29%
Physicians do not respond to my concerns in a timely manner.	14.29%
I am treated as though my time is not important.	14.29%
Physicians are condescending to me.	14.29%
Patients/visitors…	
…do not trust the information I give them and ask to speak with someone in higher authority.	25.00%
...are condescending to me.	37.50%
…make comments that question the competence of nurses.	50.00%
…criticize my job performance.	25.25%

…make personal verbal attacks against me.	12.50%
…pose unreasonable demands.	25.00%
…have taken out their frustration on nurses.	87.50%
…make insulting comments to nurses.	75.00%
…treat nurses as if they were inferior or stupid.	37.50%
…show that they are irritated or impatient.	87.50%

It is difficult to calculate statistical significance difference due to the very small sample size. Since the sample size was very small, only large differences between the pre-class responses and post-class responses would likely be significant. Also, respondents were not able to be matched pre-class and post-class due to the wide unequal number of pre-class and post-class respondents; and attempting to match the respondents could obstruct anonymity of the participants. Therefore, data analysis was based on the weighted averages of the pre-class and post-class responses. Weighted average charts the average rating for each answer choice and was used since the NIS uses Likert style levels of disagreement and agreement questions to statements of perceived incivility. The lower the weighted average indicates more disagreement to the statement. The higher the weighted average indicates more agreement to the statement.

The supervisor behavior domain was the only domain of the NIS where the mean weighted average was higher in the pre-class responses (2.15) than in the post-class responses (1.95). The mean weighted average of the uncivil behavior domain responses was 2.73 pre-class and 3.05 post-class. The mean weighted average of the nurse behavior domain responses slightly changed from pre-class (2.73) to post-class (2.89). The mean weighted average of the physician behavior domain responses also slightly changed from pre-class (2.46) to post-class (2.57). Finally, the mean weighted average of the patient and visitor domain responses was 2.46 pre-class and 3.08 post-class. The following table summarizes the weighted average to each statement.

Table 3: Pre-Class and Post-Class Weighted Averages

Nursing Incivility Scale Statement	Pre-Class Weighted Avg	Post-Class Weighted Avg
Hospital employees raise their voices when they get frustrated.	2.78	3.83
People blame others for their mistakes or offenses.	3.28	3.50
Basic disagreements turn into personal verbal attacks on other employees.	2.71	3.25
People make jokes about minority groups.	2.65	3.25
People make jokes about religious groups.	2.17	2.75
Employees make inappropriate remarks about one's race or gender.	2.61	2.63
Some people take things without asking.	2.35	2.88
Employees don't stick to an appropriate noise level (e.g., talking too loudly).	3.06	2.88
Employees display offensive body language (e.g., crossed arms, body posture).	2.95	3.00
Nurses on my unit…		
…argue with each other frequently.	2.12	2.25
…have violent outbursts or heated arguments in the workplace.	2.00	2.13
…scream at other employees.	2.11	2.38
…gossip about one another.	3.53	3.88
…gossip about their supervisor at work.	3.41	3.50
…bad-mouth others in the workplace.	3.47	3.88
…spread bad rumors around here.	2.88	3.00
…make little contribution to a project but expect to receive credit for working on it.	2.56	2.75
…claim credit for my work.	2.58	2.63
…take credit for work they did not do.	2.63	2.50
My direct supervisor…		
…is verbally abusive.	1.88	1.88
…yells at me about matters that are not important.	1.81	1.75
…shouts or yells at me for making mistakes.	1.78	1.63
…takes his/her feelings out on me (e.g., stress, anger, "blowing off steam).	1.94	1.75
…does not respond to my concerns in a timely manner.	2.84	2.50
…is condescending to me.	2.56	1.88
…factors gossip and personal information into personnel decisions.	2.26	2.25
Some physicians are verbally abusive.	2.61	3.29

Physicians yell at nurses about matters that are not important.	2.47	2.71
Physicians shout or yell at me for making mistakes.	2.24	2.43
Physicians take their feelings out on me (e.g., stress, anger, "blowing off steam").	2.12	2.43
Physicians do not respond to my concerns in a timely manner.	2.41	2.43
I am treated as though my time is not important.	2.76	2.43
Physicians are condescending to me.	2.58	2.29
Patients/visitors…		
…do not trust the information I give them and ask to speak with someone in higher authority.	2.17	2.50
…treat nurses as if they were inferior or stupid.	2.22	2.63
…show that they are irritated or impatient.	2.35	2.88
…criticize my job performance.	2.06	2.50
…make personal verbal attacks against me.	2.00	2.38
…pose unreasonable demands.	2.00	2.75
…have taken out their frustration on nurses.	3.06	4.13
…make insulting comments to nurses.	2.89	3.88
…treat nurses as if they were inferior or stupid.	2.67	3.13
…show that they are irritated or impatient.	3.11	4.00

Discussion

UAP perceive incivility in their workplace. The effects of incivility training suggest a slightly better understanding and general awareness of workplace incivility. After attending an incivility training class, UAP were more likely to agree to the uncivil behavior statements of the first domain of the NIS. There was more agreement to perceiving that "employees raise their voices when they get frustrated" and "employees display offensive body language" (Guidroz, et al., 2010). There was also greater agreement that "people blame others for their mistakes or offenses" and "basic disagreements turn into personal verbal attacks on other employees" (Guidroz, et al, 2010). Unfortunately, UAP do perceive employees joke about minority and religious groups (Guidroz, et al., 2010). Interestingly, there was more disagreement to the statement, "employees don't stick to an appropriate noise level" (Guidroz, et al., 2010) after the

incivility training classes. Although shift work data was not collected, it is possible that perceived incivility may differ between night shift and day shift personnel based on varying noise levels and different staffing matrices between the two shifts.

Those who attended an incivility training class also agreed more to uncivil behaviors among nurses. UAP perceive that nurses on their units, "argue with each other frequently, have violent outbursts or heated arguments in the workplace, scream at other employees, gossip about one another, gossip about their supervisor, bad-mouth others, and spread bad rumors" (Guidroz, et al., 2010). This perception mirrors that of perceived incivility among registered nurses (Griffin & Clark, 2014; Lasater, et al., 2015; Taylor, 2016; Warrner, et al., 2016). Nurse-to-nurse incivility is well-documented and further investigation of UAP-to-UAP incivility is needed.

It is encouraging that UAP perceive the most civility among their direct supervisors. UAP perception of incivility from their direct supervisors revealed little change after the incivility training classes. UAP mainly disagree that their direct supervisors are "verbally abusive, yells…about matters that are not important, shouts or yells…for making mistakes" and "takes his/her feelings out on me" (Guidroz, et al., 2010). UAP perception that their direct supervisor "does not respond to my concerns in a timely manner" remained unchanged after attending an incivility training class (Guidroz et al., 2010). UAP perceived less condescending behavior from their direct supervisors after attending an incivility training class; however, they agreed more that direct supervisors factor "gossip and personal information into personnel decisions" (Guidroz, et al., 2010).

The greatest uncivil behaviors UAP perceive from physicians are those that are verbally abusive and those who "yell at nurses about matters that are not important" (Guidroz, et al., 2010). After attending an incivility training class, UAP still agreed that physicians "shout or yell

at me for making mistakes," "take their feelings out on me," and "do not respond to my concerns in a timely manner" (Guidroz, et al., 2010). After incivility training classes, UAP agreed somewhat less that physicians treat them as though their time is not important and are condescending (Guidroz, et al., 2010).

UAP perceive incivility from patients and families that is directed to nurses. There was high agreement to the statements, that patients and visitors "have taken out their frustration on nurses" and "make insulting comments to nurses" (Guidroz, et al., 2010). UAP agreed more to these two statements after attending an incivility training class. Furthermore, UAP also showed higher agreement to the statements that patients and visitors "make comments that question the competence of nurses" and "treat nurses as if they were inferior or stupid" (Guidroz, et al., 2010). UAP also perceive direct uncivil behavior from patients and visitors. After attending an incivility training class, UAP agree more that patients and visitors "do not trust the information I give them and ask to speak with someone in higher authority," "are condescending to me," "criticize my job performance," "make personal verbal attacks against me," and "pose unreasonable demands (Guidroz, et al., 2010). Therefore, it is not surprising that there was high UAP agreement that patients and visitors "show that they are irritated or impatient" (Guidroz, et al., 2010). Not only do UAP perceive incivility directed towards them, but also perceive uncivil behavior that is directed at others. Further incivility education and training to address uncivil behavior could equip UAP to manage situations of perceived uncivil behavior.

Limitations

There are several limitations to this project. The small sample size cannot be generalized to all UAP across the organization and this project only included UAP representing one department. It is difficult to assume if a sample using one or two in-patient units would yield

similar results. Sample size would need to be increased and paired analysis performed to detect any statistical significant difference between the responses of the pre-class participants and post-class participants. A larger sample of UAP representing multiple units across all inpatient areas may yield different findings. Furthermore, this project did not address UAP in ambulatory or out-patient settings. Another limitation is the incomplete data where some participants did not respond to all statements of the NIS survey. Although up to twenty UAP participated in the pre-training class NIS survey, only 9 attended an incivility training class. Some participants who completed the pre-training class NIS survey intended to attend a training class, but withdrew their participation due to personal or family issues and illness. Thus, the inequality of the number of participants before implementation of the training class compared to the lower number of participants after the training class increases difficulty in reaching complete data analysis. Equal participation before and after the incivility training classes could increase the veracity of the findings. Demographic data did not assess day shift or night shift personnel. Also, a 2-hour incivility training class was offered. A longer training class that includes simulation using standardized patients may have different or greater effects on perceived workplace incivility. Overall, incivility training classes seem to make UAP more aware of incivility in the workplace, at least giving them a better understanding of uncivil behavior. Because of this awareness, further education on the effects of incivility and how to address it can help to create safer environments for patients and staff.

Implications

There are several implications of this project, including implications for practice and education. Uncivil behavior among healthcare providers creates unsafe environments which can have harmful effects on patients (Felblinger, 2008; Laschinger, 2014; Meires, 2018; and

Warrner, et al., 2016). Organizations need policies in place that promote healthy working relationships. For example, hospitals have had employees sign behavior contracts, such as Codes of Conduct to promote civility in the workplace (Nikstaitis & Simko, 2014). Those in leadership-titled roles do not necessarily have to be the ones to write civility policy. Frontline healthcare providers, including nurses and UAP, should be allowed to participate in creating polices. When frontline staff is directly involved in the policy-writing, then they will feel a greater ownership and accountability for workplace safety. Leadership and all members of the healthcare team must be committed to work together to create a culture of dignity and respect. There are strategies that nurse leaders can implement to reduce incivility. These strategies include direct observation of staff of how they interact with each other, conducting surveys, setting clear expectations of acceptable behaviors, and educating staff in meeting venues of appropriate behavior (Clarke, 2019). Any organizational endeavors to combat incivility must include all healthcare providers, not just nurses, as well as support personnel who also interact with patients, such as transporters, dietary aides, and housekeepers.

The American Nurses Association (ANA) addresses this issue in a position paper on incivility, bullying, and workplace violence. The ANA recommends employers need to ensure that organizational values and goals align with a culture of respect, establish zero-tolerance policies, and provide support when staff feel threatened (ANA, 2015). The ANA also recommends that organizations have available education that includes conflict resolution, respectful communication, and sessions that define incivility, bullying and workplace violence (ANA, 2015). New employee orientation is a great avenue to introduce the importance of a safe working environment that is respectful and free from incivility. Orientation provides a great opportunity for an organization to immediately set the tone that disrespectful behavior will not be

tolerated and can detail the consequences if policy is not followed (ANA, 2015; Nikstaitis & Simko, 2014). Education needs to be ongoing as part of employees' onboarding and competency processes.

Incivility training classes for UAP need to continue that includes strategies to manage uncivil behavior. Training can include emotional intelligence as a means to address incivility. This project implemented incivility training for a small pool of specific UAP and assessed their perception of incivility in the workplace before and after the training. More investigated work is needed to better understand UAP perception of incivility in the workplace and the effects of education on their perception of uncivil behavior. The perception of incivility of UAP in other acute care areas can be surveyed, such as those who work in critical care or maternal child areas. It would also be interesting to discover perceived incivility of UAP who work in behavioral health care or in ambulatory settings.

Conclusion

This project helps to pioneer future investigation regarding UAP perception of incivility in the workplace. Unfortunately, incivility research still focuses on nurses, ignoring UAP who also provide direct patient care. It is still relatively unknown how UAP perceive incivility in hospitals. Incivility continues to be a problem in hospitals; therefore, more work is needed to understand UAP perception of incivility, including how incivility training affects their perception. Increasing organizational knowledge of UAP perception of incivility will help to fill this gap in the nursing literature. UAP are integral members of the healthcare team and are vital to promoting a healthy work environment that is free from incivility. Nursing leaders must advocate for civil work environments to ensure high staff morale, staff satisfaction, patient satisfaction, and safe patient care.

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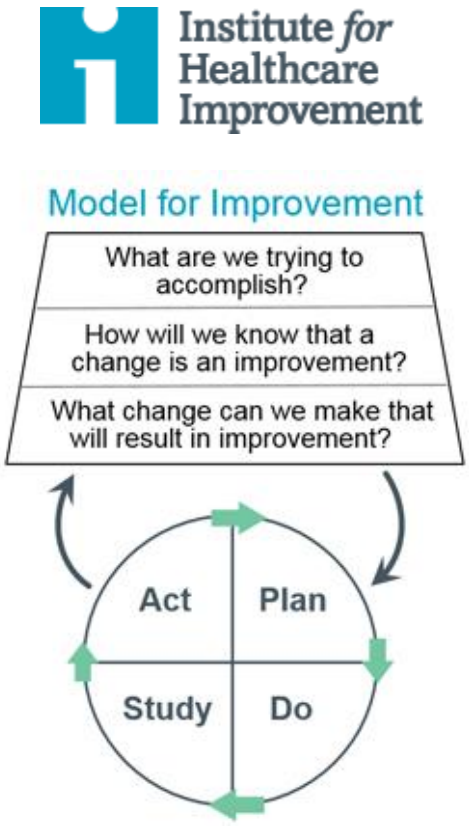
Appendix A

Institute for Healthcare Improvement

Model for Improvement



Source: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Appendix B

Determination as a QI Project

To:

Jerrihlyn McGee; Naomi King

Attachments:

Attached Image

Monday, October 01, 2018 10:10 AM

Retention Policy: UKH Default Folder 3 Year Delete (3 Years) Expires: 9/30/2021

Thank you for submitting your Quality Improvement Determination request. The request meets the criteria for QI project and is approved. In the attachment please find the signed approval. No IRB oversite is required. Best of luck and continued success in this worthwhile endeavor.

Kris Whitaker
Sr.Compliance Specialist
Office of Compliance/HRPP
Ext. 8-1655
Office hours: 7:30 to 1:30 M-F
kwhitaker@kumc.edu
Physical address:
4330 Shawnee Mission Parkway, Suite 3170
Kansas City, KS 66205

"*Partnering with our investigators to ensure safe and ethical research"*

Appendix C

Leadership Approval

Naomi King

From: Rachel Pepper
Sent: Tuesday, September 25, 2018 1:18 PM
To: Naomi King
Subject: RE: Leadership Approval for DNP Project

Naomi,

This sounds like a meaningful and important project. I look forward to hearing your results.

Thanks, Rachel

From: Naomi King
Sent: Tuesday, September 25, 2018 12:33 PM
To: Rachel Pepper <RPEPPER@kumc.edu>
Subject: Leadership Approval for DNP Project

Date: September 25, 2018

To: Rachel Pepper, DNP, RN, NEA-BC
Chief Nursing Officer, Kansas City Operations
The University of Kansas Health System

Dear Dr. Pepper,

I am currently a Doctorate of Nursing Practice (DNP) student at the University of Kansas School of Nursing. For my DNP project, I am exploring the effects of incivility training on UAP's perception of uncivil behavior in the workplace. I believe this quality improvement project will benefit the organization in providing a safer workplace for staff and thus, enhancing patient care. I am seeking leadership approval and support for this QI project. This project illustrates the mission of the organization in helping the organization's people provide patient-centered care in a safe environment. I am looking forward to implementing this QI project and will share my findings and recommendations with hospital leadership.

Warm regards,

Naomi King, MS, RN, CMSRN
DNP Student

Appendix D

Project Support

Naomi King

From: Jennifer Williams
Sent: Tuesday, November 27, 2018 2:43 PM
To: Naomi King
Subject: RE: DNP Project Support

Hi Naomi,

This is fantastic progress and I am very excited to see the final product and your plans for future implementation.

Warm regards,

Jennifer

From: Naomi King
Sent: Monday, November 26, 2018 4:52 PM
To: Jennifer Williams <jwilliams28@kumc.edu>
Subject: DNP Project Support

Dear Dr. Williams,

Thank you for your support of my DNP project. Just a brief update of my progress:

- Sept 25 – DNP project approved by KU SON.
- Oct 1 – KUMC IRB approval as QI project received.
- Oct 24 – Permission granted from Dr. Guidroz to use Nursing Incivility Scale.
- Oct 26 to present – ongoing data collection: email invitations sent to float pool PCAs to participate in my project by completing NIS survey pre and post a 2-hour incivility training class. Classes being held this week and in December. Seeking up to 20 participants, 11 have been recruited to date.

Warm regards,

Naomi King, MS, RN, CMSRN
DNP Student
University of Kansas School of Nursing

From: Naomi King
Sent: Tuesday, September 25, 2018 1:06 PM
To: Jennifer Williams <jwilliams28@kumc.edu>
Subject: DNP Project Support

To: Jennifer Williams, PhD, RN, ACNS-BC
Director of Nursing Research, Education & Development
The University of Kansas Health System

Dear Dr. Williams,

I am currently a Doctorate of Nursing Practice (DNP) student at the University of Kansas School of Nursing. For my DNP project, I am exploring the effects of incivility training on UAP's perception of uncivil behavior in the workplace. I will be using the Nursing Incivility Scale (NIS) to assess UAP's perception of incivility. I am seeking your support for this QI project; and asking for permission to email the NIS instrument via electronic survey to the hospital's Patient Care Assistants who work in the float pool department. I believe this quality improvement project will benefit the organization in providing a safer workplace for staff and thus, enhancing patient care.

Warm regards,

Naomi King, MS, RN, CMSRN
DNP Student
University of Kansas School of Nursing

Appendix E

Nursing Incivility Scale

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

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

---

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

1. Hospital employees raise their voices when they get frustrated.
2. People blame others for their mistakes or offenses.
3. Basic disagreements turn into personal verbal attacks on other employees.
4. People make jokes about minority groups.
5. People make jokes about religious groups.
6. Employees make inappropriate remarks about one's race or gender.
7. Some people take things without asking.
8. Employees don't stick to an appropriate noise level (e.g. talking to loudly).
9. Employees display offensive body language (e.g., crossed arms, body posture).

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

1. …argue with each other frequently.
2. …have violent outbursts or heated arguments in the workplace.
3. …scream at other employees.
4. …gossip about one another.
5. …gossip about their supervisor at work.
6. …bad-mouth others in the workplace.
7. …spread bad rumors around here.
8. …make little contribution to a project but expect to receive credit for working on it.
9. …claim credit for my work.
10. …take credit for work they did not do.

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

1. …is verbally abusive.
2. …yells at me about matters that are not important.

3. …shouts or yells at me for making mistakes.
4. …takes his/her feelings out on me (e.g., stress, anger, "blowing off steam").
5. …does not respond to my concerns in a timely manner.
6. …is condescending to me.
7. …factors gossip and personal information into personnel decisions.

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

1. Some physicians are verbally abusive.
2. Physicians yell at nurses about matters that are not important.
3. Physicians shout or yell at me for making mistakes.
4. Physicians take their feelings out on me (e.g., stress, anger, "blowing off steam").
5. Physicians do not respond to my concerns in a timely manner.
6. I am treated as though my time is not important.
7. Physicians are condescending to me.

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

1. …do not trust the information I give them and ask to speak with someone of higher authority.
2. …are condescending to me.
3. …make comments that question the competence of nurses.
4. …criticize my job performance.
5. …make personal verbal attacks against me.
6. …pose unreasonable demands.
7. …have taken out their frustrations on nurses.
8. …make insulting comments to nurses.
9. …treat nurses as if they were inferior or stupid.
10. …show that they are irritated or impatient.

Guidroz, A., Burnfield-Geimer, J., Clark, O., Schwetschenau, H., Jex, S. (2010). The nursing incivility scale: Development and validation of an occupation-specific measurement. *Journal of Nursing Measurement, 18*(3), 176-201.

Appendix F

Permission to Use Nursing Incivility Scale

Secured Message Reply ReplyAll Forward

From: Ashley Guidroz <guidroza@trinity-health.org>

To: "nking@kumc.edu" <nking@kumc.edu>

Date: 10/27/2018 04:20:43 PM CDT

Subject: Re: [External] RE: [secure] Permission to use Nursing Incivility Scale

Good Morning Naomi! No problem at all! My organizations email has right filters so it limits acc essing links from outside our firewall. Thank you for sending the original ask. I hope the NIS is u seful to you in your study of incivility with unlicensed assistive personnel. Please let me know if you need anything else from me. Best of luck in your research!

Ashley

From: Naomi King <nking@kumc.edu>
Date: October 26, 2018 at 16:47:11 EDT
To: Ashley Guidroz <guidroza@trinity-health.org>
Subject: [External] RE: [secure] Permission to use Nursing Incivility Scale

Warning: This email originated from the Internet!
DO NOT CLICK links if the sender is unknown, and NEVER provide your password.

Thank you, Dr. Guidroz. I am sorry for the difficulty my emails had reaching you. Below is a copy of the email I was trying to send. I appreciate your time and correspondence.

Dear Dr. Guidroz,
My name is Naomi King and I am currently pursuing my Doctorate of Nursing Practice (DNP) at the University of Kansas School of Nursing. I am writing to ask your permission to use your Nursing Incivility Scale for my DNP project. I am implementing a project at an academic medical center regarding incivility among unlicensed assistive personnel. I look forward to hearing from you at your earliest convenience.
Thank you,
Naomi King, MS, RN, CMSRN
nking@kumc.edu
913-588-4759

----------Original Message:

From: Ashley Guidroz <guidroza@trinity-health.org>
To: Naomi King <nking@kumc.edu>
Date: 10/24/2018 08:57:52 AM CDT
Subject: RE: [secure] Permission to use Nursing Incivility Scale

Naomi,

I cannot open these messages you keep sending me as they are encrypted and my company will not allow me to open. If you are seeking permission to use the NIS, please accept this email as permission to use the NIS for research purposes only.

Thank you,

Ashley

From: Naomi King [mailto:nking@kumc.edu]
Sent: Tuesday, October 23, 2018 5:46 PM
To: Ashley Guidroz
Subject: [External] [secure] Permission to use Nursing Incivility Scale

Appendix G

Invitation to Participate E-mail

Dear Gold Standard Patient Care Assistants,

I am inviting you to participate in a quality improvement project looking at how patient care assistants view incivility in the hospital setting. Incivility is behavior that lacks respect, is rude and mean-spirted. Examples include name-calling, yelling, gossiping, spreading rumors, eye-rolling, sarcastic remarks, and berating others. The purpose of this project is to understand how you see incivility where you work. It is my hope this project will help you with better teamwork and improve your communication skills. This project is being done as part of my requirement for the Doctorate in Nursing Practice degree program at the University of Kansas Medical Center. I will be offering classes on incivility training as part of this project.

To participate in my project:

- you will take the survey by clicking on the link here, https://www.surveymonkey.com/r/MLDR6NW
- attend one of my incivility training classes
- then take the survey again about 3 weeks after the class

The survey should only take approximately 5-10 minutes to complete. All information that you provide is not identifiable. Please feel free to contact me and let me know if you have any questions. (nking@kumc.edu, 913.588.4759)

After you have taken the survey, please email me back which training class you will attend. All class times are 0800-1000 and breakfast will be served. Here are the options:

- Monday, Nov 26
- Tuesday, Nov 27
- Wed, Nov 28
- Thursday, Nov 29
- Friday, Nov 30
- Monday, Dec 3
- Wed, Dec 5
- Thursday, Dec 6
- Friday, Dec 7

Thank you for your time.
Sincerely,
Naomi King, MS, RN, CMSRN
nking@kumc.edu
913.588.4759

Appendix H

Recruitment Flyer

Dear Float Pool PCAs,

I am inviting you to participate in a quality improvement project looking at how patient care assistants view incivility in the hospital setting.

The purpose of this project is to understand how you see incivility where you work. It is my hope this project will help you with better teamwork and improve your communication skills. I will be offering classes on incivility training as part of this project.

To participate in my project:

1. **you will take the survey by going on the link here,** https://www.surveymonkey.com/r/MLDR6NW
2. **attend one of my incivility training classes**
3. **then take the survey again about 3 weeks after the class**

The survey should only take about 5-10 minutes to complete. All information you provide will not be able to identify you. Please feel free to contact me and let me know if you have any questions. (nking@kumc.edu, 913.588.4759)

After you have taken the survey, please email me back which training class you will attend. All class times are 0800-1000 and breakfast will be provided. Here are the options:

- **Monday, Nov 26**
- **Tuesday, Nov 27**
- **Wed, Nov 28**
- **Thursday, Nov 29**
- **Friday, Nov 30**
- **Monday, Dec 3 (09:15-11:15)**
- **Wed, Dec 5**
- **Thursday, Dec 6**
- **Friday, Dec 7**
- **Monday, Dec 17**
- **Wed, Dec 19**
- **Thursday, Dec 20**
- **Friday, Dec 21**

This is a great opportunity to learn about incivility and how to deal with it in the workplace.

Thank you!
Naomi King, RN

Appendix I

Incivility Training Class Content Outline

Incivility Training for Unlicensed Assistive Personnel in the Float Pool

Objectives:

At the end of the class, the learner will be able to:

1. Define incivility, bullying, and lateral violence in the healthcare workplace.
2. Discuss recognition of uncivil behavior among healthcare providers.
3. Describe negative effects of incivility on patient care.
4. Integrate emotional intelligence interventions to address uncivil behaviors in the workplace.
5. List strategies to promote a civil and respectful work environment.

Content Outline:

I. Introduction to incivility, bullying, and lateral violence
   A. Definitions of incivility, bullying, and lateral violence
      1) Incivility – behavior that lacks respect, is rude and mean-spirited; form of aggression and harassment
      2) Bullying – act of belittling another person, is more deliberate and usually has a target in mind and is habitual in nature
      3) Lateral violence – harmful and deliberate behavior that is directed by one's peers
   B. Examples of uncivil behavior
      1) Verbal – gossiping, jokes about minority/religious groups, screaming/yelling, condescending remarks, insults, spreading rumors, sarcastic remarks, rumors, criticizing, verbal threats
      2) Nonverbal – eye-rolling, glaring, sighs, body language/hand gestures, throwing objects, unfair assignments, pretending to not notice a struggling coworker
   C. Negative effects of incivility on patient care
      1) Missed care, delayed care
      2) Hesitation to ask for help
      3) Patient harm (falls)
      4) Stifled communication between coworkers
      5) Poor teamwork and poor team performance
      6) Poor job satisfaction

II. Emotional intelligence interventions

A. Definition – refers to a person's ability to understand his/her emotions and the emotions of those around them
B. Emotional intelligence self-assessment
C. Goleman's emotional intelligence framework
    1) Emotional self-awareness
    2) Emotional self-management
    3) Social awareness
    4) Relationship management
D. Promoting a positive work environment
    1) Know your triggers
    2) Don't jump to conclusions
    3) Empathize
    4) Do not spread rumors
    5) Resist blaming others
    6) Listen more and talk less
    7) Seek common ground
    8) Use proactive kindness
    9) Say thank you

References:

Goleman, D. (1998). Working with emotional intelligence. New York, New York: Bantam Dell.

Felblinger, D. M. (2008). Incivility and bullying in the workplace and nurses' shame responses. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 37,* 234-242. doi: 10.1111/j.1552-6909.2008.00227.x.

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

Lower, J. (2012). Civility starts with you. American Nurse Today, 7(5). Retrieved from https://www.americannursetoday.com/civility-starts-with-you/.

Meier's, J. (2018). The essentials: Here's what you need to know about bullying in nursing. *Urologic Nursing, 38(*2), 95-102. doi: 10.7257/1053-816X.2018.38.2.95.

Appendix J

Incivility Training Class Learner Evaluation

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

1 = strongly disagree or very dissatisfied
2 = disagree or dissatisfied
3 = average or minimally satisfied
4 = agree or satisfied
5 = strongly agree or very satisfied

Education Evaluation

Date: 7 Sessions: November 29 – December 20, 2019
Number of Respondents: 9

Offering Title: Incivility Training for Unlicensed Assistive Personnel

Please rate your satisfaction with the following:

General Satisfaction FOR ANY ITEM THAT YOU RATE THREE OR BELOW PLEASE EXPLAIN IN DETAIL	☹	SEE ABOVE			☺	AVG
My overall satisfaction with the quality of the offering	1	2	3	4	5	4.89
The offering content was at an appropriate level to improve professional practice.	1	2	3	4	5	5.0
My knowledge of the subjects was enhanced.	1	2	3	4	5	5.0
This class has empowered me to change my practice/performance.	1	2	3	4	5	4.89

Please rate how the learning objectives were met:

Learning Objectives FOR ANY ITEM THAT YOU RATE THREE OR BELOW PLEASE EXPLAIN IN DETAIL	☹	SEE ABOVE			☺	AVG
Define incivility, bullying, and lateral violence in the healthcare workplace.	1	2	3	4	5	4.89
Discuss recognition of uncivil behavior among healthcare providers.	1	2	3	4	5	4.89
Describe negative effects of incivility on patient care.	1	2	3	4	5	4.89
Integrate emotional intelligence to address uncivil behavior in the workplace.	1	2	3	4	5	4.89
List strategies to promote a civil and respectful workplace.	1	2	3	4	5	4.89

Speaker: Naomi King, RN

Demonstrated knowledge/expertise of the subject.	1	2	3	4	5	5.0
Presentation skills-organized and clear presentation.	1	2	3	4	5	4.89
Presentation style engaged audience/maintained interest.	1	2	3	4	5	5.0
Teaching methods simulated critical thinking and/or discussion.	1	2	3	4	5	4.89

Comments regarding the speaker:
Very hands on and interactive.
Used a personalized approach with examples from her personal experience!!! Humanizes the speaker.
Awesome and provided breakfast

Comments regarding the training/recommendations or suggestions for future classes.
I think was an eye opening.
Very informative and pertinent!
Training was well paced and informative. I loved the various types of learning techniques used to teach throughout the demonstration.
I don't think this incivility training could've been any better. Naomi is always very detailed and I love how she gives examples with clips to show examples. Great class! She always makes me strive to wanna do better?