


# Examining the presence and sources of incivility within nursing

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## Abstract

**Aims:** Examine the presence and various sources of incivility among nursing staff working within an academic medical centre utilizing the Nurse Incivility Scale (NIS).

**Background:** Evidence suggests various forms of negative behaviour including incivility exist among nurses. Established consequences of these behaviours include increased employee turnover rates, decreased job satisfaction, decreased productivity and increased absenteeism.

**Methods:** A descriptive survey design was used which included the NIS instrument to measure the presence of incivility within the nursing workforce and specific sources of these behaviours among 414 nurses in an academic medical centre.

**Results:** Hospital nurses working within the intensive and intermediate care unit experienced significantly greater incivility from patients and families than other participants within the study [ $F(3, 413) 8.62, p = .001$ ]. No other significant differences existed in sources of incivility between various levels of direct care.

**Conclusions:** Nursing staff working within high-risk areas for incivility such as the intensive care and intermediate care units may require additional interventions to reduce perceptions of incivility from patients/families.

**Implications for Nursing Management:** Findings suggest further research is necessary to develop targeted interventions for nurses practicing within intensive care and intermediate units to alleviate the perceived burden of incivility from patients/families.

## KEYWORDS

bullying, incivility, Nurse Incivility Scale, registered nurses

## 1 | INTRODUCTION

Incivility remains an established well-known issue in nursing (Fida, Laschinger, & Leiter, 2018). Researchers have consistently documented incivility across the nursing continuum, in education and practice (Lynette, Echevarria, Sun, & Ryan, 2016). Incivility is a pervasive issue within nursing culture and most commonly defined in the literature as “low intensity” deviant behaviours with ambiguous intent to harm the target, in violation of workplace norms of mutual respect (Andersson & Pearson, 1999; Vagharseyyedin, 2015).

Incivility is a type of negative behaviour displayed within health care. The differences between incivility and bullying are due to a lack of clear intentionality, an element of repetitive bullying behaviours (Andersson & Pearson, 1999; Cortina, Magley, Williams, & Langhout, 2001). Incivility differs from bullying in that there is a lack of clear intentionality on the part of the person displaying the behaviour. Additionally, incivility may occur only once in contrast to bullying which is repetitive. Workplace bullying occurs when an individual perceives being a target of negative behaviour by one or more individuals over time (Houck & Colbert, 2017; Matthiesen

& Einarsen, 2007). Nurse incivility, with nurses as the victim and/or the perpetrator, is defined by Guidroz, Burnfield-Geimer, Clark, Schwetschenau, and Jex (2010) as a variety of rude behaviours such as ignoring, yelling, interrupting, spreading rumours or taking credit for someone else's work. Examples of incivility presented within the literature include consuming others supplies without permission, exclusion of individuals from unit-based social events, sarcasm, insincere listening to others and disregarding others (Hutton & Gates, 2008; Vagharseyyedin, 2015; Walrath, Dang, & Nyberg, 2010).

## 1.1 | Consequences of incivility within the workplace

Incivility adversely influences turnover rates, job satisfaction, productivity and absenteeism (Wilson, Diedrich, Phelps, & Choi, 2011). The presence of incivility increases nurse turnover rates (Laschinger & Fida, 2014) and absenteeism (Kivimäki, Elovainio, & Vahtera, 2000) while decreasing productivity (Hutton & Gates, 2008) and job satisfaction (Hutton & Gates, 2008). The economic burden of nursing turnover varies by organisation; however, a recent study reported a range of \$22,000–\$64,000 per nurse (Oyeleye, Hanson, O'Connor, & Dunn, 2013).

While turnover is known to increase expenses for organisations, nurse incivility may also increase costs in other less evident ways. Incivility among nurses is associated with poor patient outcomes, including adverse safety events and mortality (McNamara, 2012; Wilson & Phelps, 2013). Nurses exposed to incivility experience decreased professional and psychological functioning, which can have significant implications for quality of life for the nurse as well as quality of care for the patient (Trépanier, Fernet, Austin, & Boudrias, 2016). Laschinger (2014) identified workplace incivility and bullying negatively influence nurse-assessed patient quality based on their influence on perceptions of patient safety. Moreover, sources of workplace incivility included co-worker, physician and supervisor. Pein, Cheng, and Cheng (2019) examined associations between various types of workplace violence and nurses' health. These researchers identified that external violence (coming from patients/families) was more prevalent than internal violence (coming from peers, physicians, supervisors or managers; Pien et al., 2019). The aim of this study was to examine the presence and sources of incivility among nurses at an academic level one trauma centre in the southeastern United States by comparing mean prevalence of incivility at the study site from five sources (general incivility, nurse incivility, supervisor incivility, physician incivility and patient/family incivility).

## 1.2 | Conceptual framework

The study site utilized Swanson's theory of caring to inspire the implemented professional practice model for employed nurses within the organisation. Therefore, Swanson's theory of caring was utilized to conceptualize the measured sources of incivility within this study as factors that could interfere with the caring process. This theory encompasses five categories of the caring process which include *knowing*, *being with*, *doing for*, *enabling* and *maintaining belief* (Swanson, 1991).

*Knowing* is described as understanding an event as it has meaning within the life of another, this process is free from assumptions and centred on the recipient of the caring behaviour (Swanson, 1991). *Knowing* may be weakened by general incivility, which includes experiences with hostility, rudeness and inappropriate jokes in the context of the workplace. *Being with* describes the process of emotional presence of the care provider with the individual receiving care (Swanson, 1991), which may be threatened by experiences of supervisor incivility. When supervisors lack emotional presence, incivility may be an unintended consequence. While *doing for* describes acts of service completed by the caregiver that the recipient of care would do for themselves if it were possible (Swanson, 1991). *Doing for* can be compromised by the presence of physician incivility because collaboration is essential between the nurse and physician to ensure patient needs are met. *Enabling* defines the facilitation of another's passage through transitional stages and unfamiliar events, often viewed as validating feelings and offering emotional support when observed in clinical practice (Swanson, 1991). Patient/family incivility potentially interferes with the ability to provide the caring behaviour of enabling, as this type of incivility may result due to patient/family frustration with progress or ultimate patient outcomes. Finally, *maintaining belief*, describes sustenance of faith in the recipient of caring; observed in clinical practice as an attitude of realistic optimism by the provider of care in the recipient's abilities and outcomes of provided care (Swanson, 1991). Nursing incivility potentially impedes the caring behaviour of maintaining belief as nurses who experience incivility from their peers may often wish to believe negative behaviours displayed by other nurses will be modified in the future. Identifying and addressing incivility are important to not undermine efforts to utilize Swanson's caring theory to guide care.

## 2 | METHODS

### 2.1 | Setting

Approved by the University Institutional Review Board (UMCIRB-18-00949), this study engaged all nursing staff employed at a 909-bed level one trauma centre during the recruitment period as eligible study participants. The principal investigator received permission to utilize the Nurse Incivility Scale (NIS) from the developer of the NIS for this study. The hospital is an academic teaching hospital in the southeastern United States, which employed 2,435 nurses at the time of the study. The survey period occurred for two months from April 2016 to June 2016 with electronic mail reminders sent every two weeks throughout the study period. A power analysis revealed 332 participants were necessary to achieve a 95% confidence level with a 5% margin of error (Survey Monkey, 1999).

### 2.2 | Recruitment and survey administration

Registered nurses employed at the study site were invited to participate in the study, while student nurses, nurses employed per diem or nurses on orientation at the time of the study were excluded. A convenience sample of eligible registered nurses was invited to

participate in the study via electronic mail, flyers and a hyperlink on the study site's intranet. Participants viewed an electronic consent paragraph prior to completing the electronic survey. Participants that wished to participate in the study following review of the consent paragraph proceeded to complete the Nurse Incivility Scale (NIS) as well as a few demographic questions. Demographic data including level of care, gender, ethnicity, age, shift, work status, experience and role were also gathered for analysis by the primary investigator and co-investigators.

### 2.3 | Measures

A descriptive survey design which utilized the Nurse Incivility Scale (NIS) instrument (Guidroz et al., 2010) to measure the presence of incivility within the nursing workforce and specific sources of these behaviours. The NIS instrument contained 42-items addressing the general incivility (9 items), nursing incivility (10 items) supervisor incivility (7 items), physician incivility (7 items) and incivility experiences from patients and families (10 items). A five-point Likert scale was utilized by participants to answer items from 1-*strongly disagree* to 5-*strongly agree*. Eight demographic questions were also included within the survey. Exploratory factor analysis demonstrated acceptable convergent and discriminate validity, Cronbach's alpha for the five subscales range from .85 to .94 with the overall Cronbach's alpha at .76 (Guidroz et al., 2010).

### 2.4 | Data analysis

Data were screened for missing values, and a consistent coding strategy was applied where higher values indicated a higher presence of incivility with lower scores indicating less incivility. Mean imputation was utilized to replace missing values for individual survey responses within each of the five subscales (general incivility, nurse incivility, supervisor incivility, physician incivility and patient/family incivility) prior to calculating each of the five subscales. Descriptive statistics and Kruskal-Wallis test were conducted using SPSS version 22 (IBM, 2013) with four levels of care as the independent variables (general care, intermediate and ICU, specialty care, nursing clinical support) and the five NIS subscales described previously as dependent variables to determine whether experiences of incivility differ based on level of care. Nonparametric tests were utilized due to the non-normal distribution of the dependent variables.

## 3 | RESULTS

Descriptive statistics by level of care for selected demographic data for the sample population are described within Table 1. Overall response rate for this study was 17% ( $n = 414$ ) of eligible nurses. The majority of the sample population reported working full time (83%,

**TABLE 1** Descriptive statistics by level of care

		General Care 47 (11%)		ICU and Intermediate Care 178 (43%)		Specialty Care 141 (34%)		Nursing Clinical Support 48 (12%)		Total 414 (%)	
	Variable										
Ethnicity	White	35	8%	149	36%	119	29%	44	11%	347	84%
	Black/African American	8	2%	14	3%	7	2%	3	1%	32	8%
	Other	4	1%	15	4%	15	4%	1	0%	35	8%
Age	Less than 25	1	0%	17	4%	1	0%	0	0%	19	5%
	25-55	46	11%	158	38%	139	34%	48	12%	391	94%
	56-65	0	0%	1	0%	0	0%	0	0%	1	0%
	Greater than 65	0	0%	0	0%	0	0%	0	0%	0	0%
	Missing data	0	0%	2	0%	1	0%	0	0%	3	1%
Experience	Less than 5 years	13	3%	60	14%	21	5%	4	1%	98	24%
	6-10 years	11	3%	43	10%	22	5%	5	1%	81	20%
	11-20 years	13	3%	38	9%	37	9%	19	5%	107	26%
	21-30 years	6	1%	25	6%	34	8%	12	3%	77	19%
	Greater than 30 years	4	1%	11	3%	26	6%	8	2%	49	12%
	Missing data	0	0%	1	0%	0	0%	0	0%	1	0%
Role	Leadership Roles	5	1%	20	5%	15	4%	20	5%	60	14%
	Advanced Practice Nurse (NP, CNS)	0	0%	2	0%	1	0%	6	1%	9	2%
	Nursing Support Roles (Educator, Quality & Safety)	0	0%	2	0%	2	0%	21	5%	25	6%
	Direct Care Nurse	41	10%	153	37%	121	29%	1	0%	316	76%

$n = 344$ ), employed women (89%,  $n = 369$ ). Eighty percent ( $n = 328$ ) of the participants reported ages between 25 and 55 years with 88% of participants ( $n = 366$ ) reporting direct care nursing as their job role. Within the patient and family subscale, 29% ( $n = 47$ ) of overall respondents "agreed" or "strongly agreed" that patients and families "criticize my job performance" while 29% ( $n = 47$ ) of overall respondents responded patients and families "make personal attacks against me" compared to 7% ( $n = 28$ ) respondents working within the intensive care or intermediate unit for both questions. At the time of this study, the demographic results of the participants closely aligned with demographic statistics of the overall nursing workforce where the sample occurred.

Overall results from the Kruskal–Wallis analysis as well as mean, standard deviation and confidence intervals by source subscales by levels of care for the NIS are displayed within Table 2. Higher mean scores indicate more incivility while lower mean scores indicate less incivility. Intensive care and intermediate care nurses reported significantly more incivility experienced by patients/families than other specialties ( $\chi^2 = 22.78$ ,  $df = 4$ ,  $p < .001$ ), while general incivility was more prevalent within general care, specialty units and support areas these results were not significant ( $\chi^2 = 4.09$ ,  $df = 4$ ,  $p = .25$ ).

## 4 | DISCUSSION

Prevalence of incivility at the study site was reported less frequently from nursing staff than the reported prevalence of from physician and management sources from the initial administration of the NIS by Guidroz et al. (2010). While nurses at the study site reported lower prevalence of incivility from general sources and peer nursing sources than some of the other published studies utilizing the NIS albeit participants from the study site reported the highest levels of incivility from patient and family sources when compared to other published studies utilizing the NIS (Guidroz et al., 2010; Lewis &

Malecha, 2011; Nikstaitis & Simko, 2014; Warrner, Sommers, Zappa, & Thornlow, 2016). In the era of patient care delivery transforming to meet the Institute for Healthcare Improvement quadruple aim of quality, safe, effective care and joy in the workplace while partnering with patients and families in their care an unintended consequence may be increased experiences of incivility of nursing staff from patients and families. Existing interventions are focused on improving relationships among health care professionals (nurses, physicians, supervisors; Gillen, Sinclair, Kernohan, Begley, & Luyben, 2017). Specific interventions focused on reducing incivility experienced by patients/families are lacking. Strategies for organisations and health care leaders to mitigate these experiences include educational strategies for nursing staff which are mentioned extensively within the literature with mixed results (Nikstaitis & Simko, 2014; Warrner et al., 2016), awareness programs for nursing leadership also reported within the literature (Armstrong, 2017; Gillen et al., 2017; Nikstaitis & Simko, 2014; Spence Laschinger, Leiter, Day, Gilin-Oore, & Mackinnon, 2012). An existing gap based on these results is the need for providing specific practical strategies to maintain patient and family respect and dignity while not becoming passive recipients of incivility from this population. Additionally, nurse leaders and hospital leadership also require targeted interventions and understanding of specific strategies to ensure ability to support nurses in executing successful tactics.

### 4.1 | High-risk clinical areas

Intensive and intermediate care units, along with emergency departments and operating rooms are clinical areas at higher risk for workplace incivility (Rosenstein, 2006). This phenomenon may occur because health care professionals within these environments provide care to critically ill patients, which are often accompanied by family members experiencing high levels of stress, anxiety and possibly frustration depending on individual patient circumstances. The

**TABLE 2** Kruskal–Wallis results, means, standard deviations and 95% confidence intervals for Nurse Incivility Subscales by level of care

Nurse Incivility Subscales	General care M (SD)	ICU and intermediate care M (SD)	Specialty care M (SD)	Nursing clinical support M (SD)	$\chi^2$	<i>p</i>
General Incivility	2.72 (0.72)	2.66 (0.70)	2.82 (0.73)	2.66 (0.76)	4.09	0.25
95% C.I.	(2.50, 2.93)	(2.55, 2.76)	(2.50, 2.93)	(2.44, 2.88)		
Nursing Incivility	2.49 (0.76)	2.55 (0.87)	2.66 (0.82)	2.47 (0.90)	3.34	0.34
95% C.I.	(2.27, 2.72)	(2.42, 2.68)	(2.53, 2.80)	(2.21, 2.74)		
Supervisor Incivility	1.66	1.68	1.73	1.55	1.42	0.70
95% C.I.	(1.46, 1.85)	(1.56, 1.80)	(1.58, 1.87)	(1.35, 1.74)		
Physician Incivility	2.44	2.49	2.44	2.63	1.24	0.74
95% C.I.	(2.18, 2.71)	(2.36, 2.63)	(2.33, 2.66)	(2.34, 2.93)		
Patient/Family Incivility	2.62	2.86	2.49	2.25	22.78	0.001
95% C.I.	(2.34, 2.89)	(2.73, 2.93)	(2.34, 2.63)	(2.05, 2.45)		

Note: Higher mean scores indicate more incivility while lower mean scores indicate less incivility.

prevalence of stress within intensive care health care professionals is reported as high as 48.78% for mild stress and 19.5% for moderate stress within nursing and 19.5% in physicians for mild stress and 14.6% for moderate stress in physicians (Kumar, Pore, Gupta, & Wani, 2016). The combination of stressed health care professionals along with patients and families increased stress levels is the perfect storm for potential incivility between these groups.

## 4.2 | Established interventions

Phillips, Stalter, Winegardner, Wiggs, and Jauch (2018) categorize interventions into four types including preventions strategies, education, leadership and system/systems thinking. Established preventions strategies include acknowledgement of incivility (Lynette et al., 2016), and educational interventions specifically targeted at decreasing incivility among nurses (Lynette et al., 2016). Examples of educational interventions include cognitive rehearsal strategies as a mechanism to communicate effectively Griffin (2004), this technique was revisited ten years later and remains effective (Griffin & Clark, 2014).

Leadership interventions include structured communication methods such as those offered by Agency for Research and Healthcare Quality TeamSTEPPS 2.0 released in 2007 provide another resource for nursing leaders to foster meaningful, effective two-way communication between team members and the leader/team member dyad (Agency for Healthcare Research and Quality, 2007). Further clinical leaders role modelling open communication, authentic and transformational leadership, compassion and caring foster healthy work environments (Frederick, 2014; Phillips et al., 2018; Skehan, 2015; Spence Laschinger, Wong, & Grau, 2012) thus providing these foundational skills to new clinical leaders and remediation for established leaders lacking these capacities are imperative to diminishing incivility within health care. Finally, a recent published intervention included the development of a "Professionalism Taskforce" utilized to guide organisational strategies elevating professionalism to influence team member perceptions related to prevalence of these behaviours (Layne et al., 2019). Systems thinking interventions include formal policies which provide necessary infrastructure supporting a safe working environment for nurses; however, enforcement of these policies is critical to decreasing the presence of all forms of negative behaviours among nursing staff (Longo, 2010; Skehan, 2015). Consideration of revising productivity targets by nursing leaders in an effort to offset the cost of the consequences of incivility in nursing is a potential mitigation strategy (Phillips et al., 2018).

A multi-faceted approach to reducing the presence of incivility within nursing is necessary and requires the development of targeted interventions for high-risk nursing populations such as intensive/intermediate care areas. Another critical step includes equipping nursing leadership with the necessary skills to develop, enforce zero-tolerance policies as well as fostering a healthy work environment through role modelling, and authentic and transformational leadership. Direct care nurses require interventions aimed at

the various sources of incivility (nurse incivility, supervisor incivility, physician incivility and patient/family incivility).

## 5 | LIMITATIONS

Nonresponse and self-selection bias are potential study limitations as well as sampling error due to convenience sampling the sample population may not have been representative of all health care workers. The cross-sectional study design limits causal inference. Findings may be difficult to generalize, as majority of the sample population were white female full-time direct care nurses between the ages of 25–55 with varied experience between 11 and 25 years in nursing.

## 6 | CONCLUSIONS

Nursing staff employed within intensive or intermediate care units experience higher incidence of incivility from patients/families based on the results of this study. Nursing incivility has a negative impact on the culture of an organisation. Nursing leaders have the obligation to be aware of the prevalence of incivility and assess for the occurrence. This study validates the need for assessment of nursing incivility in one's practice setting. Identification of the primary source of incivility within the nursing work environment should drive development of targeted interventions to reduce experiences of incivility for nursing staff.

## 7 | IMPLICATIONS FOR NURSING MANAGEMENT

Further research is necessary to develop targeted interventions for nurses to effectively communicate with patients and families while minimizes experiences of incivility from patients and families. Clinical significance of these findings indicates that nursing staff working in high-risk clinical areas may benefit from targeted training to provide strategies for effective communication skills and conflict resolution skills to minimize experiences of incivility from patients and families. Moreover enhancing the relationship between patients and families with their caregivers inspires trust between patients and their nurses, which is a critical component of a therapeutic caring relationship necessary for patient healing. Additional research is required to determine whether patients and families are consistently a source of incivility for nurses as well as other members of the health care delivery team. Deploying effective interventions aimed at preparing nurses for effective communication with patients and families where nurses perceive being recipients of incivility from patients/families is a critical component to improving relationships among the clinical care team specifically between nursing staff and the patients, with which they collaborate in care delivery.

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## ETHICAL APPROVAL

Approved by the University Institutional Review Board (UMCIRB-18-00949).

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