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Development of a Lateral Workplace Incivility Nurse Liaison Position in the Psychiatric Healthcare Setting

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Development of a Lateral Workplace Incivility Nurse Liaison Position
in the Psychiatric Healthcare Setting

by

Christopher L. Brown

A capstone project submitted to the faculty of
Gardner-Webb University School of Nursing
in partial fulfillment of the requirements for the degree of
Doctorate of Nursing Practice

Boiling Springs

2013

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Abstract

Workplace incivility is becoming commonplace in all work environments including health care. Research highlights the dangerous, distressing, and costly side effects of lateral workplace incivility (LWPI) including nursing staff's overall health, organizational commitment, and intent to stay. Historically, organizations have been considered safe work environments but LWPI has increased over the last several decades. There has also been limited research related to LWPI as it affects psychiatric healthcare staff and no study recommending a needs assessment or developing a position to educate and assist victims. The purpose of this project was to assess psychiatric healthcare staff's understanding and exposure to lateral workplace incivility, develop and provide education on LWPI, and develop a position for a LWPI Nurse Liaison to develop zero tolerance policies, provide immediate intervention when LWPI occurs, and develop processes of progressive action in response to repeated acts of incivility.

Keywords: lateral workplace incivility, horizontal incivility, bullying, nurses, job satisfaction, job commitment, intent to stay, role development, zero tolerance policy

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Chapter I

Development of a LWPI Nurse Liaison Position

American workplaces have a problem with incivility and it is getting worse. A recent survey of registered nurses published in *The American Nurse* (2012) found 74% suffer from the effects of acute and chronic on the job stress. One identified form of stress which is surprisingly common is workplace bullying or lateral workplace incivility. The Joint Commission (2008) reported increased exposure to abuse in the healthcare industry while Simons (2008) cited incivility as a significant reason nurses leave their job within the first year. Organizations have historically been thought of as safe work environments (Clements, DeRanieri, Clark, Manno, & Kuhn, 2005) although research during the last several decades shows increases in lateral workplace incivility (LWPI) from patients, visitors, and colleagues with 70% of nurses reporting exposure to workplace bullying in 2005, up from 40% in 2001 (Hutchinson, Vickers, Jackson, & Wilkes, 2006).

Effects of LWPI render healthcare environments as harmful, fearful, and abusive places which frequently perpetuate negative behaviors. One of the major problems in addressing LWPI lies in the fact that there are no definitive definitions of what constitutes incivility. Workplace incivility has been defined as unsolicited humiliation, rudeness, sarcasm, denial of opportunity for advancement, gossiping, open hostility, and blatant disregard for the welfare and safety of others (Caza & Cortina, 2007; Hegney, Eley, Plank, Buikstra, & Parker, 2006). Less obvious activities have been cited as equally uncivil, such as taking credit for others' work, checking and sending emails during a meeting, showing up late for work or meetings, leaving unfinished work for others, and

withholding information, which is virtually risk-free uncivil behavior difficult to prove (Pearson & Porath, 2009). Reasons offered for this increase in LWPI include declining resources; increased patient acuity; healthcare restructuring; age; gender; type of nursing unit; the acceptance of uncivil behaviors in society, media, and the internet (Hippelli, 2009); and the retirement of “baby boomers” who are being replaced by the more frustrated, disenchanted, and cynical “generation X-ers” (Seligman, 2009). Lamontagne (2010), in an article reviewing concept analysis of intimidation, reported that patient safety is being compromised due to LWPI, based on sentinel events related to LWPI dating back to 1996. She reported that, although workplace intimidation has been around for years, it is only since 1996 that data has been collected to support the relationship between LWPI and effects on patient care. Remington and Darden (2002) reported half of people believe that “life is so hectic and people are so busy we forget to be nice” (p. 31).

Costs of incivility in the workplace are just beginning to surface with an estimated loss of 4-6 million dollars per year in the United States due to increased health claims, decreased productivity, and intent to leave the workplace (Farrell, Bobrowski, & Bobrowski, 2006). Nurse turnover rates may cost an institution up to \$74,888, depending on the position, due to marketing, recruitment, and training expenses (Daniel, 2006; Brewer, Kovner, Greene, Tukov-Shuser, & Djukic, 2011). The Occupational Health and Safety Administration (OSHA) reported that 40% of workers are affected by workplace incivility (Mayhew et al., 2004).

Multiple studies suggest that increased stress due to incivility causes depression, anxiety, insomnia, and an overall decreased level of general health which in turn drains nurses of their enthusiasm for the job and undermines attempts by organizations to

provide safe, satisfying workplaces (Thomas, 2003; Daiski, 2004; Stanley, Martin, Michel, Welton, & Nemeth, 2007; Yildirim, 2009; Oore et al., 2010; Hutchinson, Vickers, Wilkes, & Jackson, 2010). The stressing effect of workplace violence has a direct impact on nurses, which in turn affects the provision of safe patient environments (Beyea, 2004). Kohn, Corrigan, and Donaldson (2000) in the Institute of Medicine report, *To Err is Human: Building a Safer Health Care System*, stated that 98,000 patients per year die from medication errors with 70% due to poor communication between health care professionals. Additionally, medical errors alone can increase a patient's length of stay at a cost of \$4,685 per patient (Foote & Coleman, 2008). Patient safety concerns, rising costs, and the prevalence of workplace incivility has sparked much discussion over the need for safer and more satisfying environments in which to practice. The Joint Commission (2008) created sentinel events related to aggression, indicating a zero tolerance approach for healthcare organizations seeking accreditation. Other organizations asserting a more aggressive approach include the American Nurses Association (2005), the Institute of Medicine of the National Academics (2011), and the American College of Nurse Practitioners (2012).

Problem Statement

Lateral workplace incivility occurs with regularity. Many episodes of LWPI go unreported due to fear of retribution, apathetic behaviors by administration, and views of incivility as part of the job of nursing (Roberts, Demarco, & Griffin, 2009). Incivility in nursing has devastating costs to the victim, the patient, and the organization (Farrell et al., 2006; Mayhew et al., 2004).

Purpose and Need for the Project

Incivility in the workplace has been reported as far back as 1405 (Pearson & Porath, 2009) with studies supporting its existence over the last decades. Sociologists and psychologists have most often undertaken studies to define the cause and effect relationships of LWPI. While there has been significant work related to LWPI, there has been no study recommending a needs assessment or implementing development of a position to educate and assist victims. The needs assessment for this project consists of surveying psychiatric healthcare workers to identify the incidence of LWPI in the psychiatric health setting.

The LWPI Nurse Liaison position, if warranted, will be the first of this type of position in the psychiatric facility and has the potential to support victims and improve organizational commitment and intent to stay. Proposed benefits of this LWPI Nurse Liaison project include increase in staff knowledge and understanding of workplace incivility, improvement in job satisfaction and commitment to the organization, better retention of employees, organizational financial savings, and increased patient satisfaction. Barriers to success of the LWPI Nurse Liaison project include apathy by the staff and administration toward change, lack of administrative support for change, fear of retribution for reporting uncivil behavior, and immediate competing factors which may prevent staff from taking an active role in organizational change.

The psychiatric healthcare staff is poised to address mental stressors through training and daily interaction with patients in need of therapeutic intervention. Having this knowledge assists in the development of a LWPI Nurse Liaison position to more effectively create the environment needed for processing of incidents at the time of

occurrence. Immediate on-site intervention has the potential to save time and money, prevent loss in productivity, reduce the need for employee assistance program (EAP) care, allow for immediate intervention and debriefing by a trained staff member, and show organizational commitment in addressing negative workplace behavior. The LWPI Nurse Liaison project will also include development of programs to address incivility at all levels of nursing care, which is a topic of current debate in the profession.

Assumptions

It is assumed for this project that staff working in the psychiatric healthcare setting desire a satisfying work environment, but that LWPI exists in the psychiatric healthcare setting and causes increased stress and decreased job satisfaction. Further, it is assumed that this decreased job satisfaction correlates with poor performance, lack of commitment, and decreased intent to stay. Also underlying this project is the assumption that staff can interact with their environment, progressively shifting it to address incivility.

Project Questions

The following project questions directed the LWPI Nurse Liaison project:

What is the knowledge level of psychiatric healthcare staff regarding LWPI?

What is the level of organizational commitment and intent to stay of psychiatric healthcare staff prior to implementation of a LWPI Nurse Liaison?

Will psychiatric healthcare staff, educated on LWPI, utilize an LWPI Nurse Liaison?

Will psychiatric healthcare staff, utilizing an LWPI Nurse Liaison, choose health promoting behaviors resulting in enhanced organizational commitment and intent to stay?

Definition of Terms

Lateral Workplace Incivility

Unsolicited negative behaviors experienced laterally (peer to peer) in the nursing workplace such as rude comments, gossiping, open hostility, blatant disregard for safety of others, and similar behaviors constitute lateral workplace incivility (Caza & Cortina, 2007).

Stimuli

Stimuli are defined as any factor which interacts with the individual's personal environment including both positive and negative events (Sakraida, 2006).

Job Satisfaction

Contentment with the job, feelings of empowerment, satisfying work relationships, and intent to remain in current position comprise job satisfaction (Caza & Cortina, 2007).

LWPI Nurse Liaison

The LWPI Nurse Liaison is a registered nurse with specialized training in recognition of and addressing negative behaviors in the workplace. This person may be an advanced practice nurse (APN) who is empowered by the organization to interact with victims of workplace violence, perpetrators, and administration to deter further incidences.

Individual Experience

The ability of the individual to respond to negative behavior constitutes their individual experience. Factors which affect this include age, professional experience, gender, and prior exposure (Sakraida, 2006).

Prior Related Behavior

Prior related behavior is the factors impacting processing of information related to workplace violence exposure and interventions. Factors include psychological variables such as self-esteem, personal, and organizational support; biological factors including age, gender, and experience; and personal socio-culture factors which include perception of benefits, barriers, and commitment to action (Sakraida, 2006).

Behavioral Outcomes

Behavioral outcomes are the commitment and plan of action to address or tolerate lateral workplace incivility (Sakraida, 2006).

Chapter II

Research Based Evidence

Lateral workplace incivility affects all organizations at all levels and is especially dominant in the healthcare arena. Causes, costs, demographics, and effects of incivility are addressed in the literature.

Causes of Lateral Workplace Incivility

Multiple studies on the causes of LWPI exist in the literature. Hippelli (2009), in an article reflecting on the need for multi-disciplinary teamwork as an approach to LWPI, referred to nursing as a profession that “eats its young” (p. 186), citing that 60% of new nurses leave their jobs within six months due to poor treatment by their peers. He also surmised that being viewed as second class citizens by society when compared to physicians may cause increased amounts of stress which have to be directed somewhere. Co-workers present easy access for this misdirected stress, with less chance for repercussion for uncivil behavior when compared to administrative employees and physicians. Key recommendations from the author include developing multi-disciplinary teams to address LWPI, commitment from the organization, and good communication.

Duffield and O'Brien-Pallas (2006), when looking at reasons for the nursing shortage and high turnover, cited LWPI as a contributing factor being brought on by declining health resources, increased patient acuity, healthcare restructuring, and lack of administrative support. They state that up to 65% of nurses are dissatisfied with the response of administration toward the negative behaviors which manifest from these workplace stressors. Recommendations included staff education on how to recognize and address LWPI plus organizational support and policies.

Oppressed group behavior and its relevance to LWPI were explored by Hutchinson et al. (2006). They reported that media and the Internet are sources of blame as they portray incivility towards nurses as an accepted form of behavior. Their findings indicating that nurses felt oppressed group behavior was a part of their assumed role in quality patient care were further supported by Hippelli's work in 2009.

An article by Longo and Sherman (2007) defined oppressed group behavior as being alienated and losing autonomy in practice thus beginning a cycle of lowered self-esteem and decreased job satisfaction. Staff members, rather than fighting back against their attackers or reporting it to administration, tend to place blame on co-workers. New healthcare reform rules will further burden the healthcare profession as more people are given access to healthcare. As more consumers, exposed to incivility as an acceptable practice, emerge, the numbers of occurrences will continue to rise. This will include physical violence towards staff which has historically been limited to emergency departments and psychiatric settings. Acts of incivility, both physical and non-physical, will permeate the nursing profession at levels, in all patient care units, and all organizations.

Costs of Incivility

Incivility has the potential to create great costs to the organization in terms of operational expenses, revenue, and retention of qualified staff, thus endangering overall viability. Mayhew et al. (2004) cited the average cost of replacing an employee at greater than fifty thousand dollars per person and an overall yearly cost of greater than three hundred billion dollars in the United States. They interviewed over 800 employees in education, healthcare, and long haul trucking occupations, finding that non-physical

LWPI was as damaging to the victim as violence, and played a key role in organizational commitment and intent to stay. Recommendations included education and policies aimed at a zero tolerance stance in any organization.

These recommendations were supported by Becher and Visovsky (2012) who reported an organizational cost of \$30,000 to \$100,000 dollars per individual related to WPLI. These costs resulted from increased absenteeism, poor work performance, and medical treatment for depression from repeated exposure to negative behaviors.

Forty percent of the American population admits to increases of on the job stress due to incivility (Reivich & Shatte, 2002). This makes LWPI the top cause of employee disability, with insurance claims 1.5 times higher for stress than from workplace injury.

Ahmad and Oranye (2010) conducted a descriptive study examining the relationship between nurses' feelings of empowerment, job satisfaction, and organizational commitment within teaching hospitals in Malaysia and England. They found that nurses who reported more empowerment, also defined as self-efficacy, reported a greater commitment to stay in the organization. Their recommendation was to have organizational involvement in developing policies to afford staff a greater sense of empowerment in the organization, thus increasing commitment and retention of qualified staff.

Results of an exploratory study to look at the effects of empowerment on job stress and satisfaction among Italian mental health nurses were reported by Lautizi, Laschinger, and Ravazzolo (2009). They found a statistically significant correlation between empowerment and job satisfaction. Recommendations were for organizations to

empower nurses through engagement in organizational policies and to enhance commitment with lifelong learning opportunities.

In an article on nursing power and job satisfaction, Manojlovich (2007) stated that powerless nurses are ineffective nurses, less satisfied with their jobs, and more susceptible to burnout and depersonalization. She asserted that power is achieved through a workplace that has structures in place to promote power, a personal sense of power and ability to use that skill, and effective working relationships. In assessing the attributes of the previous articles as they relate to LWPI, it is plausible to assume that any activity aimed at increasing nursing's power and job satisfaction, such as zero tolerance policies and organizational support, will have the positive outcomes of happier staff, more committed staff, and an environment conducive to quality patient care.

Deery, Walsh, and Guest (2011) looked at insider initiated harassment (staff, peers, administration) and outsider initiated harassment (patient, families) in a group of British nurses and its effect on retention. They found that both types of behaviors have a major effect on morale, absenteeism, turnover, and performance. Recommendations to control these variables included organizational commitment to zero tolerance of LWPI with adoption of policies to address behaviors at time of occurrence.

Demographics of Incivility

In reviewing the literature related to LWPI to address a needs assessment for a LWPI Nurse Liaison position, an understanding of the demographics of incivility is helpful in identifying at risk staff. Multiple studies linked a correlation between workplace incivility and gender.

Farrell et al. (2006) completed a study in which 6,326 surveys were sent to nurses in Australia. Surveys revealed that the majority of nurses reporting LWPI were female (92.8%) and between the ages of 41-50 (38.9%) followed by the 31-40 age group (25.5%).

A descriptive study of nursing students (Caza & Cortina, 2007) found that victims of incivility were predominately white females between the ages of 26-30 years. They hypothesized, and found, that nurses who experience incivility often blame the organization for not addressing issues. This alters their intent to stay in a workplace allowing that behavior.

Sakellaropoulos, Estes, and Jasinski (2011) conducted a descriptive study of certified registered nurse anesthetists (CRNA). They found a strong correlation between female gender and incivility ($p = 0.02$). Their study also revealed that 92.2% of CRNA's surveyed reported exposure to active or passive instances of LWPI.

Multiple risk factors for LWPI were found by Howerton-Child and Mentis (2010), with younger female nurses being at the highest risk. Reasons offered included lack of experience, type of workplace setting (emergency room, psychiatry), and the fact that many older nurses were in administrative positions with less interaction with staff, patients, and families. Another reason for younger nurse victims was that older, more seasoned nurses were more comfortable in addressing LWPI, presumably due to having developed relationships with other medical professionals. They cited that perpetrators of physical violence tend to be patients and family members, while non-violent incivility perpetrators are physicians, administration (vertical violence), and colleagues (lateral violence).

Simons and Mawn (2010) conducted a qualitative study to investigate the effects of workplace bullying on newly licensed registered nurses to identify trends in behaviors experienced. Their sample of 184 newly licensed registered nurses in the United States found the majority of nurses experiencing workplace bullying to be female (92%) with a median age of 35.8 years. Overall findings were that workplace bullying occurred in all workplaces, at all educational levels, and ages. Recommendations were more research aimed at targeting populations and determining roots of behavior and their effects on staff.

Very little information exists related to LWPI and its continued occurrence as staff age and gain experience. The exception to this was a descriptive study of 3000 Australian nurses by Hegney et al. (2006). They found that LWPI decreased as the age of the nurse increased, indicating that experience and age played a major role in how and when negative behaviors occurred.

Effects of Incivility

Many studies have shown the effects of incivility as it relates to job satisfaction, organizational commitment, and intent to stay. There have been studies that show LWPI causes depression, anxiety, worry, insomnia, and overall decreased levels of health. Still, sadly, many reports of incivility go unreported for reasons including fear of retribution, lack of administrative support, and apathy (Oore et al., 2010). Their descriptive study of 17 patient care units in Canadian hospitals indicated that increased workload and negative work relationships have a major impact on the effects of LWPI. Recommendations included constant communication, development of zero tolerance work policies, and staff education about the harmful effects of LWPI. As part of their study, they developed an

educational offering entitled Civility, Respect, and Engagement at Work (CREW) to increase overall awareness of LWPI and identify ways to address behaviors positively. During the study they found daily exposure to verbal abuse to be the most troubling as it was the behavior linked to intent to leave the workplace.

An earlier study by Farrell et al. (2006), designed to gain a better understanding of the extent of aggression suffered by staff, paralleled these findings. They reported that even minor acts of LWPI can leave the victim emotionally scarred, eventually affecting their commitment to the organization. They found that 80% of nurses do not report episodes when they occur. Explanations for non-reporting were that responses to incivility must be minimized to cope and survive in a hostile work environment, negative colleague interaction was not important or was considered part of the job, fear of retaliation, and feelings of apathy.

Results from tolerance of the LWPI behavior included increased work stress (90.9%), decreased job satisfaction (84.4%), decreased morale (84.6%), and feelings of anger (81.8%). Resultant actions include decreased productivity, decreased overall health, increased absenteeism, decreased patient care, minimal work effort, and resignation (Melchior et al., 2007).

Murray (2009) reported that nurses need to recognize when bullying is occurring. Negative effects of LWPI on nurses include decreased personal health, sleeping disorders, and eating disorders. This stress and effects on general health can even turn into post-traumatic stress disorder. Nurses also need to identify ways to support victims. One example he cited was development of a code pink when a staff member is being victimized. When a code pink is called, all available staff go to area and silently stare at

the offender. He felt these interventions empowered staff to recognize, address, and avoid the lasting negative effects of LWPI.

Other effects of LWPI were reported by Pearson and Porath (2009). They stated that victims are two times more likely to become abusers themselves, with women more prone than men. An understandable 94% of victims want to get even with their offenders while a surprising 88% get even with their organizations. Further, they reported incidences of customers observing bad behavior in the workplace and never returning.

Responses to Incivility

Poor responses by institutions occur when LWPI is ignored. Hutchinson, Jackson, and Wilkes (2006) reported that organizations can be fully aware of incivility in the workplace and choose to ignore it. They suggest that informal networks within organizations allow negative behaviors to occur at many levels. Consequences of ignoring bad behaviors bring about the decline of the organization's infrastructure, customer perception, and ability to hire new employees. Word spreads when an organization is guilty of "looking the other way" and assures that perspective employees will steer clear.

Creating a culture of mutual respect and zero tolerance policy towards incivility is recommended in literature. Olender-Russo (2009) recommended intensive organizational assessment for areas of bullying. They also suggest administrative commitment to transformational and purposeful modeling behaviors which support a zero tolerance for bullying.

A comprehensive organizational violence program, with development of monitoring tools to measure success, was recommended by Clements et al. (2005). They

added that organizations need to have a variety of group and individual efforts to show support of the staff.

Middleby-Clements and Geyner (2007) compared training programs in workplace violence with Australian and New Zealand nurses. The first group received training in aggression minimization while the second group received training in a zero tolerance approach to aggression behavior. Group one reported a decrease in rigid attitudes towards management of aggression and group two showed an increase in rigid attitudes and decreased tolerance toward aggression. Both groups gained increased confidence and skills to address LWPI. This supports literature recommendations for training on recognition and intervention of LWPI.

Lastly, Farrell and Cubit (2005) compared 28 aggression management programs. Sadly, their findings were that most programs did not address the psychological aspects on the staff or the organizational costs. Recommendations offered were a comprehensive orientation that included review of organization policies and grievance processes, information on both physical and psychological LWPI, and best practice for reducing LWPI by development of a core group of individuals specially trained for dealing with intervention.

The planning of programs doesn't occur spontaneously or as a quick fix reaction to incivility in the workplace. Identification of the problem and its relationship to nursing theory is a first step in developing evidence-based guidelines for addressing the behavior. While multiple facilities address aggression within the facility, few have documented zero tolerance policies to address lateral incivility.

Gaps in Literature

The literature review produced a plethora of information related to LWPI in the clinical setting, including violence toward emergency department and psychiatric staff. However, no studies were identified specifically addressing the prevalence of non-physical lateral workplace violence towards nursing staff in the psychiatric health area of practice.

Strengths and Limitations of Literature

No studies linking nursing theory to practice as it relates to lateral workplace aggression were found. Consistent recommendations throughout all studies include a heightened awareness of workplace aggression and implementation of steps to address negative behaviors before they affect job satisfaction, well-being, and patient safety.

Theoretical Framework

The theoretical framework utilized to develop the LWPI Nurse Liaison Project for addressing lateral incivility is Nola Pender's Health Promoting Behaviors (HPB) Model (Pender, 1975). Pender's mid-range theory addresses how individuals interpret stimuli, process the information, and choose whether or not to make positive changes leading to health promoting behaviors, thus focusing on the importance of cognition in the decision-making process.

Pender asserts that an individual's interactions with the environment are multi-faceted and health promotion is motivated by desires to increase well-being and self-efficacy (1975). The model is based upon three major foci: individual characteristics and experiences, behavior specific cognitions and affect, and behavioral outcomes. It addresses unique characteristics experienced by individuals as they relate to events. Then,

cognitive processing leads to choices in response to the behavior. It is at this stage where individuals take into account perceived benefits and barriers to behavior change, perceived self-efficacy or esteem, and activity related cognition which enhances the decision making process.

Additional factors inherent in the process include interpersonal influences, such as supportive family and friends, and options available. The process assists the individual to commit to a plan of action leading to health promoting behavior. Immediate barriers to making positive choices include work load, apathy, physical exhaustion, and organizational support. In clinical use, the individual processes all variables and chooses health promoting behaviors. The LWPI Nurse Liaison proposed by this project interacts with the individual's environment, creating a milieu that optimizes effective cognition. This then creates actions that can be addressed to overcome negative experiences and leads the nurse to adopt health promoting behaviors. Application of the HPB model to lateral workplace violence is shown in Figure 1.

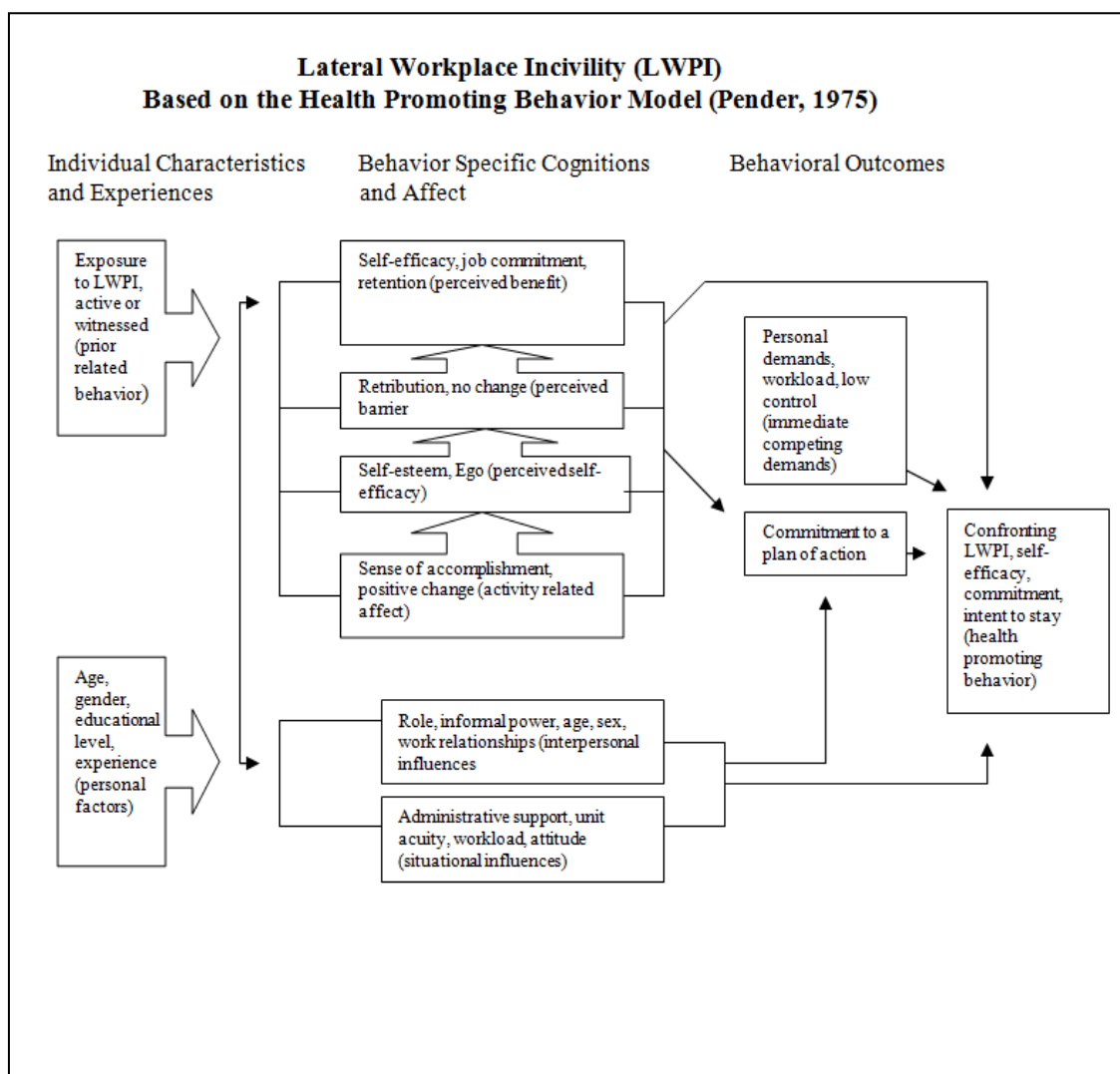


Figure 1. Lateral workplace incivility within the framework of the Pender Health Promotion Model.

In the LWPI Nurse Liaison project, Pender's model is applied at each stage (Figure 2). The individual characteristics are the nurse's biological and psychological factors such as age, gender, prior exposure, and work experience. The prior related behavior is the nurse's exposure to lateral workplace incivility either actively or passively.

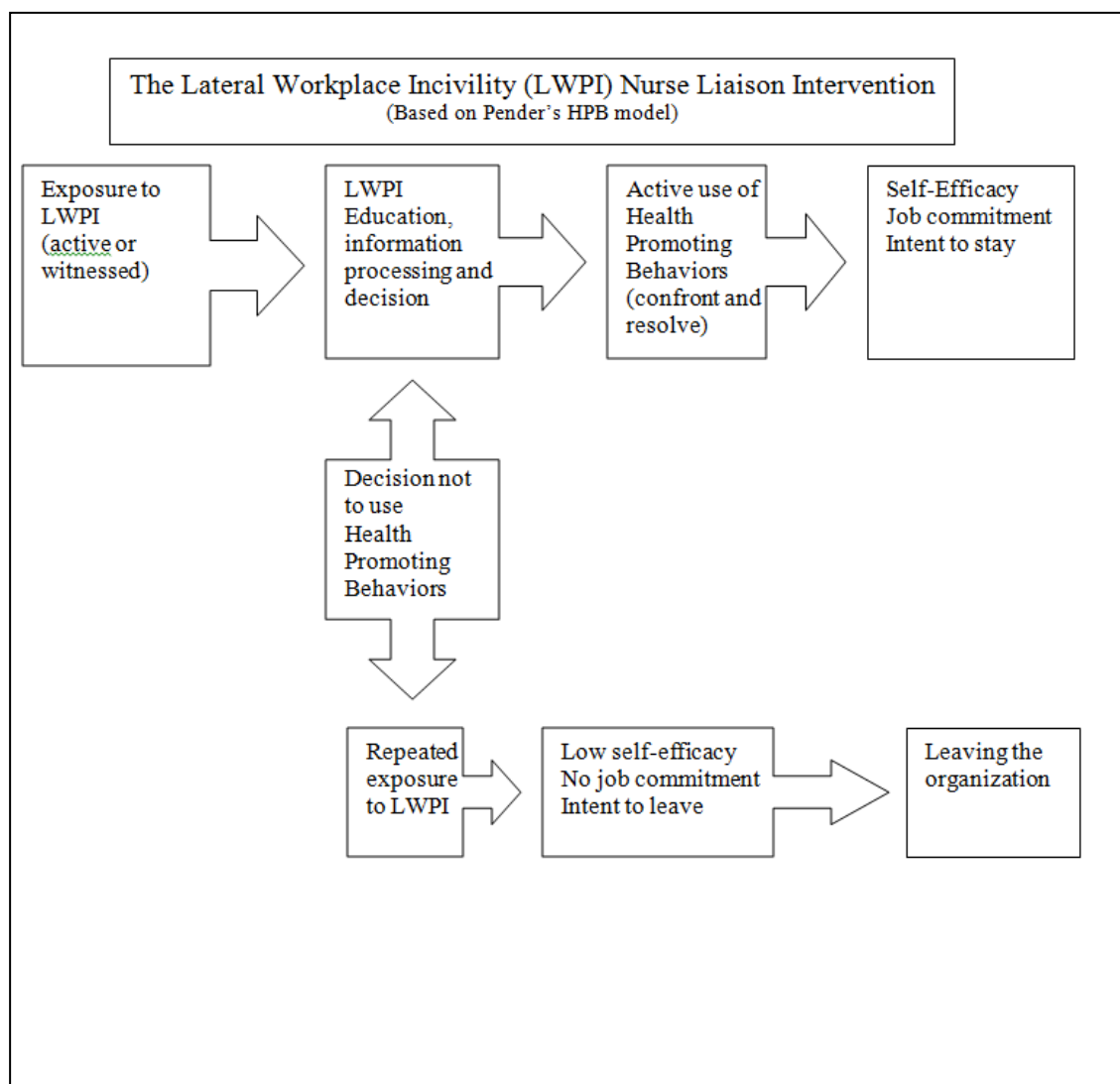


Figure 2. Lateral workplace incivility education and Nurse Liaison intervention applied to the Pender Health Promotion Model.

Behavioral cognitions and affect includes how the nurse will respond to the stimuli. It is at this level that the LWPI Nurse Liaison serves as a critical key in the effective processing and interpretation of information. The LWPI Nurse Liaison assists

the victim in overcoming barriers, both immediate and perceived, for commitment to a plan of action to occur.

Behavioral outcomes include immediate barriers to health promoting behavior and choosing interventions to resolve episodes of LWPI or adapt to repeated exposure. The LWPI Nurse Liaison is critical in guiding the nurse toward a positive action rather than tolerance of behavior which affects stress levels, job satisfaction, intent to stay, and ultimately patient care and perception of care.

Summary

Organizations have a legal, ethical, and moral responsibility to respond to acts of incivility, no matter the level, and take initiatives to stop it. As current nurses retire they will be replaced by newer, often younger, nurses, who are at higher risk for experiencing LWPI. The costs of LWPI include loss of general health and self-efficacy, therefore affecting long term commitment to an organization. If the healthcare worker doesn't maintain a feeling of organizational support they will leave, causing the organization to experience the financial strain of turnover. Eventually the organization could be filled with unhappy staff with no organizational commitment, apathy for their jobs, and increased instances of patient safety concerns.

Psychiatric staff exposed either actively or passively to LWPI can apply Pender's behavior specific cognitions and affect to process how they will respond to instances of LWPI, hopefully in a positive mode that will improve their overall health, organizational commitment, patient satisfaction, and improved patient care. Literature supports the role of empowering nurses within the organization through providing lifelong learning opportunities, such as recognition of and addressing LWPI, as tantamount to improved

job satisfaction, commitment, and intent to stay. In Pender's model, organizations can play a key role in establishing zero tolerance incivility policies which shows employer commitment to a safe workplace, thus increasing the possibility of employee retention, a formidable cost for organizations.

The Project Administrator identified a need for investigation into nursing theory, specifically Pender's health promoting behavior model and its application to LWPI, education on addressing episodes of LWPI, and development of a Nurse Liaison position to deter the negative consequences.

Chapter III

The LWPI Nurse Liaison Project

The purpose of the LWPI Nurse Liaison Project was to identify the incidence of LWPI, educate key psychiatric healthcare professionals regarding LWPI, and develop a LWPI Nurse Liaison position to assist victims of LWPI. Additionally, a process to allow evaluation of the utilization and effectiveness of the LWPI was proposed. It was projected that implementation of the LWPI Nurse Liaison would improve the retention rate of staff and enhance organizational policies aimed at addressing negative behavior. Other potential benefits included a possible increase in job satisfaction and retention, patient satisfaction and quality of care, and financial savings for the organization.

Aim and Design

The aim of the LWPI Nurse Liaison project was to increase psychiatric healthcare staff's job commitment and intent to stay as a result of the establishment of a LWPI Nurse Liaison position. The project intended to translate survey data and literature analysis into clinical application. Education on recognition of and intervention for LWPI and newly developed protocols to address repeated violations were to be disseminated throughout the organizational leadership.

Setting

Organization A was a moderate sized, suburban, private psychiatric facility located in the upstate region of a southeastern state. The facility offers a full range of services including acute inpatient care, intensive outpatient therapy, electroconvulsive therapy (ECT), and partial hospitalization services. The average length of stay is 10 days.

The facility serves as a referral agency for counties within three southeastern states and offers immediate psychiatric evaluation at a number of emergency rooms.

Organization B was a large, full service, private acute care suburban hospital in the upstate region of a southeastern state. The acute gerontology psychiatric unit surveyed within organization B was a small, self-contained unit with specially trained staff offering acute psychiatric and dementia services inpatient care. The average length of stay is 14 days. No outpatient psychiatric services are offered at organization B.

Sample

Target participants for the LWPI Nurse Liaison Project were psychiatric healthcare staff in the inpatient and outpatient settings at two private healthcare facilities in a suburban upstate southeast region. Staff were defined as registered nurses, licensed practical nurses, psychiatric health technicians, and support staff (therapists and recreational therapists) actively working on psychiatric units. With the aim of reaching large numbers of staff, there were no exclusions for age, race, gender, educational level, or clinical experience. Work status could be full-time, part-time, or casual staff and participation was voluntary. Management and administrative staff were excluded to prevent potential contamination of data due to vertical incivility.

Protection of Human Subjects

This project was approved through an institutional review board process to ensure protection of participants. Organizational approval for the project was obtained from each organization. Participants received a letter explaining the reasons for the project, minimal risk associated with the project, assurance that participation was voluntary, and that data would be presented as aggregate thus maintaining anonymity. Further, participants were

informed that completion of the survey instruments did not require attendance at the inservice education and they could withdraw at any time without consequence. Finally, potential benefits of participation, both personally and organizationally, were described. Individual benefits of the project included enhanced understanding and development of skills related to addressing workplace incivility, increased job satisfaction, and increased intent to stay. Organizational benefits included data supporting the need for policies addressing workplace incivility, staff empowerment and commitment to the organization, and lowered orientation costs due to job retention.

Instruments

Participants in the LWPI Nurse Liaison project completed four instruments. Considered in aggregate, the results of these surveys revealed the participants' sense of workplace incivility, organizational commitment, and current and future intent to leave. The first survey gathered demographic data (Appendix A) including age, sex, title, and years of experience in healthcare.

The Uncivil Workplace Behavior Scale-Revised (UWBS) (Appendix B) was developed by Martin and Hine (2005). Permission was granted for use and modification (Appendix C). The UWBS-revised is a 17 item questionnaire measuring exposure to workplace incivility. Questions are rated on a Likert scale from 1 (*never*) to 5 (*very often*) or 0 (*does not apply*). The scale was altered to reflect the current clinical psychiatric setting. Three invasion of privacy questions were excluded, specifically, "opened desk drawers without prior permission," "took items from desk without permission," and "took stationary from desk without returning later." Scoring is computed by taking the mean of

scores across the 13 items. Subscales are: hostility (items 4, 8, 10, 11, and 13), exclusionary behavior (items 1, 3, 5, 9, and 12), and gossiping (items 2, 6, 7, and 10).

The Staying or Leaving Index (SLI) (Appendix D) was developed by Bluedorn (1982) and was used with permission (Appendix E). The SLI is an eight item scale measuring intent to stay or leave an organization. Responses are rated on a Likert scale from 1 (*unlikely*) to 7 (*definitely*). Items are scored and summed to produce a total score. The higher the score, the more likely one is to leave the organization. Testing of the instrument showed strong reliability with Cronbach's alpha at 0.83 (greater than 0.80 significant). The scale was altered to include six items, rather than eight, related to projected timeframe for leaving. Administrators at the organizations did not want to measure intent to leave beyond one year. Two additional questions requiring a Likert scale response rated from 1 (*unlikely*) to 7 (*definitely*) were developed to assess feelings towards incivility education and organizational involvement as indicators of staying or leaving.

The Organizational Commitment Questionnaire (OCQ) (Appendix F) developed by Mowdy, Steers, and Porter (1979), is a 15 item questionnaire scale requiring categorical "yes" or "no" responses to each statement. Testing of the scale showed strong reliability ranging from 0.82 to 0.93 for six samples where greater than 0.80 was significant. Permission was granted for both use and modification (Appendix G).

Data Collection

Organizational assessment of lateral workplace incivility started with input from staff and managers. Surveys to identify the level of knowledge regarding LWPI, organizational commitment, and intent to stay were distributed to all active staff in seven

inpatient psychiatric units and one outpatient psychiatric unit of two moderate sized (greater than 100 beds) suburban southeastern hospitals. After final approval for the LWPI Nurse Liaison project from the facilities was obtained, staff education regarding the intent and purpose of the project was disseminated through monthly hospital wide staff meetings and educational postings on the units. Anonymous surveys were given to the staff during unit meetings and placed in individual employee mailboxes with stamped return address envelopes to the project administrator to ensure no viewing of responses by the facility. Surveys were distributed with a cut-off date for completing the surveys approximately three weeks after distribution, and before education on LWPI, to prevent contamination of data.

In determining whether to use online surveys versus printed surveys, a review of the literature related to staff surveys was utilized. While many organizations use systems for scoring job satisfaction, incivility, and other factors online it has been suggested that staff will not truthfully answer online surveys due to fear of it being tracked back to them (Pearson & Porath, 2009). Both facilities utilize anonymous online scoring systems to assess staffs thoughts, feelings, and recommendations for improvement in the organization. Staff reported there was fear of identification as the anonymous surveys require sign in using employee identification numbers.

The LWPI Nurse Liaison project utilized anonymous surveys with no encrypted data to improve the accuracy of results and response. The only method of identifying which facility the survey came from was from stamps applied to the self-addressed stamped envelopes for returning surveys to the project administrator. One stamp represented surveys returned from organization A and a different stamp represented

surveys returned from organization B. After extrapolation of data, surveys were stored securely at the project administrator's office. The data regarding staff insight into incivility, along with organizational commitment and intent to stay, were used to develop educational components and create a LPWI Nurse Liaison position.

Data Analysis

Data obtained from the LWPI Nurse Liaison project were analyzed using Statistical Package of Social Sciences version 19.0 (SPSS Inc., Chicago, IL, USA). Descriptive statistics including frequencies and percentages were used to identify main characteristics of the data. Means, standard deviations, and inter-correlations of variables were calculated for statistical significance. Simple analysis of variance (ANOVA) tested the significance of workplace incivility education and program development related to its influence in organizational commitment and intent to stay.

LWPI Staff Education

A LWPI educational program based on staff survey data, a review of the literature, and current best practice was presented to all active staff. The LWPI educational presentation was a 60 minute interactive activity supported by Power Point and led by the project administrator scheduled for all shifts to increase staff accessibility to the program. The project administrator presented education on general survey results, incivility training, and the development of the LWPI Nurse Liaison position. The LWPI educational presentation included information regarding incivility, recognition of uncivil behaviors, gender and age differences which increase the chance of incivility, skills to address negative behavior, the importance of zero tolerance policies for all levels of providers within the organization, and discussion of the usefulness of a LWPI Nurse

Liaison within the organization. Practical examples and scenarios were used to enhance the attendees' understanding and the role of the LWPI Nurse Liaison. The organization's position regarding incivility and its response to initial and repeated violations was discussed and clearly communicated. A total of three educational classes were offered by the project administrator to organization A. Nineteen staff attended the educational offerings at organization A and one credit continuing education unit credit was awarded each participant.

Although data from organization B was not used in the project, the program administrator offered the same educational offerings at four different educational opportunities opened up to the entire organization. A total of 36 staff members attended with a one hour continuing education unit credit awarded to each participant. Based upon the outcomes of the in-service educations at organization B, the chief nursing officer requested an additional class that was attended by nursing leadership. A total of 14 nursing administration staff attended the in-service.

Implementing the LWPI Nurse Liaison Position

The establishment of a Nurse Liaison position would assist in educating staff regarding the need to immediately address LWPI and develop skills in confronting it. The need for a position of this type was identified after the project administrator and human resources director met regarding staff retention trends and rates. Organization A reported an 11.66% turnover rate for 2012 at the time of project implementation and 26.77% if per diem employees were included. During the same time period, Organization B reported a turnover rate of 14.98% when compared to the previous year of 9.46%. Following an identification of a need for LWPI education, several meetings occurred involving the

project administrator, the human resources director, the chief operating officer, the director of nursing, and the director of risk management. The primary investigator was available for consultation by phone and could be brought into the project environment if needed. A timeline was developed (Appendix H) to guide the position development, job description development, approval for the position at a corporate level, and the recruitment of the LWPI Nurse Liaison.

The LWPI Nurse Liaison job description (Appendix I) was developed from a review of generic registered nurse job descriptions accessed through an online Google™ search as well as a comparison of current registered nurse, nursing supervisor, and unit coordinator job descriptions that existed for organization A. The completed job description was reviewed by a committee including the directors of human resources, nursing, and risk management, and the project administrator, to assure all legal and ethical regulations were followed as prescribed by the occupational safety and health administration (OSHA), the equal employment opportunity commission (EEOC), and state level licensing and labor laws.

Key essentials for success of the position included a need for organizational commitment and authority to create an environment of civility. The LWPI Nurse Liaison position was developed as a unique position to be posted in the facility and publically through employment search engines and local and statewide nursing organizations to encourage a variety of applicants with varying backgrounds. Applicants with a strong fundamental knowledge of working within a psychiatric setting were desired. A team consisting of the director of human resources, the director of nursing, and the chief nursing officer would be responsible for all interviews once background checks were

completed by human resources. While input from other disciplines could be sought, the committee had sole decision in choosing the preferred candidate and offering the position.

The position ideally was to be a stand-alone position but, due to budgetary constraints, the duties could perhaps be assigned to nursing supervisors who, in many health care facilities, have both the administrative and clinical authority to affect staffing. This option would assure around the clock availability and access for immediate intervention. The LWPI Nurse Liaison position included the authority to alter staffing patterns and offer counseling and immediate de-escalation. These actions could be up to and include sending offending staff home if needed to preserve the unit's continued operation, patient care, and milieu. The role required a minimum of a bachelor's degree in nursing education given the need for objective assessment of situations with the advanced skills to negotiate to a positive end. The role required an experience level of at least two years in a clinical setting utilizing therapeutic communication skills, preferably in psychiatry.

Following selection from all available candidates, The LWPI Nurse Liaison would go through a general facility orientation, including the organization's policy and procedures for addressing repeated episodes of LWPI, and orientation by the project administrator who is qualified to train the LWPI Nurse Liaison based upon advanced education at the post-masters level, 30 years of experience as a registered nurse in multiple clinical settings, 14 years as a family nurse practitioner, six years of experience in a psychiatric facility, and continuing education through conferences.

Orientation would also include a one week training period with each discipline within the facility to understand unit dynamics, one week with the director of nursing, one week with the human resources director, and one week with the director of risk management. Attendance at select conferences and educational opportunities would be expected to gain understanding and confidence in the position. Additionally, the LWPI Nurse Liaison would be versed in conflict management, therapeutic communication, and reporting process developed for incidences of LWPI. The plan for the LWPI Nurse Liaison position was to develop and implement policies within the clinical setting which addressed the progressive disciplinary process as supported by the organization's zero tolerance incivility and workplace violence policies. An initial evaluation period established for the position was at 90 days, then at six months, and annually thereafter.

Budget and Timeline

Costs for the LWPI Nurse Liaison Project were incurred by the project administrator. Costs for educational offerings were related to refreshments served during in-services at a cost of approximately five dollars per participant. A total of 19 participants for each of three presentations represented a cost of ninety-five dollars with an additional one hundred dollars utilized for the cost of stamps and envelopes to return surveys. Printing costs of surveys, unit advertisement, and other materials were absorbed by the individual facilities. No salary costs to participants occurred as attendance was voluntary although chief nursing officers at both facilities authorized staff to attend educational in-services while on duty if indicated. The project timeline is outlined in Appendix J.

Limitations

One immediate limitation to the LWPI Nurse Liaison project was the restricted time frame for the project. Future considerations could include a longitudinal study of longer duration. Because of the restricted time frame it was not feasible to return to the facilities after implementation of the position to assess its effectiveness.

The subjective nature of how individuals define incivility may influence data accuracy as experiences, exposure, and level of interest may be reflected in responses. The program was developed by the project administrator for healthcare employees which may affect the generalization of the program to other types of organizations, such as businesses, information systems, or academia.

During the timeframe of this project, neither organization immediately developed a position based upon the need and identified concerns of the staff. Organization B has launched several administrative meetings regarding the feasibility of a LWPI Nurse Liaison position, but as of the completion of this project had not committed to creating the position.

Chapter IV

Results

Workplace violence has been defined as unsolicited humiliation, rudeness, sarcasm, denial of opportunity for advancement, gossiping, open hostility, and blatant disregard for the welfare and safety of others. Historically, organizations have been a safe place to work, but increasingly, lateral workplace incivility (LWPI) is increasing from patients, visitors and colleagues. This unwarranted behavior is cited as a major cause of frustration, decreased morale, and decreased commitment to employers. These manifest as increased turnover, absenteeism, and decreased job productivity, all of which ultimately affect patient care and organizational viability. Additionally, nurses impacted by LWPI experience stress and decreased health.

The purpose of this capstone project was first to identify the understanding of, and exposure to, LWPI at two southeastern moderate sized facilities that provided a full range of psychiatric services. Additionally, this project presented a possible solution for dealing with negative behavior at the time of occurrence, thus preventing loss of morale, increasing job commitment and staff productivity, and decreasing the resultant risks to patient care.

Sample Characteristics

Surveys were submitted to all professional staff (registered nurses, licensed practical nurses, mental health technician, and therapists) in the psychiatric setting of two moderate sized suburban healthcare facilities. At organization A, 198 surveys were distributed to staff with 66 returned for a 33% response rate. At organization B, 17 surveys were distributed; two were returned by staff in positions addressed by this

project, for a 1.1% response rate. Due to the low response rate from organization B, only the 66 surveys of healthcare professionals from organization A were used in the data analysis for this project.

Demographics

Participants ranged in age from 23 to 64 years ($M = 39.38$, $SD = 12.03$). Five participants did not indicate their age. The mean years of experience reported by participants was 9.86 years ($SD = 10.21$). Fifty-seven (84.4%) of the participants were female, eight (12.1%) were male, and one person failed to indicate their gender. Nurses accounted for 55.4% of the respondents ($n = 36$), mental health technicians comprised 22.7% ($n = 15$), and therapists constituted 21.2% ($n = 14$) of the sample. One participant failed to indicate their job category.

Major Findings

Knowledge of Staff about LWPI

The first question this project proposed to address was the knowledge level of psychiatric healthcare staff regarding LWPI as measured by the Uncivil Workplace Behavior Questionnaire-revised (Martin & Hine, 2005). The potential scores for the subscales were: hostility 0 to 25, exclusionary behavior 0 to 25, and gossiping 0 to 20. Means for each subscale (standard deviations in parentheses) were hostility 10.58 (4.28), exclusionary behavior 7.37 (3.09) and gossiping 9.66 (4.10). The subscale responses by occupation are shown in (Table 1).

Table 1.

Occupation and experience of workplace hostility, gossiping, and exclusionary behavior

Type of Workplace Incivility	Profession	Mean	SE
Hostility	Nurses	2.38	.13
	Mental Health Technicians	2.00	.21
	Therapists	1.54	.22
Gossiping	Nurses	2.76	.16
	Mental Health Technicians	1.98	.25
	Therapists	1.98	.26
Exclusionary Behavior	Nurses	2.76	.16
	Mental Health Technicians	1.80	.25
	Therapists	1.69	.26

There was a negative correlation between a participant's job and reporting that they had experienced hostility ($R = -.391, p = .001$) or gossiping ($R = -.363, p = .003$) in the workplace. Nurses (RN/LPN) were more likely to report experiencing incivility and gossip in the workplace than were mental health technicians and therapists.

A multivariate analysis of variance (MANOVA) was conducted to examine if occupation was related to exclusionary behavior, hostility, or gossip in the workplace. A MANOVA was selected to reduce error while examining multiple dependent variables (e.g. exclusionary behavior, hostility, and gossip in the workplace) with one independent variable (e.g., occupation). There was a significant relationship between occupation and hostility, $F [2, 64] = 5.58, p = .006$. There was also a significant relationship between occupation and gossiping, $F [2, 64] = 5.21, p = .008$. Nurses reported the highest level of

experiencing workplace hostility, followed by mental health technicians (MHT), and then therapists. Nurses also reported higher levels of gossiping than MHTs. There was no relationship between occupation and exclusionary behavior, $F(2, 64) = .487, p = ns$.

Organizational Commitment and Intent to Stay

The Staying or Leaving Index (Bluedorn, 1982) and the Organizational Commitment Scale (Mowdy et al., 1979) were used to measure staff commitment. Because of the exploratory nature of this study, correlations were performed to determine significant relationship between the variables. There was a negative correlation between a participant's job and indicating that they were likely to leave the workplace due to incivility. Nurses were more likely to indicate they would be willing to leave their job due to incivility than were mental health technicians and therapists.

There was a positive correlation between a participant's age and scores on the Organizational Commitment Scale ($R = .272, p = .034$) with older participants indicating that they had more commitment to their organizations than did younger participants. There was also a positive correlation between a participant's years of experience and organizational commitment ($R = .262, p = .041$), as nurses with more years of experience had a higher organizational commitment.

There was also a significant positive relationship between scores on the Organizational Commitment Scale and reporting exclusionary behavior in the workplace ($R = .234, p = .067$) and experiencing gossiping in the workplace ($R = .353, p = .005$). Participants who experienced high levels of hostility, exclusionary behavior and gossiping indicated less organizational commitment than participants who did not experience lateral workplace incivility.

An analysis of variance (ANOVA) was performed to examine if age and years of experience were predictive of organizational commitment. A full factorial model for age by years of experience was examined. The interaction between age and years of experience was not significant and therefore it was excluded from the model. There was no significant main effect between age and organizational commitment, $F(24, 1) = 1.10$, $p = ns$, nor years of experience and organizational commitment, $F(20, 1) = 1.67$, $p = ns$.

To determine if there was a predictive relationship between organizational commitment and experiencing exclusionary behavior, hostility, or gossip in the workplace another ANOVA was conducted. A full-factorial model examining the interaction between exclusionary behavior, hostility, and gossip was run. There were no significant two-way or three-way interactions therefore, they were excluded from the model. An ANOVA conducted on the simple main effects revealed no statistically significant relationship between organizational commitment and exclusionary behavior, $F[10, 1] = 1.10$, $p = ns$, and hostility, $F[13, 1] = 1.10$, $p = ns$. There was also no significant relationship between gossip and organizational commitment, $F(14, 1) = 1.10$, $p = ns$.

Anticipated Use of LWPI Nurse Liaison

The final two project questions on whether psychiatric healthcare staff, educated on LWPI, would utilize an LWPI Nurse Liaison and whether, if doing so, staff would choose health promoting behaviors could not be addressed as neither organization A nor B implemented the LWPI Nurse Liaison position during the timeframe of this project. However, in organization A, where 17 staff completed program evaluations, 13 strongly

agreed that content of the program was helpful and relevant and four staff agreed that information was useful and relevant.

Summary

Workplace incivility is becoming commonplace in all work environments including health care. Research has supported the dangerous and distressing relationship between LWPI and nursing staff's overall health, organizational commitment, and intent to stay. This project explored psychiatric healthcare employee perception of workplace incivility and whether this influenced organizational commitment or intent to stay. Data were used to support discussions about creation of an LWPI Nurse Liaison position.

Chapter V

Discussion

This project examined exposure to lateral workplace incivility, job satisfaction, and intent to stay in the organization among nurses, mental health technicians, and therapists in an outpatient and inpatient psychiatric setting. Lateral workplace incivility has been linked in the literature to job dissatisfaction, employee turnover, employee stress and ill health, and ultimately to negative impact on patient care. Participants in this project were invited to complete four surveys, specifically demographics, the Uncivil Workplace Behavior Questionnaire-revised (Martin & Hine, 2005), the Staying or Leaving Index (Bluedorn, 1982), and the Organizational Commitment Scale (Mowdy et al., 1979). Sixty-six sets of surveys were returned, representing a 29% return rate. Data supported the assumptions that LWPI occurs in mental health nursing, that increased LWPI leads to decreased employee morale, and nursing staff want to work in a satisfying work environment.

Implication of Findings

Knowledge of Staff about LWPI

This addressed knowledge level of psychiatric healthcare staff regarding LWPI as measured by the Uncivil Workplace Behavior Questionnaire-revised (Martin & Hine, 2005). Nurses, mental health technicians, and therapists all reported experience with gossiping, workplace hostility, and exclusionary behavior. Nurses reported the highest level of experiencing both workplace hostility and gossiping, followed by mental health technicians, and then therapists. There was no relationship between occupation and exclusionary behavior which supports the assumption that LWPI incivility occurs across

the healthcare environment and not with one distinct profession. Implications are for organizations to develop programs that span the entire field of healthcare to address global bullying.

Organizational Commitment and Intent to Stay

Nurses were more likely to indicate they would be willing to leave their job due to incivility than were mental health technicians and therapists. One possible reason may be that nurses as a profession can find employment more easily than MHTs or therapists. Mental health technicians and therapists may be more willing to tolerate incivility to keep a job due to the decreased mobility and opportunities they have.

There was a positive correlation between a participant's age and years of experience with scores on the Organizational Commitment Scale. This was an expected correlation as someone who has stayed with the organization for an extended period of time would have already shown more organizational commitment. Those unhappy with their organization would have left before gaining the years of experience.

Participants who experienced high levels of hostility, exclusionary behavior, and gossiping indicated less organizational commitment than participants who did not experience LWPI. This correlation was expected, as literature suggests that professionals who experience negative work place behavior are less satisfied with their positions and have less organizational commitment.

Follow-up analyses were conducted to examine the predictive relationships between variables that showed a significant correlational relationship. The main effect was between organizational commitment and exclusionary behavior. The findings supported the literature that staff who does not feel a part of the team or organizational

support are less likely to report organizational commitment and will leave within the first year.

Surprisingly, no correlation between the variables studied and job commitment were revealed, indicating that perhaps there were other variables not assessed in the surveys, such as salary or type of unit, that might be at play. This indicates a need for a larger study in which salary scales and unit types are assessed. This also was in direct conflict with literature reviews and previous studies.

Anticipated Use of LWPI Nurse Liaison

Implications of developing a LWPI Nurse Liaison position are far reaching. Research has supported the high costs of training a new employee. The fact that psychiatric staff experience LWPI aligns with research demonstrating that LWPI is a problem throughout the healthcare arena. Development of a LWPI Nurse Liaison position could be utilized within any organization, as LWPI affects staff in many positions, working in all types of units and levels of care.

Application to Theoretical Framework

Application of Nola Pender's health promoting behaviors model (1975) was supported by staff feedback on educational in-service evaluations that they would utilize a LWPI Psychiatric Nurse Liaison. Psychiatric staff in this project did report exposure to LWPI and stated they would use a position if created. This parallels the model's assertions that when people perceive a negative stimulus, they process the information and decide either to make a health promoting behavioral change, such as use of the LWPI Psychiatric Nurse Liaison or confrontation, versus not choosing a health promoting behavior, possibly leaving the organization.

The behavior specific cognitions were not examined in detail such as barriers to making a positive decision and personal influences in making a decision. In retrospect, choosing to leave the organization could have been a positive health promoting behavior by decreasing the stress brought on by LWPI.

Limitations

The ability to generalize the project findings was limited in several ways. The survey was conducted in one southeastern state, which may not represent the nation as a whole. The survey was carried out in two psychiatric facilities with a small sample size of mental health staff, which may not represent the population of nurses, mental health technicians, and therapists nationwide. A small sample size and inadequate survey return rate for organization B did not allow for data extrapolation regarding knowledge and exposure to LWPI. Inability to control for number of times the participant completed the survey, and limited area of study (mental health) may have influenced generalizability of the findings.

Only responses from participants in organization A were used for data analysis. The exclusion of data from organization B due to low response rate may effect generalization of data results. This project did not include further investigation to determine why response rates were so low.

An underlying assumption from the literature is that staff desire to work in a good environment. A limitation of this study is that no data was collected to confirm or reject this assumption for psychiatric staff. In hindsight, this assumption should have been left out of the original indications for the project.

The subjective nature of how individuals define incivility for themselves, despite provision of a definition for the project, may influence data accuracy as experiences, exposure, and level of interest may be reflected in responses. Staff members with prior exposure to LWPI may have pre-conceived ideas of LWPI in the current workplace before completing questionnaires.

The education program was developed by the project administrator for healthcare employees which could affect the generalizability of the program to all types of organizations, such as businesses, information systems, or academia. Additionally, there was no follow-up after LWPI education, for instance at three to six months post-program, to assess the recurrence rate of incivility, staff member's use of learned skills, or whether creation of the LWPI Psychiatric Nurse Liaison position would have an effect on staff job satisfaction or intent to stay. Follow-up on turnover rates, and whether they were affected by creation of the LWPI Nurse Liaison position, was also limited by the timeframe of this project. Future considerations would include considering a longitudinal study of longer duration.

Both organizations were pleased with the project and its findings, but both reported financial complications which prevented them from moving on with the component of the project related to implementing a LWPI Nurse Liaison position. Organization B has launched several administrative meetings regarding the feasibility of a LWPI Nurse Liaison position but as of the completion of this project, have not committed to creating the position. Both organizations stated intent to re-evaluate the position in 2013 before the next budgetary year starts.

Lastly, during analysis of data it was discovered that the tool for measuring was coded differently than its intended coding, thus negating the variables of hostility and gossiping in determining organizational commitment. Recommendations include repeating the study with coding set up exactly as indicated in the tool.

Implications for Nursing

Allowing LWPI to occur can have adverse effects on any healthcare organization leading to apathy, low productivity, stress, and strained working relationships. The negative effects of these behaviors can be seen by the patients who in turn cause decreased revenue for the organization through complaints, lack of organizational loyalty by the consumer, and even negative publicity.

The implications for nursing are far reaching in that the ability to have immediate access to LWPI intervention may increase staff's awareness of uncivil environments and provide the support needed to address negative behavior. Rapid intervention to LWPI may enhance staff perceptions of organizational zero tolerance of uncivil work environments, thus indicating organizational value in the employee. In turn, positive perceptions of the organization and comfort level in knowing intervention is possible may increase the staff's willingness to commit to the organization. Addressing LWPI may, therefore, decrease organizational costs for recruitment and retention of qualified employees, improve overall staff health due to decreased stressors presented by LWPI, and ultimately enhance patient care and safety.

Recommendations

Organizations have an opportunity to recognize and respond to the dangerous effects of LWPI by establishing positions dedicated to addressing negative behavior.

Further study should be pursued to confirm this project's findings of decreased commitment due to LWPI. This should include examination of other variables which may affect organizational commitment, such as salary, work flow, or type of patient encountered, to determine strength of correlation of organizational commitment with LWPI.

Results of this project may be used to justify the development of, and financial investment in, positions such as the LWPI Nurse Liaison within an organization. Viability of this position could be reinforced through ongoing evaluation of staff perceptions of exposure to LWPI and intervention program efficacy through surveys and monitoring of retention data.

Conclusion

The negative implications of LWPI and its effects of job satisfaction, organizational commitment and intent to stay are well described in the literature. Stress caused by uncivil behaviors decreases general health and well-being, interferes with performance and interpersonal interactions, may lead to exiting behaviors in the workplace, and ultimately affects patient care and organizational viability. While non-physical peer to peer incivility has been documented in varying types of healthcare units, such as pediatrics and medical-surgical units, little attention has been given to the psychiatric environment. Most literature about the emergency department and psychiatry discusses physically violence initiated predominately by patients and family members.

Accrediting agencies, such as the Joint Commission and Occupational Safety and Health Administration, have called for "zero tolerance" policies to afford safe, ethical treatment of employees in healthcare. Implications of incivility education and

development of a LWPI Nurse Liaison position are far reaching. Addressing negative behavior will meet regulatory requirements, provide an ethical framework for practice, and ultimately positively impact patient care. As more staff report job satisfaction there is a correlational decrease in turnover rates and finances needed to orient new staff for positions.

Costs of LWPI are staggering to organizations in terms of staff training, commitment to the organization, patient satisfaction, overall patient safety, and staff general well-being. Identifying the types of incivility and their relevance to nursing staff is critical to understanding key attributes of staff retention. Development of organizational policies supporting a zero tolerance of LWPI is also critical. These steps indicate organizational support of a happy and productive staff which directly affects job commitment and indirectly affects patient safety and satisfaction.

The Health Promoting Behaviors model developed by Nola J. Pender provides a theoretical framework for how healthcare staff perceive, process, and act upon incidences of incivility. The model provides guidance for the development of a LWPI Nurse Liaison role to assist staff in positively responding to acts of incivility, thus improving their health, productivity, and job satisfaction. Organizations poised to provide support for controlling workplace incivility stand to gain commitment from the employees, financial savings due to decreased absenteeism and turnover, and enhanced public image from satisfied patients.

The project administrator created and presented an educational offering on identification of uncivil behavior in the workplace and methods for addressing LWPI. Education also covered responsibilities for organizations to confront LWPI, perhaps with

development of a LWPI Nurse Liaison position. Effective development and use of a LWPI Psychiatric Nurse Liaison position would be used as an intervention to promote health. It is surmised that staff who effectively utilize the LWPI Psychiatric Nurse Liaison could improve their overall health, commitment to the organization, and intent to stay. These both demonstrate positive application of Nola Pender's theory.

Implications for the future include development of an educational in-service with particular focus on addressing needs of females and new graduates, the populations experiencing the most incivility. With staff "buy-in" and use of the position several assumptions are supported. Those include making changes to a positive "healthy" environment which in turn enhances staff commitment to the organization, improves patient perceptions and satisfaction with the organization, and improves overall safe working environments with organization viability.

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Appendix A

Demographic Questionnaire

Demographic data: Please check the most appropriate response

I am a: RN _____

 LPN _____

 MHT _____

 Therapist _____ (includes counselors, rec. therapy, etc.)

Gender: Male _____

 Female _____

Age: _____

Years of experience in healthcare: _____

Appendix B

Uncivil Workplace Behavior Scale - Revised

R. Martin and D.W. Hine (2005)

Reproduced with permission

Please circle the number most relevant in the right hand column. Scale to be used is 1 = Never, 2 = Rarely, 3 = Occasionally, 4 = Often, 5 = Very often, 0 = Does not apply.

During the past **12 months**, or as long as you have been with your current organization, how often have you been in a situation where a co-worker:

- | | | | | | | |
|---|---|---|---|---|---|---|
| 1. Avoided consulting you when they normally would be expected to do so. | 1 | 2 | 3 | 4 | 5 | 0 |
| 2. Talked about you behind your back. | 1 | 2 | 3 | 4 | 5 | 0 |
| 3. Was excessively slow in returning your phone messages or emails without good reason for the delay. | 1 | 2 | 3 | 4 | 5 | 0 |
| 4. Used an inappropriate tone when speaking to you. | 1 | 2 | 3 | 4 | 5 | 0 |
| 5. Was unreasonably slow at dealing with matters that were important to you. | 1 | 2 | 3 | 4 | 5 | 0 |
| 6. Gossiped behind your back. | 1 | 2 | 3 | 4 | 5 | 0 |
| 7. Publicly discussed your personal information. | 1 | 2 | 3 | 4 | 5 | 0 |
| 8. Spoke to you in an aggressive tone of voice. | 1 | 2 | 3 | 4 | 5 | 0 |
| 9. Intentionally failed to pass on information to you. | 1 | 2 | 3 | 4 | 5 | 0 |
| 10. Made snide remarks about you or to you. | 1 | 2 | 3 | 4 | 5 | 0 |
| 11. Raised their voice while speaking to you. | 1 | 2 | 3 | 4 | 5 | 0 |
| 12. Did not consult you in reference to a decision you should have been involved in, such as leaving the unit, going on break, etc. | 1 | 2 | 3 | 4 | 5 | 0 |
| 13. Rolled their eyes at you. | 1 | 2 | 3 | 4 | 5 | 0 |

Appendix C

Permission to Use Uncivil Workplace Behavior Scale - Revised

From: Donald Hine
Sent: Wednesday, February 29, 2012 1:19 AM
To: Mr. Christopher Lee Brown
Subject: Re: Permission to use the Uncivil Workplace Behavior Scale-revised (UWBQ) for capstone research

Dear Christopher,
 Thanks for your interest in our work. Please find attached a copy of the UWBQ. There are no costs associated with using the questionnaire, and please feel free to modify to suit your needs.
 Good luck with your research.
 Don



Don Hine PhD
 Professor, Psychology
 School of Behavioral, Cognitive and Social Sciences
 University of New England
 Armidale NSW 2351 Australia
 61 2 6773 2731

From: Mr. Christopher Lee Brown
Date: Wed, 29 Feb 2012 02:59:26 +1100
To: Don Hine
Subject: Permission to use the Uncivil Workplace Behavior Scale-revised (UWBQ) for capstone research

Dear Dr. Hine,
 I am a doctoral student at Gardner-Webb University, and I plan to undertake capstone research this fall in relation to lateral workplace incivility in mental health staff. I am extremely interested in using the UWBQ-revised scale developed by you and am writing to request permission for its use or referral to how I can purchase a copy for use. Any information you can provide on proper use of the instrument is appreciated. Thank you in advance for your help. I hope to hear from you soon.

Respectfully:

Christopher Brown
 Doctoral student, nursing practice
 Gardner-Webb University

Appendix D

Staying or Leaving Index (SLI)

Allen Bluedorn (1982)

Reproduced with permission

Please answer the questions based upon the scale 7 = definitely, 6 = very likely, 5 = likely, 4 = so-so, 3 = unlikely, 2 = very unlikely, 1 = definitely unlikely.

How do you rate your chances of still working at this healthcare facility?

- | | | | | | | | |
|---------------------------|---|---|---|---|---|---|---|
| 1. Three months from now: | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 2. Six months from now: | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 3. One year from now: | 7 | 6 | 5 | 4 | 3 | 2 | 1 |

How would you rate your chances of quitting this healthcare facility?

- | | | | | | | | |
|---------------------------|---|---|---|---|---|---|---|
| 1. Three months from now: | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 2. Six month from now: | 7 | 6 | 5 | 4 | 3 | 2 | 1 |
| 3. One year from now: | 7 | 6 | 5 | 4 | 3 | 2 | 1 |

How would you rate lateral workplace incivility as a factor in deciding to stay or leave?

7	6	5	4	3	2	1
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How would you rate an active plan to address incivility in your decision to stay or leave the organization?

7	6	5	4	3	2	1
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Appendix E

Permission to Use Staying or Leaving Index

Hi Christopher,

You certainly have my permission to use the Staying or Leaving Index (SLI) in your academic, noncommercial research. Attached is a PDF of the publication in which I presented it originally (see pp. 93-99), including instructions on how to use it.

Good luck with your research.

Al

Allen Bluedorn
Associate Dean for Graduate Studies and Research
Emma S. Hibbs Distinguished Professor
Robert J. Trulaske, Sr. College of Business
University of Missouri
Columbia, Missouri 65211-2600
573-882-3089

From: Mr. Christopher Lee Brown
Sent: Tuesday, February 28, 2012 10:14 AM
To: Bluedorn, Allen C.
Subject: Permission to use Turnover Intentions Measure for capstone research

Dear Dr. Bluedorn,

I am a doctoral student at Garner-Webb University, and I am planning to undertake capstone research in the fall on lateral workplace incivility in mental health professionals as it relates to intent to leave the workplace. I am interested in using the Turnover Intentions Measure you developed and am writing to request permission for its use or referral to a site where I can purchase it for use. Any information you can provide on proper use of the tool is greatly appreciated. Thank you in advance for your help. I hope to hear from you soon.

Respectfully:

Christopher Brown
Doctoral student, Nursing practice

Appendix F

Organizational Commitment Questionnaire (OCQ)

Mowday, Steers, and Porter (1979)

Reproduced with permission

Please respond to the question by circling the answer.

- | | | |
|---|-----|----|
| 1. I am willing to put a great deal of effort beyond that normally expected to help this organization be successful. | Yes | No |
| 2. I talk up this organization to my friends as a great place to work | Yes | No |
| 3. I feel very loyal to this organization. | Yes | No |
| 4. I would accept almost any job assignment in order to keep working for this organization. | Yes | No |
| 5. I find that my values and the organizations values are similar. | Yes | No |
| 6. I am proud to tell others that I work here. | Yes | No |
| 7. I could just as well work for another organization as long as the work is the same. | Yes | No |
| 8. This organization inspires the best in me in the way of job performance. | Yes | No |
| 9. It would take very little change in my present circumstances to cause me to leave this organization. | Yes | No |
| 10. I am extremely glad that I chose this organization to work for. | Yes | No |
| 11. There is not much to be gained by staying here indefinitely. | Yes | No |
| 12. Often, I find it difficult to agree with this organization's policies on important matters relating to its employees. | Yes | No |
| 13. I really care about this organization. | Yes | No |
| 14. For me, this is the best of all organizations for which to work. | Yes | No |
| 15. Deciding to work for this organization was a definite mistake. | Yes | No |

Thank you for taking the time to complete this survey. Your answers are confidential and in no way reported individually to the organization. To assure your answers are anonymous, please put the survey into the stamped return envelope and mail to my attention. Any questions or concerns can be directed to my personal cell phone at ().

Again, thank you for participating as your input is invaluable.

Christopher Brown
 Doctoral candidate, nursing practice
 Gardner-Webb University

Appendix G

Permission to Use Organizational Commitment Questionnaire (OCQ)

From: Porter, Lyman

To: Mr. Christopher Lee Brown

Thursday, March 22, 2012 7:30 PM

Dear Mr. Brown:

No permission is required to use the OCQ. It is in the public domain. Good luck on your research project.

Lyman Porter

From: Christopher Lee Brown

To: lwporter@uci.edu

Sent: Thursday, March 22, 2012 11:49 AM

Dear Dr. Porter,

I am a doctoral student at Gardner-Webb University and I am planning on undertaking capstone research this summer on the topic of lateral workplace incivility in mental health nursing and its relationship to organizational commitment and intent to stay. One of the instruments I would like to use is the OCQ developed by you. I am writing to request your permission for use of the tool or referral to a site where I can purchase the tool for use. Any information you can provide on proper use of the tool is greatly appreciated. Thank you in advance for your help. I hope to hear from you soon.

Respectfully:

Christopher Brown

Doctoral student, Nursing practice

Appendix H

Projected Timeline for Development and Implementation of LWPI Nurse Liaison

Date	Activity	Recommendations
Feb. 24, 2012	Meeting with hospital admin. Organization B	Given approval for project
Mar. 23, 2012	Meet with hospital admin. Organization A	Given approval for project
May, 2012	Distribution of surveys to organization A and B	Pending survey results
Jun., 2012	Compilation of survey results	
Jul., 2012	Meeting with admin Organization B with results	Identified need for project
Jul., 2012	Meeting with CNO Organization A with results	Decision made to exclude organization A data from project (poor survey response)
Aug., 2012	Several meetings with HR director, nursing director to develop job description	LWPI Nurse Liaison job description, screening, and interview process developed; interview committee members.
Aug., 2012	Development of educational in services	
Oct., 2012	LWPI in-services and presentation of Nurse Liaison Position to Organization B	
Nov., 2012	LWPI in-services and presentation of Nurse Liaison Position to Organization B.	
Nov. 8, 2012	Final meeting with CNO organization A	Data kept. Interest exists for LWPI position; budgetary constraints prohibit hiring. Based upon educational offerings, organization A developed a LWPI task force and will move forward in 2013
Nov. 12, 2012	Final meeting with admin. Organization B	Data kept. Interest exists for LWPI position; budgetary constraints prohibit hiring for the position developed. Task force developed to consider adding aspects of the position to the current nursing supervisor role
Dec., 2012	Project completed	Based upon budget the organizations did not move forward with marketing, interviewing, and hiring a position as proposed initially

Appendix I

LWPI Nurse Liaison Job Description

JOB DESCRIPTION:**TITLE: Psychiatric Nurse Liaison****REPORTS TO: Facility Chief Operating Officer****STATUS: Exempt****SUPERVISES: No Direct Supervision****SUMMARY OF JOB DUTIES:**

- Develops organization policies and procedures related to workplace incivility.
- Assumes responsibility for educating new employees regarding workplace incivility, assures current staff's education and role in workplace incivility.
- Assumes responsibility for direct intervention, coaching, and counseling of employees when workplace incivility is identified; maintain records of interventions.
- Chair team responsible for determining outcomes, progressive discipline for repeated acts of workplace incivility.
- Serves as a role model for appropriate workplace behavior.

QUALIFICATIONS AT ENTRY:

Must possess a minimum of a bachelor's degree from an accredited school of nursing and have a current unencumbered RN license in the state of practice. Must demonstrate sound leadership skills and utilize these skills in organizing the activities for medical and/or non-medical tasks. Must have a record of consistently high quality of clinical and interpersonal skills to be an exemplary role model to others. Displays basic knowledge of treatment procedures; displays knowledge of interventions common to acute psychotic as well as to non-violent crisis intervention practice; basic knowledge of abnormal psychology and application of this knowledge through the provision of nursing care; basic knowledge of medical terminology especially those terms associated with the treatment of psychiatric and addictive disease care; thorough familiarity of psychopharmacology and the use of psychotropic medications as a part of the treatment of psychiatric and addictive disease care; basic teaching and training skills; skill in facilitating or co-facilitation psycho-educational groups, eligible for CPR certification; ability to establish and maintain effective working relationships with peers; willingness to maintain all medical/staff interventions as highly confidential.

Must be able to develop organizational policies and procedures regarding instances of lateral workplace incivility as well as actively serve or chair a committee of staff and administration which reviews and addresses repeated violations of workplace incivility policies. Must be responsible for education of new staff as well as current staff; education and evaluation of the program. The position will be evaluated for its effectiveness yearly by the chief operating officer of the facilities.

PHYSICAL AND MENTAL REQUIREMENTS OF JOB:

Able to stop, crouch, reach, walk, and stand for sustained periods of time; use extremities to press against something with steady force, as well as pull objects, using extremities to draw, drag, haul, or tug in a sustained motion; able to feel, grasp, and finger objects and lift them from a lower to higher position or horizontally from one position to another; express and exchange ideas via spoken or written work to convey detailed information in an audible and quick manner, able to make fine discriminations in sound and to perceive the nature of sounds with no less than a 40lb loss @Hz, 1,000 Hz and 2,000 Hz, with or without correction; able to substantially move wrist, hands and/or fingers in a repetitive motion.

Must be able to exert up to 20 lbs. of force occasionally, and/or up to 10 lbs. of force frequently, and occasionally exert up to 50 lbs. of force.

VISUAL ACUITY:

Visual acuity required adequate for preparing and analyzing data and figures, accounting, transcription, characters on computer terminals, reading, and visual inspections necessary.

PHYSICAL SURROUNDINGS:

The worker is not substantially exposed to adverse environmental conditions.

EMOTIONAL OR MENTAL STRESS:

Must be able to work with distractions including the physical health and well-being of the acutely ill psychiatric patient. Must be able to deal with aggressive, hostile and irrational behaviors of patients and staff. Must be able to respond immediately in crisis situations concerning patients, family members, and/or staff.

The above statements are intended to describe the general nature and level of work being performed by people assigned to this classification. They are not intended to be construed as an exhaustive list of all responsibilities, duties and skills of personnel so classified.

Appendix J

Proposed Project Timeline

Month	Activity	Expected Completion Date
Jan. 2012	Class starts, meet with chair.	Feb. 2012
Feb. 2012	Meet with facility(MBMH) CNO and director of gero-psych for Incivility power point presentation, tour unit, etc.	Feb. 24, 2012
Mar. 2012	Obtain instrument developers for permission to use tools.	Mar. 2012
Mar. 3, 2012	Proposal sent to chair for review	Mar. 2012
Mar. 9, 2012	Meet with Chair to review practice logs, discuss proposal draft.	Mar. 9, 2012
Mar. 23, 2012	Meet with facility (CCBH) CNO, COO, Risk manager, HR director to present the Incivility power point presentation. Discussion of how proposal to be completed.	Mar. 23,2012
Apr., 2012	Attend unit staff meetings at facilities x 2. Introduce staff to proposal	Apr., 2012
May, 2012	Anonymous surveys out	Jun., 2012
Jun., 2012	Analyze surveys	Jun., 2012
Jul. – Aug., 2012	Employee educational sessions on Incivility, creation of liaison role.	Aug., 2012
Oct., 2012	Data to statistician	Jan., 2013
Feb., 2013	Final presentation to facilities based upon statistics.	Feb., 2013
Mar., 2013	Final meeting with chair before submission.	Mar., 2013
Mar - Apr., 2013	Final project to library for binding, committee defense.	Apr., 2013