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Incivility Among Nurses - Prevalence and Impact

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INCIVILITY AMONG NURSES – PREVALENCE AND IMPACT

by

Nadin Knippschild

A thesis submitted to the faculty of
Gardner-Webb University School of Nursing
in partial fulfillment of the requirements for the
Degree of Master of Science in Nursing

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Date

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Abstract

Title: Incivility among nurses – prevalence and impact.

Incivility, horizontal violence, uncivil behavior or bullying are only a few terms used to describe the conduct one individual may display toward another that are undesirable in healthcare organizations and consequently gained the attention of regulatory agencies, such as The Joint Commission. Incivility adversely affects healthy work environments, impedes with patient safety and collaboration, has negative financial implications for organizations, and represents an ethical concern in nursing. The purpose of this study was to identify the overall prevalence as well as prevalence based on work areas. In addition, further aims were to examine the likelihood of the study participants calling in sick and/or leaving the organization/department.

The study design was descriptive correlational and utilized a web-based survey distributed to 581 nurses (577 registered nurses and 4 licensed practical nurses) at a 258-bed acute care facility in Western North Carolina. The sample (n= 153) was obtained via non-random convenient sampling. The assessment tool was based on the Horizontal Survey, which was used and modified with the author's permission. Descriptive and correlational statistics revealed the General Medical Unit to have the highest prevalence (M = 4.1, SD = 0.8) in this sample. No correlation was found between the experience of incivility and work absences, whereas, the subjects' expressed thought calling in sick showed a weak correlation to the subjects' active job seeking (r = 0.567). The findings of this study may assist nurse leaders in creating improved work environments as well as inform future research.

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Chapter I - Introduction

At the core of nursing is the desire to care for other human beings. “The majority of health care professionals enter their chosen discipline for altruistic reasons ... “ (TJC, 2008). Sadly, however, that same caring nature does not necessarily pertain to nurse-to-nurse interpersonal relationships. Andersson and Pearson (1999) point out that the United States has evolved into a society of “whatever, implying that no one wants to make a judgment, impose a standard, or call a conduct unacceptable” (p. 453). Further emphasizing this fact, Harris (2011) notes, “many nurses know colleagues, nursing faculty or nursing leaders who practice incivility” (p. 16). Many terms have been used to describe an increasingly occurring behavioral phenomenon that can be observed in the workplace. Those terms range from lateral violence (LV), horizontal violence (HV), horizontal hostility (HH), and bullying to more recently workplace or nursing incivility (Harris, 2011; Stanley, Martin, Michel, et al. 2007). Nursing incivility is the disruptive behavior that is often considered ‘milder’ and ranges from overt manifestations such as silent treatment, to sarcasm, disparaging tones and remarks. Generally, the three key characteristics describing incivility are that they represent a norm violation, have an ambiguous intent, and are of low intensity (Lim, Cortina, & Magley, 2008). The concept of workplace incivility has been well described in the literature for nearly two decades, with many studies surfacing in recent years examining sources of incivility, the impact on nurses’ physical and psychological health as well as the impact on the nursing environment in healthcare facilities. Nurses have historically been subject to incivility from many different groups, such as physicians, patients and/or their families. Although,

some level of incivility has been around forever, the issue appears to have become more prevalent and more severe in hospitals across the country.

Purpose

The purpose of the research study “*Incivility among nurses –prevalence and impact*” was to examine and describe the prevalence of incivility experienced by nurses in a mid-size, suburban, acute healthcare organization in Western North Carolina. The study sought to identify the overall prevalence as well as prevalence based on work areas. In addition to the prevalence, further aims were to examine the likelihood of the study participants calling in sick and/or leaving the organization/department. The data from this study may aid in identifying areas with greater risk of nursing incivility and potential turnover in order to enhance strategies to improve work environments as well as retention of professional staff.

Background and Significance

With many nurses nearing retirement, it is imperative to evaluate causes for attrition in nursing departments. Aiken and Cheung (2008) note that the US has the largest professional nurse workforce in the world with almost 3 million nurses; however, the US does not produce enough nurses to meet its growing demand (p. 4). They further predict a shortage of over 650,000 professional nurses by 2015 and just over one million by 2020 (Aiken & Cheung, 2008, p. 29). Faced with such imminent nursing shortage, losing nurses as a result of factors related to the work environment is unfavorable; furthermore, it is critical that nursing work environments are structured in ways that increases nursing retention.

Incivility has a wide-reaching impact. Leiter and Maslach point out that “annual

cost of stress alone due to incivility at US corporations is \$300 billion” (as cited in Harris, 2011, p. 16). The economic impact associated with behavioral disturbances, such as incivility is not only costly but also effects patient safety as it effects nursing staffing patterns, turnover and vacancy rates. Harter and Moody (2010) estimate the cost to recruit, hire, and orient medical surgical nurses to be \$92,000 and \$145,000 for specialty nurses. Aside from costs related to recruitment and orientation, additional “costs come from emotional and physical symptoms that result from lateral violence” and may manifest itself in increased use of sick leave (Harter & Moody, 2010, p. 4). Lim et al. (2008) found significant relationships between incivility, employee health and wellbeing as well as turnover intentions. In addition, research has linked incivility with outcomes as noted by Cortina et al. (as cited in Spence Laschinger, Leiter, Day, & Gilin, 2009) who “linked workplace incivility to important organizational outcomes, such as work distress, job dissatisfaction, and withdrawal behaviours...” (p. 303). This knowledge emphasizes the need for incivility prevention.

In 2008, The Joint Commission acknowledged incivility as a significant concern in healthcare by issuing a Sentinel Event Alert stating, “Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments.” (TJC, 2008). Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. Wilson, Diedrich, Phelps, and Choi (2011) note that incivility has become such a commonplace occurrence that The Joint Commission “implemented a standard beginning January 2009 requiring accredited

hospitals to define and address all forms of disruptive behavior” (p. 453). It is apparent that in order to maintain patient safety as well as a healthy work milieu, healthcare organizations must create a respectful environment that fosters collaboration and communication.

Nursing incivility is in conflict with what is considered ethical conduct for nurses as outlined in the Nursing Code of Ethics. In specific, Provision 1.5 describes interpersonal relationships as follows: “The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems” (ANA, 2001, p. 1).

Extensive literature is available on the broad topic of workplace hostility and even a growing body of knowledge regarding nursing incivility in specific. However, only a limited number of studies are available which examine the overall prevalence of nursing incivility in correlation with departmental prevalence. An additional component in this study is to examine the likelihood of absences from work or leaving the department or organization entirely. This research study aims to answer the following questions:

Research Questions

1. What is the overall prevalence of nursing incivility experienced by nursing staff in the organization?
2. Is there a significant difference of incidences among the different units (such as Medical, Surgical, Emergency Department, Critical Care Unit, Day Surgery, and so forth)?

3. Is there a greater likelihood of call-ins or nurses leaving the organization/department in those individuals that experience nursing incivility?

Definitions/Variables

Andersson and Pearson (1999) were the first ones to present the concept of workplace incivility and defined it as “low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. Uncivil behaviors are characteristically rude or discourteous, displaying a lack of regard for others” (p. 457). Incivility is a single term used to describe rude, disruptive, intimidating, and undesirable behaviors toward another person (Harris, 2011). A perpetrator of incivility often uses abnormal, aggressive behaviors in an effort to gain control and power. Examples of such uncivil conduct include sarcasm, hostile stares, silent treatment, spreading rumors, badgering, back-stabbing, verbal abuse, continual criticism, failing to support a co-worker, intimidation, spreading rumors, undermining of work, destroying someone’s confidence, loosing one’s temper, and so forth (Harris, 2011; Lim et al., 2008). Harris (2011) also emphasizes that for the people involved, incivility often results in psychological or physiological distress. Incivility, or uncivil behavior, will be measured using a survey created based largely on the horizontal violence survey, which has been modified with the author’s permission.

Additional variables in this study are absences and turnover. A *work absence*, or calling-in/out sick, for the purpose of the proposed research project is defined as any self-reported employee initiated failure to report for a scheduled shift. The cause for such absence is rooted in self-reported physical or psychological manifestations as a result of incivility. To measure this variable, a three-item questionnaire will be developed in

collaboration with the study facility's primary researcher (Director for the Department of Research and Evidence-Based Practice) to elicit expertise. *Turnover*, in the context of the proposed study, is defined as any self-reported likelihood of the employee initiating a request for discontinuing employment at the organization/department. Turnover will be measured using the three-item job withdrawal scale.

Theoretical Framework

The Affective Event Theory, or AET serves as the theoretical framework used to guide this research project. AET seeks to aid in explaining the “role of emotion and evaluative judgment in the relationship between an individual's experiences and his or her behaviors.” (Carlson, Kacmar, Zivnuska, Ferguson, Whitten, 2011, p. 298-299). The core premise of AET is that one's affective response to workplace events mainly determines one's attitudes and consequent behaviors. AET stresses the role of affective response in the development of work attitudes. Carlson et al. (2011) note “affect refers to employees' moods and emotions, attitude is an evaluative, cognitive judgment based on affect” (p. 298). AET specifically identifies job satisfaction as an attitude that arises out of one's affective state or mood. Per Lim et al. (2008), job satisfaction drives factors such as turnover; furthermore, negative incidents tend to generate stronger effects than positive events do. “Empirical research has supported the basic tenets of AET, as studies have demonstrated that emotional experiences explain how a number of workplace events influence job satisfaction, counterproductive work behaviors, and organizational withdrawal” (Carlson, et al., 2011, p. 298-299). Given the nature of this inquiry into individuals' attitudes, moods, and behaviors, the AET appears well suited to providing

structural and conceptual guidance (see Figure 1).

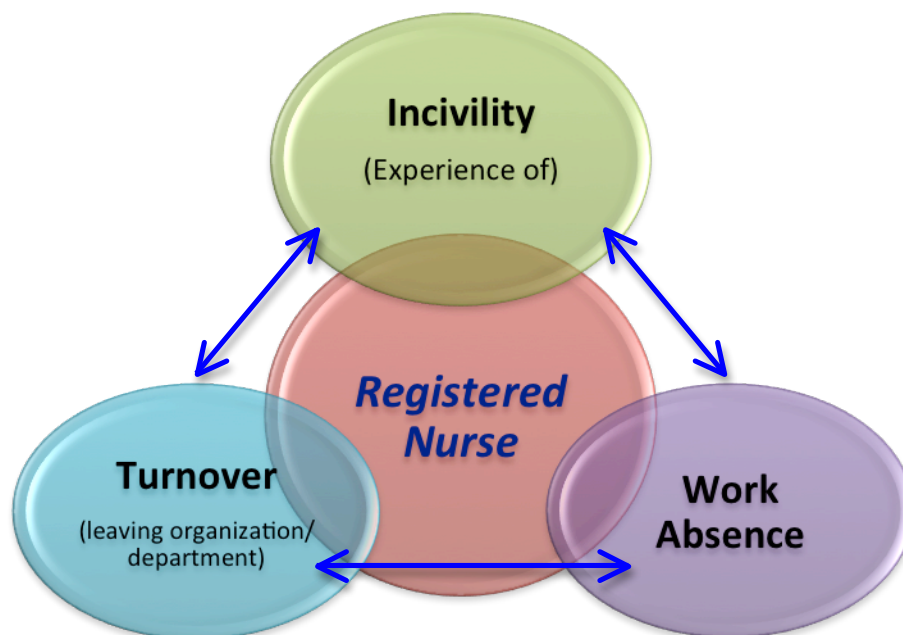


Figure 1: Schematic Theoretical Framework

In summary, the research study “*Incivility among nurses – prevalence and impact*” is an extension of previously conducted studies. This particular study has the potential to identify areas that are at greater risk for experiencing incivility and explore the perceived impact of such. In addition, the study will provide insight into the correlation between experiencing incivility and organizational outcomes such as work absences and turnover. Andersson and Pearson (1999) argued that workplace incivility left unchecked might spiral into workplace violence. The knowledge gained has the potential to educate enhancements to the work environment and processes within.

Chapter II – Review of Literature

The past two decades have brought forth many research studies and literature examining the nature and impact of disruptive behavior in workplaces. Searching the online library for nursing and allied health journals (CINAHL) using the keywords incivility, or lateral violence, or horizontal violence yields 218 articles ranging from the year 1995 to 2012. The origins of the articles show how widespread the issue of disruptive behavior is globally with studies from China, Australia, and New Zealand to name a few. To further narrow down the search, the keywords ‘incivility and nursing’ were used with the parameters of showing only peer reviewed articles that are available in full text and were published between 2008 and 2012. This search yielded 23 articles of which a number serve for this review of the literature.

Stanley and colleagues (2007) set out to examine nursing lateral violence (LV) in a southeastern tertiary care medical center in their study ‘Examining Lateral Violence in the Nursing Workforce’. To accomplish this task, the authors developed a survey instrument to gather information about nurses’ perception regarding existence of LV in the workplace. The authors described their primary objective as pilot testing the instrument for measuring LV so that nurse leaders can intervene appropriately in their setting. The study was conducted on 35 inpatient units at a tertiary care center in the Southeast. Approximately 1850 registered nurses and ancillary staff were contacted and invited to participate in the survey via institutional e-mail. This non-random convenient sample generated a response rate of 36%, or 663 responses of which 91% were registered nurses. Stanley et al. (2007) found that 46% of the respondents reported that LV

behaviors were 'very serious' (14%) or 'somewhat serious' (32%); furthermore, they found that 18% of respondents acknowledged perpetrating LV 'often' or 'sometimes'. They also found that 14% of the respondents reported that LV was a major contributing factor in their decision to leave a nursing position. Stanley and colleagues survey also had a qualitative component. Respondents noted "rude behavior is common in the work area and adopted by coworkers" and that participants in the survey stated LV recipients were "unwilling to stand up to his or her coworker or was not supported by others" (Stanley et al., 2007, p. 1258). After this pilot study of the survey tool, the following conclusions were drawn by the authors: a) LV contributes to stress and tension in the workplace, b) respondents attributed unit-by-unit variances to nurse manager expertise and the ability of individual nurse to deal with LV, c) even when positive mediators (example believe that something can be done about LV) are present or an individual does not perceive LV to be a problem, the presence of oppressors (such as unwillingness to stand up to oppressor or inadequate staffing) will likely outweigh the positive influencers that could prevent LV (Stanley et al., 2007).

Hutton and Gates (2008) sought to examine the association between demographics and workplace incivility in their study 'Workplace Violence and Productivity Losses Among Direct Care Staff'. The authors note that research has shown the costs of workplace violence to the healthcare industry; however, few researchers have studied the human and financial cost of incivility in healthcare workplaces (Hutton & Gates, 2008). The authors' specific aim in their study was to examine the incivility experienced by direct care staff in health care workplaces. The setting in this study was a large hospital in a metropolitan area in the Midwest that had 10 inpatient units, an

emergency department, and outpatient clinics. The participants in the study were direct care registered nurses and nursing assistants. A total of 850 survey packets, including an information sheet and direction sheet, were distributed to direct care staff. The original data collection phase of two weeks was extended to a total of four weeks due to initial low survey return rate. 184 surveys, or 22% were returned with 145 from RNs and 33 from nursing assistants. The survey results showed a mean frequency of incivility of 2.13 (SD = 0.50) with the lowest frequency from direct supervisors (M=1.38), whereas the greatest frequency was from the general environment (M=2.5). The authors found a correlation between workplace incivility from direct supervisors and productivity ($r=0.284$) and incivility from patients and productivity ($r=0.204$). They concluded that the source of incivility has a greater impact on productivity than the frequency of incivility. Hutton and Gates also examined the cost of incivility. They found the mean per-person cost from decreased productivity was \$1,235.14 for nursing assistants and \$1,484.03 for RNs. In this setting, the total losses for the sample were estimated at \$264,847.34 and \$1.2 million for all direct care staff annually. The main limitation of this study was the low response rate of 22% leaving sampling error as possible factor.

The aim of the study published by Lim et al. (2008) was to develop a theoretical model of the impact of workplace incivility on employees' occupational and psychological well-being. Lim et al. (2008) argue that "exposure to incivility in the workplace is a type of job stressor that can be experienced at a personal level (being a direct target) as well as a characteristic of the work environment that can manifest at the group level" (p. 96). This particular study was actually sub-divided into two studies. In study one, the authors tested the model of 1,158 employees, finding that satisfaction with

work and supervisors, as well as mental health, partially mediated effects of personal incivility on turnover intentions and physical health. This process that was identified did not vary by gender. In study two, these results were cross-validated and in addition, the results were extended on an independent sample of 271 employees, showing negative effects of workgroup incivility that emerged over and above the impact of personal incivility. Lim and colleagues proposed in their model that effects of workplace incivility on employee well-being are mediated job related affect. Lim et al. (2008) note that management should model appropriate workplace behavior and clearly state expectations of civility in mission statement.

A recent study by Wilson et al. (2011) examined the impact of horizontal hostility in the hospital setting as it relates to the intention to leave the organization. Following the review of the literature, the authors felt that additional research was needed to fully explore the incidence of peer incivility in the hospital setting and the impact on RN turnover. Therefore, the authors surveyed RNs at a community hospital in the Southwest to determine a) the degree of Horizontal Hostility (HH) in the workplace and b) the extent that the perception of HH affected ill calls and the likelihood of leaving their current position. Wilson and colleagues used a retrospective descriptive cross-sectional design in conducting the study. The survey tools used were the AACN survey (from the study "Silence Kills") and the "Lateral Violence in Nursing Survey". One hundred thirty surveys were completed, representing a response rate of 26%. In this study, Wilson and her colleagues found that most nurses (85%, n=105) had seen or experienced HH in the hospital environment. Additionally, they found that nearly 90% noted difficulty in confronting someone who was exhibiting HH, and 20% admitted to calling in ill at some

point because of perceived hostile environment. Furthermore, nurses who had witnessed or personally experienced HH were significantly more likely to plan to terminate employment. Given the results of this study, the authors suggest, “An assessment of the hospital work environment should include nurse perception of hostility or intimidating behaviors. Steps must be taken to educate staff, managers, and leaders to minimize the occurrence of HH and provide effective systems and processes for handling HH if these behaviors occur.” (Wilson et al., 2011, p. 457).

Dumont, Meisinger, Whitacre, and Corning conducted a national online survey in the months of March through May of 2011 investigating the frequency of horizontal violence (HV) as well as information about the perpetrator of HV and how HV has affected the nurses who experience it. The survey had 955 respondents of which 778 (82%) reported experiencing or witnessing at least one event of HV daily or weekly. The most frequent perpetrator of HV was reported to be nurse peers (RNs or LPNs) with a mean of 4.67 (SD 1.7). Second on the list of offenders of incivility scored supervisors with a mean of 4.2 (SD 1.5). The qualitative portion of the survey revealed three major themes: 1) the stress and complexity of care in which nurses work; 2) relationship of management to an environment that fosters bullying or HV; 3) fear of retaliation. Dumont et al. (2011) conclude, “HV isn’t isolated to a particular age, gender, educational background, work setting, or tenure in nursing. No one is exempt, and the behaviors associated with HV are destructive to individual and to the healthcare system” (p. 49). The main limitation of this study is that only 955 individuals participated in this online survey. Considering there are over 3 million RNs and over 750,000 LPNs in the United

States, a sample size of 955 is rather small rendering the possibility that a large component of nurses may not think HV is a problem at all (sampling error).

As you can see, the broad topic of incivility, lateral violence, horizontal violence, or whatever the term may be, has been studied in many geographic locations and examined from various perspectives. The prevalence of incivility, the source of the uncivil behavior, the impact of incivility on the individual, and the cost to the organization, including health care facilities, has been studied over the past two decades. An area that has received less attention is the exploration of the correlation between departmental prevalence and likelihood of an individual that has experienced incivility calling in sick or leaving a particular unit or possibly even the organization overall. Therefore, this study has significant potential in adding new knowledge and understanding to the wide-range subject of workplace incivility.

Chapter III – Methodology

The aim of this *study incivility among nurses – prevalence and impact* is to describe the prevalence of incivility experienced by nurses as well as prevalence based on work areas. Moreover, this study also aims to examine the likelihood of the study participants calling in sick or leaving the organization/department. The data from this study may aid in identifying work areas with greater risk of nursing incivility and potential turnover in order to enhance strategies to improve work environments as well as retention of healthcare professionals.

Research Design

This research utilizes a descriptive design to examine the occurrence and frequency of experienced incivility and a descriptive correlational design to describe the individuals' likelihood of calling in sick or leaving their job in correlation with experienced incivility. The schematic in Figure 2 is a pictorial representation of the descriptive correlational design.

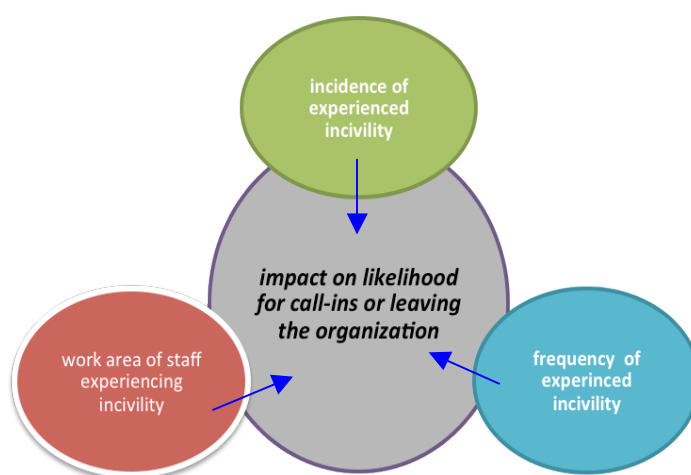


Figure 2: Descriptive Correlational Design of Study Variables

Context

Prior to survey conduction, the researcher obtained permission from the Institutional Review Board (IRB) for Gardner-Webb University in Boiling Springs, North Carolina. The study setting is a 258-bed acute care facility in Western North Carolina and permission from the healthcare facility's IRB was obtained in addition to the University's IRB. Participation in the study was voluntary and anonymous. Consent from the participants was gained prior to data collection. Data are confidential.

Sample population

The target population of interest in this study consisted of the healthcare organizations' Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). RNs and LPNs included in the accessible target population consisted of healthcare professionals with current North Carolina licensure that are maintaining employment at the facility during the time of the study. At the time, this target population consisted of 577 RNs and 4 LPNs (N = 581). Based on response rate information provided by the University of Texas (2011), "acceptable response rates vary by how the survey is administered" (para. 5). The suggested response rate for online surveys is an average of 30% (University of Texas, 2011). One hundred sixty three (163) respondents completed the survey for an original response rate of 28.06%. Ten (10) subjects submitted incomplete survey data and were therefore excluded. The sample size consisted of 153 (n) with a response rate of 26.33%. Although the study response rate of 26.33% is below the mark suggested by the University of Texas, the present sample size suggested this study's sample to be representative of the target population. This survey methodology design utilized a non-

random convenient sampling approach to eliciting participation in order to establish its study sample (n).

Ethical Consideration

Prior to surveying the healthcare professionals who agreed to participate in the study, informed consent was obtained. The informed consent form detailed the purpose of the study and the right for participating in the research study. Each participant had the opportunity to read and have explained the information of the consent form. At any time during the study, the participants were able to decline to participate in the study. The consent form was visible as soon as the potential study participants clicked the survey link contained in an organizational e-mail sent by the study facility's Director for the Department of Research and Evidence-Based Practice (see Appendix A). The body of this organization e-mail requested participation in the study by voluntarily following the link to the survey. The form provided the participant with contact numbers of the primary investigator (PI) and the Internal Review Board (IRB) at Gardner-Webb University. The detailed consent provided information concerning the potential risks and benefits of the study and was available to participants before beginning the online survey (see Appendix A). Following the link to the survey and acknowledging the consent form was considered the study participants' consent to participate in the study. Every individual had the option to complete or not to complete the survey. There were no negative consequences for not participating.

Data Collection Methods

This study utilized a non-random survey methodology. The Department for Research and Evidence-Based Practice within the organization distributed the assessment

tool to the study target population via a link in an organizational e-mail. This email included a link to the survey tool in an effort to maintain the participants' confidentiality and anonymity. The survey vendor utilized was Zoomerang™, which is a web-based survey provider. Zoomerang™ received the survey results from the participants and supplied the study investigator with the survey responses without any identifiers for data analysis while preserving study subjects' anonymity and confidentiality. Once the organizational e-mail was sent to the target population, the survey was open for participants to complete the survey for two weeks (14 days) to give ample time for completion. After that time, the survey was closed which resulted in no more data collection by Zoomerang™. No one assessment tool was found that measured all aspects of this study's components; therefore, the investigator modified the horizontal violence survey after obtaining authorization by the author (see Appendix C). The horizontal violence survey is an assessment tool that measures the perceived frequency of HV in the acute care work environment (Dumont, 2012). The modifications included the addition of four questions developed to assess the participants' perceived likelihood of work absences related to the experience of incivility in the work place and the addition of the three-item job withdrawal scale.

The research questions of this study were assessed using the modified horizontal violence survey with a total of 26 questions (see Appendix B). Ten questions taken verbatim from the original horizontal violence survey were designed to capture the perceived frequency of workplace horizontal violence among nurses and its impact within the preceding 12 months. The frequency of horizontal violence was measured using a 6-point Likert scale and be interpreted as follows: 1= never, 2= once, 3= a few

times, 4= monthly, 5= weekly, and 6= daily. The horizontal violence survey assessment tool has a content validity of 0.94 and the baseline perception of frequency of HV was measured with a sample (N) of 425 subjects yielding Cronbach's Alpha of 0.948 (Dumont, 2012).

The study survey also contained questions assessing the participants' perceived turnover intent using a 5-point Likert scale in which 1= strongly disagree and 5= strongly agree. Within the 26 questions contained in this modified horizontal violence survey, nine questions established *demographics* of the participants, such as age, gender, current position, years of experience, primary work area, years on that unit, and educational level. To measure an individual's *likelihood of calling-in/out sick*, a four-item tool was used that was designed by the primary investigator in collaboration with the primary researcher employed at the study facility. To two questions, the respondents provided their level of agreement to the questions using a 6-point Likert scale and are interpreted as follows: 1= never, 2= once, 3= a few times, 4= monthly, 5= weekly, and 6=daily. The remaining two questions were answered with either 'Yes' or 'No' responses.

The individual's *likelihood of leaving the facility* or Turnover Intent (Kelloway et al., 1999; Spence Laschinger et al., 2009) was measured using a three-item job withdrawal scale, using a 5-point scale (1 = strongly disagree to 5 = strongly agree). The questions that were asked to measure a health-professionals likelihood of leaving the organization/department are: 'I plan on leaving my job within the next year'; 'I have been actively looking for other jobs'; and 'I want to remain in my job'. Reliability testing of

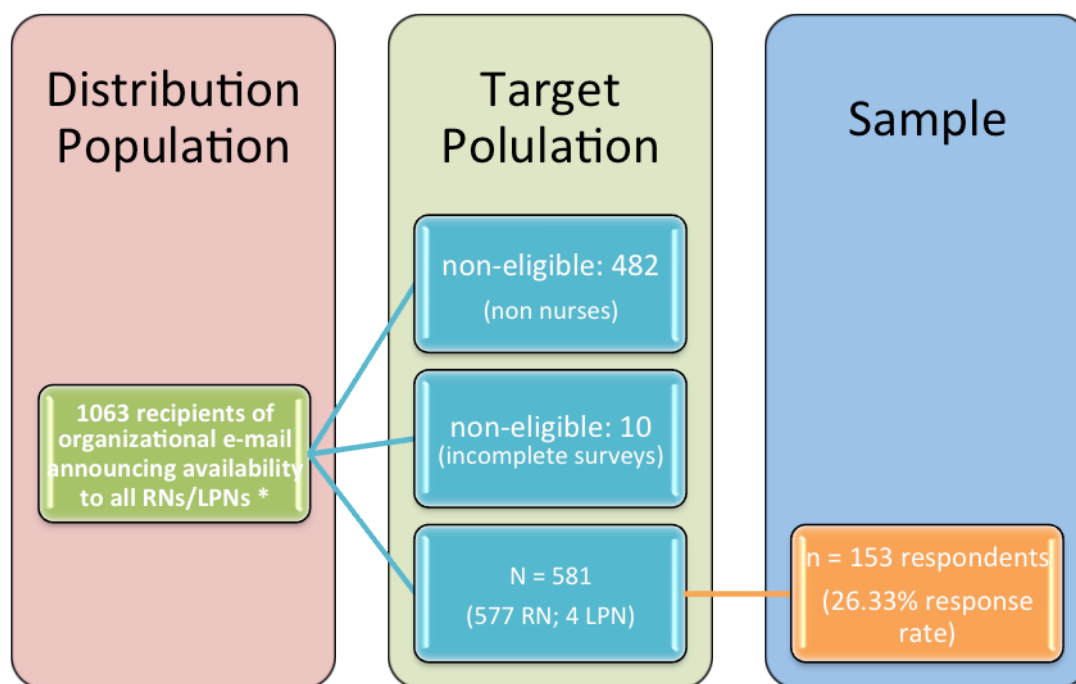
the original scale indicated internally consistent at $\alpha = 0.92$ (Kelloway et al., 1999) and $\alpha=0.82$ in a study conducted by Spence Laschinger and her colleagues (2009).

Data analysis (measurement method)

Data were analyzed using SPSS (Statistical Package for the Social Sciences) and Microsoft Excel. Relationships among demographic variables were analyzed descriptively in the context of frequencies and central tendencies. Point-Biserial Correlation Coefficients (r_{ϕ}) evaluations were conducted to examine factors of perceived intend/likelihood to leave the organization/unit (categorical variable) and perceived uncivil behavior using a calculated mean incivility score. In addition, the correlation between the perceived likelihood of work absences and the presence of incivility was examined. Correlation between age, gender, and perceived incivility experience were evaluated as well.

Chapter IV – Results

The organizational e-mail that was sent by the study facility's Research and Evidence-Based Practice department was distributed to 1063 recipients with a target population of 581 RNs and LPNs (see Figure 3). Due to incomplete surveys, ten respondents were excluded yielding a final sample size of 153 subjects or 26.33%.



* due to the fact that the organization did not have a current e-mail address book recipient group for registered nurses (RN) and licensed practical nurses (LPN), the organizational e-mail alerting potential participants to the survey availability was sent to departments with the comment of applicability to RNs/LPNs only.

Figure 3. Population and Sample description

Demographics

Figure 2 provides a visual description of how the study sample (n) was established. The characteristics of the nurses represented in this study are shown in Table 1. There was a significantly larger proportion of female nurses (n=143 or 93.5%) in comparison to male nurses (n=10 or 6.5%). This distribution does appear to be

representative of the organizations study population; furthermore, historically, nursing consists to a significantly larger proportion of female nurses. More than half of the subjects were between the ages of 31 to 50 years. The largest numbers of study participants (27.5%) were in the age group of 31 – 40 years followed closely by the age group of 41-50 years with 25.5%. None of the subjects were younger than 21 years of age whereas almost 20% (n=28/18.3%) were between the ages of 51 to 60 years.

More than half of the study subjects stated their primary work area to be in direct patient care (n=88/57.2%) and 28.8 % (n=44) worked primarily in management (20.3%) or education roles (8.5%). An additional almost 12% (n=18) consisted of advanced practice nurses of the organization.

The time each subject has been in their current position was well distributed between the age ranges with 56.9% (n=87) of respondents having been in their positions between three and ten (10) years. Interesting to note is that almost 16% of subjects have been in their positions less than two years and 16.3% of participants have been in their current roles for more than 15 years. Study participants have been working in their current units for a mean of 7.37 years (SD 6.65). The average years of nursing licensure is just over 16 year (M= 6.18/SD 11.46).

Table 1. *Characteristics of the Sample*

	N (153)	Mean (M)	Standard Deviation (SD)
Male (n,%)	10 (6.5%)		
Female (n,%)	143 (93.5%)		
Age (in years)	153 (100%)	3.68 (31-40 years)	
1. < 21	0 (0%)		
2. 21-30	30 (19.6%)		
3. 31-40	42 (27.5%)		
4. 41-50	39 (25.5%)		
5. 51-60	28 (18.3%)		
6. > 61	13 (8.5%)		
Unknown	1 (0.7%)		
Current Position	153 (100%)		
Direct Care	88 (57.2%)		
Education Role	13 (8.5%)		
Management Role	31 (20.3%)		
Adv. Practice RN	18 (11.8%)		
Other	3 (2%)		
Length of time in current position (yrs)	153 (100%)		
< 2	33 (15.7%)		
3-5	52 (34%)		
6-10	35 (22.9%)		
11-15	9 (16.3%)		
> 15	24 (16.3%)		
Years on current work unit		7.37	6.65
Years licensed as nurse		16.18	11.46

Figure 4 and 5 provides a visual representation of the distribution of study participants according to their highest level of education (see Figure 4) as well specialty certification (Figure 5). Close to half of the sample population were baccalaureate prepared and the other near 25% were either Associate's Degree nurses or Master's level prepared. Two-thirds of the subjects were certified in a nursing specialty.

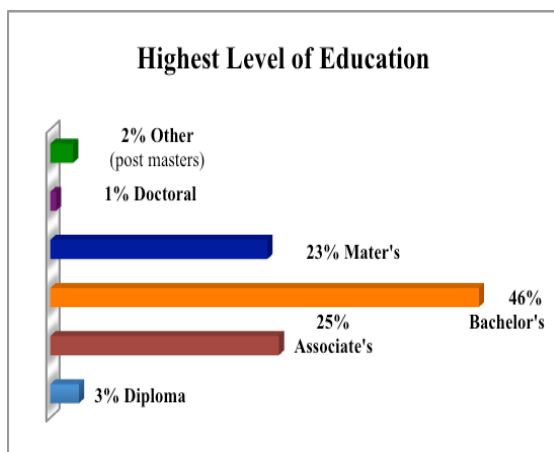


Figure 4. Highest Level of Education

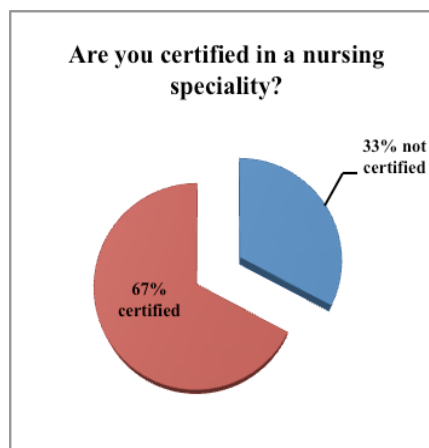


Figure 5. Certification

Overall and Departmental Prevalence

The study participants were working in diverse settings throughout the study facility. Figure 4 shows the distribution of subjects based on the reported primary work area. This question had eleven answer choices with ten representing specific work areas within the organization and one response option called 'other' to accommodate individuals that may not have felt their work area was represented in any of the other ten choices. Staff attained the greatest number of responses from the Operating Room (OR), Post Anesthesia Care Unit (PACU) and Day Surgery (DS) with 17% of the replies followed by the Birthing Center, Pediatrics, and Nurseries with 16%. The participation by unit ranged from 1% to 17% of the overall replies with four out of 11 work areas representing more than 10% of the responses.

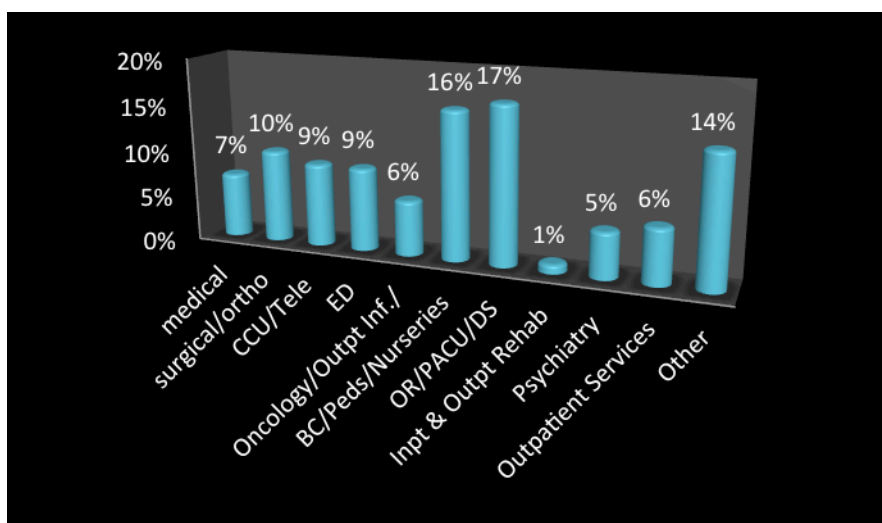


Figure 6. Responses by Primary Work Areas

The perceived presence of incivility among nurses was examined by evaluating the respondents' reported frequency of personally experiencing or witnessing certain behaviors that are considered uncivil (survey questions one through five). Those specific survey questions were answered using a Likert scale of six items in which 1= never, 2= once, 3= a few times, 4= monthly, 5= weekly and 6= daily. Table 2 displays the overall prevalence (n, M [mean], SD) as well the prevalence based on departments. The overall prevalence score of incivility in this study was 3.28 (M) with a standard deviation (SD) of 1.14. The overall mean of 3.28 indicated that the perceived incivility is experienced or witnessed between 'a few times' to 'monthly'. The general medical reported the highest score unit (M = 4.1/SD 0.8) indicating the subjects perceived uncivil behavior to occur monthly. The surgical units and the oncology unit shared the same mean score of 3.7 (SD 1.3). Third on the list of highest mean scores were the OR/PACU/DS units with a mean of 3.6. The lowest mean score was observed in the inpatient and outpatient rehabilitation units with a mean of 1.8 (SD 0.8) indicating subjects perception of uncivil behavior

occurring between ‘never’ and ‘once’. The outpatient service areas showed the second lowest mean score of 2.8 (SD 0.8).

Table 2. Frequency of experienced or witnessed incivility over the past 12 months

Department	N	Score (mean)	SD
Birth Center, Peds, Nurseries	23	3.3	1.2
Critical Care, Tele Emergency Department	14	3.0	1.4
General Medical Inpt. & Outpt. Rehab	15	3.4	1.3
	11	4.1	0.8
	2	1.8	0.8
Oncology, Outpt. Inf., Rad. Oncology	7	3.7	1.3
OR, PACU, DS	26	3.6	1.2
Other (ex: management, anesthesia, hospitalist)	22	3.6	1.2
Outpt. Services (ex: clinics, cath lab)	9	2.8	0.8
Psychiatry	8	3.1	1.2
Surgical (general & ortho)	16	3.7	1.3
Total	153	3.28	1.14

Work Absences

To examine any correlation between the perceived experience of incivility and the subjects’ self-reported likelihood of work absences, the Point-Biserial Correlation Coefficient (r_{ϕ}) was utilized. Due to the nature of the response of questions one through five, neither Pearson’s nor Spearman’s correlation techniques were appropriate for the categorical variables of this study. For each respondent, an incivility score (NCV score) was established based on the responses to questions one through five, which was then utilized to compute the phi correlation coefficient of the NCV score (r_{ϕ} NCV

score) in correlation with questions 14 (Q15) 'I have missed a day from work because of my experience with incivility (uncivil behavior) in my workplace' and 17 (Q17) 'I have not missed any time at work as a result of experiencing incivility in my workplace'. The following results were obtained: Q14 r phi NCV score = 0.143310565 and Q17 r phi NCV score = 0.315916677 indicating no correlation in this sample between the experience of incivility and work absences.

Turnover Intent

An additional question of this study was the correlation between experienced incivility and subjects' perceived likelihood of leaving their job. Table 3 shows the correlations between the subjects' perceived likelihood of calling in sick as a results of incivility (Q15) and their perceived intent to leave their job in the next year (Q11) and expression of active job seeking (Q12). The expressed thought of the study subjects showed a weak correlation to their active job seeking ($r = 0.567$). No other correlations were identified.

Table 3. Correlation Incivility and Turnover Intent

	Plan to leave (Q11)	Job Seeking (Q12)	Thought of calling in (Q15)
Plan to leave (Q11)	1		
Job Seeking (Q12)	0.812233053	1	
Thought of calling in (Q15)	0.448647134	0.566525048	1

.5 - .79 = weak correlation; .8 - .89 = moderate; .9 - .94 = good; .95 or > = strong

Gender

The correlation between the subjects' gender and the NCV score was examined using the Point-Biserial Correlation Coefficient (r phi NCV score). The result in this study did not show a correlation (r phi NCV score of 0.199219).

Age

To examine whether or not there was any age specific difference in perceived incivility experience, the mean and standard deviation were compared for each age group (see Table 4). The greatest mean scores were seen in the age group of 21 – 30 year olds (M=2.978, SD 0.667) and in individuals over the age of 60 years (M=2.866, SD 0.376). The younger group of respondents had a larger response count in addition to the higher mean score but also showed a greater standard deviation in comparison to the age group of individuals over 60 years.

Table 4. Do NCV Scores track similarly across age categories of respondents?

Age category	Count	M	SD
21 – 30	30	2.978	0.667
31 – 40	42	2.760	0.447
41 – 50	39	2.864	0.541
51 – 60	28	2.760	0.493
Over 60	13	2.866	0.376
Unknown: 1 respondent with a NCV Score of 3.6 (cannot compute M & SD)			

Chapter V – Discussion

Significance of the Findings

This study adds to the existing literature that supports the notion of the existence of uncivil behaviors among nurses. The findings of this study show a mean occurrence of incivility among nurses of 3.28 (M, SD 1.14) indicating that the subjects' either personally experienced or witnessed uncivil behavior more than 'a few times' but less than 'monthly'. This finding illuminates the overall prevalence to be of considerable significance.

In addition to examining the overall prevalence, this study sought to evaluate the departmental incidences and identify areas of higher prevalence (see Table 2). The presence of uncivil behavior is commonly attributed to areas such as the emergency department, critical care or post anesthesia recovery unit because of the often urgent and intense nature of the work. However, the findings in this study do not support that belief. The so-called high stress areas rank fourth (OR,PACU), sixth (ED), and ninth (CCU/Tele) out of the overall eleven different work area. The highest frequency of experienced or witnessed incivility among nurses is found in the General Medical area (M = 4.1, SD 0.8). The work unit's mean indicates incivility to occur monthly. In addition, this unit also shows the smallest standard deviation, which further emphasizes congruence in the subjects' responses.

This study also looked at the likelihood of subjects missing work in correlation with experienced incivility in the workplace. Two questions (14 and 17) were evaluated in correlation to the established incivility score (NCV score) described in the results section. No significant correlation is apparent in this sample as evidence by the

correlation coefficient scores of r phi NCV score = 0.143310685 (Q 14) and 0.315916677 (Q 17). Question 14 states '*I have missed a day or more of work ...*' and question 17 states '*I have not missed any time at work ...*' with a 'yes' or 'no' response scale. The discrepancy represents lack of congruence by the respondents in 25 cases; however, either correlation coefficient is at a level where inferences between the experience/witnessing incivility and work absences can be made.

Turnover intent, or leaving the unit or organization was evaluated as well. Pervious literature (see Chapter II) indicates a correlation between one's experience of hostile or uncivil behavior and the desire to leave one's job. The findings of this study support this notion in that a weak correlation ($r=0.567$) is established between subjects who think about being absent from work and those who actively seek new positions/jobs. This finding may be suggestive of subjects that contemplate being absent from work to be a precursor for actively seeking other employment. This finding could be helpful for nursing leaders in the management of human resources.

Gender was evaluated in context of experienced or witnessed incivility among nurses. The NCV Score is used to establish the Point-Biserial Correlation Coefficient between these two variables. The correlation was established for r phi NCV score = 0.199, which indicates that in this sample no correlation between gender and perceived incivility exists. This finding is different from common perceptions of gender differences in the workplace and in society in general.

Age appears to play a role in the perception of incivility as the greatest mean score are found in the youngest group (21 – 30 yrs) and the group of individuals over the age of 60 years (oldest group). The range of all age group means are between 2.76 and

2.976 indicating the perception of incivility occurring or being witnessed ‘a few times’ over the past 12 months.

Implications for Nursing Practice

In addition to increasing the existing body of knowledge surrounding the topic of incivility among nurses in the workplace, the findings of this study confirm the presence of incivility among nurses in this study facility. Furthermore, the findings identify work areas to be at higher risk, which may aid in the development of targeted interventions to enhance the work environment at the study facility. The findings of this study do not confirm the theory that commonly perceived high-stress areas, such as the emergency department, PACU, or critical care are experiencing a higher prevalence of perceived incivility among nurses. The perception of experienced or witnessed incivility appears to differ between different age groups with the youngest and the older respondents perceiving incivility at a greater frequency. This knowledge may also be valuable to nursing leaders in shaping the work environment for nurses.

Limitations and recommendations for future research

The sample size in this study consists of 153 (n) subjects, which represents a response rate of 26.33%. At such response rate, sampling error in which the sample is not representative of the population cannot be entirely excluded. For that reason, the replication with a larger sample is desirable in order to extract more conclusive inferences. In addition, this study was conducted in a single site design. Future research is needed not only with a larger sample but also that is designed to study subjects at multiple study sites. In addition, a longitudinal study design to evaluate changes over time would also be very beneficial.

Another limitation lies in the design of the study that relies on self-reported data by subjects as this may potentially interfere with the strengths of relationships. The assessment tool consists of 26 questions in total that ask the respondent to answer based on their experience over the previous year. Upon data analyses of question 14 and 17 (subjects' work absence related incivility) inconsistencies are identified in the responses. In 25 cases, the responses are not consistent in their answer limiting the reliability of those questions.

Questions one through five (Q1-Q5) inquire about the subjects' personal experience or witnessed experience of incivility in the workplace. This study sought to investigate any correlations between experienced incivility and variables such as work absences and turnover intend. Future research could investigate the revision of assessment question to only include personal experiences in order to draw improved inferences.

Implications for Nursing

Although this study represent a small sample and a single site inquiry, it certainly has the potential to create awareness about incivility and serve as a motivator to further inquire about the uncivil behavior in the study facility as well as a other settings.

Conclusion

The research *study incivility among nurses – prevalence and impact* supplies valuable insights into the study setting's overall and work area specific prevalence of uncivil behavior as well as age related impact. With the knowledge of a looming nursing shortage in foreseeable future, every effort ought to be exerted to ensure that scientific knowledge educates nursing leaders' efforts to create healthy and civil work

environments that foster the retention of high quality healthcare professionals and provide safe quality care.

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Appendices

- Appendix A – Study Information/Consent (as it will be appearing in the body of the organization e-mail send to the target population)
- Appendix B – Survey Tool to be completed via Zoomerang™ (compiled from the Horizontal Violence Survey, Turnover Intention, and Likelihood of Calling-In sick)
- Appendix C - Authorization to use/modify Horizontal Survey Assessment Tool

Appendix A – Consent **Nadin Knippschild (Master’s of Science in Nursing Student) -**

Gardner-Webb University

Study Information

Dear Study Participant,

You are invited to participate in a research study. The purpose of the study is to examine and describe the prevalence of incivility experienced by nurses in a mid-size, suburban, acute healthcare organization. A link to the study survey is provided in this e-mail. The survey will take approximately 7 - 10 minutes to complete. Participation in the study is strictly voluntary. You may choose not to take part in the study or discontinue participation at any time during the survey. Refusing to participate will not result in any penalty or loss of benefits to which you are entitled. The survey is anonymous and no identifying information will be collected. Confidentiality will be protected by collecting only information needed to assess study objective, minimizing to the fullest extent possible the collection of any information that could directly identify subjects, and maintaining all study information in a secure manner. All survey information will be shredded at the conclusion of the research. Participants must be at least 18 years of age and have a valid RN or LPN license to participate. There are no foreseeable risks in the participation of this study. There are no incentives, payments or benefits to be received by completing the survey. Your participation in this survey would be greatly appreciated. Following the link to the survey and completion thereof will be considered as consent. If you have questions or concerns, you can contact the Principle Investigator Nadin Knippschild at nknippsc@gardner-webb.edu (phone# 828-638-2270) or Dr. Janie Carlton, GWU at jcarlton@gardner-webb.edu. Gardner-Webb University IRB contact:

Dr. Franki Burch, IRB Institutional Administrator at (704) 406-4724 or email at

fburch@gardner-webb.edu

Appendix B – Survey Tool

Survey Tool – Horizontal Violence

Please read each item and mark the answer that best represents your experience.

Within the last 12 months, how often have you personally experienced or witnessed the following:

1. Harshly criticizing someone without having heard both sides of the story.
 1. Never
 2. Once
 3. A few times
 4. Monthly
 5. Weekly
 6. Daily

2. Belittling or making hurtful remarks to or about coworkers in front of others.
 1. Never
 2. Once
 3. A few times
 4. Monthly
 5. Weekly
 6. Daily

3. Complaining about a coworker to others instead of attempting to resolve a conflict directly by discussing it with that person.
 1. Never
 2. Once
 3. A few times
 4. Monthly
 5. Weekly
 6. Daily

4. Raising eyebrows or rolling eyes at another coworker.
 1. Never
 2. Once
 3. A few times
 4. Monthly
 5. Weekly
 6. Daily

5. Pretending not to notice a coworker struggling with his or her own workload.
 1. Never
 2. Once
 3. A few times

4. Monthly
5. Weekly
6. Daily

Answer the questions from the perspective of how you personally have been affected within the last 12 months at your current workplace.

6. I've felt discouraged because of lack of positive feedback.
 1. Never
 2. Once
 3. A few times
 4. Monthly
 5. Weekly
 6. Daily

7. I haven't spoken up about something I thought was wrong because of fear of retaliation.
 1. Never
 2. Once
 3. A few times
 4. Monthly
 5. Weekly
 6. Daily

8. I've hesitated to ask questions for fear I'd be ridiculed.
 1. Never
 2. Once
 3. A few times
 4. Monthly
 5. Weekly
 6. Daily

9. I've left work feeling bad about myself because of interactions with coworkers.
 1. Never
 2. Once
 3. A few times
 4. Monthly
 5. Weekly
 6. Daily

10. I've had physical symptoms such as inability to sleep, headaches, or abdominal pain because of poor interactions with certain coworkers.
 1. Never
 2. Once
 3. A few times
 4. Monthly

5. Weekly
6. Daily

Reflecting on the last 12 months, state to what level you agree with the following statements.

11. I plan on leaving my job within the next year.

- 1 = Strongly disagree
- 2 = Disagree
- 3 = Neutral
- 4 = Agree
- 5 = Strongly agree

12. I have been actively looking for another job.

- 1 = Strongly disagree
- 2 = Disagree
- 3 = Neutral
- 4 = Agree
- 5 = Strongly agree

13. I want to remain in my job.

- 1 = Strongly disagree
- 2 = Disagree
- 3 = Neutral
- 4 = Agree
- 5 = Strongly agree

Answer the questions from the perspective of how you personally have been affected within the last 12 months at your current workplace.

14. I have missed a day or more from work because of my experience with incivility (uncivil behaviors) in my workplace.

1. Yes
2. No

15. I have **thought about** calling-in/staying out sick because I have experienced incivility at work.

1. Never
2. Once
3. A few times
4. Monthly
5. Weekly
6. Daily

16. It has occurred to me, although I have not acted on it, that I should look for another nursing position at my facility or in another healthcare setting (e.g., doctor's office, outpatient clinic, etc.) due to experiencing incivility.

1. Never
2. Once
3. A few times
4. Monthly
5. Weekly
6. Daily

17. I have not missed any time at work as a result of experiencing incivility in my workplace.

- a. Yes
- b. No

Demographic data

18. What is your age?

- Under 21
- 21 – 30
- 31 – 40
- 41 – 50
- 51 – 60
- Over 60

19. What is your gender?

- Female
- Male

20. What is your current position?

- RN in Direct Patient Care Role
- RN in Education Role
- RN in Management Role
- Advanced Practice RN
- other (please specify): _____

21. How long have you been in your current position?

- 2 years or less
- 3 to 5 years
- 6 to 10 years
- 11 to 15 years
- over 15 years

22. In what type of unit do you primarily work?

- General Medical
- Surgical (general, Ortho/Neuro)
- Critical Care Center (CCU, Telemetry)
- Emergency Department
- Oncology, Outpatient Infusion, Radiation Oncology
- Birthing Center, Pediatrics, Nurseries
- OR/PACU/Day Surgery
- Inpatient and Outpatient Rehabilitation
- Psychiatry
- Outpatient Services (Clinics, Cath Lab, radiology, etc.)
- Other (please specify): _____

23. How long have you worked in this unit? _____ year(s)

24. How long have you been a nurse? _____ year(s)

25. What is your highest level of education?

- Diploma in Nursing
- Associate's Degree
- Bachelor's Degree
- Master's Degree
- Doctoral Degree

26. Are you certified in a nursing specialty?

- Yes (please specify): _____
- No

Appendix C – Authorization to use/modify Horizontal Survey Assessment Tool

-----Original Message-----

From: Nadin Knippschild [<mailto:nknippschild@catawbavalleymc.org>]

Sent: Friday, March 30, 2012 11:00 AM

To: Nadin@charter.net; Iindalj2622@comcast.net; Dumont, Cheryl

Subject: Horizontal Violence Survey

Dr. Dumont & Ms. Laskowski-Jones,

my name is Nadin Knippschild, and I am currently working on my Master's Degree in Nursing at Gardner-Webb University (North Carolina). I am presently devising my thesis proposal and am interested in using your horizontal violence survey that was published in Nursing2011 and Nursing2012 (results). I would like to ask official permission to use the tool with some modifications.

My proposed research questions are aimed to examine experienced incivility in context of work areas and likelihood of work absences and turnover. Is there a higher prevalence in certain work areas such as CCU and ED. My modifications would entail leaving out the questions about the source of the uncivil behavior and the addition of six questions evaluating the likelihood of missing work and turnover intent.

Also, has the instrument been tested for reliability? If so, would you share that information with me?

Please feel free to ask me any additional questions about my proposed research project. I will be glad to supply more details if needed. I appreciate your time and hope to hear from you soon.

Respectfully,

Nadin Knippschild, RN-BC, BSN
 Administrator on Duty
 Patient Care Administration
 Catawba Valley Medical Center
 (828) 326-3720
nknippschild@catawbavalleymc.org

>>> "Dumont, Cheryl" <cdumont@valleyhealthlink.com> 3/30/2012 11:07 AM >>>

Dear Nadin, The short version that was in the journal survey was not tested but the longer version we used at our hospital was tested with a content validity index by a panel of experts, internal reliability by subscales and for criterion related validity compared to RN-RN satisfaction. If you would like those details I can send to you next week. And I can let you use our long version. We only asked to be referenced for credit.

Cheryl Dumont, PhD, RN,CRNI
 Director Nursing Research and Vascular Access Team
 Winchester Medical Center

MOB 1 Suite 3J
 1840 Amherst Street
 Winchester, VA 22601
cdumont@valleyhealthlink.com
 Phone 540 536 6835
 Cell 540 409 6071

From: Nadin Knippschild [<mailto:nknippschild@catawbavalleymc.org>]

Sent: Wednesday, April 04, 2012 9:03 AM

To: Dumont, Cheryl

Subject: RE: Horizontal Violence Survey

Dr. Dumont,

are you still willing to provide me with the long versions to use in my research project as part of my MSN thesis? If you are, you mentioned a long version having been tested. Could you share the long version with me as well as the exact reliability data?

Just to clarify:

1) You are allowing me to use either version as long as you are referenced.

2) Only the long version has been tested. The short versions had not.

I hope you are doing well. Again, I appreciate your willingness to share your instrument. I appreciate your kindness!

Respectfully,

Nadin Knippschild, RN-BC, BSN

Administrator on Duty

Patient Care Services

Catawba Valley Medical Center

(828) 326-2848 or (828) 326-3720

nknippschild@catawbavalleymc.org

>>> "Dumont, Cheryl" <cdumont@valleyhealthlink.com> 4/10/2012 9:31 AM >>>

Nadin, Here is the survey in a word document. I actually put it in Survey Monkey to send out. If you want to use that I can send you the link and you can email it out to your subjects. I would have to download the data for you into excel and send it to you.

Here is also the proposal for a small grant that includes a description of the tool development and the psychometrics.

Yes just site us – you can site the unpublished proposal I guess since I have not gotten around to getting it published yet.

Cheryl Dumont, PhD, RN,CRNI

Director Nursing Research and Vascular Access Team

Winchester Medical Center

MOB 1 Suite 3J

1840 Amherst Street
Winchester, VA 22601
cdumont@valleyhealthlink.com
Phone 540 536 6835
Cell 540 409 6071

From: Nadin Knippschild [mailto:nknippschild@catawbavalleymc.org]
Sent: Tuesday, April 10, 2012 1:26 PM
To: Dumont, Cheryl
Subject: RE: Horizontal Violence Survey

Thank you so much Dr. Dumont! I was thinking about survey monkey or zoomerang for the survey. I haven't decided yet, so I may take you up on your generous offer at a later point. Since I am looking at identifying the prevalence in correlation of work areas and likelihood of turnover, the source of the incivility is not particular part of my question. With that said, I just want to make sure you are also fine with me leaving those questions out and essentially modifying the tool. I will add two or three questions about turnover intent. Thanks so much again!

Nadin Knippschild, RN-BC, BSN
Administrator on Duty
Patient Care Services
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>>> "Dumont, Cheryl" cdumont@valleyhealthlink.com

4/10/2012 1:28 PM>>>

Yes, of course, just state how you modified it Best of luck!

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