2020

Interventions for Cultivating Civility in the Healthcare Team: Review of the Literature

Elizabeth Knapp
University of Central Florida

INTERVENTIONS FOR CULTIVATING CIVILITY IN THE HEALTHCARE TEAM: REVIEW OF THE LITERATURE

by
ELIZABETH KNAPP
University of Central Florida, 2020

A thesis submitted in partial fulfillment of the requirements
for the Honors in the Major program
in the Department of Nursing
in the College of Nursing
at the University of Central Florida
Orlando, FL

Spring Term
2020

Thesis Chair: Dr. Nora Warshawsky

Abstract

OBJECTIVE: The aim of this literature review was to examine the most current research regarding effective, evidence-based programs for reducing incivility among the healthcare team, particularly nurses. **BACKGROUND**: Incivility in the work environment is linked to a variety of negative outcomes, including diminished productivity, impaired judgement, and reduced employee retention. Incivility is especially detrimental to the healthcare team because it is correlated with decreased quality of patient care and increased medical errors. Despite regulations and statements made by the Joint Commission and the American Nurses Association to combat this serious problem, incivility continues to plague healthcare. **METHODS**: CINAHL and MEDLINE databases were reviewed for interventions to reduce incivility or bullying. Articles that evaluated interventions for practicing nurses were included in the review. **RESULTS**: The majority of studies evaluated training programs based on cognitive theory or cognitive rehearsal training as an intervention for incivility or bullying. Most studies showed positive correlations between the intervention and reducing incivility or bullying in some areas, however, results were inconsistent, most evidence ranked low and most studies shared sub-optimal quality. **CONCLUSION**: Most current studies towards reducing incivility in the healthcare team are poorly designed for demonstrating causation. More research is required to examine effective, evidence-based solutions for cultivating civility. Research must distinguish independent variables, incorporate teams instead of individuals, and fit into the structure of the work environment that it is serving.

Keywords: incivility, bullying, disruptive behaviors, intervention, review

Table of Contents

List of Tables and Figures

Background

Incivility is distinguished by more passive behaviors of harm, whereas bullying is persistent, and usually aggressive, mistreatment (Kisner, 2018). These destructive behaviors disturb the work environment, hinder communication and productivity amongst the healthcare team, and contribute to stress, burnout, and staffing shortages (Aiken et al., 2011; Laschinger, Leiter, Day, & Gilin, 2009; Porath & Pearson, 2010; Porath, Foulk, & Erez, 2015). This can ultimately cause adverse or even fatal outcomes for both patients and employees (Aiken et al., 2011; Slopen et al., 2012; Lim et al., 2008; Rosenstein & O'Daniel, 2008). Disruptive behaviors can be as subtle as exclusion from a clique or as obvious as an aggressive public reprimand from a supervisor (Edmonson & Zelonka, 2019; Clark, 2013; Porath & Pearson, 2010). Qualifications for disruptive behaviors vary between cultures, backgrounds, and personal views, but the overarching theme asserts that incivility is any behavior or act interpreted as disrespectful (Porath & Pearson, 2010).

The prevalence of incivility in the workplace, and especially in the healthcare field, has been a rising concern for several decades now. Numerous studies have revealed that tolerating, enabling, or ignoring disruptive behaviors is expensive, severely counterproductive, and unhealthy for everyone involved (Pearson, Andersson & Porath, 2000; Rosenstein & O'Daniel, 2008; Shirom, Toker, Akaly, Jacobson, & Balicer, 2011). Conversely, businesses that actively nurture civility in their workplace benefit from increased productivity, increased employee satisfaction, and overall success (Pearson et al., 2000; Walumbwa, Muchiri, Misati, Wu, & Meiliani, M., 2016; Kutney-Lee et al., 2009; Porath et al., 2015).

Incivility is the foremost cause of 30 – 50% of registered nurses, especially new graduates, resigning from their jobs and sometimes even leaving the profession altogether (Clark, 2013; Moore, Leahy, Sublett & Lanig, 2013; Laschinger et al., 2009). Employee turnover rates, employee performance, and customer satisfaction can place an appreciable financial burden on companies when incivility is at work (American Hospital Association, 2002; Laschinger et al., 2009; Porath, 2016). Nurse turnover costs in hospitals can range between 4 and 7 million dollars annually (Edmonson & Zelonka, 2019). Healthcare professionals at the bedside are particularly dissatisfied and have been known to warn others against pursuing the career they chose (American Hospital Association, 2002). However, a positive work environment and supportive team members are the primary reasons that nurses remain loyal to their company and career (Evans, 2017; Aiken, Clarke, & Sloane, 2002). This is why intentionally cultivated civility in the workplace leads to attraction and retention of talented workers (Pearson et al., 2000; Smith, Andrusyszyn, & Laschinger, 2010; Adams, Hollingsworth, & Osman, 2019; Shortell, et al., 1994). It could also potentially affect society as a whole, since the current increase of chronically ill populations and projected shortages in healthcare workers is expected to lead to a global crisis if a solution cannot be found (American Hospital Association, 2002; Edmonson & Zelonka, 2019; Institute of Medicine, 2001).

Decreased patient satisfaction, increased medical errors, and, most importantly, increased patient mortality also add to the costs of incivility in healthcare (Rosenstein & O'Daniel, 2005; Rosenstein & O'Daniel, 2008). Preventable medical errors alone cost hospitals hundreds of millions of dollars, and a majority of these errors can be traced back to human factors such as communication failures (Institute of Medicine, 2000). Incivility is known to break down communication and cohesion in teams (Walumbra et al., 2016; Porath et al., 2015; Porath &

Pearson, 2010; Hunger & Wheelen, 1975), decrease helpfulness (Porath et al., 2015; Walumbra et al., 2016; Porath & Pearson, 2010), and even impair judgement (Porath & Pearson, 2010; Porath et al., 2015). In 2001 the Institute of Medicine listed developing effective teams as one of the six challenges that healthcare organizations would need to meet to improve quality of care. Various surveys targeting the experiences of nurses have revealed mutual concerns regarding the effects of unsupportive teams and workplace incivility on patient care (Laschinger, 2014; Aiken et al., 2002; Walumbwa et al., 2016; Aiken et al., 2011). This is due to the fact that the healthcare team suffers when disruptive behaviors are not corrected. Studies simulating clinical care and medical teams demonstrate a correlation between incivility and poor performance (Katz et al., 2019; Riskin et al., 2015).

Workplace leaders and employees in a position of authority are more prone to initiate and propagate incivility (Pearson et al., 2000; The Joint Commission, 2008), but most disruptive behaviors do not stem from ill-natured intentions. Porath, a prominent scholar and leader of current workplace civility research, summarized that, "Incivility usually arises not from malice but from ignorance…most bad behavior reflects a lack of self-awareness" (2016, p. 12). Current evidence has further validated this statement, as incivility education and awareness programs showed promising results in decreasing disruptive behaviors (Rosenstein & O'Daniel, 2005; Lasater, Mood, Buchwach, & Dieckmann, 2015; Kile, Eaton, daValpine, & Gilbert, 2019).

Significance

In 2008 the Joint Commission issued a sentinel event alert regarding the profound dangers and repercussions of incivility. They called all healthcare institutions to action and listed recommendations for confronting the problem, including a "zero tolerance" policy towards intimidating and disruptive behaviors (TJC, 2008). In the following year the Joint Commission implemented a code of conduct and civility program requirement for all hospitals (The Governance Institute, 2009).

Fostering civility in any collaborative team is multi-faceted and complex, yet some mutual themes have emerged. Several organizations have offered solutions or guidelines to help measure and cultivate a healthy work environment for the sake of patients and the teams who care for them. The Veteran's Health Association established a program called CREW (Civility, Respect, and Engagement in the Workforce) that has shown potential in increasing civility objectives (Osatuke, Moore, Ward, Dyrenforth, & Belton, 2009). Multiple screening instruments are available to assess and re-assess factors of incivility in the work environment to monitor progress and measure efficacy (Einarsen, Hoel, & Notelaers, 2009; Guidroz, Burnfield-Geimer, Clark, Schwetschenau, & Jex, 2010; Blake, 2012). It would appear that the healthcare field has a variety of tools to choose from to progress towards a more civil work environment.

However, despite current standards, resources, and consistent research demonstrating the necessity of nurturing a positive environment for healthcare teams, incivility remains a serious issue in today's workplace (Edmonson & Zelonka, 2019). This may be attributed to minimal implementation of interventions or insufficient programs. In 2013 a follow-up survey conducted by the Institute for Safe Medication Practices affirmed that there had been no progress in ten years regarding incivility and its impact on unsafe medication practices. In fact, one-third of

respondents confessed to compromising care for the purpose of avoiding conflict with certain uncivil team members (Grissinger, 2017). Having policies and standards for civility is a good start, however, team members must be given evidence-based, effective tools to succeed against this alarming problem.

Design & Data Retrieval

The intention of this project was to review the literature for effective interventions to combat incivility. This was for the purpose of comparing programs and outcomes, identifying trends as well as gaps in research, and assessing for areas that could be improved upon.

Methods

A PIO question, as follows, was used to guide this literature review. In the healthcare team, what are the most current, evidence-based interventions for increasing civility and reducing disruptive behaviors among colleagues? EBSCOhost software was utilized to search the CINAHL and MEDLINE databases on February 19th, 2020. Search terms included, "incivility or bullying or lateral violence or horizontal violence"; and "intervention"; and "nurs*"; not "child* or youth, or adolescen*". Results were limited to the last 5 years (2015 – 2020) and the English language. Only articles evaluating interventions for healthcare workers were included. Dissertations and studies using students as participants were excluded.

Outcome

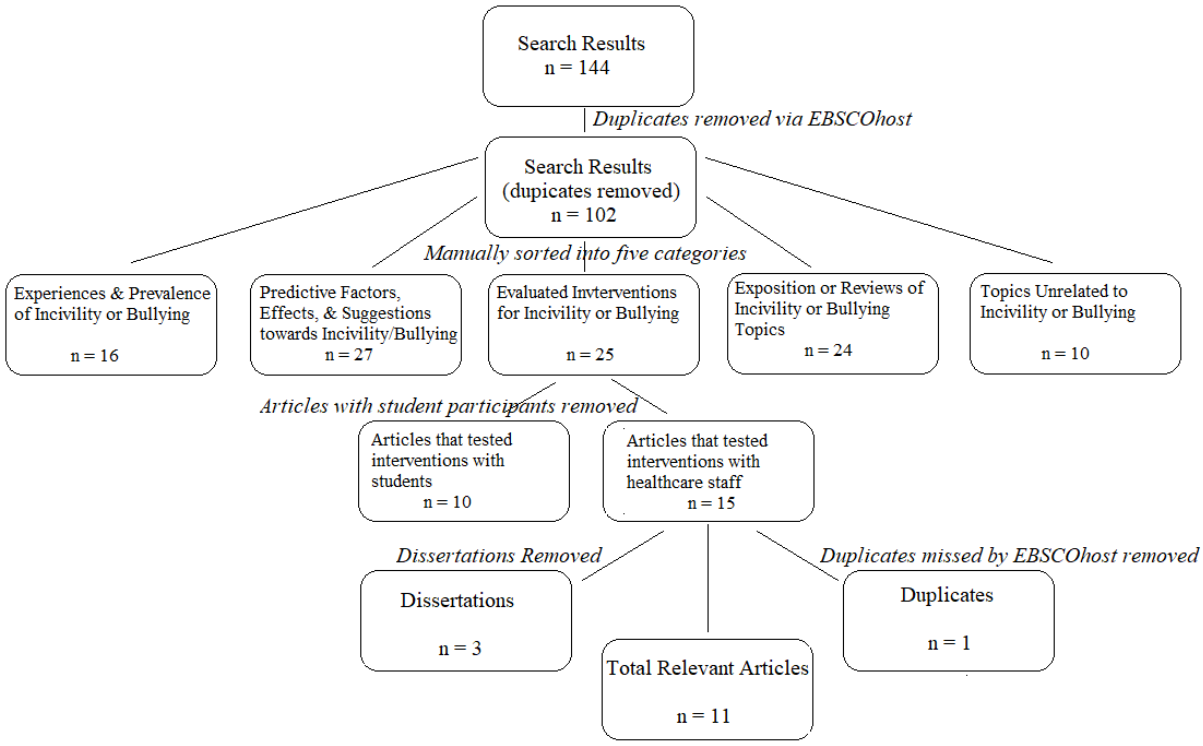
The search yielded 144 results. When EBSCOhost removed duplicate articles, 102 results remained. Articles were then sorted into the following categories: Experiences & prevalence of incivility or bullying (n = 16), Predictive factors, effects, & suggestions regarding incivility or bullying (n = 27), Exposition & reviews regarding incivility or bullying (n = 24), Unrelated topics (n = 10), and tested interventions for incivility or bullying (n = 25).

Only these 25 articles were relevant to the PIO question because they evaluated interventions for incivility or bullying. However, some articles targeted the nursing student population (n = 10) and were removed for the purpose of focusing on more universal interventions. Nursing students tend to be more malleable and receptive to learning, so

interventions on this population may not translate well to the general healthcare team. The remaining 15 articles were evaluated. After duplicates missed by EBSCOhost software (n = 1) and dissertations (n = 3) were removed, a total of 11 relevant articles remained.

Figure 1

Data Retrieval and Sorting Process



Quality Appraisal

The Johns Hopkins Evidence Appraisal tools were utilized to rank evidence from strongest (Level I) to weakest (Level III) and grade article quality as high (A), moderate (B), or poor (C). Level I articles included 2 randomized control trials graded A (n = 1) and B (n = 1) in quality. Level II articles included 3 quasi-experimental studies graded B (n = 2) and C (n = 1). Lastly, 6 Level III articles included 1 qualitative focus group graded A (n = 1), 4 mixed method studies graded B (n = 1) and C (n = 3), and a nonexperimental case study graded C (n =1). A detailed list of each article rank and grade can be found in Appendix A.

Results

Across studies, sample sizes ranged from 9 to 94. Two were pilot studies and only two incorporated a control group for comparison. An overwhelming majority of participants were women working as registered nurses in a hospital for at least six months or longer. Participants were mostly recruited through advertisement and volunteer-based methods. Most of the studies either did not account for power analysis or were not able to meet the minimum number of participants required. (See Appendix A for a detailed evidence table.)

Program Description

Study sites varied and consisted of public hospitals in different areas of the United States (n = 7), an Air Force medical treatment facility in the United States (n = 1), university hospitals in South Korea (n = 2), and an unspecified variety of clinical settings (n = 1). Studied interventions included a modified CREW (Civility, Respect, and Engagement in the Workplace) program (n = 1), the BE NICE Champion (BNC) training program (n = 1), an online education program (n = 1), and cognitive rehearsal training (CRT) or a program designed from cognitive theory (n = 7). One study featured a complex multidimensional approach that included the TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) training program, CRT, and retreats (n = 1). The most popular intervention was Cognitive Theory or Cognitive Rehearsal Training. Training approaches across studies ranged from 20 minutes to 8 hours in length with a frequency of about 1 to 5 to an unspecified number of sessions. The time period of the studies ranged from about 1 day to 4 years. Common training techniques incorporated into these programs were didactic education and role-playing. Other techniques included a cell phone application, business retreats, an online module, and assignments to take home or materials to carry while working. (See Table 1 for a summary of the findings.)

Measurements

The NIS (Nursing Incivility Scale) was the most popular instrument used across studies (n = 3) (Razzi & Bianchi, 2019; Lasater, Mood, Buchwach, & Dieckmann, 2015; Kile, Eaton, daValpine, & Gilbert, 2018). Reported Cronbach alpha scores ranged from 0.6 – 0.9, demonstrating adequate to good reliability. The Negative Acts Questionnaire Revised (n = 3)(O'Connell, Garbark, & Nader, 2019; Kang, Kim, & Yun, 2017; Kang & Jeong, 2019) and National Database for Nursing Quality Indicators (n = 2)(Kile, Eaton, daValpine, & Gilbert, 2018; Lasater, Mood, Buchwach, & Dieckmann, 2015) instruments were also fairly popular. Instruments that were only featured in one study included the Workplace Incivility Scale (Armstrong, 2017), the Confidence Scale (Armstrong, 2017), the New York Organization of Nurse Executives Horizontal Violence Survey (NYONE HV)(Parker, Harrington, Smith, Sellers, & Millenbach, 2016), a modified Horizontal Violence Survey (Schwarz & Leibold, 2017), the Relationship Change Scale (Kang, Kim, & Yun, 2017), the Brief Symptom Inventory(Kang, Kim, & Yun, 2017), the Yun's Nurse Turnover Intention tool (Kang, Kim, & Yun, 2017), a modified "Intent to Quit" questionnaire (Kang & Jeong, 2019), a Workplace Harassment Survey 2013 (WHS-2013) (Balevre, Balevre, & Chesire, 2018), the New General Self-Efficacy Scale (NGSE)(Lasater, Mood, Buchwach, & Dieckmann, 2015), and the Workplace Collective Efficacy Scale (WCES)(Lasater, Mood, Buchwach, & Dieckmann, 2015). Several studies also included personally-tailored questionnaires or surveys to evaluate participant feedback on the program (O'Connell, Garbark, & Nader, 2019; Schwarz & Leibold, 2017; Razzi & Bianchi, 2019; Kile, Eaton, daValpine, & Gilbert, 2018). One study used solely qualitative coding and themes (Keller, Allie, & Levine, 2019). One study used feedback narratives from staff but did not categorize them (Balevre, Balevre, & Chesire, 2018).

Outcomes

Incivility and bullying in the workplace are very complex, multi-faceted phenomena. The variety of outcomes that the different studies monitored to assess and re-evaluate civility are a testament to this. Some common themes that emerged were the team member's ability to recognize instances of incivility or bullying, the team member's sense of empowerment or ability to respond productively to concerning instances, and the different ways that incivility or bullying manifest in the work environment, from interpersonal relationships to low retention rates. These themes have been condensed into the concepts of awareness, empowerment, and manifestations for simplification.

In general, interventions that engaged teams as a whole, instead of focusing on the individual, appeared to show better outcomes. Only one study involving an online education module toward individuals showed significant results in increasing awareness and decreasing manifestations of incivility or bullying (Schwarz & Leibold, 2017). The only team-based intervention that did not show significant results in at least one of the three themes still showed some significant improvements in specific areas, such as decreased inappropriate jokes, displaced frustration, and lack of respect (Kile, Eaton, daValpine, & Gilbert, 2018).

Another common pattern across studies was the structure and organization of the specific work environment and how this affected the participant's reception of the intervention. Several studies noted that the work environment, or the way the intervention was structured around work, may have had an impact on results (Armstrong, 2017; O'Connell, Garbark, & Nader, 2019; Balevre, Balevre, & Chesire, 2018). Obstacles included program availability, employee perceptions towards reporting disruptive behaviors, and the way that the program was incorporated into the work environment (Armstrong, 2017; Keller, Allie, & Levine, 2019;

O'Connell, Garbark, & Nader, 2019; Balevre, Balevre, & Chesire, 2018; Lasater, Mood, Buchwach, & Dieckmann, 2015). In addition, a majority of the studies did not use control groups, which makes the distinction between effects of the environment and effects of the intervention difficult to ascertain.

Programs appeared to be consistently effective in improving the awareness of incivility, regardless of the intervention used. Incivility and bullying education correlated with an increase in the coworker's aptitude towards identifying disruptive behaviors or instances (Armstrong, 2017; Keller, Allie, & Levine, 2019; Schwarz & Leibold, 2017). One study suggested that the rise of post-survey incivility scores was a result of increased awareness (Armstrong, 2017). This may also be due to the fact that incivility and bullying education helps refute the acceptance of disruptive behaviors in healthcare as a cultural norm (Keller, Allie, & Levine, 2019).

Studies that measured empowerment reported either a significant (Armstrong, 2017; Keller, Allie, & Levine, 2019; Balevre, Balevre, & Chesire, 2018) or partial (Schwarz & Leibold, 2017; Lasater, Mood, Buchwach, & Dieckmann, 2015; Kile, Eaton, daValpine, & Gilbert, 2018) increase in empowerment. Participants generally felt better equipped to respond to incivility or bullying in the workplace when incivility or bullying occurred (Armstrong, 2017; Keller, Allie, & Levine, 2019; Balevre, Balevre, & Chesire, 2018). Empowerment was also influenced by the team member's perceived risk of retaliation or sense of support from leadership, which is consistent with current literature (O'Connell, Garbark, & Nader, 2019).

Lastly, current interventions showed a mixed influence over manifestations of incivility or bullying. Each study focused on different types of manifestations of incivility or bullying via the instruments they used. Factors measured across studies included disrespectful behaviors, abandonment behaviors (such as ignoring opinions), unfriendly communication, invasion of

privacy (such as taking personal items without permission), intimidation or humiliation behaviors, occupational devaluation (such as being given tasks below competency), negative views on interpersonal relationships, negative symptoms experienced (such an anxiety and depression), turnover or retention rates, collective efficacy in the workplace, and job satisfaction.

Two studies based on cognitive rehearsal (Balevre, Balevre, & Chesire, 2018; Lasater, Mood, Buchwach, & Dieckmann, 2015), one study based on a multidimensional approach (Parker, Harrington, Smith, Sellers, & Millenbach, 2016), and one very simple study based on online education (Schwarz & Leibold, 2017) showed significant results towards reducing different manifestations of incivility and bullying. All other studies were indeterminate, as some factors increased, some factors decreased, while others did not yield significant results.

Table 1: Summary of Current Research

Overview of Studies										
Article	**Interventions**				**Team vs. Individual Focus**	**Effects**			**Social Frame work**	**Reference & Study Type**
	D	**R**	**O**	**CR**		**A**	**E**	**M**		
1	X	X			T	SR	SR	N	Fh	(Armstrong, 2017) **MM**
2	X	X	X		T	SR	SR	Mx	Fh	(Keller, Allie, & Levine, 2019) **QL**
3	X	X		X	I	0	N	SS	Fm	(O'Connell, Garbark, & Nader, 2019) **MM**
4	X	X	X	X	T	0	0	SR	Fh	(Parker, Harrington, Smith, Sellers, & Millenbach, 2016) **CS**
5			X		I	SR	SS	SR	Fv	(Schwarz & Leibold, 2017) **MM**
6		X		X	I	0	0	SS	Fk	(Kang, Kim, & Yun, 2017) **QN**
7	X		X	X	I	0	0	SS	Fk	(Kang & Jeong, 2019)

										QN
8	X		X	X	I	0	0	SS	Fh	(Razzi & Bianchi, 2019) **MM**
9	X		X	X	T	0	SR	SR	Fh	(Balevre, Balevre, & Chesire, 2018) **MM**
10	X	X		X	T	0	SS	SR	Fh	(Lasater, Mood, Buchwach, & Dieckmann, 2015) **MM**
11	X	X		X	T	0	SS	SS	Fh	(Kile, Eaton, daValpine, & Gilbert, 2018) **MM**

TABLE KEY

Interventions

D = Didactic education intervention
R = Roleplay intervention
O = Other intervention
CR = Cognitive Rehearsal or cognitive theory intervention
X = corresponding intervention was utilized

Effects

A = Awareness of incivility or bullying
E = Empowerment towards handing incivility or bullying
M = Manifestations of incivility or bullying (ranging from behaviors to staff retention)

Results

SR = Significant results or indications
SS = Some significance; a few measured variables showed positive statistical significance
N = Nonsignificant results or indications
Mx = Mixed results (applies to qualitative studies only)
0 = not measured

Social Framework

Fh = U.S. Hospital
Fm = U.S. Military Base
Fk = South Korean University Hospital
Fv = Various clinical settings

Study Type

QN = Quantitative
CS = Case Study
QL = Qualitative
MM = Mixed Methods or Quasi-Experimental

Discussion

Based on these most recent studies, it is clear that an effective program to resolve incivility or bullying in healthcare is still in its infancy. However, several themes have emerged to help improve program designs and guide the direction of research moving forward. First of all, the program must be concise, consistent, and reproducible. Current programs either introduced several different interventions at once or displayed inconsistent results, making clear connections between cause and effect practically impossible. Second, evidence implied that interventions may be more impactful when centered around teams instead of individuals (Armstrong, 2017; Keller, Allie, & Levine, 2019; Parker, Harrington, Smith, Sellers, & Millenbach, 2016; Balevre, Balevre, & Chesire, 2018; Lasater, Mood, Buchwach, & Dieckmann, 2015), and especially potent when leadership is actively engaged in the process (Parker, Harrington, Smith, Sellers, & Millenbach, 2016; Balevre, Balevre, & Chesire, 2018). Lastly, the program design must fit into the politics and social framework of the targeted healthcare facility, as common obstacles in implementing these programs or facilitating staff engagement were connected to the unique challenges of each work environment. Program availability and employee perceptions towards reporting disruptive behaviors are just a few structural challenges that surfaced (Armstrong, 2017; Keller, Allie, & Levine, 2019; O'Connell, Garbark, & Nader, 2019; Balevre, Balevre, & Chesire, 2018; Lasater, Mood, Buchwach, & Dieckmann, 2015).

The most popular intervention for workplace civility appears to be Cognitive Rehearsal Theory, or cognitive theory. Seven out of eleven studies—eight if the multidimensional study is also included—incorporated the principles of cognitive rehearsal into their program design. The catalyst of this trend seems to originate from an exploratory descriptive study conducted by Griffin (2004) and later reviewed alongside similar studies with Clark (2014). Cognitive

rehearsal training theoretically empowers nurses to confront incivility at work as well as resolve problematic behaviors and increase staff retention rates (Griffin, 2004; Griffin & Clark, 2014). However, the most current studies, featured in this review, show contradicting and mixed results.

For example, the two studies with highest rank and quality use Cognitive Rehearsal Theory in their program design and were led by Kang from South Korea (Kang, Kim, & Yun, 2017; Kang & Jeong, 2019). Note that both of these studies used control groups, whereas Griffin's study from 2004 did not. Although these studies did show an increase in staff retention, there was not a significant effect in workplace bullying or incivility overall. The reason for differing results could be cultural, or the reason could be that Griffin's study sampled newly licensed nurses, whereas the studies from Kang ensured that participants had at least six months of experience in the field. However, whether this information truly reflects cognitive rehearsal training cannot be determined because each study added different variables and methods of delivery. A more concise, consistent, and reproducible program is needed to address this problem and form clear distinctions between cause and effect. Independent variables must be tested and compared individually if an evidence-based program is to be designed with confidence.

Another interesting consideration that surfaced in the literature was individual-based training versus unit-based training. Interventions appeared to have a greater impact when members of the same healthcare team or unit participated together. Six out of the eleven studies focused on teams. Five of these studies displayed significantly better results than the studies that targeted individuals (Armstrong, 2017; Keller, Allie, & Levine, 2019; Parker, Harrington, Smith, Sellers, & Millenbach, 2016; Balevre, Balevre, & Chesire, 2018; Lasater, Mood, Buchwach, & Dieckmann, 2015). This is consistent with current knowledge of leadership's influence over the

culture and civility of a team (Pearson et al., 2000; The Joint Commission, 2008; Vessey, DeMarco, & DiFazio, 2011).

Lastly, current studies demonstrated the importance of accommodating and accounting for the structure of the workplace. Convenience, mostly in the form of scheduling, played a major role in the degree of participation of a program (Armstrong, 2017; Keller, Allie, & Levine, 2019; Balevre, Balevre, & Chesire, 2018; Lasater, Mood, Buchwach, & Dieckmann, 2015). Designing a program that fits well into to the work environment is essential for increasing employee engagement and participation. It would also help target populations that would be more suitable for testing interventions, thereby ensuring more reliable results.

For example, one pilot study targeted night shift nurses, yet this shift typically does not interact with the healthcare team as frequently as the day shift. Possible associations between shifts and conflict were validated by the fact that uncivil behaviors were mostly reported in day shift nurses (Armstrong, 2017). In other words, "there was not a great deal of room for improvement" in this unit's night shift population (Armstrong, 2017, p. 129). Compare this to a study that chose to test its intervention on a unit with high reports of incivility and turnover rates. Although this study also utilized popular methods such as Cognitive Rehearsal Training, the results were less impressive than similar studies (Kile, Eaton, daValpine, & Gilbert, 2018). The chosen sample population may skew results.

Every medical facility has its own set of unique obstacles, as demonstrated by the study conducted by O'Connell, Garbark, and Nader on a medical Airforce base (2019). The researchers inferred from their results that the hierarchical structure, mistrust of superiors, and frequent relocations of staff in this facility may have influenced both the participant's reception of the intervention and the accuracy of the assessment and re-evaluation of participants. Every medical

facility's structure and culture is different and should be considered when designing civility programs to ensure the accuracy of data collection as well as the efficacy of interventions.

Limitations

An addition of detailed search terms with the inclusion of related terms may benefit a more comprehensive literature review in the future. This review also only included the most recent interventions being studied, although older studies may still offer relevant insights into how to best reduce incivility. Finally, this review mainly focused on nurses and did not include studies implemented in work environments outside of healthcare. However, other approaches from other healthcare professionals and work environments may be beneficial in the future to approach the problem of incivility and bullying from other diverse perspectives.

Conclusion

Studies were interested in using interventions to affect awareness of incivility or bullying, empowerment towards handling it, and manifestations of incivility or bullying in the workplace. Cognitive Rehearsal training was the most frequently examined intervention, yet only two studies with this intervention showed significant results in all measured areas. Common patterns that arose in the literature were the benefits of team-based interventions and the effects of the work environment structure or culture on the reception and implementation of the program.

Current research in healthcare regarding the reduction of incivility or bullying in the work environment appears to have a lot to be improved upon. Control groups are not being utilized and interventions could be organized better to help determine cause and effect. Moving forward, different interventions for this multi-faceted issue must be tested separately, and with control groups, for a more evidence-based, concrete, and reproducible solution. Cognitive Rehearsal Therapy, for example, is comprised of two different variables: didactic education and role-play exercises. These should be tested and compared separately to determine the significance of each. Additionally, programs should be designed around teams instead of individuals and programs must take the structure of the work environment, as well as the baseline of the work culture, into account to help affirm validity of studies.

APPENDIX A

EVIDENCE TABLE

APPENDIX A: EVIDENCE TABLE

PIO Question: In the healthcare team, what are the most current, evidence-based interventions for increasing civility and reducing disruptive behaviors among colleagues?

Article	Author, Date, & Location	Evidence Type	Sample, Size, & Setting	Principal Findings	Observable Measures	Limitations	Evidence Level & Quality
1	Armstrong 2017 USA	Quasi-Experimental	9 Registered nurses (evening shift) in a medical-surgical unit in a VA medical center (hospital)	• A CREW-based program of four sessions did not show statistical significance in influencing civility in the unit, although in some cases incivility scores slightly increased (which could be attributed to increased awareness) • Statistically significant increase of all areas of Confidence Scale, indicated increased ability to recognize and confidently respond to incivility	Workplace Incivility Scale to measure incivility in the unit Confidence Scale to measure participant's ability to recognize and respond to incivility	• Intervention intended for work environments that do not have "major" incivility issues, however, this was not defined quantitatively • No psychometric analysis for the Confidence Scale • Pilot study • Lacking day shift nurse perspectives and feedback • Participants were all women and mostly Caucasian • Program duration and length of sessions were unconventionally short for CREW and learning setting or conditions may not have been ideal (held during the shift)	**Level II** **Grade B**

2	Keller, Allie, & Levine 2019 USA	Qualitative Focus Group Retrospective study	25 Registered Nurses who completed voluntary BNC training at NYU Langone Tisch Hospital (4 – 12 Participants per focus group)	• 3 Themes: increased awareness and understanding of bullying, ability to correctly identify all four steps (standby, support, speak up, and sequester), and feeling prepared and empowered • Positive feedback of program included feeling supported, better interactions with coworkers, and feeling better equipped to deal with bullying • Negative feedback included lack of availability or awareness from other coworkers and fear of retaliation if they intervened in a bullying situation • Participants stated that the volunteers of Be Nice Champion (BNC) training program tended to be outspoken and supportive by nature • Participants recommended the expansion of the program to other disciplines and more BNC training opportunities • Generally viewed as a success	Recorded, transcribed, and coded into three themes	• Data collected was based off of memory from 4 years ago • Incentive of $10 offered helps encourage participation but also may skew data • Positive themes were coded, however, negative themes were not (although they were mentioned)	**Level III** **Grade A**
3	O'Connell, Garbark, & Nader 2019 USA	Mixed Method (Exploratory)	Registered Nurses in Air Force medical treatment facility; RNs working in the perioperative area of the facility; and the	• Intervention using didactic teaching, Cognitive Rehearsal Training (CRT), and role-play received generally positive feedback and reports of applying lessons to real life • Nurses who refused to list their department were also more likely to report lateral violence	Negative Acts Questionnaire-Revised (NAQ-R) to measure lateral violence Intervention evaluation questionnaire	• Physical and psychological strains of duty (not related to incivility) may influence results • Staff expressed fear of retaliation from superiors if answers were exposed • Staff moves frequently between areas, causing	**Level III** **Grade C**

			whole RN population Phase I: 76 Phase II: 10 Phase III: 39	• Allegations and pressure not to claim an item one is entitled too significantly decreased • NAQ-R results did not indicate significant impact or support efficacy of intervention • Results may be another example of how organizational factors can play into results		reassessment to be challenging or not possible (inconsistent participants) • Presence of management staff hindered participation of clinical staff in active learning	
4	Parker, Harrington, Smith, Sellers, & Millenbach 2016 USA	Nonexperimental: Case Study	An unspecified number of nurses employed in an acute care hospital	• Culture change was based on several foundational ideas, including a focus on influencing "Longo's Levels"—organization, leadership, and individual • Lighting the Way Retreat helped unify coworkers • Multidimensional, collaborative approach and setting initiatives in the company appeared to have helped decrease horizontal violence • CRT interventions included in leadership retreat	New York Organization of Nurse Executives Horizontal Violence Survey (NYONE HV) to measure prevalence of horizontal violence	• Interventions are mostly generalized and nonspecific, causing this to be impossible to replicate or verify • Multiple interventions mean multiple variables, which makes correlation and causation impossible to determine • Information about process is highly anecdotal	**Level III** **Grade C**
5	Schwarz & Leibold 2017 USA	Quasi-Experimental	27 Registered nurses who worked in various clinical settings and were completing their baccalaureate degree at a	• Online education of incivility utilizing an article titled, "Incivility in Nursing" show a statistically significant increase in incivility identification • Postsurvey allegedly indicated increased understanding of strategies to deal with incivility	Modified Horizontal Violence Survey for measuring incivility Nursing workplace postsurvey added questions regarding feedback on program	• Only 27 out of 57 participants completed the posttest and may have skewed results • Self-selected participants not the best representation of a population • Small sample size with no control group	**Level II** **Grade C**

			public university			• Many questions in the survey depended on memory	
6	Kang, Kim, & Yun 2017 South Korea	Randomized Control Trial	40 Nurses (6+ months experience) from university hospitals who had not received communication training within 1 year were randomly assigned to either the wait list or 10 session CR program Experimental: 20 Control: 20	• The 10 sessions totaling 20 hours of the Cognitive Rehearsal Program (CRP) was correlated with an increase in interpersonal relationships and retention of nurses • Although a nonviolent communication teaching approach seemed to influence interpersonal relationships, it did not have a significant effect on workplace bullying • The CRP program did not appear to have an effect on workplace bullying or symptom experiences, which may be explained by individualized focus instead of unit-focused study • Results of civility education and training may depend on specific organization of program (individual-based vs. unit-based)	Relationship Change Scale to measure perception of interpersonal relationships Negative Acts Questionnaire-Revised (NAQ-R) to measure negative behaviors Brief Symptom Inventory to measure negative symptoms experienced Yun's Nurse Turnover Intention tool to measure retention	• Possible underestimation of sample size • Study accounted for individual factors; however, organizational factors are important to consider in interventions for workplace bullying • Length and mode of CRP may need to be modified to better facilitate learning programs for nurses • Trial registered after study concluded	**Level I** **Grade A**

7	Kang & Jeong 2019 South Korea	Quasi-Randomized Control Trial	73 General Staff Nurses (6+ months experience) across 4 units in a university hospital, recruited voluntarily and sorted quasi-randomly Experimental: 36 Control: 37	• Instances of intimidation-related bullying were not affected by the intervention • Instances of work-related bullying, person-related bullying, and turnover intentions were reduced in experimental group • Cognitive Rehearsal may not need to be face-to-face to be effective, which can help reduce cost of civility training programs	Negative Acts Questionnaire-Revised (NAQ-R) to measure workplace bullying Modified version of "Intent to Quit" questionnaire to measure turnover intention	• Inability to verify that participant is the one using the app or amount of times app is used due to lack of supervision • Only six scenarios available for training; more scenarios needed to prepare for different challenges • Technological limitations prevented recording of app usage and could also alter personal experiences of app between different phone models and systems • Sample size not sufficient (needed at least 80 participants for counterbalance)	**Level I** **Grade B**
8	Razzi & Bianchi 2019 USA	Quasi-Experimental	24 Nurses employed throughout departments at a community hospital voluntarily attended 1-hour education and cognitive rehearsal training sessions and were encouraged to practice these techniques at	• Statistically significant decrease in inappropriate jokes, gossip or rumors, free riding, abusive supervision, and lack of respect • Overall increased awareness and decreased incidence of civility correlated with quality improvement program involving education and cognitive rehearsal training • Majority of participants gave positive feedback on program and said they were "very likely" to recommend it	Nursing Incivility Scale (NIS) to measure effects on incivility Post-evaluation survey to measure participant satisfaction with program	• Volunteer-based convenience sample may not adequately represent the views or reception of the general population toward the program • Small sample size with no control group • Allotted time was not ideal for survey responses • Final survey data incomplete as some responses lacked answers	**Level II** **Grade B**

			work within a month				
9	Balevre, Balevre, & Chesire 2018 USA	Mixed Method (Convergent)	About 25 clinical staff members employed at a medical-surgical hospital unit (Over 50 attended sessions but most did not take the survey) were administered a 9-week didactic and active NPD program	• The Nursing Professional Development (NPD) program appeared to show statistically significant results in decreasing perceived risk of reporting bullying, decreasing the belief that the report would not be taken seriously, and decreasing the idea that nothing would be done if bullying was reported • The NPD program of education and cognitive rehearsal appeared to have a positive and empowering effect on unit culture towards addressing bullying behaviors	Workplace Harassment Survey 2013 (WHS-2013) to measure perception of and ability to counter workplace bullying Narrative of staff reports stated throughout article but not categorized	• Limited NPD staff meant that sessions may not have been available or convenient for all staff • More staff participated in the program than completed the surveys • Concrete number of staff who participated in sessions is unknown • By writer's own admission, success of program seems to depend on leadership participation and engagement • No control group	**Level III** **Grade C**
10	Lasater, Mood, Buchwach, & Dieckmann 2015 USA	Mixed Method (Explanatory & Multiphasic): Quantitative & Qualitative	94 staff (RNs, clinical support staff, leadership staff) from two units of a large hospital were given 3 phases of didactic and active learning intervention, the	• Statistically significant increase in self-efficacy and decrease in perceived incivility correlated with this intervention • Qualitative data from interviews suggested increased awareness of incivility and confrontation of incivility behaviors, desire for more members of the healthcare	Nursing Incivility Survey (NIS) to measure specific types of incivility prevalence New General Self-Efficacy Scale (NGSE) to measure self-efficacy	• Qualitative data from interviews was from a small portion of participants when compared with the total and data was not fully described with themes • Different phases of intervention (multiple variables) makes finding a correlation between	**Level III** **Grade C**

			third only open to leadership volunteers Unit A: 63 Unit B: 31 Four volunteers from each unit were participants for the interview portion that occurred 2 – 3 months after the 3rd phase	team to be included in intervention, and importance of leadership involvement in assisting progress • Collective efficacy did not appear to be impacted by these interventions • NDNQI at start of intervention and 24 months after showed significant increase in RN satisfaction between nurse and doctor interactions, however, this correlation cannot be confidently attributed to causation due to a plethora of other factors at work	Workplace Collective Efficacy Scale (WCES) to measure collective efficacy in the workplace National Database for Nursing Quality Indicators (NDNQI) to compare job satisfaction Audio recorded interviews to facilitate qualitative data collection	individual variables impossible • No control group and no baseline obtained before interventions began • Heavy participant attrition and missing data as well as inconsistent sample size and sample target between interventions	
11	Kile, Eaton, daValpine, & Gilbert 2018 USA	Mixed Method (Convergent): Quantitative & Qualitative	19 Registered nurses employed in a PACU in a rural hospital of Virginia Five training sessions (2 hours) utilized didactic and role-play methods of education over three weeks	• General decrease in uncivil behavior after intervention • Statistically significant decrease in inappropriate jokes, displaced frustration, and lack of respect after intervention • Qualitative data indicated that incivility had negative effect on job satisfaction, work environment, and coworkers • Intervention appeared to increase self-awareness in participants and effort to decrease incivility behaviors • Incivility behaviors did not significantly decrease after intervention • Although intervention occurred over a relatively	Nursing Incivility Survey (NIS) to measure specific types of incivility prevalence Nurse Interaction subscale of the National Database of Nursing Quality Indicators (NDNQI) for measurement of job satisfaction in the unit An open-ended questionnaire designed by	• Pilot study; very small sample size may skew data, larger study needed to further explore effects of incivility and the intervention • Intervention was studied over a relatively short time period (Intervention conducted over 3 weeks; final assessment conducted 6 weeks after intervention) • Data from two participants was excluded due to missing or improperly collected data • Qualitative data did not specifically assess	**Level III** **Grade B**

				short period of time, incivility behaviors appeared to trend down and confrontation of incivility appeared to trend up	researchers for qualitative data regarding participant's handling of incivility and effects of incivility on job satisfaction	change in job satisfaction after intervention • No control group	

References

Adams, A., Hollingsworth, A., & Osman, A. (2019). The implementation of a cultural change toolkit to reduce nursing burnout and mitigate nurse turnover in the emergency department. *Journal of Emergency Nursing, 45*(4), 452-456. https://doi.org/10.1016/j.jen.2019.03.004

Aiken, L.H., Clarke, S.P., & Sloane, D.M. (2002). Hospital staffing, organization, and quality of care: Cross-national findings. *International Journal for Quality in Health Care, 14*(1), 5-13. https://doi.org/10.1093/intqhc/14.1.5

Aiken, L.H., Sloane, D.M., Clarke, S., Poghosyan, L., Cho, E., You, L., …Aungsuroch, A.Y., (2011). Importance of work environments on hospital outcomes in nine countries. *International Journal for Quality in Health Care, 23*(4), 357-364. DOI: 10.1093/intqhc/mzr022

American Hospital Association (2002). *In our hands: How hospital leaders can build a thriving workforce*. Available from https://eric.ed.gov/contentdelivery/servlet/ERICServlet?accno=ED476023

Armstrong, N. E. (2017). A Quality Improvement Project Measuring the Effect of an Evidence-Based Civility Training Program on Nursing Workplace Incivility in a Rural Hospital Using Quantitative Methods. *Online Journal of Rural Nursing & Health Care*, *17*(1), 100–137. https://doi.org/10.14574/ojrnhc.v17i1.438

Balevre, S. M., Balevre, P. S., & Chesire, D. J. (2018). Nursing Professional Development Anti-Bullying Project. *Journal For Nurses In Professional Development*, *34*(5), 277–282. https://doi.org/10.1097/NND.0000000000000470

Blake, N. (2012). Practical steps for implementing healthy work environments. *AACN Advanced Critical Care, 23*(1), 14-17. http://dx.doi.org/10.1097/NCI.0b013e318240a44e

Clark, C.M. (2013). National study on faculty-to-faculty incivility strategies to foster collegiality and civility. *Nurse educator, 38*(3), 98-102. DOI: 10.1097/NNE.0b013e31828dc1b2

Clark, C.M., Cardoni, C., Olender, L., & Kenski, D. (2011). Fostering civility in nursing education and practice: Nurse leader perspectives. *The Journal of Nursing Administration, 41*(7/8), 324-330. DOI: 10.1097/NNA.0b013e31822509c4

Edmonson, C. & Zelonka, C. (2019). Our own worst enemies: The nurse bullying epidemic. *Nursing Administration Quarterly, 43*(3), 274-279. DOI: 10.1097/NAQ.0000000000000353

Einarsen, S., Hoel, H., & Notelaers, G. (2009). Measuring exposure to bullying and harassment at work: Validity, factor structure and psychometric properties of the Negative Acts questionnaire-revised. *Work & Stress, 23*(1), 24-44. DOI: 10.1080/02678370902815673

Evans, D. (2017). Categorizing the magnitude and frequency of exposure to uncivil behaviors: A new approach for more meaningful interventions. *Journal of Nursing Scholarships, 49*(2), 214-222. DOI: 10.1111/jnu.12275

Griffin, M. & Clark, C. (2014). Revisiting cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 Years later. *Journal of Continuing Education in Nursing, 45*(12), 535-542. https://doi.org/10.3928/00220124-20141122-02

Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *Journal of Continuing Education in Nursing, 35*(6), 257-263. https://doi.org/10.3928/0022-0124-20041101-07

Grissinger, M. (2017). Unresolved behavior in health care: Practitioners speak up (again)—part 1. *Pharmacy and Therapeutics, 42*(1), 4-5. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5215268/

Guidroz, A.M., Burnfield-Geimer, J.L., Clark, O., Schwetschenau, & Jex, S.M. (2010). The nursing incivility scale: Development and validation of an occupation-specific measure. *Journal of Nursing Measurement, 18*(3), 176-196. DOI: 10.1891/1061-3749.18.3.176

Hunger, J.D., & Wheelen, T.L. (1975). The relationship between group dynamics and team performance in business simulation games. *Academy of Management Proceedings, 1975*(1), 43-35. https://doi.org/10.5465/ambpp.1975.4978499

Institute of Medicine (2004). *Keeping patients safe: Transforming the work environment of nurses.* Washington, D.C.: National Academies Press.

Institute of Medicine (2001). *Crossing the quality chasm: A new healthcare system for the 21st century*. Washington, D.C.: National Academies Press.

Institute of Medicine. (2000). *To err is human: Building a safer health system.* Washington, DC: National Academy Press.

Kang, J., Kim, J. I., & Yun, S. (2017). Effects of a Cognitive Rehearsal Program on Interpersonal Relationships, Workplace Bullying, Symptom Experience, and Turnover Intention among Nurses: A Randomized Controlled Trial. *Journal Of Korean Academy Of Nursing, 47*(5), 689–699. https://doi.org/10.4040/jkan.2017.47.5.689

Kang, J., & Jeong, Y. J. (2019). Effects of a smartphone application for cognitive rehearsal intervention on workplace bullying and turnover intention among nurses. *International Journal Of Nursing Practice, 25*(6), e12786. https://doi.org/10.1111/ijn.12786

Katz, D., Blasius, K., Isaak, R., Lipps, J., Kushelev, M., Goldberg, A., ..,DeMaria, S. (2019). Exposure to incivility hinders clinical performance in a simulated operative crisis. *BMJ Quality & Safety, 28,* 750-757. https://doi.org/10.1136/bmjqs-2019-009598

Keller, R., Allie, T., & Levine, R. (2019). An evaluation of the "BE NICE Champion" programme: A bullying intervention programme for registered nurses. *Journal Of Nursing Management, 27*(4), 758–764. https://doi.org/10.1111/jonm.12748

Kile, D., Eaton, M., daValpine, M., & Gilbert, R. (2019). The effectiveness of education and cognitive rehearsal in managing nurse-to-nurse incivility: A pilot study. *Journal of Nursing Management, 27*, 543-552. DOI: 10.1111/jonm.12709

Kisner, T. (2018). Workplace incivility: How do you address it? *Nursing, 48*(6), 38-40. http://dx.doi.org/10.1097/01.NURSE.0000532746.88129.e9

Kramer, M., & Schmalenberg, C. (2004). Development and evaluation of essentials of magnetism tool. *Journal of Nursing Administration, 34*(7/8), 365-378.

Kramer, M., Schmalenberg, C., & Maguire, P. (2010). Nine structures and leadership practices essential for a magnet (healthy) work environment. *Nursing Administration Quarterly, 34*(1), 4-17. DOI: 10.1097/NAQ.0b013e3181c95ef4

Kozlowski, S.W.J. & Ilgen, D.R. (2006). Enhancing the effectiveness of work groups and teams. *Psychological Science in the Public Interest, 7*(3), 77-124. https://doi.org/10.1111/j.1529-1006.2006.00030.x

Kutney-Lee, A., McHugh, M.D., Sloane, D.M., Cimiotti, J.P., Flynn, L., Neff, D.F., & Aiken, L.H. (2009). Nursing: A key to patient satisfaction. *Health Affairs, 28*(3), w669-w677. https://doi.org/10.1377/hlthaff.28.4.w669

Kutney-Lee, A., Stimpfel, A.W., Sloane, D.M., Cimiotti, J.P., Quinn, L.W., & Aiken, L.H. (2015). Changes in patient and nurse outcomes associated with magnet hospital recognition. *Medical Care, 53*(6), 550-557. https://doi.org/10.1097/MLR.0000000000000355

Lasater, K., Mood, L., Buchwach, D., & Dieckmann, N.F. (2015). Reducing civility in the workplace: Results of a three-part educational intervention. *The Journal of Continuing Education in Nursing, 46*(1), 15-24. DOI: 10.3928/00220124-20141224-01

Laschinger, H.K.S. (2014) Impact of workplace mistreatment on patient safety risk and nurse assessed patient outcomes. *Journal of Nursing Administration, 44*(5), 284-290. DOI: 10.1097/NNA.0000000000000068

Laschinger, H.K., Leiter, M., Day, A., & Gilin, D. (2009). Workplace empowerment, incivility, and burnout: Impact on staff nurse recruitment and retention outcomes. *Journal of Nursing Management, 17*, 302-311. DOI: 10.1111/j.1365-2834.2009.00999

Lim, S., Cortina, L.M., & Magley, V.J. (2008). Personal and workgroup incivility: Impact on work and health outcomes. *Journal of Applied Psychology, 93*(1), 95-107. DOI: 10.1037/0021-9010.93.1.95

Lux, K.M., Hutcheson, J.B., & Peden, A.R. (2012). Successful management of disruptive behavior: A descriptive study. *Issues in Mental Health Nursing, 33*(4), 236-243. https://doi.org/10.3109/01612840.2011.647256

McHugh, M.D., Kelly, L.A., Smith, H.L., Wu, E.S., Vanak, J.M., & Aiken, L.H. (2013). Lower mortality in magnet hospitals. *Medical Care, 51*(5), 382-388. http://dx.doi.org/10.1097/MLR.0b013e3182726cc5

Moore, L.W., Sublett, C., & Leahy, C. (2017). Nurse managers speak out about disruptive nurse-to-nurse relationships. *The Journal of Nursing Administration, 47*(1), 24-29. DOI: 10.1097/NNA.0000000000000432

Moore, L.W., Leahy, C., Sublett, C., & Lanig, H. (2013). Understanding nurse-to-nurse relationships and their impact on work environments. *Medsurg Nursing, 22*(3), 172-179. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/23865278

Nayback-Beebe, A.M., Forsynthe, T., Funari, T., Mayfield, M., Thoms, W., Smith, K., & Bradstreet, H. (2013). Using evidence-based leadership initiatives to create a healthy nursing work environment. *Dimensions of Critical Care Nursing, 32*(4), 166-173. DOI: 10.1097/DCC.0b013e3182998121

O'Connell, K. M., Garbark, R. L., & Nader, K. C. (2019). Cognitive Rehearsal Training to Prevent Lateral Violence in a Military Medical Facility. *Journal Of Perianesthesia Nursing: Official Journal Of The American Society Of Perianesthesia Nurses*, *34*(3), 645–653.e1. https://doi.org/10.1016/j.jopan.2018.07.003

Osatuke, K., Moore, S.C., Ward, C., Dyrenforth, S.R., & Belton, L. (2009). Civility, Respect, Engagement in the Workforce (CREW). *Journal of Applied Behavioral Science, 45*(3), 384-410. DOI: 10.1177/0021886309335067

Parker, K. M., Harrington, A., Smith, C. M., Sellers, K. F., & Millenbach, L. (2016). Creating a Nurse-Led Culture to Minimize Horizontal Violence in the Acute Care Setting: A Multi-Interventional Approach. *Journal For Nurses In Professional Development*, *32*(2), 56–63. https://doi.org/10.1097/NND.0000000000000224

Pearson, C.M., Andersson, L.M., & Porath, C. L. (2000). Assessing and attacking workplace incivility. *Organizational Dynamics, 29*(2), 123-137. DOI: 10.1016/S0090-2616(00)00019-X

Porath, C. (2016). *Mastering civility: A manifesto for the workplace*. New York, NY: Grand Central Publishing. Porath, C.L., Foulk, T., & Erez, A. (2015). How incivility hijacks performance: It robs cognitive resources, increases dysfunctional behavior, and infects team dynamics and functioning. *Organizational Dynamics, 44*, 258-265. DOI: 10.1016/j.orgdyn.2015.09.002

Porath, C. & Pearson, C. (2010). The cost of bad behavior. *Organizational Dynamics, 39*(1), 64-71. https://doi.org/10.1016/j.orgdyn.2009.10.006

Razzi, C. C., & Bianchi, A. L. (2019). Incivility in nursing: Implementing a quality improvement program utilizing cognitive rehearsal training. *Nursing Forum, 54*(4), 526–536. https://doi.org/10.1111/nuf.12366

Riskin, A., Erez, A., Foulk, T.A., Kugelman, A., Glover, A., Shoris, I., …Bamberger, P.A. (2015). The impact of rudeness on medical team performance: A randomized trial. *Pediatrics, 136*(3), 487-495. http://dx.doi.org/10.1542/peds.2015-1385

Rosenstein, A.H. & O'Daniel, M. (2008). A survey of the impact of disruptive behaviors and communication defects on patient safety. *The Joint Commission Journal on Quality and Patient Safety, 34*(8), 464-471. DOI: 10.1016/S1553-7250(08)34058-6

Rosenstein, A.H., & O'Daniel, M. (2005). Disruptive behavior & clinical outcomes: Perceptions of nurses & physicians. *American Journal of Nursing, 105*(1), 54-65. Available from https://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=106573816&site=eds-live&scope=site&custid=current

Schwarz, L. M., & Leibold, N. (2017). Education as an Intervention Toward Recognizing and Eliminating Incivility. *Creative Nursing, 23*(4), 232–241. https://doi.org/10.1891/1078-4535.23.4.232

Shirom, A., Toker, S., Akaly, Y., Jacobson, O., & Balicer, R. (2011). Work-based predictors of mortality: A 20-year follow-up of healthy employees. *Health Psychology, 30*(3), 268-275. DOI: 10.1037/a0023138

Shortell, S., Zimmerman, J.E., Rousseau, D.M., Gillies, R.R., Wagner, D.P., Draper, E.,…Duffy, J. (1994). The performance of intensive care units: Does good management make a difference? *Medical Care, 32* (5), 508 – 525. Retrieved from https://www.jstor.org/stable/3765883

Slopen, N., Glynn, R.J., Buring, J.E., Lewis, T.T.,Williams, D.R., & Albert, M.A. (2012). Job strain, job insecurity, and incident cardiovascular disease in the women's health study: Results from a 10-year prospective study. *Public Library of Science, 7*(7), e40512. DOI: 10.1371/journal.pone.0040512

Smith, M.S., Andrusyszyn, M.A., & Laschinger, H.K.S. (2010). Effects of workplace incivility and empowerment on newly graduated nurse' organizational commitment. *Journal of Nursing Management, 18*, 1004-1015. https://doi.org/10.1111/j.1365-2834.2010.01165.x

The Governance Institute (2009). Leadership in healthcare organizations: A guide to joint commission leadership standards [PDF file]. Retrieved from https://www.jointcommission.org/leadership_in_healthcare_organizations/

The Joint Commission (2008). Behaviors that undermine a culture of safety. *Sentinel Event Alert, (40*). Retrieved from http://www.jointcommission.org/assets/1/18/SEA_40.pdf.

Thomas, S.P. (2003). Professional development: 'Horizontal hostility'. *The American Journal of Nursing, 103*(10). Retrieved from https://www.jstor.org/stable/29745409?seq=1#page_scan_tab_contents

Vessey, J.A., DeMarco, R., & DiFazio, R. (2011). Bullying, harassment, and horizontal violence in the nursing workforce: The state of the science. Annual Review of Nursing Research, 28, 1944-4028. DOI: 10.1891/0739-6686.28.133

Walumbwa, F.O., Muchiri, M.K., Misati, E., Wu, C., & Meiliani, M., (2016). Inspired to perform: A multilevel investigation of antecedents and consequences of thriving at work. *Journal of Organizational Behavior, 39*(3), 249-261. DOI: 10.1002/job.2216