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Managing Nursing Incivility: An Integrative Literature Review

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Managing Nursing Incivility: An Integrative Literature Review

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Abstract

Incivility among nurses is a problem that affects healthcare at multiple levels. Incivility can lead to intimidation that can distract clinical judgment, putting patient safety in jeopardy. Incivility affects patient safety as it is a "contributing factor to 98,000 deaths each year in acute care settings" (Lesater, Mood, Buchwach, & Dieckmann, 2015 p. 17). In addition, incivility impacts healthcare organizations related to nursing turnover rates and can cost hospital organizations up to 125% of a registered nurse's (RN) annual salary to replace each individual nurse who leaves their job (Stagg, Sheridan, Jones, & Speroni, 2013). The Joint Commission and American Nurses Association recommend zero-tolerance for such disruptive behavior and express goals to improve recognition of incivility and address the behaviors within the nursing profession as well as medical institutions. The purpose of this integrative literature review is to identify a relationship between nursing incivility and nursing turnover intentions as well as identify the impact an educational program has on nurse's confidence in managing uncivil behaviors when witnessed. Martha Griffin's (2004) Cognitive Rehearsal Program (CRP) has supporting evidence to manage incivility in nursing and combining this program with The Johns Hopkins Nursing Evidence-Based Practice model can be utilized to integrate positive changes into the nursing culture. The effects of a CRP were studied quantitatively and qualitatively with supportive levels of evidence. The literature reviewed supported a CRP for managing nursing incivility as there was an overall decrease in nursing incivility

post intervention and a raised nursing awareness of incivility. Schwarz and Leibold (2017) surveyed nurses using a Likert scale pre and post an online educational intervention and found nurses ability to identify uncivil behaviors statistically improved ($p = 0.013$). Cognitive rehearsal programs taught nurses to reflect on their own behavior and how they may be perceived by other co-workers. Interestingly, 70% of nurses surveyed reported a positive change in their own behaviors after an educational course on nursing incivility (Stagg et al. 2013). Ultimately, there is a wealth of research to support an evidence based educational intervention to promote a change to prevent nursing incivility in hospital settings.

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Introduction

Introduction to the Inquiry

The concept of incivility has been a documented challenge within the nursing profession for decades (Kile, Eaton, deValpine, & Gilbert, 2018; Schwarz & Leibold, 2017; Taylor, 2016). It has been reported that 70% of hospital nurses have been exposed to uncivil behaviors (Gillen, Kernohan, Begley, & Luyben, 2017); more specifically a survey in 2016 found that in a 12-month period over 50 percent of nurses reported being verbally abused by other nurses (The Joint Commission, 2016). Throughout the literature, nurse to nurse incivility has been called various terms including horizontal hostility, lateral violence, disruptive behavior, bullying, aggression, and nurses "eating their young". Incivility is defined as rude or disruptive behavior that may affect another's physical or psychological well-being and is considered disrespectful (Griffin & Clark, 2014; Kile et al., 2018; Schwarz & Leibold, 2017). Kile et al. (2018) found that this behavior can be considered on a continuum, "from distractive and annoying behavior such as eye-rolling and sarcasm to more overt, aggressive, and potentially violent behaviors, including physical violence and even homicide" (p. 232).

Background and Rationale for the Inquiry

Incivility in nursing is a problem that affects the patient, the nursing profession and the healthcare organization. Incivility may lead to intimidation that can distract a nurse's clinical judgment and jeopardize patient safety and "may be a contributing factor to the 98,000 patient deaths each year in acute care settings" because nurses lack the skill

set to intervene when associated with or experiencing uncivil behaviors (Leaster et al. 2015, p. 17). In addition, incivility has a significant financial impact on healthcare organizations related to nursing turnover and retention. Approximately 40% of nurses who identify as those who have experienced bullying or disrespectful behavior leave their position. The lack of retention can cost hospital organizations "75% to 125% of an RN's annual salary, with the expenses related to recruitment, orientation, overtime, compensation to ensure patient safety, loss of productivity, and customer satisfaction" (Stagg et al., 2013, p. 334). Kroning (2019) states that the effects of incivility can affect an employee's motivation, communication, and creates trust issues with co-workers, ultimately leading to an increase in vacant nursing positions.

The Joint Commission on Accreditation of Healthcare (JCAHO) and American Nurses Association (ANA) have zero-tolerance for disruptive behaviors (verbal abuse, sabotage, verbal and nonverbal intimidation or humiliation) and provided goals for healthcare organizations to improve recognition of incivility and address the behaviors in the nursing profession and medical institutions (Kile et al., 2018; Kroning, 2019; Schwarz & Leibold, 2017; Wilson & Diedrich, 2011). "The Joint Commission reported incivility to be at an epidemic level" and "issued a Sentinel Event Alert for all behaviors that undermine a culture of safety" (Kroning, 2019, p. 52). However, nursing incivility can be difficult to identify and confront due to incivility being "ingrained in the nursing culture" (Taylor, 2016, p. 1) causing the behavior to not be recognize; therefore, not addressed. Taylor (2016) observed interaction of 80 nurses and other ancillary staff on a nursing unit for five months and witnessed uncivil behaviors such as eye rolling, face

making, shouting, or condescending tone of voice during every period. When nurses were interviewed by Taylor (2016) post observation, the majority didn't have a name for this type of behavior and only one nurse referred to it as bullying. When these behaviors are considered normal it causes some to perpetrate disrespect to others while being unaware of even doing it (Ceravol, Schwartz, Foltz-Ramos, & Castner, 2012). In addition, there is not a single term for the incivility phenomenon in the literature, making this a challenging behavior to identify (Taylor, 2016). Research shows that there is an inability among nurses to identify and confront uncivil behavior, which leads to the clinical question "would a nursing-based educational intervention for all nurses provide increased recognition of incivility, decrease disruptive behavior, and in turn, increase retention?"

Purpose of the Inquiry

The purpose of this integrative literature review is to identify a relationship between nursing incivility and nursing retention; as well as, identify the impact an educational intervention program has on nurse's confidence in managing uncivil behaviors when witnessed.

Clinical Question

Based on the provided information above, a clinical question was developed to guide the literature search and review. The clinical question, in Population (P), Intervention (I), Control (C), and Outcome (O), PICO format is the following: For nurses working in a hospital setting, how does an educational program on nursing incivility and tools to combat uncivil behavior compared with no educational program affect nurses'

knowledge and confidence in identifying and confronting nurse to nurse incivility and improve retention after receiving such education?

Method Used for the Inquiry

The method for this scholarly inquiry process was an integrative literature review. This method of inquiry gives a comprehensive review of the evidence in the literature to aid in a better understanding of the clinical problem and knowledge of interventions. It is supported by the literature to resolve and/or provide recommendations to the clinical problem described above.

Literature Review

Introduction

An extensive literature review was completed using several search engines to gain a broader understanding of nursing incivility and to review current studies on this issue. A variety of research articles were selected based on their level of evidence according to Ackley, Swan, Ladwig, and Tucker (2008). There were common themes identified in the systematic literature review and grouped: methodologic, background, and intervention. Methodologic themes identified common theories and framework to describe incivility: Social Cognitive Theory, Ray's Bureaucratic Caring Framework, and Oppressed Group Theory. Background themes grouped together authors' reasoning for studying the issue of incivility. Lastly, intervention themes evaluated the literature for the type of intervention performed to manage nursing incivility.

Search Strategy

Several search engines were utilized for a thorough literature search to be completed (see Table 1). Search engines included: Cochrane Library, Google Scholar, Nursing Collective @OVID, ProQuest, PubMed, and Scopus (which covers Medline and CINAHL.) Keywords to guide the literature search included: bullying, horizontal hostility (HH), workplace incivility, incivility, job satisfaction, nurses, intervention, prevention program, in-service, turnover, Cognitive Rehearsal Program. A second search was conducted that was aimed at specific authors that were frequently cited in the initial literature which included: Wilson, Barbara and Griffin, Martha. The searches took place in January 2019, February 2019, March 2019, and October 2019. Articles used in this inquiry were current and published between 2010 to 2019. An exception made to the literature review included a study by Martha Griffin (2004). This study provided a basis for many future studies which were all based on her intervention of Cognitive Rehearsal Program (CRP); therefore, the study was important to include. Articles were chosen based on abstracts that addressed an educational intervention for nurse to nurse incivility and turnover intents. Articles that were excluded were those articles in which the studied intervention took place in nursing academia settings. Studies chosen for this literature review can be viewed in Table 2. The chosen articles had an array of levels of evidence including one systematic review and a combination of quantitative and qualitative studies.

Levels of Evidence

The articles chosen were rated on a level of evidence based on Ackley, et al., (2008) evidence framework (Table 3.) The level of evidence associated with the studies

are as follows: one systematic review (level I), one Randomized Control Trial (RCT) (level II), four quasi-experimental (level III), two mixed methods (level VI), one descriptive quantitative and three qualitative studies (level VI) and one expert opinion (level VII). For the purpose of this topic, it was important to include quantitative and qualitative articles due to the subjectivity of this issue and the fact that nursing incivility is perceived and influenced differently by society and culture (Eka & Chambers, 2019).

Appraisal and Themes

A literature appraisal was completed which focused on nursing incivility; specifically looking at increasing nurses' knowledge and confidence in the management of uncivil behaviors and the effects incivility has on nursing turnover intentions. Several themes were identified from the literature and summarized in Table 4.

Methodological Themes

Social Cognitive Theory was a common underpinning theory in relation to an educational intervention for managing nursing incivility (Griffin, 2004; Kile et al., 2018; Lesater et al., 2015; Sanner-Stiehr, 2018). These authors stated the importance of learning and role-modeling new knowledge to strengthen self-efficacy and help individuals understand the cause and effect relationship of uncivil behaviors. Skarbek, Johnson, and Dawson (2015) conducted an exploratory phenomenological study utilizing Ray's bureaucratic caring framework for questions to attempt to capture the interrelationship nurses have with each other since these relationships are multifaceted. The central research questions utilized are displayed on Figure 1.

How did each participant define bullying?
What did the nurse manager (NM) do to address the issue?
What interventions were effective in addressing the behavior, and what interventions were no effective?
What did the NM perceive to be the scope of the problem?
What did the NM perceive comprises a healthy, caring work environment?

Figure 1. Central Research Questions
(Skarbek, Johnson, and Dawson, 2015)

Another theory discussed by Griffin (2004) is that nursing is part of an oppressed group due to the hierarchy nurses' function under and are dominated by leadership and management, and physicians. This hierarchy creates a power struggle and aggressive behaviors among nurses on the lower end of the hierarchy. Griffin (2004) researched an educational intervention on lateral violence to "liberate an oppressed individual by helping them to see that stopping the dominant group or individual from oppressing them… liberation allows learning to continue" (Griffin, 2004, p.258-259).

Both quantitative and qualitative studies were utilized in this review to assist with the understanding of nurse to nurse incivility behaviors. It was important to research both types of studies as incivility can be perceived differently based on cultures and personal situations: qualitative studies were able to examine personal perspectives and provide such dialogue. A common limitation identified from most of the quantitative studies was small sample sizes (Johnson et al., 2019; Kang, Kim, & Yun, 2017; Lesater et al., 2015; Schwarz & Leibold, 2017; Stagg et al., 2013; Wilson & Diedrich, 2011).

Additional limitations included convenience sampling and lack of a power analysis was generally absent, with the exception of Kang et al. (2017) RCT. Many of the quantitative studies recognized that post intervention assessments may have been completed to early (less than six months post intervention), leading to question sustainability of the interventions. Ceravolo et al. (2012) had the longest period studied, over three years. This was a large quality improvement project aimed to "reduce nurse-to-nurse lateral violence and create a more respectful workplace culture through a series of workshops" (p. 599). The educational workshops were 60 to 90 minutes in length, with a goal to teach nurses to identify verbal and non-verbal lateral violence, the negative impact the behavior has on nurses, and to learn assertive communication skills. The education was completed through slide presentation, sharing of uncivil scenarios, and role-play. Participants were electronically surveyed from an adapted form of the Verbal Abuse Survey and measured on a Likert type scale prior to the start of the workshops in 2008, then after the completion of the workshops in 2011. The intervention left a positive impact on the workplace culture where nurses felt more respected and supported by peers. Nurses reported a safe environment to express opinions, and a decrease in unnecessary communications. Overall verbal abuse among nurses decreased 90% from 76% (Ceravolo et al., 2012). Despite the limitation of early reassessment, majority of the literature had comparable final results.

Background Themes

Incivility in the nursing profession impacts multiple layers within healthcare organizations. Incivility results in increased turnover rates among nurses, creating a

significant expense for organizations. Kile et al. (2018) estimated $23.8 million is spent in the United States related to uncivil behaviors for "absenteeism, loss of productivity, altered workloads, and increased nursing turnover" (p. 2). Wilson and Diedrich (2011) had a similar finding "that employers spend $300,000 per year in nurse turnover costs for every 1% increase in turnover rates" (p. 454) due to loss of productivity, due to absenteeism from work, cost to recruit, hire, and orient.

A secondary background theme related to the research of nursing incivility is the attention this problem has received from JCAHO and ANA. Kile et al., (2018), Schwarz and Leibold, (2017), and Skarbek et al., (2015) identified that these organizations have recommended that nurses should recognize, acknowledge, address, and eliminate this disruptive, unprofessional behavior. ANA (2015) *Nursing Code of Ethics* Provision 1.5 Relationships with Colleagues and Others states that uncivil behaviors in nursing, bullying, and intimidation are morally unacceptable. The full version of this provision is seen in Figure 2.

1.5 Relationships with Colleagues and Others
Respect for persons extends to all individuals with whom the nurse interacts. Nurses maintain professional, respectful, and caring relationships with colleagues and are committed to fair treatment, transparency, integrity-preserving compromise, and the best resolution of conflicts. Nurses function in many roles and settings, including direct care provider, care coordinator, administrator, educator, policy maker, researcher, and consultant. The nurse creates an ethical environment and culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect. This standard of conduct includes an affirmative duty to act to prevent harm. Disregard for the effects of one's actions on others, bullying, harassment, intimidation, manipulation, threats, or violence are always morally unacceptable behaviors. Nurses value the distinctive contribution of individuals or groups as they seek to achieve safe, quality

patient outcomes in all settings. Additionally, they collaborate to meet the shared goals of providing compassionate, transparent, and effective health services.

Figure 2. Nursing Code of Ethics Provision 1.5
(ANA, 2015, p. 4)

Intervention Themes

The ability of the nursing profession to identify nurse to nurse incivility was identified as a challenge by several authors due to incivility being perceived differently based on culture and personal situations. There was evidence that this could be improved with an educational program. Schwarz and Leibold (2017) noted an online educational intervention helped nurses to identify uncivil behaviors ($p = 0.013$) ($r = -0.48$). The online education consisted of defining incivility in nursing, examples of incivility, the impact of incivility, and refection and application questions. Skarbek et al.'s (2015) phenomenological study with nurse managers identified a theme of awareness to uncivil behaviors as a priority in tackling the problem of incivility. Kile et al. (2018) found 25% of participants reported self-awareness of their own actions of incivility type behaviors after education on the topic and Stagg et al. (2013) had similar results where 70% of nurses surveyed reported changing their own behaviors after an educational course. Most shocking was an RCT by Johnson et al. (2019) which showed that 66% of subjects in the experimental group, who experienced incivility prior to performing cardiopulmonary resuscitation, made an error in giving an extra shock to the mannikin, whereas this error was not made by the control group. The uncivil behavior the experimental group faced was impatience of tapping a foot, frowning at the participants, and arms crossed by the simulation actor. Participants were also greeted in a poor manner by the actor: "This is

my equipment. I am here to make sure you take care of it…nurses can't clean up after themselves…I'm going to stick around to keep an eye on my stuff" (Johnson et al.,2019, p. 3). The results from the study were not statistically significant; however, this does raise concern that incivility can have negative consequences on teams performing clinical tasks while performing patient cares (Johnson, 2019).

Cognitive rehearsal programs created by Dr. Martha Griffin (2004) was the intervention of choice for the majority of the studies reviewed, with the exception of the systematic review reported by Gillen et al. (2017), which excluded Griffin (2004) because they felt CRP was focused on management of incivility versus prevention. Gillen et al. (2017) reported on a systematic review that determined that there were very low levels of evidence to demonstrate interventions in a workplace that can prevent bullying on the bases of reported RCTs. However, this review was not limited to hospital settings and excluded studies that focused on management of the problem.

The effects of a CRP intervention were studied both quantitatively and qualitatively, with levels of evidence ranging from II to VII. Kang and Yun (2017) completed an RCT in South Korea and Johnson et al. (2019) completed an RCT in the United States. Kang and Yan's (2017) intervention was the most time consuming. They lead ten different educational sessions lasting 20 hours each when compared to Lesater et al., (2015) being three educational sessions totaling seven hours and Kile et al., (2018) was five different educational sessions lasting two hours each. Kang and Yan (2017) evaluated the hypothesis that interpersonal relationships of participants that attended a CRP will be different from those who did not using a tool adapted from the "Relationship

Change Scale by Schlein & Guerney" (p. 693). This Relationship Change Scale measured communication, sense of trust, friendliness, sensitivity, openness and understanding. The tool had a Cronbach's alpha of 0.90. This hypothesis was supported statistically ($p = 0.022$). A follow-up assessment was completed four weeks post intervention, with the effects of the intervention still favorable ($p = 0.024$). Lesater et al., (2015) completed a mixed method study that demonstrated a decrease in perceived incivility and increase in self-efficacy to manage uncivil behaviors in two large hospital units studied following a three-part intervention of didactic, role-play and simulation. The intervention took place over a six-month period and participants were surveyed along to way. There were four tools used to assess the intervention goal, one was the *Nurse Incivility Scale* (NIS), this was uses to measure workplace conflict, stress, and job satisfaction (Cronbach's alpha of 0.81-0.94). The NIS uses a 5-point scale "measuring hostile climate, inappropriate jokes, inconsiderate behavior, gossip and rumors, free-riding, abusive supervision, lack of respect, and displaced frustration" (Lesater et al., 2015, p. 19). Kile et al., (2018) too utilized the NIS and results demonstrated statistical improvement in incivility behaviors post-intervention for the variable: lack of respect ($p = 0.003$). Ceravolo et al. (2012) project took three years to complete due to having 203 training sessions for over 4000 participants. In the training sessions, nurses attended with hopes to foster healthy conflict resolution and to change the culture of nurses not willing to speak up about incivility.

Throughout the literature, the effects of a CRP intervention on a nurse's ability to respond and confront uncivil and disruptive behaviors, such as scapegoating, nonverbal

innuendo, undermined activities, withholding information, sabotage, and backstabbing were evaluated. Sanner-Stiehr's (2018) quasi-experimental study found that nurses who had an educational intervention aimed at disruptive behavior and were taught how to respond to disruptive behaviors by role-playing showed statistical improvement in doing so compared to baseline data; both immediately after the educational intervention ($p = 0.000$) and three months post education ($p = 0.012$). Sanner-Stiehr (2018) characterized the disruptive behavior as behaviors referred to as bullying or incivility. This study was more concerned with the effects of the disruptive behavior that "compromise respectful relationships and ultimately decrease quality of patient care" (p. 106). These favorable findings were also supported in the qualitative studies from Griffin (2004), Kile et al. (2018), Lesater et al. (2015), Schwarz and Leibold, (2017), and Stagg et al. (2013). Ceravolo et al. (2012) and Kile et al. (2018) concluded after an education intervention program nurses had increased awareness of incivility. A cognitive rehearsal intervention empowered nurses to confront uncivil behaviors and instilled determination to solve communication issues that can be the culprit of incivility, which in turn creates a positive culture change (Ceravolo et al. 2012).

In addition to analyzing how an educational intervention is effective in managing nursing incivility, the research analyzed the effects incivility had on nursing intention to leave their job. Wilson and Diedrich (2011) analyzed data from surveyed nurses and identified a relationship between horizontal hostility and intentions to leave their job ($F= 4.604$) ($p = 0.000$); furthermore, Schwarz and Leibold's (2017) study demonstrated that if a nurse was negatively affected by incivility at least once in the past twelve months that

almost 52% of nurses sought out other job opportunities. Kang et al. (2017) hypothesized that the turnover intention of nurses that received a CRP would differ from those that were on the waitlist for the CRP education. This hypothesis had a statistically significant finding ($F=5.55$) ($p = 0.024$) initially post-intervention and at a four-week follow-up ($F=3.17$) ($p = 0.024$). Ceravolo et al. (2012) completed a large institutional incivility educational intervention to reduce incivility between nurses. The educational intervention goal was to create an environment where nurses had awareness of incivility, stronger skills communication and abilities to collaborate in a positive way. The post intervention surveys showed results for a better work culture and reduced nursing turnover. Turnover at the start of the intervention was as high as 11.5% and the rate decreased to 6% after the three-year educational intervention.

Summary of Evidence

This literature review revealed few high levels of evidence and the systematic review demonstrated "low levels" of evidence available. However, qualitative studies reviewed demonstrated reader believability and transparency. The majority demonstrated supporting evidence that there is a need for an intervention to eliminate nursing incivility. Despite these findings, more RCTs aimed at the effectiveness of educational programs to decrease or eliminate nurse to nurse incivility are needed to decrease organizational costs due to nursing turnover and maintain patient safety. Longer follow-up time periods are needed to evaluate the effects of the intervention. Gillen et al. (2017) recommend follow up at a minimum of six months to demonstrate change and Kile et al. (2018) question the need for repeated annual education training for sustainability. Nursing incivility has been

documented in the literature for decades, and this issue has negatively influenced the nursing culture. Working to overcome nurse to nurse incivility through an annual educational intervention can create the positive culture change the ANA is calling for.

Summary of the Literature Reviewed

Ultimately, there is enough research to support an educational intervention for nurses related to nurse to nurse incivility within the profession and medical institutions. A major gap in the literature was the inability to evaluate long term, greater than six months, effects of an educational intervention for uncivil behavior. Another gap recognized is that majority of participants were white women; as nursing continues to become more gender and culturally diverse, it would be beneficial to have more diversity in the studied population.

Regardless of the gaps, nursing incivility is an issue that has plagued the nursing profession for decades. The ANA called for action to be taken; therefore, an educational program based on Dr. Martha Griffin's Cognitive Rehearsal program for nurses is a step in the right direction for patients, nurses, and organizations.

Conceptual Framework

Johns Hopkins Nursing Evidence-Based Practice Model

The Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) Model (2017) offers a streamline process that can be utilize when working to create the culture change that is needed. It begins with asking a practice question. In this step a team is recruited, a problem is defined, a question is developed, stakeholders are identified, and a schedule is created. Next is finding evidence related to the best practice for the question by doing

a literature review, appraising and leveling each piece of evidence, synthesizing the evidence, and developing recommendations based on the synthesis. The recommendations are then translated it into an action plan. One needs to then secure the support and resources needed and implementing the plan. Finally, evaluate the outcome of the plan, report it to the stakeholders, and disseminate the findings.

The JHNEBP model was chosen for the simplicity and adaptability the model offers; as well as the conceptual model that takes into consideration internal and external factors. Nursing incivility is a problem that is influenced by internal factors (societal and hospital cultures, staffing numbers, technology, and organization standards) and external factors (ANA and JCAHO). In addition, this model is applicable to "clinical, administrative, and educational nursing settings "(Mazurek Melnyk & Fineout-Overholt, 2015, p. 305) and this research question impacts all three of these settings. Permission was granted by John Hopkins Nursing to utilize their model and Appendix A is a project plan template.

Conclusion, Recommendations, Implications for Nursing

Introduction

The purpose of this integrated literature review was to identify a relationship between nursing incivility and a nurse's intent to leave their current work unit; as well as, identify the impact an educational program has on nurse's confidence in managing uncivil behaviors when witnessed. This section will conclude the review, give implications, and recommendations for the future management of nursing incivility.

Conclusions

Incivility has troubled the nursing profession for decades. This issue can cost medical institutions a significant amount of money every year and can impact patient care and outcomes. The literature demonstrates that a CRP educational intervention can be beneficial to the profession by decreasing incivility, improving nurse's awareness of behavior, giving tools to combat the negative behavior to better communicate with others, and decreasing nursing turnover intentions. Since incivility varies with perception and is socially and culturally influenced, it would be beneficial to offer a CRP to new nurses entering the field and reinforce CRP yearly for experienced nurses through an online learning module and role-play during a mandatory two-hour annual meeting. These interventions will help the nursing profession continue to work towards a goal set forth by JCAHO and ANA for a culture of safety.

Implications for Nursing

It is imperative that healthcare organizations recognize incivility as this continues to be an ongoing issue. The research shows that even after cognitive rehearsal teaching, incivility continues to be reported by nurses. As there is ongoing change within nursing profession as social groups, generations, technology, and cultures change, education about nursing incivility needs to be constant. A key piece to managing nursing incivility identified in this integrative literature review, is first awareness; awareness to the definition of incivility and behaviors that fit such a definition as well as acknowledgement of one's own behaviors that might perpetrate uncivil behavior. Organization leaders can support nurses by providing education to their employees as

well as providing workplace policies aimed at incivility and utilizing a CRP to create the culture of safety for nurses.

Recommendations

Based on the integrative literature review, an evidence-based project that can support sustainability for managing nursing incivility is recommended utilizing the JHNEBP model to implement an intervention based off Dr. Martha Griffins CRP (2004). The initial intervention should start at the nursing unit level and continue with orientation for new nurses starting the nursing field. This same training should continue to be reinforced annually for experienced staff. Reinforcement is imperative due to the continual changes to the nursing profession, social groups, and culture. Managing nursing incivility is important to the nursing population as uncivil behaviors can impair clinical judgment and jeopardize patient safety (Lesater et al., 2015). The educational intervention will include a combined learning method of an online module, and a didactic course with role-playing scenarios from Dr. Martha Griffin's (2004) top identified behaviors seen with nurse to nurse incivility (Figure 3).

1. Nonverbal innuendo (raising of eyebrows, face-making).
2. Verbal affront (covert or overt, snide remarks, lace of openness, abrupt responses).
3. Undermining activities (turning away, not available).
4. Withholding information.
5. Sabotage.

6. Infighting (bickering with peers).
7. Scapegoating (all that goes wrong is one individuals' fault).
8. Backstabbing.
9. Failure to respect privacy.
10. Broken confidences.

Figure 3. Martha Griffin's Identified 10 Most Forms of Nurse to Nurse Incivility (Griffin, 2004, p. 259)

A pre-intervention NIS survey will be given to nurses via the participants work e-mail and a text message reminder to complete it will be sent out. Once the pre-intervention NIS survey is completed, an assigned online education module with the basis of Griffin's CRP will be completed prior to a didactic course with role-playing. This course will take two hours and will be taken annually; the first hour will be didactic review and the second hour role-play. After the educational sessions are completed, the same NIS survey will be repeated immediately post course and again at six months post course. The results of the NIS survey will be submitted to the hospitals statistician for evaluation of the outcome at three different intervals to evaluate knowledge and confidence in identifying and confronting nurse to nurse incivility and turnover intentions. The six-month follow-up survey could help determine the sustainability the intervention has on knowledge, confidence, and turnover intentions. During implementation of this project, there should be unit-based leaders that will lead by example and check in with nurses throughout the year to offer support in real time.

The instrument of choice for this project will be the NIS, "which was designed to assess hospital nurses' experiences with incivility- according to specific sources- physicians, coworkers, patients, and direct supervisors (Guidroz, Burnfield-Geimer, Clark, Schwetschenau, & Jex, 2010, p.176). For the purpose of this project, the NIS will be modified (given the authors' permission) to only utilize the portions of the survey assessing for General Incivility and Nurse Incivility. The portion of the survey related to The Supervisor and Physician Incivility will be omitted at this time since this research question focuses on nurse to nurse incivility. The survey questions will be answered using the 5-point Likert scale. According to Guidroz et al. (2010), the NIS has a Cronbach alpha of 0.89 and the General Incivility portion has an alpha of 0.85 for reliability. The validity of the NIS was compared to previous validation measurements and "established convergent validity in predicted patterns of correlation with measures of workplace conflict, nurse stress, and job satisfaction" (Lesater et al., 2015, p. 19). Therefore, this instrument will assist with the evaluation of uncivil nursing behaviors and turnover intentions before and after the educational intervention. In addition to the NIS, two nominal questions (Figure 4) will be added to the second and third survey to evaluate if the intervention assisted the nurse in identifying and confronting nurse to nurse incivility (strongly agree to strongly disagree).

• Since the educational intervention about nursing incivility, has your ability to identify incivility improved? Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree
• Since the educational intervention about nursing incivility, has your ability to confront uncivil behavior improved? Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree

Figure 4. Nominal Question Related to Nurse Confidence Level to Recognized and Confront Incivility

Summary

The impact of incivility is harmful to the health and wellbeing of the very people caring for others, nurses. The literature demonstrated supportive evidence for the need of an educational intervention to eliminate nurse to nurse incivility. A recognized gap in the literature is the lack of diversity of the participants that were studied; it would be beneficial to have more diversity in the studied population to help understand how sex and race affect the perception of nurse to nurse incivility. Developing higher level quantitative studies aimed at the effectiveness of CRP to decrease or eliminate nurse to nurse incivility is needed to reduce organizational costs due to nursing turnover and improve patient safety. An evidence-based project for managing nursing incivility through a CRP would be a beneficial start to trouble-shooting this issue, with hopes to see incivility amongst nurses continue to decrease. Longer follow-up time periods are needed to evaluate sustainability of a CRP. By utilizing the JHNEBP model to create, implement, and evaluate a plan is a step in the right direction. Sustainability could be achieved by providing an annual refresher course for nurses. This is our nursing duty set forth by the ANA (2015) *Nursing Code of Ethics* Provision 1.5 Relationships with Colleagues and Others to manage nurse to nurse incivility.

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Table 1
Databases Searched and Data Abstraction

Date of Search	Keyword Used	Database/Source Used *(CINAHL, OVID, ProQuest.*	# of Hits		
			Listed	Reviewed	Used
01/30/2019	Horizontal hostility, nurse, turnover	*PubMed*	188k	8	1
01/30/2019	Horizontal hostility, intervention, RCT	*Google Scholar*	645	6	1
01/31/2019	Nursing bullying	*Cochrane Library*	10	2	1
01/31/2019	Horizontal hostility, nurse, intervention, in-service	*Scopus*	16	4	4
02/09/2019	Horizontal hostility, intervention	*Google Scholar*	17,100	5	1
3/22/2019	Wilson, D. 2011	*Nursing Collection@OVID*	1	1	1
3/24/2019	Griffin 2004, Lateral violence	*PubMed*	1	1	1
10/24/2019	Nurse, incivility	*ProQuest*	524	8	1
10/24/2019	Nurse, incivility	*Cochrane Library*	1	1	1
10/24/2019	Horizontal Hostility, nurse, intervention	*PubMed*	5	2	1
10/27/2019	Horizontal Hostility, nurse, Cognitive Rehearsal	*PubMed*	10	3	1

Table 2

Literature Table for Managing Nursing Incivility

Citation/ Search Engine	Purpose/ Objectives	Study Population/ Sample/ Setting	Study Design/ Variables/ Instruments	Results/ Main Findings	Implications/ Critique	Themes/ Comments	Level of Evidence
Ceravolo, D. J., Schwartz, D. G., Foltz-Ramos, K. M., & Castner, J. (2012). Strengthening communication to overcome lateral violence. *Journal of Nursing Management, 20,* 599-606. http://dx.doi.org/10.1111/j.1365-2834.2012.01402.x Google Scholar	"Quality improvement project aimed to reduce nurse-to-nurse lateral violence and create a more respectful workplace culture through a series of workshops" (p. 599). To assess if this project had an impact on nursing turnover rates.	5 hospitals under one health-care delivery system. Northeast United States. Population: Nurses Study over years 2008-2011 Conveniences sampling.	Quasi-experimental 60-90-minute workshops. Electronic Pre intervention survey n= 703 completed in 2007; Post intervention survey n=485 completed in 2011. Survey adapted from Verbal Abuse Survey (this survey used in 2 nationwide studies.) Likert type scale. Turnover and vacancy data retrieved from human resource	Nurses that experienced verbally abused pre n=634 90%; post n=370 76%. Verbally abusive incident- post survey nurses were more determined to solve the problem n=170 or 37.9% vs pre n=194 or 29%. Self-esteem didn't change pre and post. Fear, confused, and embarrassed feelings increased on post intervention survey. Vacancy and turnover rate 8.9% at beginning of intervention. Post vacancy rate was 3% and turnover rate 6%	Limitation: Response rate only 23% probably related to 4 years between survey; only on hospital system and economic conditions may have impacted turnover and vacancy. "finding signal the need for continued persistence and commitment to combating lateral violence" (p. 604).	Creating a culture of change. Need for continued awareness of issue. "Participants self-reflected and awareness that they had perpetrated lateral violence and a new awareness may have lowered self-esteem" (605).	III

Citation/ Search Engine	Purpose/ Objectives	Study Population/ Sample/ Setting	Study Design/ Variables/ Instruments	Results/ Main Findings	Implications/ Critique	Themes/ Comments	Level of Evidence
Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *The Journal of Continuing Education in Nursing*, *35*(6), 257-263. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/15584678	"Provide a theoretical basis for understanding the origins and manifestations of the professional practice of lateral violence in nursing" "provide instruction on the use of cognitively rehearsed program (CRP) suggested responses to the 10 most frequent forms of lateral violence (LV) in nursing" (p.259).	N= 26 (this was 39% of the new hires to this hospital) Newly licensed RN Large tertiary acute care hospital in Boston.	Exploratory descriptive Qualitative 2-hour education class given within first 2 weeks of being hired. Hour 1- didactic, 2- cognitive rehearsal, responses to 10 most frequent forms of lateral violence. One year follow up (at this time RN were employed full-time >6months) videotaped given 6 open ended questions in a focus group.	Phenomenon noted was that once newer nurse worked longer with experienced nurse, behavior once thought to be lateral violence was "just very direct" communication. 46%, N=12 stated LV was directed at them. Did you respond to the LV when it happened? N=26, 100% yes. -75% N=9 stated when confronted the RN, they were shocked that the new nurse felt that way. 96% recommended education to all hospital nurses about LV in nursing.	Behavior won't change without conscious effort made to educate people involved. Limitation: There were no common themes identified only percentages to the questions answered. Unknown reliability and validity. No audit trails. Atypical uses of percentages in qualitative. However, multiple studies since 2004 use Griffins CRP. Findings resonate.	Lateral violence among nurses is related to being part of an oppressed population. This article really explains the intervention of CR.	VI

Citation/ Search Engine	Purpose/ Objectives	Study Population/ Sample/ Setting	Study Design/ Variables/ Instruments	Results/ Main Findings	Implications/ Critique	Themes/ Comments	Level of Evidence
Griffin, M., & Clark, C. (2014). Revisiting cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later. *The Journal of Continuing Education in Nursing. 45(12)*, 535-542. http://dx.doi.org/10.3928/00220124-20141122-02 PubMed	The purpose was to follow up from Griffin et al original study 10 years prior. To synthesis findings from studies that utilized Cognitive rehearsal as an intervention to improve nursing communication and safety.	A handful of studies that took place in hospitals.	"Retrospective article of synthesis of research concerning incivility in nursing" (p. 541).	One study showed results of positive sense of empowerment and self-esteem. One study found and CRP prepared staff and student nurses "to have improved communication in critical encounters" (p. 538). One study found a decrease in bullying behaviors after CRP intervention.	Primary prevention of incivility is a framework to managing the issue.	Utilizing a CRP is beneficial.	VII

Citation/ Search Engine	Purpose/ Objectives	Study Population/ Sample/ Setting	Study Design/ Variables/ Instruments	Results/ Main Findings	Implications/ Critique	Themes/ Comments	Level of Evidence
Gillen, P. A., Sinclair, M., Kernohan, W. G., Begley, C. M., & Luyben, A. G. (2017). Interventions for prevention of bullying in the workplace. *Cochrane Database of Systematic Reviews*, *1*(1), 1-69. http://dx.doi.org/10.1002/14651858.CD009778.pub2 Cochrane Library	"To explore workplace interventions to prevent bullying in the workplace" (p. 1). Review looked at organizations policies, society, and educational interventions	Multiples studies. Countries: US, UK, Australia, Ireland. Settings: Hospital, Civil department, Police department. One study done with adults with learning disabilities. "All studies where participants were employees were paid to work within the public, private, or voluntary organizations" (p. 9). Informational or educational interventions were aimed at altering behaviors or perceptions.	Systematic Review Included studies: RCT, clustered RCT, interrupted time series studies. Search criteria specific to PICO included: clear aims, detailed intervention, theoretical underpinning, more on p.9. Reviewers search terms: "Key words, including commonly used synonyms for bullying, the workplace setting, employees, and workplace interventions (p.9). Downs and Black quality assessment tool used for bias assessment. Page 13 displays study flow of all studies included.	Concern for self-reporting likely causes bias. Cognitive Intervention vs No intervention: Risk of being bullied- RR 0.55, 95% CI (0.24-1.25), no change at 3 months, Not statistically significant. Perpetration risk of bullying others- RR 0.64, 95% CI (0.27-1.54), at 3 months RR 0.69, 95% CI (0.26-1.81, * "Wide CI, small sample size creates uncertainty about true effect" (p. 20)	Quality data from 2 large studies show small improvement. Recommendations for a minimum follow up of 6 months to demonstrate change, give employees feedback and provide continual small amounts or interventions.	This review wasn't isolated to nursing or hospitals. Griffin's (2004), cognitive rehearsal program is used for this intervention; unfortunately, Gillen excluded this from the review because it focused on management instead of prevention of bullying.	I

Citation/ Search Engine	Purpose/ Objectives	Study Population/ Sample/ Setting	Study Design/ Variables/ Instruments	Results/ Main Findings	Implications/ Critique	Themes/ Comments	Level of Evidence
Johnson, S. L., Haerling, K. A., Yuwen, W., Huynh, V., & Le, C. (2019). Incivility and clinical performance, teamwork, and emotions. *Journal of Nursing Care Quality*, http://dx.doi.org/10.1097/NCQ.0000000000000407 Cochrane Library	"What effect does exposure to incivility have on team performance and team behavior in a clinical simulation scenario?" (p.2)	RN that were in a completion undergraduate program. N=58 Convenience sampling. 95% female Average age 31.5 years. Scenario given in a simulation laboratory that mimicked a hospital setting. CPR manikin that was able to generate a score with high-fidelity.	RCT with no blinding. Experimental group exposed to scripted incivility. Control group not exposed to incivility. Both groups prepared for the scenario with education on basic life support. Instrument: Emotional states-PANAS-X given 1 week prior to simulation and immediately after. Cronbach alpha 0.87. Likert scale. Team behavior-TEAM tool. Cronbach alpha 0.89, Likert scale. Mixed-effects modeling for statistics.	No significate difference found between groups of CPR score, cognitive scores, rating team performance. Manikin feedback: 6 of 10 experiment groups gave 2 consecutive shocks to manikin instead of 1 per protocol. Control group made no mistake	Suggest low level of incivility may contribute to medical errors and negatively impact performance of tasks. Limitations: Sample size. One geographic area, not generalizable. Convenience sampling. Instruments used had good reliability and validity in previous studied but didn't perform as well in this one. Cronbach alpha decreased for both.	Self-reporting tool didn't demonstrate difference between groups, but manikin report showed error.	II

Citation/ Search Engine	Purpose/ Objectives	Study Population/ Sample/ Setting	Study Design/ Variables/ Instruments	Results/ Main Findings	Implications/ Critique	Themes/ Comments	Level of Evidence
Kang, J., Kim, J., & 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*, *45*, 689-699. doi:10.4040.jkan.2017.47.5.689 Google Scholar	Aim is to "investigate effect of CRP on the interpersonal relationships, workplace bullying… turnover intention of nurses"(p.691). Hypothesis 1: The interpersonal relationships those who participated in CRP will differ from those of who did not participate in CRP. Hypothesis 4: The turnover intention in the experimental group will differ from that of the wait-list group.	N 40 used total Publicly recruited. Identification number assigned. Random allocation Inclusion: Nurses with 6 months or more experience at a hospital. Exclusion: Nurses employed less than 6 months. Nurses that have received communication training within the past year. South Korea.	-Quantitative RCT Variables: Interpersonal relationships, workplace bullying, turnover intention. Instruments: Interpersonal relationship: Relationship Change Scale and Liker-type scale. Cronbach's alpha .90. Workplace bullying: Negative Acts Turnover intention: Yun and Likert scale. Cronbach's alphas .88. 10 sessions, 2 hours for 5 weeks: Role play, creating communication standards, feedback and evaluation.	At baseline the 2 groups had no significant differences. Hypothesis 1 was supported (p=0.022) (F=6.21). CRP helpful for improving interpersonal relationships, Mean pre-3.38, post-3.54. Hypothesis 4 was supported (p=0.024) (F=5.55) 4-week follow up effects related to hypothesis 1 (p=0.037) (F=3.63) and 4 (p=0.054) (F=3.17) were favorable for CRP.	South Korea culture surrounding bullying behaviors may differ from American. The intervention is resource intensive. Sample size per group may be small. (a power analysis of .80 showed the study needed N=20, the study was exactly 20 in each group). Study didn't examine organizational culture's influence r/t effects of bullying.	Teaching communication techniques improved individuals' communication. CRP is useful, need to focus on unit level. Overall study didn't show bullying reduced in workplace. "Possible that the turnover intention was decreased because of the improved interpersonal relationships after the CRP" (p.697). Post measurement taken too early after intervention. Role play impacted nurses	II

Citation/ Search Engine	Purpose/ Objectives	Study Population/ Sample/ Setting	Study Design/ Variables/ Instruments	Results/ Main Findings	Implications/ Critique	Themes/ Comments	Level of Evidence
Kile, D., Eaton, M., deValpine, M., & Gilbert, R. (2018). The effectiveness of education and cognitive rehearsal in managing nurse-to-nurse incivility: A pilot study. *Journal of Nurse Management*, 1-10. http://dx.doi.org/10.1111/jonm.12709 Scopus Database	"Teach nurses to recognize incivility, confront it using cognitive rehearsal (CR) techniques, thereby improving job satisfaction (p.1)." Intervention: education about incivility and CR, followed Dr. Martha Griffin's program. Learning and role-playing, cue cards. -5 training sessions, 2 hours each over 3 weeks.	N=17 32 participants were eligible, 59% response rate. Convenience sampling. Post-Anesthesia Care Area (PACU), that had a reputation for incivility. Recruited via email, flyers, and personal contact. Inclusion: PACU RNs Exclusion: ancillary personnel and non-English language.	Mixed Method Pilot study. Bandura's Social Learning Theory was used for educational intervention. Nurse Incivility Scale (NIS) (Cronbach's alpha 0.81-0.94). NDNQI Index of Work Satisfaction Nurse Interaction subscale with Likert scale (Cronbach's alpha 0.66-0.82). 2 open-ended questions. Survey done prior, immediately after education and 6 weeks after, submitted via Qualtrics. Qualitative data analysis- Bengtsson's four-stage process	"Effective in increasing nurses' recognition of incivility and ability to confront it. Perceived instances of incivility deceased over time (p.1)." NIS- improved intervention to 6 weeks post: Inappropriate Joke intervention from SE of 0.557 to 0.639, (p=0.003); Lack of respect SE decreased 1.61to 2.23, (p=0.003); Displaced frustration SE 0.86 to 0.989 (p=0.043). NDNQI satisfaction throughout intervention (p=0.109). Qualitative: 25% (N=3) reported self-awareness of own actions of uncivil behavior.	This study supports previous CR effectiveness studies. Qualitative results supported Quantitative findings in awareness of incivility. Repeated education and training needed for sustainability. Limitation: Small initial sample size, loss of subjects, missing or improperly collected data.	Awareness of incivility and enabled them to confront the offenders. Use of Martha Griffin's CR. Cost impact of turnover.	VI

Citation/ Search Engine	Purpose/ Objectives	Study Population/ Sample/ Setting	Study Design/ Variables/ Instruments	Results/ Main Findings	Implications/ Critique	Themes/ Comments	Level of Evidence
Lesater, K., Mood, L., Buchwach, D., & Dieckmann, N. F. (2015). Reducing Incivility in the workplace: Results of a three-part educational intervention. *The Journal of Continuing Education in Nursing*, *46*(1), 15-24. http://dx.doi.org/10.3928/00220124-20141224-01 PubMed	Is an educational program, modeling interventions would reduce uncivil acts and improve individual ability to manage these types of situations when they occur. 4 goals "to decrease perceived incivility on the units and increase self-efficacy of individuals on the units to manage incivility" and "increase workplace satisfaction," which in turn would help attract and retain nurses.	Quantitative: 2 units A and B A (N=63) B (N= 31). Qualitative: 4 interviews Large health sciences center hospital. Participants: RN, technical and support staff and leadership staff. Purposive sampling.	Mixed Method Bandura's social cognitive theory. 3 educational phases: 1hour, 4 hour, 2 hours sessions; didactic and role-play. Used Dr. Griffin's 4 postintervention surveys. Qualitative data audio recorded. Instruments: NIS (Cronbach's alpha 0.81-0.94), NGSE (Cronbach's alpha 0.86-0.90), WCES (Cronbach's alpha 0.91-0.92), NDNQI (study hospital collects data every 24-months). Quantitative data analyzed using ANOVA and Longitudinal analyses	NIS significant ($p<0.001$) for both Unit A and B for post intervention evaluation 1, 2, 3, 4. Unit B NGSE improved post intervention, measured at 1, 2 ($p<0.05$). Goal of "increased self-efficacy of individuals on the units to manage uncivil situations was met (p. 22)." "WCES used to measure individuals' beliefs in their team ability to address incivility and change unit culture. No significant change.	Attrition lost over time, missing data. Greatest attrition seen with NIS, 75% A, 66% B. Limitation: loss of participants leading to a smaller N. Intervention time consuming and likely costly to pay wages. "NDNQI data collected immediately after the intervention to 24 months later showed impressive increases in RN satisfaction on both units… and awarded Magnet status (p.22)." "Magnet demonstrates ability to attract and retain nurses (p.22)."	Follow up educational sessions needed for sustainability. This education gave participants awareness of their own behavior.	III

Citation/ Search Engine	Purpose/ Objectives	Study Population/ Sample/ Setting	Study Design/ Variables/ Instruments	Results/ Main Findings	Implications/ Critique	Themes/ Comments	Level of Evidence
Sanner-Stiehr, E. (2018). Responding to disruptive behaviors in nursing: A longitudinal, quasi-experimental investigation of training for nursing students. *Nurse Education Today*, *68*, 105-111. http://dx.doi.org/10.1016/j.nedt.2019.05.029 Scopus	"What is the impact of a cognitive rehearsal intervention on self-efficacy to respond to disruptive behaviors among nursing students in their final academic year (p.106)?" CR training given during scheduled class time. Goal to increase confidence to respond to disruptive behavior. Hypothesis listed on page 107.	Nursing students in final academic year. Midwestern US N=129 initially. N=109 at 3-month follow-up. Convenience sampling. Exclusion: enrollment in post-Baccalaureate programs, accelerated pre-licensure programs, RN-BSN programs. Power=0.80 and moderate effect size (f=0.25) for enrollment of N=112. Retention higher than expected	Longitudinal, quasi-experimental. Data collected pre-intervention, immediately post (both handwritten), 3 months follow up (electronically). Social Cognitive Theory Self-Efficacy to Respond to Disruptive Behaviors (SERDB) questionnaire. (Cronbach's alpha 9.12 prior to intervention, 8.97 post intervention) Paired samples t-tests to address study aim and hypothesis and results at 95% CI	Knowing how to respond effectively to disruptive behavior pre vs post intervention statistically significant, mean 5.44 to 7.87 (highest 10), df 128 (p=0.000). Pre vs 3 months 5.44 to 7.21, df 106 (p=0.000). Post vs 3-month follow up: 7.87 to 7.21, df 106 (p=0.012). I believe in my abilities to respond effectively, pre vs post intervention mean 6.35 to 7.65, df 128, (p=0.000). Pre vs 3-month follow-up mean: 6.35 to 7.21, df 106 (p=0.002). Post vs 3-month follow up: 7.65 to 7.21, df 106 (p=0.112).	This study was part of a larger study looking at turnover rate of newly licensed nurses, still in progress. 82.2% females, 17.8% males educated and questioned. Not gender diverse. Retention higher than expected possible because the Principle Investigators (PI) active role in recruiting, intervention, and use of mobile phones for communication and follow-up questionnaire. Since PI interacted with participants reliability of results is limited and replication is warranted to confirm results.	Social Cognitive Theory Awareness of own behavior because of education: - thought to be a positive finding because "participants had assimilated the information delivered in the intervention and used it to reflect on their own actions (p.109)."	III

Citation/ Search Engine	Purpose/ Objectives	Study Population/ Sample/ Setting	Study Design/ Variables/ Instruments	Results/ Main Findings	Implications/ Critique	Themes/ Comments	Level of Evidence
Schwarz, L. M., & Leibold, N. (2017). Education as an intervention toward recognizing and elimination incivility. *Creative Nursing, 23,* 232-241. http://dx.doi.org/10.1891/1078-4535.23.4.232 Scopus database	"Explore the effectiveness of an online educational intervention to assist nurses with identifying incivility" (p.235). "Determine the effectiveness of the online educational intervention toward assisting nurses to understand ways to address incivility" (p. 235).	Associate degree registered nurse in an online RN-BSN program. Midwestern public university. RN worked in hospital. N- 27 Convenience sample via email. N-57 took pretest, N-27 posttest. Only 27 included in results.	Quasi-experimental Quantitative study. Online education intervention Horizontal Violence Survey pretest and posttest design given via SurveyMonkey. Likert scale. Cronbach's alpha of 0.96 for the horizontal violence survey Wilcoxon matched pairs signed ranks test	"Education was effective at increasing nurses' knowledge of incivility" (p.237). Pre-education vs. post-education in participant identification of incivility (p=0.013) (r=-0.48). 96.2% N=25 agreed intervention helped understand how to deal with incivility. 51.9% N=14 looked for another job because of feeling bad about interactions with other nurses.	These findings are similar to other studies. Online education is feasible to adopt. Settings for education are likely the same. Limitations: Sample and size. One university, no control group, those who took the survey were self-selected and likely have salient memories or opinions about incivility. Survey asks retrospective questions.	Thorough literature review. Clear definition of incivility. Nurses don't recognize behaviors of incivility as being abnormal, after intervention able to identify behavior. Inclusion of the Nursing Code of Ethics Provision 1.5. Cost impact of turnover. This education gave participants awareness of their own behavior.	III

Citation/ Search Engine	Purpose/ Objectives	Study Population/ Sample/ Setting	Study Design/ Variables/ Instruments	Results/ Main Findings	Implications/ Critique	Themes/ Comments	Level of Evidence
Skarbek, A. J., Johnson, S., & Dawson, C. M. (2015). A phenomenological study of nurse manager interventions related to workplace bullying. *The Journal of Nursing Administration*, *45*, 492-497. http://dx.doi.org/10.1097/NNA.0000000000000240 Google Scholar	"The aim of this study was to acquire nurse manager's (NM) perspectives as to the scope of workplace bullying, which interventions were deemed as effective and ineffective" (p.492); especially because effects recruiting and retaining nursing staff. Research question: "What are the perspectives and lived experiences of NMs as they endeavor to address workplace bullying among RNs at their institution" (p494)?	N=6 (5 females, 1 male) Purposeful sampling NMs work in nonrural hospital settings in Midwest and Northeastern US. Inclusion: current RN managers with at least a year experience in the role, were of both genders, were employed in hospital setting.	Exploratory Qualitative, Phenomenological study. Ray's theory of bureaucratic caring framework. Five questions. Phone interviews using Rubin and Rubin's responsive interview model. Transcribed verbatim and reviewed again by participants. Data analyzed using horizontalization and priori and open coding.	Themes and trends identified from the data: Awareness, scope of the problem, quality of performance, healthy, and caring work environment. All NM agreed that in order to establish a healthy, caring work environment it must be evident to those entering and transitioning into the profession by senior staff RNs and nursing leadership who model positive social practices (p.945). Bullying negatively impacts patient care.	Key information "that emerged from the study and that are supported by the literature are that RNs at all levels of the hierarchy must 1st acknowledge that workplace bullying exists. RNs must be able to recognize that signs, manifestations, and outcomes associated with the behavior" (p.496). Author's did not analyze the study limitations. Rigor- verbatim transcript, peer debriefing, external auditor.	This education gave participants awareness of their own behavior. Intervention at unit levels needed. "Organizations need system to address and manage workplace bullying to create a healthy working environment" (p.496).	VI

Citation/ Search Engine	Purpose/ Objectives	Study Population/ Sample/ Setting	Study Design/ Variables/ Instruments	Results/ Main Findings	Implications/ Critique	Themes/ Comments	Level of Evidence
Stagg, S. J., Sheridan, D. J., Jones, R. A., & Speroni, K. G. (2013). Workplace bullying: The effectiveness of a workplace program. *Workplace Health & Safety*, *61*(8), 333-338. http://dx.doi.org/10.3928/21650799-20130716-03 Scopus Database	To evaluate the effectiveness of a workplace bullying CR program (p.334). Objective to determine if cognitively rehearsed responses to common bullying behaviors decreased bullying behaviors (p.334)	N=15 medical and surgical nurses took CR training. 67% (N=10) completed 6-month follow-up survey, internet based. All participated in CR training. Inclusion: English communication and provision of signed informed consent. No exclusion criteria. Recruited via email and direct contact (convenience sampling).	Non-experimental pilot study. Qualitative. Workplace Bullying Follow-Up Survey, 14 questions. Surveyed weeks 1, 3, 5. Descriptive statistics were used to analyze yes no and multiple-choice questions (p.336). Descriptive answers used content analysis for recurring themes.	Common Themes: Increased awareness of bullying behaviors, those surveyed believed to reduce workplace bullying there should be staff education (30%, N=3). 70% (N=7) of nurses reported changing their own behaviors following the course. Bullying was directed most commonly towards staff nurse peers 100% (N=5). Prior to CR 80% (N=8) thought about leaving their current position.	Multiple limitations: Small sample size. Unknown reliability of Instrument. Not well-designed qualitative study. Evaluation was self-reported, question the difficulty of recalling experience of a 6-month period. Despite small size results were similar to larger study finding displayed in literature review. Atypical for qualitative to report percentages. Findings resonate	This education gave participants awareness of their own behavior.	VI

Citation/ Search Engine	Purpose/ Objectives	Study Population/ Sample/ Setting	Study Design/ Variables/ Instruments	Results/ Main Findings	Implications/ Critique	Themes/ Comments	Level of Evidence
Taylor, R. (2016). Nurses' perceptions of horizontal violence. *Global Qualitative Nursing Research*, 3, 1-9. http://dx.doi.org /:10.1177/ 2333393616641002 PubMed	Gain clearer understanding of the phenomenon of horizontal violence in two hospital units. Observing for any noncaring, non-supportive behavior between nurse colleagues.	400 bed nonprofit Northeaster US hospital. 2 units used Unit A, Unit B. These units had known horizontal violence occurring. N=120 staff Observed. Observation was outside patient rooms from the unit secretaries' desk. Interview semi structured N=22. All women.	Descriptive exploratory approach. Data collection over 5 months in 2012. Observation periods 5 hours, Interviews recorded and transcribed verbatim. Interviews lasted 15minutes to 2 hours. Thematic analysis used. Rigor- shared findings with other researchers, meet every 2 weeks created a code book. Reflection journal. Shared all findings with all staff in 14 page booklet.	5 themes: behaviors are minimized and not recognized, fear inhibits all reporting, avoidance and isolation are coping strategies, lack of respect and support, organizational chaos. Observer wondered, "did I just see that happen?" Often nurses didn't have time to stop and address behavior in the moment if the incivility even registered to them.	Majority nurses unaware of employer's violence policies and codes of conduct. Limitations: Single hospital and country region study, majority white women. Findings resonate with other studies.	The interviewee on units observed felt their unit was a "good unit" to work on. Nurses' didn't recognize the behaviors as incivility when experienced or witnessed.	VI

Citation/ Search Engine	Purpose/ Objectives	Study Population/ Sample/ Setting	Study Design/ Variables/ Instruments	Results/ Main Findings	Implications/ Critique	Themes/ Comments	Level of Evidence
Wilson, B. L., & Diedrich, A. (2011). Bullies at work: The impact of horizontal hostility in the hospital setting and intent to leave. *The Journal of Nursing Administration*, *41*, 453-458. http://dx.doi.org/10.1097/NNA.0b013e3182346e90 Nursing Collection @OVID	Look at the perception horizontal hostility (HH) had on the intent for an RN to leave their current job.	RNs in a community hospital. Southwest US Survey distributed to personal hospital mailboxes or hand delivered. Collection time allowed was 2-months. N=130 began survey's but not all completed in full.	Retrospective descriptive cross-sectional design. 28-item survey modeled after AACN survey from the study "Silence Kills" and "Lateral Violence in Nursing Survey" (p.454). Data analyzed: Predictive Analytic Soft Ware T tests to compare intent to leave and no intent to leave by whether participant experienced HH.	How difficult was it to confront a person demonstration HH, N=110 responded 90% answered "it was". Relationship between HH and intent to leave of N=121 39.6% were definitely leaving, 20.5% considering. T test to compare intent to leave and no HH experience to intent to leave and HH experience (t= -7.308; p=0.000) Hostility observed predictor of intent to leave (F=4.604; p=0.000) 91% female participants (comparable to national demographics of RN workforce)	Small sample size, 26% response rate, not power analysis completed. Single organizational study, unable to generalize; however, results compare to multiple other studies. Missing data.	Cost of turnover was described well with clear literature support. In previous studies there's been a relationship shown between intent to leave and actual turnover. This is a strong predictor	VI

Table 3

Levels of Evidence

Level I	Evidence from a systematic review or meta-analysis of all relevant RCTs (randomized controlled trial) or evidence-based clinical practice guidelines based on systematic reviews of RCTs or three or more RCTs of good quality that have similar results.
Level II	Evidence obtained from at least one well-designed RCT
Level III	Evidence obtained from well-designed controlled trials without randomization (i.e. quasi-experimental).
Level IV	Evidence from well-designed case-control or cohort studies.
Level V	Evidence from systematic reviews of descriptive and qualitative studies (meta-synthesis).
Level VI	Evidence from a single descriptive or qualitative study.
Level VII	Evidence from the opinion of authorities and/or reports of expert committees.

(Ackely et al., 2008)

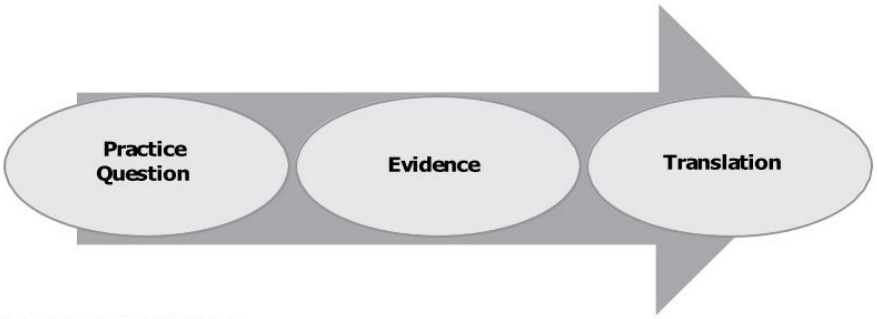
Table 4

Theme Matrix

ITEM	**METHODOLOGICAL THEMES**			**BACKGROUND THEMES**			**INTERVENTION THEMES**		
	Qualitative	Small sample size	Theory underpinning	Turnover cost related to incivility	TJC call to action	Personal inability to recognized uncivil behavior	Cognitive Rehearsal Program	Awareness of own behavior	Decrease turnover intent
Ceravolo et al., (2012)				x			x	x	x
Gillen et al. (2017)	Did not include								
Griffin (2004)	X Exploratory descriptive		X, Ground theory, Cognitive learning theory				X		X
Johnson et al., (2019).		x							
Kang et al (2017)		X		X			X		X
Kile et al. (2018)	X Mixed method Pilot		X, Social Cognitive	X	X	X	X		
Lesater et al. (2015)	X Mixed method	X	X, Social Cognitive				X	X	
Johnson et al. (2019)		X	Affect infusion model						

ITEM	METHODOLOGICAL THEMES			BACKGROUND THEMES			INTERVENTION THEMES		
Sanner-Stiehr (2018)			X, Social Cognitive	X			X	X	
Schwarz et al. (2017)		X		X	X	X	X	X	
Skarbek et al. (2015)	X Phenomenological		X, Ray's bureaucratic caring framework	X	X	X		X	
Stagg et al. (2013)	X Pilot	X		X			X	X	X
Taylor (2015)	X Descriptive exploratory l					X		X	
Wilson et al. (2011)		X		X					

Appendix A John Hopkins Nursing Evidence Base Practice Model



PRACTICE QUESTION

Step 1: Recruit interprofessional team
Step 2: Define the problem
Step 3: Develop and refine the EBP question
Step 4: Identify stakeholders
Step 5: Determine responsibility for project leadership
Step 6: Schedule team meetings

EVIDENCE

Step 7: Conduct internal and external search for evidence
Step 8: Appraise the level and quality of each piece of evidence
Step 9: Summarize the individual evidence
Step 10: Synthesize overall strength and quality of evidence
Step 11: Develop recommendations for change based on evidence synthesis

- Strong, compelling evidence, consistent results
- Good evidence, consistent results
- Good evidence, conflicting results
- Insufficient or absent evidence

TRANSLATION

Step 12: Determine fit, feasibility, and appropriateness of recommendation(s) for translation path
Step 13: Create action plan
Step 14: Secure support and resources to implement action plan
Step 15: Implement action plan
Step 16: Evaluate outcomes
Step 17: Report outcomes to stakeholders
Step 18: Identify next steps
Step 19: Disseminate findings