

Peer Accountability Program to Combat Nurse Incivility

by

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Abstract

Incivility within the nursing profession is a topic of serious concern and requires immediate interventions. This quality improvement project utilized an evidenced-based approach to implement a program directed at nurse led incivility. The Professional Accountability Program (PAP) was implemented in 26 units in two urban hospitals to empower staff to address uncivil interactions, promote teamwork, and support a shared governance model. The PAP utilized peer coaches to intervene in episodes of low intensity incivility incidents where a nurse is the alleged offender. The project was evaluated utilizing the Clark Workplace Civility Index (CWCI) survey and trending of incidents. The findings included three of the 26 units (12%) increased one civility index measurement after implementation of the program, two units (8%) decreased by one level, and 21 units (80%) remained at baseline. All units scored at “Moderately Civil” or above. Trending analysis demonstrated that Hospital 2 increased reporting >300% during the PAP. Lastly, there were 20 incidents that utilized peer coaching with only one requiring escalation to human resources. The PAP challenges nurses, aided by a peer coach, to alter negative behaviors to support an environment free from incivility. Future work is required to address the sustainability and long term effects of the PAP.

Keywords: Civility; incivility; bullying; nurse bullying; lateral violence; peer review; peer feedback; coaching; peer coaching; accountability; peer accountability; professional accountability; Clark Workplace Civility Index; CWCI

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Chapter One: Overview of the Problem of Interest

Effective communication and collaboration within nursing is paramount to safe patient care. Communication is significantly compromised when incivility occurs between nursing professionals. Incivility has additional terms of bullying and horizontal violence and unfortunately, horizontal violence/bullying within nursing occurs on an ongoing basis. Incivility among nurses negatively affects job satisfaction, patient care, organizational effectiveness and the nurse profession (Mikaelian & Stanley, 2016). Collaboration is compromised during and after incidents of incivility due to the break-down of trust within nursing colleagues. This lack of trust and strained relationships can negatively impact the patients they serve. Additionally, strained relationships may result in verbal and physical aggression that destabilizes the core of nurses' work (De Villers & Cohn, 2017). Nursing leaders must recognize incivility within their workforce, utilize effective reporting and tracking of these behaviors and have an accountability program aimed at eliminating incivility within their organization. The purpose of this chapter is to provide background into incivility in nursing, the clinical significance and implications of incivility, and define a clinical question to guide project inquiry that utilized peer accountability to address incivility within nursing in an academic medical system.

Background Information

In 2015, the American Nurses Association (ANA) assembled a panel on incivility, bullying and workplace violence which led to a published position statement. The ANA (2015) position statement included key points and recommendations on: No tolerance for violence, a culture of respect; and Strategies on prevention and mitigation across all disciplines and stakeholders. The ANA recognized that incivility in the nurse's workplace could not only have a negative impact on the nurse, but also the patients within their care.

In 2016, The Joint Commission (TJC) issued an advisory “Bullying has no place in health care”. In the advisory, TJC reports that bullying in healthcare is at epidemic levels and organizations should take safety actions to address these issues. Specifically concerning nurses, TJC notes that nurses accept nurse on nurse bullying, seeing it as a rite of passage. A prime example of this occurs in interactions between experienced and novice nurses and thus the term “nurses eat their young”.

This was not the first advisory on incivility issued by TJC. A sentinel event alert was issued in July 2008 “Behaviors that undermine a culture of safety” (TJC, 2008). In the July 2008 advisory, TJC noted the correlation between incivility and negative behaviors with increased potential for medical errors, preventable poor outcomes, and higher staff turnover. Noting particularly that clinicians who have experienced intimidation were more inclined to remain passive when witnessing or noting potentially unsafe care. TJC and other regulatory agencies have recognized the need to address incivility within the nursing workforce and have added standards and regulations health care institutions must comply with in order to remain compliant with accreditation requirements. Hospitals, health care institutions, and health systems must take notice of the building evidence of the negative effects of incivility within their nursing workforce and develop programs to address and eradicate such behaviors.

Peer accountability can be one method to address incivility in the nursing workforce. Peer accountability involves peers addressing issues of practice or behaviors directly to a peer. Utilizing peer messengers, supported by leaders, who are trained to intervene with colleagues to facilitate positive behavior changes is one example noted (Pichert et al., 2013). Using nurse messengers to address pre-identified incivility issues can empower the nurses and provide for coaching at the level of incident. This method allows for timely feedback and encourage self-

reflection (Webb et al., 2016). Self-reflection along with coaching from a peer can provide positive changes in behaviors without the need for formal discipline or manager intervention. Additionally, peer accountability can empower the workforce to take ownership of their practice and to promote acceptable behaviors that enhance communication and collaboration. A peer accountability program could also create a more positive work environment that can mitigate risk for patient safety concerns and nurse turnover.

Significance of Clinical Problem

In 2013, incidence of serious violence was four times the level in healthcare versus the private industry with 7.8 cases per 10,000 full-time employees (Occupational Safety and Health Administration [OSHA], 2015). Comparably, occupations such as construction, manufacturing and retail had a rate of fewer than two per 10,000 employees (OSHA, 2015). The incidence of violence within healthcare is increasing at an alarming rate and it is expected that actual occurrences are grossly underreported. The statistics above are only the incidents that required time away from work (OSHA, 2015). Inclusion of incidents not resulting in injury would further inflate these rates and demonstrate the growing significance of workplace violence.

A 2014 survey of 3765 registered nurses and nursing students, by the ANA, noted that 21% had been physically assaulted and over 50% verbally abused in a 12-month period (OSHA, 2015). Emergency departments, intensive care units, psychological treatment facilities and long-term care had the highest rates of violence (OSHA, 2015). The World Health Organization (WHO; 2018) reports 8% to 38% of all health care workers are victims of physical violence at some point within their careers and many more suffer from episodes of verbal aggression.

Incivility in the workplace has been shown to increase the risk of physical violence, which also takes a psychological and physical toll on nurse victims. Incivility can lead to

burnout, decreased job satisfaction, low job performance and nurses leaving the profession.

Additionally, there is a financial cost to the institution. Approximately 17.5% of new nurses leave their first employer within one year (Kovner, Brewer, Fatehi, & Jun 2014). The cost of turnover varies in literature, one study places United States nursing turnover at \$20,561 per nurse (Duffield, Roche, Homer, Buchan, & Dimitrelis, 2014). OSHA (2015) estimates the replacement cost of a nurse between \$27,000 and \$103,000 depending on the specialty. These expenses include potential overtime to compensate for vacancies, recruitment, onboarding, and impact to productivity.

Additionally, incivility can result in nursing professionals failing to provide the highest level of care. For example, stress is tied to higher risks of medication errors, patient infections and lower patient satisfaction (OSHA, 2015). Each of these examples of complications from stress can be a result of incivility and can have a financial impact on the organization. Hospitals are not paid for treatment of preventable infections acquired in the hospitals, both for expenses incurred during hospitalization as well as any potential readmission for treatment. Expenses for infections can be quite costly factoring in medications, supplies, as well as the clinical care provided. Additionally, medication errors can lead to complications resulting in additional care, poor outcomes, and can potentially pose significant patient safety issues. This can lead to longer lengths of stay, as well as additional care and treatment expenses which are also not reimbursed. As TJC noted in their 2008 and 2016 advisories, incivility and adverse behavior can lead to nurses being reticent to speak up to prevent potential errors or unsafe clinical practice (TJC, 2016).

Certainly, incidents of complications can impact patient experience, and this often is reflected in patient satisfaction scores. Additionally, incivility contributes to the overall culture

of patient care units. This can also factor into interactions between nurses and patients resulting in lower patient scores. Changes to the reimbursement models for Medicare and Medicaid patients has including lower reimbursement rates for lower performing hospitals. This can result in significant financial impact both from an expense and reimbursement standpoint (Geiger, 2012). This does not even take into consideration the potential reputational damage as infection rates, medication errors, and patient satisfaction scores are all publicly reported.

Question Guiding Inquiry (PICO)

A well-defined clinical question guided this evidence-based project through development, implementation, and evaluation. PICO is an acronym for patient population, intervention or issue, comparison, and outcome. The clinical question guiding this practice change project asked: *“For nurses in an academic medical system, does the development and implementation of a peer accountability program directed at incivility decrease the incidents of incivility as demonstrated on a valid incivility tool?”*

Population. The targeted population comprised of registered and licensed practical nurses employed at the project facilities during the time of implementation and evaluation of the project. The nurses all hold positions in direct care within the designated acute care hospitals. The nurses were all 18 years of age or older with no exclusions regarding genders, ethnicities, or years in profession.

Intervention. The intervention consisted of the development and implementation of a professional accountability program utilizing peer messengers to intervene in situations of incivility among nurses. Peer messengers that are properly trained, given support by leaders and provided with supporting data have been shown to be willing to intervene with colleagues and have a positive impact on quality/safety metrics (Pichert et al., 2013). Webb et al., (2016)

completed a study using peer messengers to promote behavioral accountability in physicians and advanced practice providers. Webb et al. indicated that 71% of recipients of the interventions did not have subsequent reports of target behaviors in a one-year follow-up period. This program utilized these founding interventions for providers and translated into utilizing peer messengers to combat incivility within nursing. The goals of this program were to decrease incivility, improve nursing communication, and empower the nursing workforce.

Comparison. There is no comparison group. However, a pre and post survey of the participating unit nursing staff was completed using the Clark Workplace Civility Index (CWCI; see Appendix A) after tool permission was obtained (see Appendix B). Comparison of incivility report was also compared pre and post program implementation.

Outcome. The goal of this evidence-based project was to empower the nursing workforce to hold peers accountable to the behaviors expected within the institutions values and ANA's code of conduct. The targeted measured outcome was to decrease incivility as evidenced by increased civility scores on the CWCI. Additionally, all acts of incivility reported through the hospital's safety reporting system was collected and compared prior to and after the invention to identify any trends or changes.

Summary

Incivility within nursing is a serious problem that affects the wellbeing of patients, organizational stability and the nursing profession. Nursing leaders must address incivility within their workforce by developing programs that empower nurses to eliminate negative behaviors. The professional accountability program for combating nurse incivility can be a positive step in eradicating incivility in the nursing profession. This type of program empowers nurses to change the culture within their profession. The professional accountability program

fosters positive communication among nurses and the ability for nurses to self-regulate their behaviors to achieve the most positive outcomes for their patients and their own wellbeing.

Chapter Two: Review of the Literature

Nurses are responsible for their behaviors and to hold each other accountable for collaborative, productive behaviors in the profession. The American Nurses Association (ANA; 2015) advocates for the adoption of evidence-based approaches to avoid and mitigate incivility within the nursing profession. Providing intervention at the bedside level empowers nurses to control their environment and promote healthy relationships. Comprehensive evidenced based literature research was utilized to develop a program to address incivility within nursing. This literature research supported utilizing peer messengers to address incivility within the workplace. This chapter provides the methodology and findings of the literature research.

Methodology

Sampling strategies. A comprehensive topic research was completed through the Laupus Health Sciences Library utilizing the following data bases: Cumulative Index to Nursing and Allied Health Literature (CINAHL); MEDLINE/PubMed, Google Scholar, and ProQuest. Key words were derived from the clinical question including: accountability, peer accountability, incivility, bullying, workplace violence empowerment, nursing empowerment, peer review, peer feedback, peer coaches, and peer messengers. Keywords were searched separately and with the Boolean operator “AND” to narrow search topic. Limits of five and 10 years published timeframes were utilized. Additional limits included: English, books and journals, peer reviewed, and full text. Selected literature was assigned a level according to Melnyk and Fineout-Overholt (2011): Level 1 – Systematic review and meta-analysis of randomized controlled trials; Level II – One or more randomized controlled trials; Level III – non-randomized controlled trial; Level IV Case-control or cohort study; Level V – Systematic review

of descriptive and qualitative studies; Level VI – Single descriptive or qualitative study; and Level VII – Expert opinion.

Evaluation criteria. The literature was evaluated utilizing the relevance to the clinical question. Additionally, literature was narrowed utilizing a critical appraisal of valid results and all levels of evidence I-VII. Studies were selected that focused on strategies to decrease the clinical problem of incivility utilizing limiters of nursing, educational opportunities, incident prevalence, and need for organizational support. Specific strategies were limited in nursing research. Broadening the limiters to include other disciplines in medicine, the intervention of utilizing peer messengers into an accountability program for decreasing incivility was determined. The program of peer messengers was developed utilizing evidenced based interventions from the medical provider aspect and translated to a program for nursing. The studies selected for inclusion for this project are provided in Appendix C.

Literature Review Findings

Embree, Bruner, and White (2013) completed a quantitative study on nurse to nurse lateral violence in a critical access hospital utilizing interventions of awareness education and cognitive rehearsal. This was a one group pre/post intervention study on perceived violence using the Nurse Workplace Scale and Silencing the Self-Work Scale. Outcomes were analyzed using independent *t*-tests. The findings of the study indicated increased awareness of nurse to nurse lateral violence, but data analysis of the study indicated no statistical significance in pre/post intervention survey data. Post survey participants indicated the ability to recognize behaviors within themselves that could contribute to nursing to nurse lateral violence and intervened when witnessing lateral violence among other nurses.

Pichert et al. (2013) conducted a retrospective, descriptive study over a four year period to determine if the use of a peer messenger intervention model reduced patient complaints and risk for malpractice lawsuits. The study addressed four specific questions: 1) Would physicians agree to be trained as peer messengers; 2) Would those who agreed, continue as peer messengers over time; 3) Were there any characteristics of high-risk physicians associated with post intervention reduction in patient complaints; and 4) Were there any characteristics with peer messengers or the intervention process associated with post intervention change in patient complaints. The intervention model included steps ranging from scheduled collegial visits to clinical coaching, mandatory mental or physical assessments, or required training. If peer messenger interventions failed at appropriately addressing behavior, the intervention progressed to Level 2 authority guided interventions. At the conclusion of the study, Pichert et al. reported that of 24,591 eligible physicians, 178 agreed to be trained as peer messengers. Over the course of the study four peer messengers decided to discontinue resulting in a 98% messenger retention rate. Utilizing coded patient satisfaction scores from 16 health care organizations, including seven community and nine academic medical centers 373 physicians were identified as high risk for patient complaints that could result in malpractice suits. Peer messengers were assigned based on the area of practice and geographic location to discuss complaints with the high-risk physicians. Pichert et al. reported that feedback from the peer messengers showed that 3% of the physicians showed anger at the first intervention, while 76% showed a positive response. Twenty percent showed a neutral response with the remaining 1% had no recorded response. Fifty-nine of the 373 physicians progressed to Level 2 authority guided interventions. Pichert et al. concluded that after 1,371 interventions, including 373 first-time and 998 follow-ups, 64% of the physicians showed a decline in patient complaints while 17% worsened, and 19% were

unchanged. As far as characteristics of the high-risk physicians that demonstrated positive changes in risk scores, Pichert et al. reported that greater proportions practiced either medicine (72%) or surgery (61%) than emergency physicians at 52%. Pichert et al. reported no specific characteristics were revealed for peer messengers post intervention. Based on study results, Pichert et al. concluded that peer messengers could be recruited, trained, and retained. The author's second conclusion was that a peer driven intervention model could prove effective in reducing patient complaints and malpractice suits by promoting physician behavior and performance changes.

Webb et al. (2016) utilized a descriptive study to determine if the use of a peer messenger interventional model to present co-worker observation reports would promote accountability for adverse behaviors by physicians and advanced practice professionals (APPs). The 2-year study included three hospitals, primary care and specialty clinics with a total of 1,352 physicians and 674 advanced practice providers. Webb et al. identified 372 reports regarding adverse behaviors exhibited by 344 physicians and 28 APP during the two year period. Of the total reports, only 34 physicians were associated with more than three reports demonstrating a pattern of behavior that resulted in Level 2 authority guided intervention. All of the 34 were physicians, no APPs This led Webb et al. to conclude that only a small number of physicians and APPs were associated with a disproportional number of reports so the use of a peer messenger model could produce better functioning teams and promote more individual accountability for behavior.

Pichert, Johns, and Hickson (2011) utilized a composite of events involving 41 pediatric cardiac surgeons to develop a case study for leaders to identify and address lapses that can occur resulting in "near misses". The case study was utilized to help healthcare leaders utilize data to demonstrate concerns to a fictional provider by comparing her risk scores to a peer group. This

allowed leaders to develop a plan for identifying and addressing issues with performance and professionalism. Specifically, the case study identified opportunities for colleagues to address issues with their peers in performance, professionalism, quality and safety to increase accountability and reduce risk (Pichert et al., 2011).

Reiter, Pichert, and Hickson (2012) noted a case study of an adverse clinical event that identified methods for dealing with colleagues whose behavior was inconsistent with professional standards. Reiter et al. identified five principles that led to tools for promoting professionalism and accountability. The five principles included: 1) promoting justice; 2) seeking freedom from conflicts of interest; 3) obtaining reasonable certainty about systems failures and individual performance problems; 4) if feedback or disciplinary action was needed, administering them in ways that maximize the recipient's likelihood of gaining insight; and 5) providing feedback and conducting disciplinary interventions in ways that first aim to restore the colleague to responsible, teamwork promoting professionalism, but failing that, dealing fairly in disengaging from those unwilling to change. Reiter et al. concluded that surgeons could be effective in assisting colleagues to improve behavior and increase professionalism.

Clark, Sattler, and Barbosa-Leiker (2018) completed a study to test the psychometric properties of a workplace civility index tool. The study consisted of a convenience sample of 393 nursing facility and practice-based nurses representing nurses in throughout the United States and Canada (Clark et al., 2018). The authors used Cynthia Clark's Workplace Civility Index (CWCI; see Appendix A), which is a 20-question tool that measures the civility within a workforce. The CWCI was designed to gather responses in a Likert scale: five equals always, four meaning usually, three for sometimes, two for rarely and one equals never. The scoring of the CWCI is 90-100 is very civil, 80-89 is civil, 70-79 moderately civil, 60-69 minimally civil,

50-59 uncivil, and less than 50 is very uncivil. Clark et al. indicated that the CWCI is a valid and reliable tool to measure workplace civility acumen.

Factor analysis was utilized to measure validity and Cronbach's alpha for reliability of the CWCI. Each question with exception of one (question 11) had a loading factor greater than .30, range .55 to .16, indicating evidence of internal validity (Clark et al., 2018). Clark et al. recommended retaining question 11 ("How often do I avoid taking credit for another individual's or team's contributions") due to evidence from previous empirical studies indicating that misuse of others intellectual property as a problem area. This study had a Cronbach's alpha of .82 with reliability considered confirmed at greater than .70. The CWCI was noted as a valid and reliable tool for this project to measure perceptions of civility within the workplace of the participants.

Limitations of Literature Review Process

There was a significant amount of research related to incivility and the negative effects in the workplace. Incidence rate research is extensively indicating the need for interventions. Specific to nursing, regulatory agencies and nursing organizations have spotlighted that incivility within the profession is a problem and that organizations need to develop evidence-based programs to address this widespread issue. Most of the literature focused on education, awareness, and techniques to encourage reporting. Additionally, the importance of policy was extensively noted as an area of concern. Specific interventions to decrease incivility within nursing was lacking. Therefore, this project was the translation of evidence from the provider (physician and advanced practice providers) to the nursing field. Specific evidence-based interventions are needed to decrease incivility within the nursing profession.

Discussion

Conclusion of findings. The findings of the literature research relied heavily on the research of Pichert and associates regarding their bundled interventions to address behaviors. The interventions of peer messengers were utilized in various situations that affected quality of care. Examples included incivility among peers, patient satisfaction, and specific service line quality. Each study utilized accountability and awareness to change behaviors. The findings from the literature review support the intervention of utilizing nurse peer messengers as the main component of the accountability program to address incivility.

Advantages and disadvantages of findings. Advantages to the literature are the prevalence studies showing that incivility in nursing is a problem that needs to be addressed. Additionally, literature supports front line accountability to address issues within the nursing profession instead of a top-down approach. Specific to peer messengers, the literature supports this structure to change behaviors and increase quality of services provided. Peer messengers can intervene in incidences of incivility and allow the respondent to change behavior through reflection and self-accountability.

Disadvantages of the literature research was the limitation of specific nursing interventions. Most of the literature related specifically to nursing indicates interventions to increase reporting, the need for organizational policies, and education. An additional focus of literature has been concentrated on new graduate nurses and the need for those nurses to be empowered to report incivility. Literature lacks interventions for the perpetrator of incivility and how to change those behaviors.

Utilization of findings in practice. A professional accountability program utilizing peer messengers to intervene in incivility within nursing empowers nurses to be in control of their environment. The victim of incivility is provided a mechanism to report and seek assistance in

dealing with incidences. The peer messenger is empowered to intervene in situations of incivility and allowed to utilize their skills to improve the working environment for themselves as well as their peers. The perpetrator of incivility is empowered to self-reflect, rectify and be accountable for their practice, collaboration and environment.

Summary

The literature evidence supports an accountability program to combat incivility in the workforce. Accountability in one's behaviors are essential to promote a collaborative, patient centered nursing profession. Literature supports peer level intervention to decrease incivility. Peer messenger implementation to support the efforts to eradicate incivility within nursing allows for the empowerment of the workforce, promotes teamwork and supports the shared governance model.

Chapter Three: Theory and Concept Model for Evidence-based Practice

This designed evidence-based project utilized Swanson's Caring Theory to guide the interventions. The population targeted in this project, Registered Nurses (RN), historically utilized the caring theory in their daily practice. Additionally, the hospitals in which this project takes place has caring of patients and each other in its overarching practice model. This project capitalizes on the population's knowledge and use of the caring theory, which translates it into the care of each other through peer accountability. The purpose of this chapter is to correlate Swanson's Caring Theory to the implementation of a peer accountability program to combat incivility and describe the systematic model, Plan, Do, Check, Act (PDCA), utilized to implement the practice change.

Concept Analysis

Incivility. Workplace incivility has been a crucial topic in organizational behavioral research. Earlier literature and research focused on aggression, bullying, deviant behaviors and abusive management behaviors that are detrimental to the workforce (Schilpzand, De Pater, & Erez, 2014). More recently, additional focus has delved into behaviors that are less overt but remain to cause negative effects on targeted individuals. Workplace incivility, in this context, is defined as low-intensity negative behaviors with unclear intentions to harm (Andersson & Pearson, 1999). This project focused on the low-intensity behaviors, incivility, within the nursing workforce. Examples of such behaviors are talking down to teammates, making condescending remarks, displaying negative body language and not listening to colleagues. Higher-intensity behaviors, such as overt aggression, did not fall into the scope of this project and were handled by the organization's human resource policies.

Peer coaching. Coaching is defined as facilitating the learning and development of another person therefore improving performance (Neenan & Palmer, 2018). The person being coached makes their own decision and alters behavior based on coordination with the guidance provided by the coach. Peer coaching entails the coach being a colleague. A colleague serves the role of guiding the process of refining performance through activities such sharing best practices, providing insight, and sharing experiences. For this project, peer coaching, is a confidential process where professional nurses review behavioral incidents and collaboratively explore alternative behaviors with the nurse exhibiting uncivil acts. The nurse being coached makes their own determination of the need to alter their individual behavior through self-reflection and insight from the peer coach.

Theoretical Framework

Kristen Swanson developed the middle range theory of caring theory in the early 1990's and included five caring processes: Knowing, Being With, Doing For, Enabling, and Maintaining Belief (Swanson, 2012). Swanson developed her theory to aid in the care of parents and promote emotional healing. Her initial studies included 20 women that had recently miscarried, a second study of caregivers of newborns in an intensive care unit, and a third study of eight young mothers receiving long-term public health services (Swanson, 2012). Swanson's caring theory can be utilized outside of the perinatal environment as evidenced by its validity in congruence with Watson's caritative factions and Benner's helping role (Swanson, 2012). Kristen Swanson's Caring Theory was utilized as the theoretical framework to guide this project.

Theory processes. The first process in Swanson's model is "Knowing" and involves the thorough assessment, avoiding assumptions, seeking cues and engaging the self (Swanson, 2012). In the nursing model, this is the assessment. The assessment of the patient and the

development of nursing interventions to meet the needs noted from the assessment. In this project, the peer coach completes an assessment of the situation and the peer by listening, gathering the facts, being non-judgmental and provide coaching based on the assessment.

The second process is “Being With”, which includes presence, conveying ability, and sharing without burdening (Swanson, 2012). The peer coach is physically, cognitively and emotionally present with the peer. The coach provides their expert advice which has been gained through training and experience. Being emotionally present is just as important as the physical presence (Swanson, 2012).

The third process “Doing For” is displayed by the peer during the same interaction. The peer coach preserves the dignity of their peer while skillfully providing coaching on how to better handle situations without becoming uncivil. The coach is actively engaged, shares experiences and best practices in handling situations where emotions arise.

The fourth process is “Enabling” (Swanson, 2012). The peer coach validates the feeling of the peer, allowing the peer to explain their views of the situation while providing alternative methods of communications that are more productive and conducive to a civil environment. The coach provides support to the peer to make their own choices while communicating the expectations of the organization.

Last is the process of “Maintaining Belief” (Swanson, 2012). The peer coach maintains a belief of optimism and expresses their belief that the peer has the ability to handle situations that arise in a professional manner. The coach provides supportive comments that encourage the peer to develop skills of healthy engagement with others. The coach maintains a belief in a positive change even during times of opposition from the peer.

Theoretical framework in practice. Swanson completed several studies utilizing her caring model. Swanson completed one study on the effects of caring on women who had experienced a miscarriage. The study involved 242 participants with 185 completing the randomized longitudinal Solomon four group investigation (Swanson, 1999). The findings concluded that one year after loss caring was effective in reducing depression, anger and overall emotional disturbance (Swanson, 1999). Additional findings included that passing of time led to increasing self-esteem, and decreased anger, depression, and confusion (Swanson, 1999).

Nurse caring has also been studied on the effects of couples after a miscarriage. Swanson, Chen, Graham, Wojnar, and Petras (2009) completed a randomized controlled trial on three couples-focused interventions and measured depression and grief post one year of miscarriage. The study involved 341 couples randomly assigned to nurse caring (three nurse counseling sessions), self-caring (three video and workbook modules), combined (nurse counseling and self-modules) or no treatment (Swanson et al., 2009). The findings noted that nurse caring had a positive impact on both men and women one-year post miscarriage with self-care accelerating resolution in women and combined accelerating in men (Swanson et al., 2009).

Swanson's caring theory has been utilized outside of the perinatal setting with positive findings. In the early 2000's, the University of North Carolina at Chapel Hill hospital utilized Swanson's caring theory in the development of their professional practice model (Tonges & Ray, 2011). The hospital developed the Carolina Care Model and guidebook to assist their staff in providing exceptional care. This model utilized Swanson's caring model to develop a core set of behaviors and practices that are standardized throughout the organization. The results showed an improvement in patient satisfaction that exceeded the 65th percentile and resulted in the first sustained and steady improvement in six years (Tonges & Ray, 2011).

Application to practice change. Incivility in nursing compromises the care of patients and the working environment. The breakdown in communication compromises collaboration and the essence of nursing. Swanson's caring theory and literature supports an accountability program to combat incivility in the workforce. The components of Swanson's Caring Theory guides the basis of this professional accountability program to combat incivility in nursing. Swanson's Caring Theory provides the framework through which the program capitalizes on the concept of peer coaches to intervene during episodes of incivility. The peer coach concept allows for accountability in one's behaviors that is essential to promote a collaborative, patient centered nursing profession. The peer accountability program implementation supports the efforts to eradicate incivility within nursing allowing for the empowerment of the workforce, promoting teamwork and shared governance.

Evidence-based Practice Change Theory

The Stewhart cycle, also termed the PDCA cycle was utilized in this project to guide the change process. The PDCA cycle originated in the industrial setting to improve the quality of productions (Spath & Kelly, 2017). This method was chosen for this project because of its strong evidence of effectiveness and its engrained understanding among the participants in the project. The PDCA cycle utilizes four steps in a continuous circular approach to guide the change process (Spath & Kelly, 2017).

The first step in the PDCA cycle is "Plan". In this step, an opportunity for change is identified (Spath & Kelly, 2017). In this project, it was identified that incivility within the nursing workforce was an opportunity. This was accomplished through an evaluation of the institution's safety reporting incidents of unprofessional conduct. Additionally, senior nursing

leaders noted incivility as an opportunity for improvement in the institution's Nursing Strategic Plan.

The second step in the process is "Do"; the implementation of change on a small scale (Spath & Kelly, 2017). During this process, the Professional Accountability Program was implemented. This involved education of staff, training for peer coaches and implementation of peer coaches to intervene in episodes of incivility within the nursing workforce. The targeted areas were limited in scope to pre-defined areas within two hospitals of the three-hospital health system. This allowed for a controlled environment with an actionable scope.

The third step in the process is "Check or study". In this step data is analyzed to determine if the project effected change (Spath & Kelly, 2017). This project utilized data from the institution's safety reporting system on incivility among nursing and pre-post Clark's Workplace Civility Index (CWCI; see Appendix A) results.

The final step in this process was "Act". This step evolves the continuous assessment of the results to enable decisions for broader implementation or to begin the cycle again (Spath & Kelly, 2017). This phase allows for the opportunity for evaluation of the project and make decisions as for expansion and/or revision.

Application to practice change. A systematic approach to change is essential to maintain control of a project and ensure that participants can evolve through the change process in an organized environment. The PDCA cycle allowed for a seamless approach to implementing the project. During the "Planning" phase, the problem was identified in a clear manner that allowed for ease of communication to the participants. The institution's safety reporting data and nursing strategic plan clearly identified the need for a program to focus on an intervention for incivility within the nursing workforce. The "Do" phase provided for a methodical approach to

implementation of the program. During this phase education, training for coaches and the components of the peer accountability program was applied. This stage incorporated all the aspects of the planning process and put the plan into action. The “Check or study” phase allowed for the evaluation of the program, analysis of data and directed the activity of the act phase. The “Act” phase allowed for the assessment of the program and the guidance for moving the program to a wider scale.

Summary

Incivility within nursing is a serious problem that affects the wellbeing of patients, organizational stability, and the nursing profession. The professional accountability program for combating nurse incivility guided by Swanson’s Caring Theory is a positive step in eradicating incivility in the nursing profession. The professional accountability program (PAP) powers nurses to change the culture within their profession. The PAP and Swanson’s caring theory fosters positive communication among nurses and the ability for nurses to self-regulate their behaviors to achieve the most positive outcomes for their patients and their own wellbeing.

The program applied the EBP model PDCA cycle to guide the change process. Following the PDCA process was familiar with the participants and allowed for expected processes during the program deployment. The problem was clearly identified, the actions defined, the measurements of effectiveness were easily understandable, and the future actions were available. The next chapter outlines the pre-implementation planning of the project.

Chapter Four: Pre-implementation Plan

Peer coaching can be a positive approach to changing uncivil behaviors in the workforce. The American Nurses Association (ANA; 2015), Occupational Safety and Health Administration (OSHA; 2015) and The Joint Commission (TJC; 2008) have instructed health care organizations to develop plans to focus on incivility within the workplace. This project, Professional Accountability Program (PAP) to combat incivility utilizes peer coaching to elicit behavioral change in targeted nurses that exhibit uncivil behaviors. The PAP capitalizes on the use of a change model Plan, Do, Check, Act (PDCA) and Swanson's Caring Theory to transform the concept of peer coaching to alter incivility into practice. The purpose of this chapter is to outline the project purpose, management of the project, the preparation for the project, and evaluation plans.

Project Purpose

The purpose of the project was to develop and implement a program to address incivility within the nursing workforce. Specifically, the project focused on developing peer coaches to intervene in situations of reported incivility incidents involving nurses. Literature supports peer coaching in changing behaviors within the medical profession (Pickert, Johns, & Hickson, 2011; Pichert et al., 2013; Reither, Pichert, & Hickson, 2012).

Project Management

Organizational readiness for change. The Chief Nursing Officers (CNOs) at the project sites agreed that incivility within nursing was an area that needed to be addressed. The Chief Nurse Executive (CNE for the health system in agreement with all the CNOs and Associate Chief Nursing Officers (ACNOs) indicated that incivility within nursing was a priority area to be addressed. The PAP was presented to the nursing executive leadership and approved

in 2017 as part of the nursing strategic plan. A small test of change of the PAP was completed in 2017 with noted support from front line staff and managers. There was no opposition or negative findings from the test of change. In 2018, the PAP was approved for Health System implementation. One of the three hospitals declined to participate in this implementation phase noting a conflicting program within their institution. PAP was approved for implementation in targeted units within two hospitals within the three-hospital system for calendar year 2019.

Inter-professional collaboration. Collaboration was key to the implementation of PAP. Medical colleagues had previously implemented a similar PAP targeting physicians and advanced practice providers. The leads of the medical provider program were utilized as content experts for the development of the Nursing PAP. Informatics personnel provided the appropriate levels of access to the data needed within the hospital's safety reporting systems. Hospital Safety Officers at the facilities assisted in the development of reports and approval for data management. The Nurse Scientist for the health system assisted in the application process for the health system's Institutional Review Board (IRB). The ACNOs and CNOs of the project sites provided support and the identification of targeted units within the health system. Human resource personnel provided guidance on incorporating PAP into the health system's Just Culture philosophy. The teams worked together to successfully develop and implement PAP.

Risk management assessment. A successful project implementation requires due diligence to maintaining organization and foreseeing obstacles that may affect the project. One method to ensure a well-managed program is to complete a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis. The findings of the SWOT analysis is provided:

Strengths. Strengths of the organizations leadership included dedication to the nursing workforce and commitment to teamwork. Taking care of each other is a part of the

organization's core values. Additionally, the dedication from the executive staff on providing a safe environment is evident in their strategic plans and safety programs. As an American Nursing Credentialing Center (ANCC) magnet designated health system, the hospitals have a robust shared governance structure and engaged staff that promoted the implementation of the PAP.

Weaknesses. Weaknesses of the organization include the size of the organization being a multi-hospital system, with clinics spread over a broad geographic region. The organization is also undergoing rapid growth in both inpatient and outpatient settings, and there is a struggle to keep up with expanding the infrastructure necessary to support such rapid growth. The growth and changes that come with it also require modifications and changes to the structure of care delivery to meet the increasing needs. And finally, the number and complexity of patients with behavioral health problems continues to grow at a rapid pace. This places a burden on the organization and community resources to meet the needs of this expanding population. These weaknesses can provide additional stress on the nurses in the organization and additional opportunities for incivility to occur.

Opportunities. The initial implementation of the PAP has been limited to nursing as the primary caregivers. There is opportunity to expand the program to include the entire interdisciplinary team. The demands of caring for complex patients and clear communication needs spans across all spectrums of the health care team. Use of the PAP among the care team would create a consistent approach and provide support to all team members involved.

Threats. Rapid growth in size, structure, and patient populations can result in realigning priorities as organizational needs and goals shift accordingly. This could pose a threat to long term success of the PAP. Additionally, with a competitive health care market inclusive of

multiple competing hospitals and health care systems, staff turnover poses a tremendous threat. This is particularly true with nursing which is already impacted by workforce shortages. A stable nursing workforce is crucial to the ongoing success of the PAP.

Organizational approval process. Approval for the PAP by the organization was required for implementation of the project. Approval was obtained through the nursing's executive council and added to the strategic plan for nursing. Content experts from the medical staff's professional accountability program were utilized to provide context and evidence of concepts of the program. Additionally, organizational data and literature was available for executive leaders to review during the approval process. Final support was obtained through project site Chief Nursing Officer (see Appendix D).

Information technology. Informational technology was instrumental in the process of the PAP. The health system's electronic safety reporting system (RL6) was utilized for the capture of incidents occurring within the organization. This is a robust system that captures the incident location, date and time of incident, the involved individuals and details of the incident. The electronic safety reporting system was additionally utilized to capture reports on trends of incidents within the targeted units for comparison. The health system's Qualtrics application was utilized for the capture of survey data. This is an electronic subscription software that is utilized by the project site's health care system for surveys. Lastly, IBM's Statistical Package for the Social Sciences (SPSS) was utilized for analysis of data.

Cost Analysis of Materials Needed for Project

The cost for this project included office supplies and refreshments for the training sessions. The applications for data, software and evaluation programs were established through

the project site's pre-program infrastructure. An itemized summary of the project budget is shown in Table 1.

Table 1

Budget for PAP

December 2018 to April 2019			
Line Item	Quantity	Unit Cost	Total
Food			
Drinks (Water & Soda)	12 cases (24/case)	\$9.99	\$119.88
Fresh fruit and vegetables	12 large trays	\$30.00	\$360.00
Candy	6 bags	\$14.49	\$86.94
			\$566.82
Office Supplies			
Copy paper	2	\$6.93	\$13.86
Colored paper	4	\$12.49	\$49.96
HP toner cartridges	1	\$158.99	\$158.99
Pens	2 packs (36/pack)	\$7.49	\$14.98
Binders	8	\$12.99	\$103.92
			\$341.71
		TOTAL	\$908.53

Note. Expenses for development and implementation of: Professional Accountability Program

Plans for Institutional Review Board Approval

Institutional Review Board (IRB) approval was attained at the organizational and project site levels (see Appendix E). The process for approval began by submitting the application for institutional and site-specific specialty committee IRB approval. IRB and then site committee reviewed the project and deemed it to be exempt and approved. Both the IRB and specialty committee agreed the project did not involve human research; therefore, the project could move forward as a process improvement project. Academic site IRB approval was obtained after program site IRB. The IRB of the Academic site agreed with the project site that the project did not involve human research and was deemed a process improvement project (see Appendix F).

Plan for Project Evaluation

Demographics. The demographics collected from the participants included nurse licensing level, age, gender, years as a nurse, and years working at the project facility (see Appendix G). Licensing level was reported by percent of participants that were licensed as a Registered Nurse (RN), Licensed Practical Nurse (LPN) or other. The participant's age was reported as a mean age with range. Gender was reported by percent male or female. Participant's years of nursing experience and years of working at the project facility were reported as mean levels with range. The data was presented in numerical form with mean and range for applicable demographics.

Civility measurement. The first outcome was the measurement of civility perceived by the nursing participants in the targeted units. The defined goal was to increase units' perceptions of civility by one level post implementation of PAP. Civility measurement was obtained using Clark's Workplace Civility Index (CWCI) tool (see Appendix A). The CWCI tool scores civility within six levels from very civil to very uncivil (Clark, Sattler, & Barbosa-Leiker, 2018). The intervention was the implementation of the PAP that includes utilizing peer coaches to intervene after incidents of incivility within nursing. The increase in perceptions of civility within the targeted units indicates positive behavioral interactions within nursing professionals.

Evaluation tool. The CWCI was the measurement tool used in the evaluation of the PAP. The CWCI is a 20-question tool that measures the perceived frequency of behaviors considered civil. The CWCI is designed to gather responses in a Likert scale: five equals always, four meaning usually, three for sometimes, two for rarely, and one equals never. The scoring of the CWCI is 90-100 is very civil, 80-89 is civil, 70-79 moderately civil, 60-69 minimally civil, 50-59 uncivil and less than 50 is very uncivil. The tool was administered to participants at the

start of the program with re-evaluation at 45 and 90 days after the implementation of the peer accountability program.

Data analysis. The percent of responses was calculated by the number of surveys returned and the total participants invited to complete the survey. The CWCI scores for each participant was tabulated to indicate the individual's perception of civility. The individual scores were then used to calculate each unit and hospitals mean score and range. The scores of the units and hospital level were then compared at pre-intervention, 45-day post intervention, and 90-day post intervention to determine the level of change in civility perceptions. Clark's six levels of civility were utilized to provide descriptive terms to the numerical levels. The goal of the project was to increase civility within the hospital's score by one level.

Incidence prevalence. The second defined outcome was the number of uncivil incidence reports for the targeted units. The number of incidents reported by staff involving nurses was measured as a numerical rate and compared for percent change. The data was collected utilizing the hospital's incident reporting system that is categorized to capture incidents of incivility. There was no pre-defined goal for percentage change as one could argue a decrease in reports to be indicative of decreased incivility but also, one could argue increase in reported incidents related to education to staff of the PAP.

Evaluation tool. The health system's incident reporting system (RL6) was utilized to capture the data on number of incidents related to incivility within the targeted units. Inclusion criteria included that the incident involved a nurse working in the targeted areas and the nurse was the perpetrator. Additionally, any individual with a noted pattern of incidents prior to the implementation of the PAP was excluded as well as incidents that involved any type of physical aggression. Incidents that did not fall within the inclusion criteria (incident not overt aggression,

non-pattern, and alleged perpetrator employed in one of the target units) for the PAP were referred to the manager of the unit and hospital's human resource department. Calculation was performed from reports within the health system's incident reporting system of employee reported incidents and a manual Excel database was maintained to track number and reasons for exclusions.

Data analysis. Incidence prevalence data was analyzed utilizing an Excel database. The number of incidents reported per month for the targeted units was determined and reported in total numerical form. Pre intervention data was collected for the targeted units from July 31, 2017 to December 31, 2018. Program introduction and implementation occurred January 1, 2019. Post intervention data was collected January 01, 2019 through April 30, 2019. Pre and post intervention data was compared for the program assessing the difference in whole number. Additionally, the data was aggregated at the unit level, hospital level and program level.

Data management. Data was stored in two electronic forms within the project site's approved informational technology data storage systems. The primary storage was on the project site's "box" that allows electronic storage of data that can be shared with author's approval. The backup electronic storage was on the project site's individual storage drive. Both electronic methods maintain data storage on the health system's secured servers that are encrypted and behind firewalls. The data maintained all electronic survey information including demographics, Excel spreadsheets, and analysis of data. Hardcopies of all forms utilized including any surveys completed by hand were electronically scanned into electronic storage. All hardcopies were stored in a locked file box within the locked office of the ACNO for a minimum of five years for publication and dissemination. At the end of five years the hardcopy documents will be securely

shredded in accordance with the project sites shredding guidelines and all digital data will be erased from electronic storage.

Summary

The development and implementation of the PAP can improve the perception of civility within the nursing workforce. The use of peer coaches to intervene in situations of incivility can empower the nursing workforce to set the standard of behaviors in their respected work environments. Incivility within the nursing profession can be detrimental to the wellbeing of the nurses providing care and to those that care is being provided. The implementation of PAP to combat incivility is thoroughly explained in the next chapter.

Chapter Five: Implementation Process

The evidenced-based practice (EBP) change process for this program was the development and implementation of a peer centered Professional Accountability Program (PAP) to address episodes of incivility within the nursing workforce of a subset of units within a hospital system. Reiter, Pichert, and Hickson (2012) noted that colleagues can be successful in intervening with negative behaviors and increasing professionalism. This project utilized nurse colleagues to intervene in episodes of incivility to improve the overall perception of civility on targeted nursing units.

Setting

The PAP was implemented in targeted units of an academic health system in central North Carolina (NC). The health system consists of three urban hospitals in a rapidly growing market. The project was implemented within the nursing division in selected units within two of the three hospitals of the health system. The units consisted of 12 inpatient medical-surgical units, three intensive care units, two emergency departments, three perioperative services, one operating suite, two procedural areas, and three outpatient units.

Participants

The participants for inclusion in the evaluation of civility measurement included all Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) employed in the selected units at the time of the project implementation through the evaluation phase of the project. An employee list was created utilizing our internal electronic database at time of implementation of the project and names of subsequent hired nurses were provided monthly throughout the program for inclusion in the program. Civility measurements were obtained for included nurses employed at

the time of each survey. Exclusion were those staff that were employed outside of the targeted units and those employed in the targeted units that were not in the job titles of RNs, or LPNs.

The participants' inclusion for the coaching role in the program included RNs employed in the targeted units. One to two coaches were selected per unit depending on the size of the unit and hours of operation of the unit. Units that were open 24 hours a day were assigned two coaches whereas small units and units that operated less than 24 hours a day were assigned one coach. Coaches were selected with input from the management team of the targeted units and desire of the employee to be a coach. The ability to clearly communicate and influence others was taken into consideration for selection of coaches. Seniority and professional tenure were not identified as criteria for the role of coach in the PAP. Exclusion criteria included RNs that were under disciplinary action or had identified communication opportunities identified by management.

Recruitment

Recruitment of participants to participate in the survey process of civility was completed by the project manager (PM) meeting with nurses in groups assigned by the unit leadership. Meeting times were determined in coordination with the manager of each unit included in the program. A description of the program was provided including the civility survey. Meetings were provided during working hours of the participants that included day, evening, and night sessions. Potential participants that were unavailable for meetings on their prospective units were invited to attend meetings on other units. A roster of attendance compared to the unit employment roster was maintained by the PM to ensure maximum exposure to the program and opportunity to participate.

Recruitment for peer coaches was completed by education of the managers of the targeted units on the program. Unit managers made recommendations to the PM for who to consider as a peer coach. A brief phone interview was completed to the recommended coaches by the PM to identify any concerns and ensure desire of the potential coach. Training, led by the PM, was provided through lecture and situational role playing exercises. The peer coaches verbally verified their ability to perform the coaching role.

Implementation Process

Program participants. All nurses in the targeted units were encouraged to participate in the PAP. Informational sessions were made available to all nurses employed in the targeted nursing units. Sessions were completed on each unit in various methods: at staff meetings, huddles, and called meetings during the first two weeks of January 2019. Proceeding the PM visiting the unit for the information session, the unit's manager sent via email an informational flyer and FAQ sheet. The informational sessions included examples of behaviors included in the scope of the program: talking down to teammates, making condescending remarks, displaying negative body language and not listening to colleagues. It was explained that overt aggression did not fall in the scope of the project and would continue to be referred to human resources and be under the scope of the unit manager. Additionally, RNs with multiple incidents of incivility during the program were excluded from additional intervention by the program and were referred to the unit manager and human resources.

Process. Additional information was provided on the process for reporting and the program specific actions. Reports of incivility were to be placed into the health system's electronic safety reporting system by the alleging victim. All pertinent information was encouraged, including word for word interactions whenever possible. The PM reviewed all

incidents within the next business day and determined if the incidents fell within the scope of the project. The PM placed a notation in the electronic system noting the determination of inclusion or exclusion into the program. Excluded incidents would be handled by the manager of the unit. If the incident was determined to fit the inclusion criteria for the program, the manager would refrain from any involvement. The PM assigned those incidents included into the program to a peer coach and provided the peer coach a summary of the incident and employee involved. This information was provided to the peer coach via email and followed up by a phone conversation when requested. The peer coach completed a coaching session with the alleged perpetrator of incivility as soon as possible considering the schedule of the alleged perpetrator and coach. The goal was for the coaching session to be completed within 48 hours. The coach notified the PM of the completion of the coaching session and whether the alleged perpetrator appeared to receive the coaching session positively. If the alleged perpetrator became overtly aggressive, then the PM was notified immediately for intervention. When the alleged perpetrator received the information without overt aggression, the file was closed on the incident by the PM. The PM noted the date and time of the intervention in the project log and the incident was marked for closure in the electronic system by the PM.

Measurement. Measurement of the project was determined by administration of the Clark Workplace Civility Index (CWCI; see Appendix A). Additionally, demographic data was collected (see Appendix G). The CWCI and demographic survey was administered directly after each information session to the participants attending the information session. The surveys were administered through the health system's approved Qualtrics survey tool sent out via email link by the PM. Participants had the ability to take the survey on a computer through a link through their email or by smart phone. Hard copy surveys were available for any participants that had

trouble with the electronic methods. A follow up CWCI survey was administered at 45 days and 90 days post implementation of the program. The CWCI survey was sent out via email link by the PM utilizing the health system's Qualtrics tool. Additionally, data was collected on the number of reports submitted and those included into the program for trend analysis.

Coaches. Peer coaches were identified through collaboration with the management team of the targeted units and the PM. The coaches were provided a two to four-hour training session by the PM that included didactic and simulation teaching methods. The didactic training included all the information provided to the staff nurses including definitions of incivility, examples, and the process for the program. Additionally, simulation training utilized specific examples that had occurred in the health system. The simulation training required the participants working in groups of three with roles of: alleged perpetrator, coach and observer. The participants simulated three incidents and rotated roles to ensure everyone participated in simulation of each of the three roles. After each simulation, a debriefing occurred to discuss any learning and/or opportunities. The roles of the alleged perpetrator included instructions for varied responses including extreme sorrow, denial, pushback and further aggression. The group discussed, during debriefing, how each different situation was handled, and guidance was provided by the facilitators.

Plan Variation

The PM intended to have all units introduced to program via staff meetings and huddles by January 15, 2019. Due to variation in dates of staff meetings and rescheduling of some prescheduled staff meetings it was requested to have introductions completed after January 15, 2019. Coaches were to be trained by January 15, 2019, but some coaches were unavailable for training, and additional training dates were scheduled. Some units also requested additional

coaches be trained resulting in delaying introductions until after January 15, 2019. The second coach for one of the emergency departments left preventing introduction to that unit by January 15, 2019. One procedural unit had 90% turnover; therefore, their data was excluded.

Summary

The implementation of the PAP program aids in combating uncivil acts within the nursing profession. The utilization of peer coaches to intervene in episodes of incivility with nurses of targeted units was projected to increase the overall perception of civility. The EBP CWCI was the measurement tool used to measure the effectiveness of this program as well as trending of reporting was completed. The results collected from the implementation of the PAP program are discussed in detail in the following chapter.

Chapter Six: Evaluation of the Practice Change Initiative

Incivility in the workplace, particularly within nursing practice, impacts performance, compromises employee and patient safety, and increases risk to organizations (Mikaelian & Stanley, 2016). This Peer Accountability Program (PAP) began July, 2017 with an assessment of the nursing workforce through surveys and reports of events involving incivility. After this assessment it was concluded that the problem of incivility was significant and appropriate intervention was needed. An extensive review of literature (see Appendix C), by the project manager (PM), found that peer coaching at other organizations had successfully addressed episodes of incivility. The PAP chose to implement a peer coaching model based on Swanson's Theory of Caring (Swanson, Chen, Graham, Wojnar, & Petras, 2009) and the Stewhart PDCA cycle (Johnson, 2002). This chapter summarizes the participants utilized for project introduction and implantation, observation and assessments throughout implementation, and outcomes following completion.

Participant Demographics

A total of 930 surveys were completed within the 26 targeted units at the two project sites for the initial survey. Demographic data was collected on the first survey only. Forty participant surveys (4%) were excluded due to completion by staff other than Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). Of the 890 qualified surveys, three (0.3%) were completed by LPNs and 887 (99.6%) were completed by RNs. Females represented 796 (89%) participants and with 88 (10%) males completing the survey. Gender was not reported on six (1%) surveys. The age range of survey participants was 21-83 with a mean age of 36.4. Age was not reported for 33 (4%) participants. Range of experience as a practicing nurse was 0-46 years with a mean of 9.64 years. Years of nursing experience was not reported by seven

participants. Participant years of experience at the project site ranged from one (1) month to 39 years, for a mean of 4.84 years. Years of experience at the project site was not reported by 59 (7%) participants.

Intended Outcomes

Civility measurement. The first outcome of the project was the measurement of perceived civility by nursing participants in the targeted units. The goal was to increase units' perceived incivility evidenced by improvement by one measurement level utilizing the Clark's Workplace Civility Index (CWCI; see Appendix A). The CWCI tool measures civility with a six level scale: very civil to very uncivil (Clark, Sattler, & Barbosa-Leiker, 2018). The PM administered the CIWA tool via survey to staff on the targeted units pre-implementation, at 45 days and 90 days post implementation of the PAP.

The CWCI is a 20 question tool measures responses of frequency of behaviors considered civil. The CIWI utilizes a Likert scale: five equals always, four indicating usually, three for sometimes, two for rarely and one equals never. Participants were asked to score each question on behalf of their perceptions of frequency of behaviors of their co-workers including themselves. The scoring totals the individual scores and reports out civility measurement on a 100 point scale. Very civil is noted as 90-100, 80-89 for civil, 70-79 moderately civil, 60-69 minimally civil, 50-59 uncivil and less than 50 is very uncivil (Clark et al., 2018). The scores of each unit, hospital and aggregate for the program were compared at pre-intervention, 45 days post intervention and 90 day post intervention to determine level of change in perception of civility.

Incident prevalence. The second defined outcome was the number of incidents of incivility reported involving nurses within the targeted units. Trending of incidents were

captured utilizing the health system's incident reporting system (RL6). There was no goal identified as decreased incidents could be indicative of decreased civility, but also, increased incidents could be related to education to staff of the PAP. Data was collected for the pre-intervention period from July 1, 2017 to December 31, 2018. Post intervention data was defined January 1, 2019 through April 30, 2019. Pre and post intervention data was compared for trending.

Findings

Civility measurement. The CWCI tool was administered by survey to nurses in 14 units in one hospital and 12 units in the second hospital for a program total of 26 units. Three units (12%) saw improvement of one civility measurement during the program, two units (8%) indicated a decline, and 21 (80%) units remained unchanged (see Appendix H). No units scored below "Moderately civil" throughout the program. Six units (23%) scored at the highest level "Very Civil" in the pre-intervention survey and eight units (30%) "Very Civil" in the post 90 day survey. Each of the two targeted hospitals scored at a measurement of "Civil" throughout the program. When the two hospital pre and post total average scored at a measurement of "Civil", both hospital's civility measurement level remained at baseline and therefore did not meet the project goal to increase by defined one level.

Incident prevalence. Incidence prevalence was evaluated by whole number of incidents reported within the health system's reporting software. The data was reported out in triannual periods (every four months) for each hospital's participating units and as a combined program (see Figure 1). Trending noted that the first four months of the calendar year had the highest reporting of incidents. Additionally, during the project implementation period (P1 2019) a spike in total number of incidents were noted. Hospital one, had a steady increase in reporting after a

significant dip in reporting in P3 of 2017 and did not meet the highest period of reporting in P1 of 2017. Hospital two noted their highest level of reporting during the project implementation period (P1 2019).

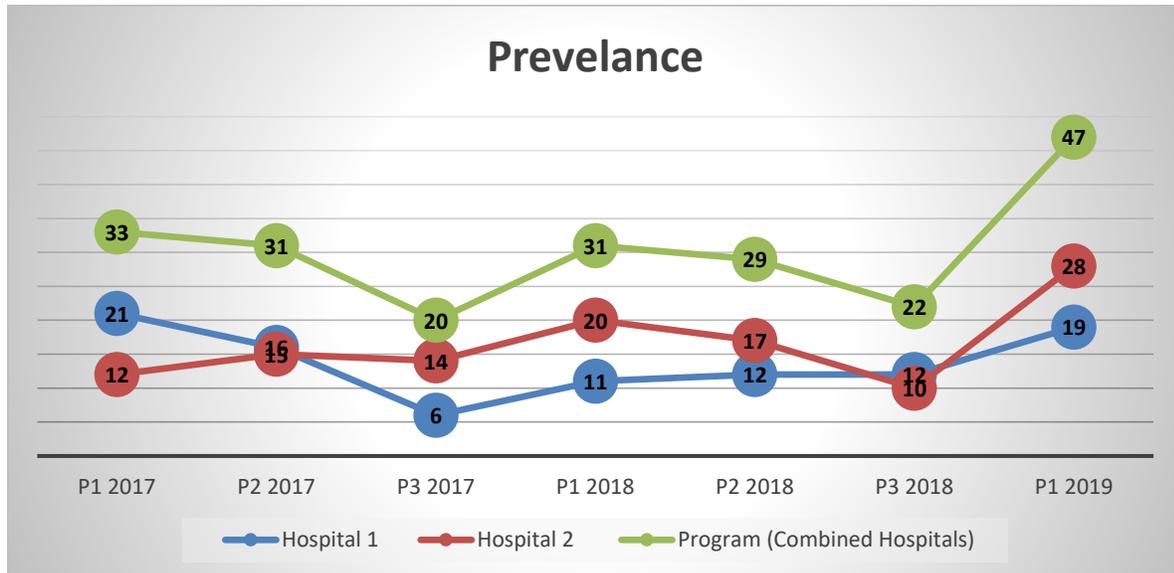


Figure 1. Nursing incivility incidents per period. P1= January through April of noted year; P2= May through August of noted year; P3= September through December of noted year.

Frequency of reported incidents by hospital. In reviewing the frequency of reported events by unit and period for Hospital 1 (see Table 2), six (43%) of the 14 units had no reports of incivility during the program phase (P1 2019). These six units consistently had low incident reporting during other periods. Additionally, all six of these units scored “Civil” or “Very Civil” on CWCI scores (see Appendix H). Units 4 and 5 had the highest number of incivility reports during the project phase (see Table 2). Unit 4, had improved CWCI ranking from “Civil” to “Very Civil” during the program (see Appendix H).

The total reports of incivility with a nurse as the alleged perpetrator for Hospital 1 was 19 reports. Twelve incidents (63%) were within scope of the project (incident was deemed low

intensity, did not require human resources intervention and the alleged nurse was employed on one of the participating units) and peer coaching was completed without further intervention required. Seven (37%) were out of scope due to incidents requiring human resources intervention, the nurse was not identified or worked in the float pool.

Table 2

Hospital 1 Frequency of Reported Incivility Events by Period

Unit	2017 P1	2017 P2	2017 P3	2018 P1	2018 P2	2018 P3	2019 P1
1	2	3	0	0	2	1	0
2	0	0	0	0	0	0	0
3	1	1	0	0	0	0	1
4	3	1	0	0	2	2	5
5	9	3	0	5	0	1	5
6	1	1	0	0	3	0	1
7	1	0	0	0	0	0	0
8	1	0	0	0	2	0	0
9	0	1	0	0	1	1	1
10	0	2	1	3	1	4	1
11	1	3	2	1	1	1	0
12	1	0	1	2	0	1	3
13	0	1	0	0	0	1	0
14	1	0	2	0	0	0	2
Total	21	16	6	11	12	12	19

Note. P1= January through April of noted year; P2= May through August of noted year; P3= September through December of noted year.

Data from Hospital 2, has one unit with no reports (8%) during the program phase (P1 2019) and this unit, had historically low reporting (see Table 2). Seven units (58%) had one to two reports during the program phase and this was consistent with previous reporting trends. Three units (25%) had four reports during the program phase with variable historical reporting trends. The highest level of reporting incidents was seven individual reports in Unit J (8%) with

variable historical reporting. Unit J's CWCI ranked at "Civil" throughout the project (see Appendix H).

The total reports of incivility with a nurse as the alleged perpetrator for Hospital 2 was 28 reports. Eight incidents (29%) were within scope of the project and peer coaching was completed without further intervention required in seven of the cases. One case had to be escalated to human resources after the coaching for further intervention. Twenty (71%) were out of scope due to incidents requiring human resources intervention (25%, $n=5$), the nurse was not identified or worked in areas outside of the targeted units (35%, $n=7$) and the issue was a process or practice issue (40%, $n=8$).

Table 3

Hospital 2 Frequency of Reported Incivility Events by Period

Unit	2017 P1	2017 P2	2017 P3	2018 P1	2018 P2	2018 P3	2019 P1
A	2	0	3	0	3	1	4
B	0	0	0	0	0	2	2
C	1	0	0	0	1	1	1
D	0	1	0	3	0	0	2
E	1	0	2	3	1	0	1
F	2	3	0	2	0	1	1
G	0	0	1	1	1	0	1
H	0	1	0	0	2	1	0
I	2	6	3	4	4	0	4
J	4	2	5	6	4	3	7
K	0	0	0	0	0	1	1
L	0	2	0	1	1	0	4
Total	12	15	14	20	17	10	28

Note. P1= January through April of noted year; P2= May through August of noted year; P3= September through December of noted year.

Summary

The first goal was to increase units' perceived incivility evidenced by improvement by one measurement level utilizing the CWCI. Three (12%) of the 26 participating units had an increase by one level of civility measurement. The PM did note that all 26 units scored in the top three of the six categorical scale in the pre-implementation phase. Overall, each hospital's CWCI remained unchanged and did not meet the goal of increasing by one measurement level. The second defined outcome was the number of incidents of incivility reported involving nurses within the targeted units and was trended based on reporting by the participants. Overall, each of the two hospitals demonstrated increased reporting during the program phase (P1 2019) of the Professional Accountability Program (PAP). Specifically, Hospital 2 had >300% increase in reported incidents. This trending indicates that increased awareness can increase reporting of uncivil incidents, which gives organizational leaders a chance to identify and remedy the causes of incivility in order to improve the work environment culture.

Chapter Seven: Implications for Nursing Practice

The American Association of Colleges of Nurse (AACN; 2006) published eight essentials to guide the education for the Doctorate of Nursing Practice (DNP) student. These essentials provide the basis for the preparation of the student to transition into doctoral focused practice. This chapter provides contents of each essential, how it was demonstrated in the project and implications for consideration in further practice.

Practice Implications

The DNP graduate utilizes collaboration to translate theory-based research into practice (AACN, 2006). This process involves identification of an issue, planning for an intervention, implementation of an evidenced-based plan of action, evaluation and dissemination of the knowledge gained. The project manager (PM) for this evidence-based practice (EBP) change collaborated with nursing executives and frontline staff to identify the need to address incivility within the nursing profession. A literature review was completed and identified serious consequences of incivility but evidenced-based projects targeted at incivility within nursing practice were limited. Mikaelian and Stanley (2016) indicated that incivility among nurses negatively affects, patient care, original effectiveness, job satisfaction and the nursing profession. The PM translated research based on programs targeting incivility with providers in the development of the professional accountability program (PAP).

Essential I: Scientific underpinnings for practice. According to the AACN (2006), DNP graduates integrate nursing science with knowledge from other disciplines, organizations, analytics, psychosocial sciences, the biophysical and ethics to enhance the nursing profession to practice at the highest level of education and training. Implications for the advancement in nursing practice utilize science-based theories to develop, implement and evaluate programs to

advance health. An example is the use of Swanson's Caring theory to guide change in employee health.

In the early 1990's, Kristen Swanson developed the middle range theory of caring and its five caring processes: Knowing, Being with, Doing For, Enabling, and Maintaining Belief (Swanson, 2012). Swanson (2012) developed her theory to aid in the care and promotion of healing in parents that were experiencing catastrophic events such as a miscarriage or newborns in the intensive care unit. Swanson's theory of caring can be translated for use outside of the patient clinical area. Future implications include the use of nursing theories by leaders, such as, Swanson's theory of caring to implement programs for the health of the nursing staff.

Additionally, the analytical sciences are instrumental in guiding programs of change. The use of the Plan, Do, Check, Act (PDCA) cycle is an excellent model to guide process change and was used in this project. The PDCA model, also termed the Stewhart cycle, originated to improve quality of productions in the industrial sector (Spath & Kelly, 2017). The PDCA model is easily used in the health care setting to provide a systematic approach to allow participants to progress through a change process in organized process. The PDCA model was used in the PAP to guide the process change of utilizing peer messengers in the coaching role for incidents of incivility within nursing. The PDCA allows for the planning of action, do it, check the effectiveness and act on what has been taught (Johnson, 2016). Future implications are to utilize the PDCA cycle to do wider tests of change by implementing the PAP throughout the health system.

Essential II: Organization and systems leadership for quality improvement and systems thinking. DNP graduates should be able to utilize systems thinking and to facilitate organizational wide change (AACN, 2006). The ability to think globally and think in

relationship to the future is paramount. Quality improvement at an organizational level may start with one incident but the solution should incorporate implementation of programs that affect the broader population.

In relation to nurse civility, the PAP utilized principles of finance, employee relations, policy and organizational workflow in the development, implementation and evaluation. Health care professionals should have knowledge and the ability to integrate systems thinking into practice (IOM, 2001). The PAP program is a systematic approach to identify and intervene in episodes of incivility among nurses. Future implications are to utilize the data from the PAP to identify underlying incivility causes and implement strategies within the program to eliminate the root causes organization wide.

Essential III: Clinical scholarship and analytical methods for EBP. DNP graduates can translate new science from research, apply new knowledge, and evaluate outcomes (AACN, 2006). The Clark's Workplace Civility Index (CWCI; see Appendix A) tool was initially developed to evaluate civility within nursing faculty, later the knowledge was translated into the use for practice-based nursing and the psychometric properties were validated (Clark, Sattler, & Barbosa-Leiker, 2018). The translation of knowledge is instrumental to use existing scientific evidence to expand into other areas of practice (Zer et al., 2018).

The CWCI is a valid tool that was translated for use in the practice-based nursing (Clark et al., 2018). The PAP program utilized the CWCI in evaluating the effectiveness of the program. The evaluation was limited to a three-month period from pre intervention to post evaluation. Future recommendations for both project sites would be to repeat the CWCI survey six months from the intervention to add additional outcome data to further evaluate the PAP.

Essential IV: Information systems/technology and patient care technology for the improvement and transformation of healthcare. The DNP graduates use information technology (IT) to support quality improvement programs and the ability to use technology in evaluate the effectiveness of interventions (AACN, 2006). It is important to use information systems and databases that track reporting of incidents of incivility and potential repercussions to either patient care or employee experience. This provides a basis to have meaningful data to review and analyze rather to rely on anecdotal information. The use of information systems, such as RL6 that was used in this project, allows for the trending of data and tracking the progress of quality improvement programs. Additionally, the use of IT can give one the ability to expand their efforts across different platforms and break down the physical barriers. Dong and Jang (2015) indicate that the use of IT can improve an organization's learning processes. DNP graduates should capitalize on the benefits of the utilization of IT to expand knowledge and transform nursing practice. Future recommendations for the project sites are to continue to use of the RL6 software to track incidences of incivility, identify patterns and identify units that need additional coaching, education, and leader support.

Essential V: Healthcare policy for advocacy in healthcare. DNP graduates can be instrumental in healthcare policy formation, implementation and evaluation (AACN, 2006). The Institute of Medicine (IOM; 2001) indicated that nurses can be influential in development, implementation, evaluation and providing recommendations for health care policies (as cited by AACN, 2006). The Joint Commission (TJC; 2016) noted in their 2008 and 2016 advisories, incivility and adverse behavior can lead to nurses being reluctant to speak up to prevent potential errors or unsafe clinical practice. Many institutions have "zero" tolerance policies for incivility but lack the ability to enforce such policies due to contracts and other restraints. In the United

Kingdom (UK), legislation on incivility was not passed on the grounds that such a law may limit democratic dissent (Edyvane, 2019). The PAP program is one example of how DNP graduates can promote changes within practice and influence policy. Future implications are that nurses define acceptable practice and set in place programs to address incivility. Additionally, DNP prepared nurses can serve as the spokesperson to change future policies that specifically addresses incivility within the workplace.

Essential VI: Interprofessional collaboration for improving patient and population health outcomes. The sixth essential emphasizes the importance for interprofessional collaboration with AACN (2006) stating, "...DNP graduates have preparation in method of effective team leadership and are prepared to play a central role in establishing interprofessional teams, participating in the work of the team, and assuming leadership of the team when appropriate" (p.14). This PAP utilized teams of coaches specifically trained, by the PM, to implement the peer coaching program. Collaboration is key to provide collegial working relationships and can mitigate the effects of incivility (Sharifirad, 2016). Continued collaboration with other professionals can define appropriate workplace behaviors that all disciplines follow to ensure the safest care of patients. Future implications include expansion of the PAP across all disciplines allowing for an organizational program for incivility.

Essential VII: Clinical prevention and population health for improving the nation's health. DNP graduates play essential roles in the prevention of disease and promotion of health. DNP graduates have the ability to evaluate occupational, biological, environmental and epidemiological data in the development, implementation and evaluation of programs for population health (AACN, 2006). Incivility can cause occupational injury in the nursing workforce. According to the Occupational Safety and Health administration (OSHA; 2015) in

2013, incidence of serious violence was four times the level in healthcare versus the private industry with 7.8 cases per 10,000 full-time employees. In 2015, the American Nurses Association (ANA; 2015) published position a statement that included key points and recommendations on: No tolerance for violence, a culture of respect. This project addressed low intensity incivility, but future recommendations include additional programs to address all areas of violence that occurs within healthcare.

Essential VIII: Advanced nursing practice. DNP graduates have advanced knowledge in one area of nursing practice. (AACN, 2006). Nursing leadership is an important specialty that is often overlooked and misunderstood in the context of advanced nursing practice. DNP graduates with a concentration in leadership are essential to advancing the practice environment and to eliminate barriers in providing quality care. This project focused on improving the civility within the nursing workforce environment. The DNP graduate has crucial attributes to lead change within the healthcare environment (Sherrod & Goda, 2016). The future of fully functioning, collaborative working environments for nurses are dependent on the recommendation that DNP prepared leaders utilize their training to collaborate, guide and develop programs to address the needs of an interdisciplinary workforce.

Summary

Healthcare is rapidly changing in the United States and abroad. It is essential that the DNP prepared professionals are educated and experienced to lead process changes within this rapidly complex environment (AACN, 2006). Incivility is a barrier to nurses being able to practice comfortably and to the full extent of their scope. Uncivil behaviors in the practice environment can lead to safety situations that affect the nurse and the patients they serve. This project utilized an evidenced-based model of utilizing peer coaches to address low level

incivility within the nursing workforce. It is the recommendation that future programs are developed and implemented to address all behaviors that inhibit nurses from practicing securely and contently.

Chapter Eight: Final Conclusions

Incivility within nursing is a critical issue that negatively affects the wellbeing of patients, organizational stability, and the nursing profession. The professional accountability program (PAP) for combating nurse incivility is grounded by Swanson's Caring Theory and utilizes a systematic approach to eradicate incivility in the nursing profession. The PAP empowers nurses to change the culture within their work area and to utilize coaches to guide coworkers to eliminate uncivil behaviors. The PAP nurtures positive communication among nurses and the ability for nurses to self-regulate their behaviors to achieve the most positive outcomes for their patients and their own wellbeing.

Significance of Findings

The PAP utilized peer coaches to intervene in episodes of nurse led incivility in 26 units across two hospitals in an urban health system. The PAP was evaluated using the Clark Workplace Civility Index (CWCI; see Appendix A) administered electronically through Qualtrics software pre-intervention and then 45- and 90-days post-intervention. Demographics and trending of incidents reported was completed using data that were entered in the health system's safety incident software system.

Three (12%) of the 26 units increased their civility score by one measurement level during the implementation of the project, two (8%) decreased their measurement score by one level. Twenty-one units (80%) civility measurements were unchanged from pre-intervention to post 90-day intervention. The two hospital's mean civility index remained unchanged at "Civil" throughout the PAP; thus, did not meet the benchmark to increase by one measurement level. These findings indicate that the PAP intervention does not produce significant short term

increases in the perception of civility. Additional time is needed to see if perception is changed over an extended period.

Twenty incidents received peer coaching during the implementation phase January 01, 2019 through April 30, 2019. No individual nurse required more than one coaching session. There were no negative reports from either the coach or the nurse being coached concerning the coaching session. All coaches readily took coaching session assignments and reported no difficulty in completing the task. This finding indicates that peer coaching is a viable option for organizations to consider versus the traditional manager and human resource corrective interventions for incivility.

The first hurdle for any civility program is that employees recognize low intensity incivility and report the incidents. Hospital 1 had steady increases in reporting from January 01, 2018 through April 30th, 2019. Hospital 2 had a decline in reporting from January 01, 2018 through December 31, 2018 and then had a >300% increase in reporting during the implementation of the PAP, January 01, 2019 through April 30th, 2019. It is noted that Hospital 1 had a previous introduction to the program in August 2017; whereas, Hospital 2 had no prior history with the PAP. Programs such as the PAP can increase awareness of uncivil behaviors in the workforce and allow for interventions to correct the negative behaviors.

Project Strengths and Limitations

A strength of the project was the dedication by staff, coaches and the leadership team. The Chief Nurse Executive (CNE) of the health system and Chief Nursing Officers (CNOs) of the two project hospitals provided their full support of the program. The CNE added nurse incivility as strategic priority and provided the project manager (PM) with the resources needed to complete the project. Additionally, the unit managers, the staff nurses and identified coaches

demonstrated their support by attending the educational sessions, completing the surveys and being open to the coaching process.

An additional strength included a robust software program (RL6) that allowed for the collection of professional conduct incident reports. The reporting system allowed for trending of data and organization of record keeping. Also, the staff were familiar with the system and had been using the software program to enter professional conduct issues prior to the implementation of the PAP.

The limitations of the program including the span and timing of the project. Hospital 1 included a span of the entire hospital but Hospital 2 was limited to one service line. Hospital 2 had multiple incidents of incivility reported on the identified units but the nurse involved was employed by another unit that was not included in the program. This restricted the ability to provide coaching to the nurse involved because they had not been introduced to the program.

Additionally, the timing of the program was a limiting factor. The health system introduced a significant quality program during the implementation of the PAP. Competing for resources, time for staff education and manager stress required plan variation for the PAP. Additionally, a pre-intervention survey, a 45 day survey and post 90 day survey was completed during the PAP. Three surveys being administered during the four month period caused confusion within the staff. Multiple staff reported that they could not recall which survey's they completed and others reported survey fatigue.

Project Benefits

The benefits of the PAP included increased autonomy and shared governance. The PAP allowed for nurses perpetrating uncivil behaviors to receive coaching from a peer versus corrective action from leaders. This provided the alleged nurse the ability to self-reflect on the

incident and behaviors exhibited and make alterations in their behaviors without the embarrassment of formal discipline. The program, additionally, provided the coaches with additional skills and knowledge of uncivil behaviors and tactics to intervene. The coaches will be able to utilize these skills not only with their peer nurses but for their own self-growth and interactions with other disciplines.

Recommendations for Practice

The PAP has shown to increase awareness of incivility and improve reporting of uncivil acts within nursing. Future recommendations include the expansion of the PAP across the health system and continue the evaluation with repeat CWCI surveys spread further apart.

Additionally, the project site can utilize other data points of civility such as results from the project sites' work culture index surveys. The PAP should be combined into the project sites' quality management system and capitalize on the institutions ingrained knowledge of using Lean methodology to solve problems. Data obtained from the PAP can be utilized to implement small tests of change in order to further develop the PAP and eradicate incivility within the project site.

The outcomes of the PAP and this project should be distributed to all leaders including the executive team at the health system. Additionally, the outcomes should be distributed to the coaches and the front line staff. Lastly, the knowledge gained from the PAP should be distributed to the nursing profession through publication, poster and podium presentations.

Final Summary

Incivility within the nursing profession is a global problem that inhibits nurses for providing optimal care to their patients. Incivility can contribute to medication errors, negative patient outcomes and stress to the nurse that can result in lost work time. Incivility has been linked to nursing turnover and negatively effects organizational effectiveness. The PAP can

assist organizations in combating the effects of incivility. A PAP increases awareness of incivility, sets the standard for acceptable behaviors and allows for nurses to self-regulate their workplace conduct.

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Appendix A

Clark Workplace Civility Index



Clark Workplace Civility Index[©]

SOURCE: Clark, C.M. (2017). *Creating and sustaining civility in nursing education*, 2nd ed, Indianapolis, IN: Sigma Theta Tau International Publishing.

The Clark Workplace Civility Index[©] is copyrighted material and should not be distributed or reproduced in any form without expressed written permission from Dr. Cynthia Clark or the publisher.

Completing the Clark Workplace Civility Index: Carefully consider the behaviors below. Respond as truthfully and as candidly as possible by answering 1) never, 2) rarely, 3) sometimes, 4) usually, or 5) always regarding the perceived frequency of each behavior. Circle a response for each behavior, and then add up the number of 1-5 responses to determine the overall civility score. Scores range from 20-100.

Ask yourself, how often do I:

(1) Never (2) Rarely (3) Sometimes (4) Usually (5) Always

1. Assume goodwill and think the best of others	1	2	3	4	5
2. Include and welcome new and current colleagues	1	2	3	4	5
3. Communicate respectfully (by e-mail, telephone, face-to-face) and really listen—	1	2	3	4	5
4. Avoid gossip and spreading rumors	1	2	3	4	5
5. Keep confidences and respect others' privacy	1	2	3	4	5
6. Encourage, support, and mentor others	1	2	3	4	5
7. Avoid abusing my position or authority	1	2	3	4	5
8. Use respectful language (no racial, ethnic, sexual, age, or religiously biased terms)	1	2	3	4	5
9. Attend meetings, arrive on time, participate, volunteer, and do my share	1	2	3	4	5
10. Avoid distracting others (misusing media, side conversations) during meetings	1	2	3	4	5
11. Avoid taking credit for another individual's or team's contributions	1	2	3	4	5
12. Acknowledge others and praise their work/contributions	1	2	3	4	5
13. Take personal responsibility and stand accountable for my actions	1	2	3	4	5
14. Speak directly to the person with whom I have an issue	1	2	3	4	5
15. Share pertinent or important information with others	1	2	3	4	5
16. Uphold the vision, mission, and values of my organization	1	2	3	4	5
17. Seek and encourage constructive feedback from others	1	2	3	4	5
18. Demonstrate approachability, flexibility, and openness to other points of view	1	2	3	4	5
19. Bring my 'A' Game and a strong work ethic to my workplace	1	2	3	4	5
20. Apologize and mean it when the situation calls for it	1	2	3	4	5

Scoring the Civility Index: Add up the number of 1-5 responses to determine your 'civility' score

90-100—Very civil

80-89—Civil

70-79—Moderately civil

60-69—Minimally civil

50-59—Uncivil

Less than 50—Very uncivil

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Appendix B

Copyright Use Approval

CC [Redacted] on

1 | Thu

Re: Request for use of Civility tool

You replied to this message on 7/19/2018 11:35 AM.

Clark Workplace Civility Index©.pdf
466 KB

Dear Roy, thank you for your interest in my work and for your civility pursuits. As requested, I have attached the Clark Workplace Civility Index©. Because the index is licensed and copyrighted, it requires my expressed written permission for use (provided by virtue of this email) and with full citation/referencing (contained on the attached). If you distribute the index in hard copy, please be sure to collect all materials in order to protect the copyright. I wish you well with your doctoral studies and your civility endeavors.

Warm regards,
Dr. Clark



Greetings Roy, yes--please feel free to use the index in the way you suggest --best wishes with your project.



On Fri, Jul 20, 2018 at 9:26 AM, Roy Hudson [Redacted]

Thank you for getting back to me. My project is working with staff nurses utilizing peer accountability program in attempts to improve civility especially among teams. In the Clark Workplace Civility Index states "Ask yourself, how do often do I..." then it lists the questions. The revised has "OR Ask yourself, how often do my co-workers [including myself]..." I was hoping to ask the question the second way in order to have themselves think about their own behavior as well as their co-workers. I am trying to improve accountability for behavior in ourselves but additionally, with our peers.

Appendix C

Evidence Matrix

Article (APA Citation)	Level of Evidence (I to VII)	Data/Evidence Findings	Conclusion	Use of Evidence in EBP Project Plan (Include your evaluation, strengths/limitations, and relevance)
Embree, J. L., Bruner, D. A., & White, A. (2013). Raising the level of awareness of nurse-to-nurse lateral violence in a critical access hospital. <i>Nursing research and practice</i> , 2013.	Level VI	Utilized education and cognitive rehearsal to determine perceived extent and awareness of nurse to nurse lateral violence. Awareness increased but no statistical incidence was noted in pre-post intervention survey on perceived extent.	Cognitive rehearsal can be effective in bringing awareness and personal identification to identified situation or problem	Utilize cognitive rehearsal in training of peer messengers. Training of peer messengers includes simulation training. Cognitive rehearsal within the simulation can provide realistic situations to better prepare the peer messengers for their responsibilities.
Pichert, J. W., Moore, I. N., Karrass, J., Jay, J. S., Westlake, M. W., Catron, T. F., & Hickson, G. B. (2013). An intervention model that promotes accountability: peer messengers and patient/family complaints. <i>The Joint Commission Journal on Quality and Patient Safety</i> , 39(10), 435-AP8.	Level VI	Utilized peer messengers to promote accountability for providers who received patient/family complaints. 97% of providers with complaints received peer feedback. 64% percent of physicians showed improvement in risk scores	Peer messengers were effective in changing behaviors of 64 % of providers given feedback	Utilize peer messengers as a strategy in the promotion of accountability program for nursing to decrease incivility within nursing.
Webb, L. E., Dmochowski, R. R., Moore, I. N.,	Level VI	Utilized accountability program that	Accountability program utilizing peer messengers	Utilize concepts to translate into accountability program for nursing.

<p>Pichert, J. W., Catron, T. F., Troyer, M., . . .Hickson, G. B. (2016). Using coworker observations to promote accountability for disrespectful and unsafe behaviors by physicians and advanced practice professionals. <i>The Joint Commission Journal on Quality and Patient Safety</i>, 42(4),149, AP1-161, AP3. Doi:10.1016/S1553-7250(16)42019-2</p>		<p>included peer messengers to address uncivil behaviors of providers (physicians and advanced practice providers). 71% of providers that had peer intervention had no further incidents at one year follow-up period.</p>	<p>were effective in changing behaviors in 71% of recipients of peer coaching</p>	
<p>Pichert, J. W., Johns, J. A., & Hickson, G. B. (2011). Professionalism in Level support of pediatric cardiothoracic surgery: A case of a bright young surgeon. <i>Progress in Pediatric Cardiology</i>, 32(2), 89-96.</p>	<p>Level VII</p>	<p>Case study showing analysis of patient complaints of 41 pediatric cardiac surgeons and implications.</p>	<p>Utilizing accountability model to address behaviors of pediatric cardiothoracic surgeons.</p>	<p>Will utilize concepts of accountability model in development of program for nursing.</p>
<p>Reiter III, C. E., Pichert, J. W., & Hickson, G. B. (2012). Addressing behavior and performance issues that threaten quality and patient safety: What your attorneys want you to know. <i>Progress in Pediatric Cardiology</i>, 33(1), 37-45.</p>	<p>Level VII</p>	<p>Composite of descriptive statistics of physician executives indicating that behaviors threaten quality. 98% of organizational executives reported behavioral problems with</p>	<p>Utilizes 5 key concepts for intervention: 1. Promoting justice; 2. Seeking freedom from conflicts of interest; 3. System failures v/s individual performance problems; 4. Administer feedback or discipline in a manner to promote</p>	<p>Utilize concepts in nursing accountability program.</p>

		physicians and nurses.	insight; 5. First aim to restore colleague to team-oriented professionalism; deal fairly with those unwilling to change	
Clark, C. M., Sattler, V. P., & Barbosa-Leiker, C. (2018). Development and psychometric testing of the workplace civility index: A reliable tool for measuring civility in the workplace. <i>The Journal of Continuing Education in Nursing, 49</i> (9), 400-406	Level VI	Validation and reliability study of CWCI tool utilizing 393 nursing faculty and practice-based nurses representing nurses in throughout the United States and Canada. CIWA determined reliable and valid tool as evidenced by >.30 factor analysis and Cronbach's alpha >.70 (.82).	Utilization of Clark's civility index scale, faculty to faculty effective in measure of civility.	Utilize Clark's Workplace Civility Index to measure effectiveness of program.

Note. Evidence matrix of literature research that supports the intervention of peer mentoring to decrease incivility.

Appendix D
Organizational Support



July 11, 2018

To Whom It May Concern:

We at have reviewed Roy Hudson's DNP Project title "Peer Accountability Program to Combat Nurse Incivility". Mr. Hudson has organizational support and approval to conduct her project within our institution. We understand that for Mr. Hudson to achieve completion of the DNP program dissemination of the project will be required by the University, which will include a public presentation related to the project and a manuscript submission will be encouraged. Our organization has deemed this project as quality improvement initiative and requiring institutional IRB review.

Thank you,



Chief Nursing and Patient Care Services Officer

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Appendix E

Institutional Review Board Determination

INSTITUTIONAL REVIEW BOARD DECLARATION OF ACTIVITY NOT MEETING THE DEFINITION OF RESEARCH

The IRB has determined that the following activity does not meet the definition of research as described in 45 CFR 46.102(d), 21 CFR 50.3(c) and 21 CFR 56.10(c) and satisfies the Privacy Rule as described in 45 CFR 164.514.

Protocol ID: Pro00100985

Reference ID: 284138

Protocol Title: Development and implementation of a peer accountability program

Principal Investigator: Deborah Allen

This IRB declaration is in effect from September 26, 2018 and does not expire. However, please be advised that any change to the proposed research will require re-review by the IRB.



Federalwide Assurance No: FWA 00009025

Appendix F

ECU Institutional Review Board Determination



Projects Requiring IRB Review vs. Quality Improvement, Quality Assessment, or Quality Assurance: A Worksheet to Assist in Determining When IRB Review is Required

Use this worksheet to help determine whether a proposed activity or project involving humans or their individually identifiable information is considered research needing IRB review or a quality related activity that would not require IRB approval.

	True	False
The PRIMARY purpose of the proposed activity or project is to learn about or learn from existing care to IMPROVE what is done here at the local institution with regard to patient outcomes, efficiency, cost, patient/staff satisfaction, etc.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The activity or project would be carried out even if there was <u>no</u> possibility of publication in a journal or presentation at an academic meeting. (**Please note that answering "True" to this statement does not preclude publication of a quality activity.)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The activity or project falls under well-accepted care practices/guidelines.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
The activity or project involves no more than minimal risk procedures meaning the probability and magnitude of harm or discomfort anticipated are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.	<input checked="" type="checkbox"/>	<input type="checkbox"/>

If any of the above answers is "False", a submission for IRB approval is most likely needed. If all the above answers are "True", then it is very likely that IRB approval is not required. Please contact the Office of Research Integrity and Compliance (ORIC) with any questions at 252-744-2914 or oric@ecu.edu. If you would like the ORIC to verify that an activity or project is not human subject research, please provide this form along with a summary of your activity to the ORIC at oric@ecu.edu and the following page will be completed and returned to you for your records.

Project title: PEER ACCOUNTABILITY PROGRAM TO COMBAT NURSE INEQUITY

Summary of activity including information about project aims/objectives, methods for carrying out the project and information about data to be collected (you may instead attach documentation describing your proposal):

See attached documents.

*** The ORIC will contact you if any further information is needed to make this determination. Please note that if the ORIC determines the activity is not human subject research, then any presentation, publication, etc. should not refer to the activity as "human subject research", "comport research" or "expedited research".

ORIC Determination:

- Not Human Research:** The ORIC has determined that based on the description of the project, approval by the IRB is not necessary. Any changes or modifications to this project may be discussed with the ORIC at that time to ensure those changes do not elevate the project to human research that would need IRB approval.
- Human Research:** This project requires review by the IRB prior to initiation. An application in the electronic IRB submission system should be submitted.

ORIC Staff Signature: Date: 11-1-18

Appendix G

Demographics Survey

Directions: Fill in the blank or bubble that represents the most accurate description of your individual professional profile. Your responses will be kept confidential.

1. Are you currently licensed as an:
 - Registered Nurse
 - Licensed Practical Nurse
 - Other: _____

2. What is your current age as of 2018?
_____ years

3. What is your gender?
 - Male
 - Female

4. How many years have you worked as a nurse as of 2018?
_____ years

5. How many years have you worked at project site?
_____ years

Appendix H

CWCI Measurement

	Unit	Pre Score	Pre Civility Measurement	45 day Post	Civility Measurement	90 day post	Civility Measurement
Hospital 1	1	86.43	Civil	87.72	Civil	83.68	Civil
	2	86.11	Civil	89.35	Civil	87.04	Civil
	3	91.94	Very Civil	91.25	Very Civil	92	Very Civil
	4	87.33	Civil	89.85	Civil	91.56	Very Civil
	5	88.11	Civil	89	Civil	87.17	Civil
	6	82.31	Civil	82.35	Civil	81.93	Civil
	7	91.08	Very Civil	93.1	Very Civil	91.5	Very Civil
	8	87.91	Civil	86.06	Civil	88.32	Civil
	9	83.38	Civil	81.56	Civil	81.4	Civil
	10	78.81	Mod. Civil	75.13	Mod. Civil	76.2	Mod. Civil
	11	91.71	Very Civil	83.07	Civil	89.5	Civil
	12	83.98	Civil	85.32	Civil	83.08	Civil
	13	86.41	Civil	85.52	Civil	87.04	Civil
	14	89.21	Civil	91.06	Very Civil	92.13	Very Civil
	Total	86.77	Civil	86.45	Civil	86.61	Civil
Hospital 2	A	81.9	Civil	79.47	Mod. Civil	79.49	Mod. Civil
	B	77.3	Mod. Civil	77.03	Mod. Civil	76.89	Mod. Civil
	C	90.47	Very Civil	89.38	Civil	90.2	Very Civil
	D	90.5	Very Civil	93.05	Very Civil	92.64	Very Civil
	E	88.19	Civil	85.69	Civil	86.07	Civil
	F	89.24	Civil	86.92	Civil	83.78	Civil
	G	90.17	Very Civil	90.16	Very Civil	91.56	Very Civil
	H	89.52	Civil	86.57	Civil	80.59	Civil
	I	83.49	Civil	83.4	Civil	85.44	Civil
	J	83.43	Civil	84.19	Civil	85.39	Civil
	K	88.11	Civil	88	Civil	93.18	Very Civil
	L	85.87	Civil	86.35	Civil	88	Civil
	Total	86.52	Civil	85.85	Civil	86.10	Civil
Program (Combined Hospital's Average)		85.41	Civil	85.27	Civil	85.19	Civil

Note. Mod. Civil = moderately civil; red denotes a negative civility measurement change

throughout intervention period; green denotes a positive civility measurement change through

intervention period; program total is average scores from all intervention units and facilities.

