8-2017

The Impact of Incivility on Hospital-Based Student Nurses, Retention as Licensed Registered Nurses and Their Post-Graduation Employment Choices

Melissa Di Natale
St. John Fisher College, melissa.dinatale@yahoo.com

The Impact of Incivility on Hospital-Based Student Nurses, Retention as Licensed Registered Nurses and Their Post-Graduation Employment Choices

Abstract

The purpose of this qualitative, phenomenological study was to explore the perceived experiences of incivility, and the impact of those incidences, which occurred during the clinical training portion of the participants' nursing education. Six newly graduated nurses were identified through referrals from nursing faculty and nursing colleagues. Research was conducted through the use of qualitative research methodology, which included in-depth written feedback, one-to-one interviews, and a focus group. Rich descriptive data was captured and coded to answer the posed research questions. Nursing graduates reported that widespread uncivil behavior existed throughout their clinical nursing training. Three major findings include: recent graduates from hospital-based nursing programs clearly defined incivility and identified several uncivil behaviors experienced within the clinical environment as nursing students; recently graduated nurses described many experiences with difficult individuals identified as instructors, cover nurses, staff nurses, aides, and doctors as the perpetrators of incivility in the clinical setting; and exposure to incivility in the clinical environment had a strong impact on retention and employment choices post-graduation. These findings pinpoint an urgent need for change on all levels of the nursing profession. This research yielded recommendations that will enhance the quality of nursing education, address the nursing shortage, and return the nursing culture to its intended purpose: incorporating the ideals of caring and wellbeing to those the profession serves, from education to the delivery of quality health care.

Document Type
Dissertation

Degree Name
Doctor of Education (EdD)

Department
Executive Leadership

First Supervisor
Cynthia P. Smith

Subject Categories
Education

The Impact of Incivility on Hospital-Based Student Nurses, Retention as Licensed

Registered Nurses and Their Post-Graduation Employment Choices

By

Melissa Di Natale

Submitted in partial fulfillment

of the requirements for the degree

Ed.D. in Executive Leadership

Supervised by

Cynthia P. Smith, Ed.D., RT (R)

Committee Member

Christine Walsh, Ed.D.

Ralph C. Wilson, Jr. School of Education

St. John Fisher College

August 2017

Dedication

I dedicate this dissertation to my husband, Mike Di Natale, who has been with me every step of the way, providing support, encouragement, and love. To my sons, Joshua and Jordan, and to my daughter, Danielle, I owe my gratitude and so much more. To my grandchildren, Mollie Lynclare, Grayson Joshua, and Alexa Rose who I love more than life itself, I hope you always follow your dreams. And last, to my parents, my late biological mom and dad for bringing me into this world and providing the start of my love for education, and to my incredible foster parents, Linda and Tim, who always supported my dreams and aspirations, reminding me I could be anything I wanted to be. To my late mother-in-law, also, who saw me through this rigorous program cheering me on the whole way. The support from everyone is what got me through.

I also dedicate this to the wonderful faculty at St. John Fisher College. To Dr. Michael Robinson, who encouraged me to begin this journey. To my committee chair, Dr. Cynthia Smith and my committee member, Dr. Christine Walsh, you both have been unbelievably patient and supportive, especially through difficult times. Your valuable insight and encouragement kept me moving forward. I hope I have made you proud.

Finally, I would like to thank my cohort members who have become my extended family. A very special thanks to team Seeds: Nancy, Tim, Ray, Kim, and Tricia who were always there with their support, encouragement, and laughter. I am a better person having known you. I wish you all well.

Biographical Sketch

Melissa Di Natale is currently an Assistant Professor at Pomeroy College of Nursing in Syracuse, NY. Mrs. Di Natale entered the healthcare field as a certified nursing assistant in 1990. She attended and graduated from OCM BOCES in 1992 as a licensed practical nurse. Ms. Di Natale attended and graduated with an Associate Degree in Nursing in 2006 from Crouse School of Nursing in Syracuse, NY. She also attended and graduated from Keuka College with a Bachelor of Science degree in Nursing (BSN) in 2013 and her Master of Science degree in Nursing (MSN) in 2015. Mrs. Di Natale began her doctoral studies in the spring of 2015 at St. John Fisher College in the Ed.D. Program in Executive Leadership. Mrs. Di Natale pursued her research on the impact of incivility on hospital-based nursing students, retention as licensed registered nurses, and their post-graduation employment choice under the direction of Cynthia Smith, Ed.D., RT (R) and Christine Walsh, Ed.D. The Education Doctorate in Executive Leadership was successfully defended and awarded in 2017. For further information about this dissertation, she can be reached at Melissa.dinatale@yahoo.com.

Abstract

The purpose of this qualitative, phenomenological study was to explore the perceived experiences of incivility, and the impact of those incidences, which occurred during the clinical training portion of the participants' nursing education. Six newly graduated nurses were identified through referrals from nursing faculty and nursing colleagues. Research was conducted through the use of qualitative research methodology, which included in-depth written feedback, one-to-one interviews, and a focus group. Rich descriptive data was captured and coded to answer the posed research questions. Nursing graduates reported that widespread uncivil behavior existed throughout their clinical nursing training. Three major findings include: recent graduates from hospital-based nursing programs clearly defined incivility and identified several uncivil behaviors experienced within the clinical environment as nursing students; recently graduated nurses described many experiences with difficult individuals identified as instructors, cover nurses, staff nurses, aides, and doctors as the perpetrators of incivility in the clinical setting; and exposure to incivility in the clinical environment had a strong impact on retention and employment choices post-graduation. These findings pinpoint an urgent need for change on all levels of the nursing profession. This research yielded recommendations that will enhance the quality of nursing education, address the nursing shortage, and return the nursing culture to its intended purpose: incorporating the ideals of caring and wellbeing to those the profession serves, from education to the delivery of quality health care.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction

The recruitment and retention of registered nurses are among the greatest
challenges facing the health care industry. Organizations are budgeting upwards of one
million dollars annually for recruitment and orientation of new nurses. Jones calculated
that the costs of a single nurse turnover in the United States ranged from $62,100 to
$88,000 per nurse (2005, 2008). This financial burden cannot be sustained. Despite
recruitment and retention's best efforts, a nursing shortage currently exists in the United
States and is expected to escalate (Hogh, Hoel, & Carneiro, 2011). The U.S. Bureau of
Labor Statistics (2011) predicts the demand for registered nurses is estimated to grow by
a 60% margin between 2008 and 2018. However, by the year 2020, the shortage of nurses
in the United States will reach 340,000 (Auerbach, Buerhaus, & Staiger, 2007). Even
though the demand for nurses is anticipated to increase, the number of new nurses is not
expected to offset the projected deficit. Further intensifying the problem is the
phenomenon of the aging baby boomer population and the projected increase in demand
for acute and chronic medical services for this group. The number of retiring academic
and clinical nurses is currently growing and will continue to climb simultaneously as this
aging population will also be in need of quality health care. For these reasons, in the
United States and abroad, the nursing shortage is recognized as a global epidemic (Chan,
Tam, Lung, Wong, & Chou, 2013).

Exacerbating the existing deficit of qualified academic and clinical nurses are
other factors, such as the complexity of the work environment and culture, commitment,

work demands, and social support of the nursing profession (Anthony & Yastik, 2011; Clark, 2013; Del Prato, 2013). These other factors can create challenges within the work environment that include tension among coworkers. As the workplace stressors rise, the likelihood of incivility also increases (Oyeleye, Hanson, O'Connor, & Dunn, 2013).

Incivility Defined

For the purpose of this study, the term *incivility* was defined as any action that degrades a person's dignity that causes the loss of self-respect, is injurious, and is caused by a perpetrator at any time in any environment, including academia and healthcare settings (Clark, 2013). Aggression, bullying, horizontal violence, lateral violence, and vertical violence are terms related to and are examples of incivility. Additionally, Lachman defined incivility as "the low-intensity disruptive behavior with indistinct intent to harm the target in violation of workplace norms for mutual respect" (2015, p. 40). Characteristics of incivility include discourteous, rude behaviors, and lack of regard for others. Various acts of incivility may also escalate into absenteeism, decreased productivity, a manifestation of illnesses, high turnover, increased accidents on the job, violence, burnout, stress, and low morale (Wilson, Diedrich, Phelps, & Choi, 2011; Marlow, 2013).

Problem Statement

While much of the research on the topic of incivility has been conducted among licensed professional nurses, little research has been documented on the possible impact of incivility on nursing students who encounter incivility during foundational training experiences. Training and supervision occur alongside licensed professional nurses who function as preceptors, mentors, and evaluators of these learners. Thus, nursing students

are subjected to a myriad of temperaments, skills, and training experiences, often dictated by cultural and generational variances. Throughout the learning continuum, incivility can be brought about by a number of psychological, social, and demographic factors. Due to the inequitable paradigm, student nurses may be particularly vulnerable to incivility and fearful of retribution as a perceived whistleblower (D'Ambra & Andrews, 2014). Therefore, for the purpose of this study, graduate nurses with less than 12 months experience, who were no longer fearful of retribution, were selected for this study. Additionally, the goal of this study was to gain additional understanding of how incivility experienced during clinical training may be contributing to learner retention and post-graduation employment considerations.

Theoretical Rationale

For the purpose of this study, three theories were examined to support the underpinnings of established professional nursing behavior standards. These three theories are the social exchange theory, peace and power theory, and the theory of caring.

Social exchange theory. Social exchange theory was originated by George Homans in 1961 for use in the economic and physiological arenas. This theory can be applied to other professions when interpersonal exchanges are viewed from a cost-benefit perspective, except when social investments such as respect, friendship, honor, and caring are alternative to monetary gain (Xerri, 2013).

The social exchange theory is a model for interpreting society as a series of interactions between people that are based on estimates of rewards and punishments. An example of the social exchange theory can be seen in the interaction of a student nurse asking a nurse for help. Simply, if the nurse says "yes," the student nurse has gained a

perceived positive experience, or reward, and is likely to repeat the interaction. Conversely, if the student nurse asks a nurse for assistance and is denied, then the student nurse may perceive this interaction as punishment. The outcome will likely cause the student nurse not to ask for future assistance from that specific nurse.

Peace and power theory. The peace and power model was originally developed by Wheeler and Chinn in 1984, from which the emancipatory philosophy and the theory of peace and power emerged (Chinn & Falk-Rafael, 2015). This theory was specifically designed to build meaningful relationships and effective ways of helping people work together. This process was developed as a means of creating healthy group interactions by reducing stress and distress created by hostile conflict and toxic work environments.

The theoretical framework of peace and power is based on several assumptions about the ways in which power is exercised differently within private and public spheres. Power is defined as the energy from which human action and interaction arise (Chinn & Falk-Rafael, 2015). Power over power, which is predominantly practiced in public spheres, includes the use of rules, hierarchy, command results, and expediency. Powers that are predominantly derived from private spheres are peace powers including the use of sharing, nurturing, integration of all points of view, distribution of all resources, and diversity.

These assumptions are based on generally-practiced cultural norms of Western society and in all cultures where a gender disparity exists. These tenets are the foundation upon which the theoretical reasoning is based: (a) all human relationships involve the use of power; (b) there is typically one person or a group of people who have relative privilege or power in any group structure and, therefore, are able to exert their will or

their values on those with less power; (c) people seek space in life where they are relatively free from competition and power imbalances and where cooperation and peace prevails; (d) in typical Western societies, the public realm tends to be associated with male power and the ability to exercise one's will, which is strong, powerful, and savvy; (e) people recognize the value of cooperative ways of working together; and (f) conflict is inevitable in all human relationships.

Conflict is viewed and acted upon very differently from the perspective of each type of power. From the power-over-power perspective, conflict is seen as adversarial, where one person or one group is ultimately the winner, and the other is the loser. In contrast, from the peace-over-power perspective, conflict is viewed as an opportunity for growth, and it focuses on ways to achieve an outcome that best expresses shared values (Chinn & Falk-Rafael, 2015).

The outcome of a peace and power group process is a movement that is shifting in the direction of peace. The interactions of the group are constantly being shaped toward the sub-concepts of PEACE, which are: (a) *Praxis* is the synchronous reflection and action to transform the world (Freire, 1970); (b) *Empowerment* is the growth of personal ability to enact one's will in the context of love and respect for others; (c) *Awareness* is a growing knowledge of self and others; (d) *Cooperation* is the commitment to group solidarity and integrity; and (e) *Evolvement* is the commitment to deliberate growth and change (Chinn, 2013).

Peace and power are grounded in the emancipatory principles developed by Paulo Freire (1970), who is widely recognized as the founder of critical approaches in education. The theory of peace and power makes an explicit connection to nursing's core

values of caring and high-level wellness. The process in practice brings these values of caring into action.

Theory of caring. Watson's (1979) theory of caring defines the attribute of caring as an interpersonal process that occurs between two people and involves both the provider of the care and the receiver of the care. This process is mutual, inter-subjective, and reciprocal (Watson, 1979, 2005, 2012). Depending on the nature of the relationship, Watson (1979) suggested that the caring moment transcends the relationship for better or for worse. Within the practice of nursing, the interpersonal characteristics of caring is most essential attribute in all relationships. Caring tends to promote peaceful social exchange. Therefore, nurses must cultivate sensitivity to others to promote peer-to-peer relationships which may promote healthier and more productive professional work environments. Whereas the primary purpose of nursing is to support patients' needs, these positive work environments result in better outcomes for patients and nurses (Laschinger, 2014). Conversely, Watson (2012) indicated that uncivil behaviors are incompatible with caring. Without a positive, caring work environment in a hospital setting, patient care and safety may be compromised.

Watson's (1979) theory of caring is the central construct of nursing ethical standards that are foundational to nursing curriculum theory and practice (Lachman, 2012). While the theory of caring focuses on the relationship between the nurse and the patient, social exchange theory addresses the interaction among undefined relationships (Homans, 1961). Additionally, the theory of peace and power considers interactions within a hierarchical relationship (Wheeler & Chin, 1984). The interaction of these three theories is demonstrated in Figure 1.1 through the Venn diagram. The combined center of

the three theories is highlighted within the figure to show the overlap of the theories and to display the theoretical underpinnings of this study.

The theory of caring is the foundational pivotal construct in the nursing profession which balances both social exchange theory and the peace and power theory of human interpersonal transactions. In an ideal, healthy clinical setting, civil encounters (i.e. positive social exchanges) lead to a peaceful working environment and enhance the caring component of the working relationship. On the other hand, incivility creates a negative social exchange leading to power struggles that compromise or destroy the caring component of the working relationship.
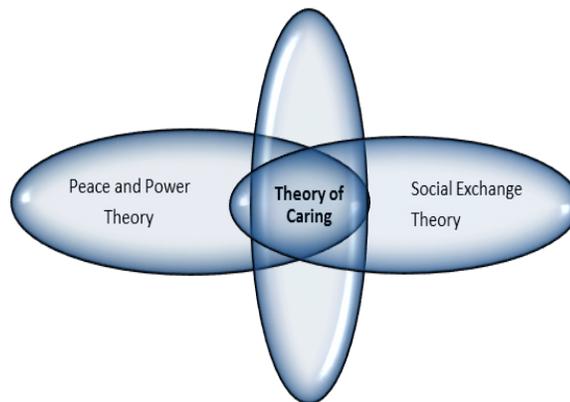
Figure 1.1. The relationship among all theories in the theoretical foundation.

Statement of Purpose

The purpose of this study is to explore an existing gap in the literature regarding how incivility experienced during clinical training impacts student nurses, retention of graduate nurses as employees, and post-graduation employment choices.

This research study will guide hospital-based nursing school's policy and curriculum consideration. Therefore, for the purpose of this study, graduate nurses with less than 12 months experience, who were no longer fearful of retribution, shared experiences about their perceived exposure to incivility during clinical education as a nursing student. This study will add to the body of knowledge by gaining additional understanding of how incivility experienced during clinical training contributes to participants' post-graduation employment considerations from recent graduates who were no longer fearful of retribution. This research study will guide hospital-based nursing school's policy and curriculum consideration.

Research Questions

Not every encounter in the health care industry is favorable. Incivility in the nursing profession has been described as acts of violence, bullying, aggression, and horizontal or lateral violence. Nursing students have reported feelings of being offended when witnessing any form of incivility (Clark, 2011). The student nurse may feel compelled to act but may have little or no power to respond in the hierarchy of the institution. Research supports the adage that the bullied will bully others (DeCamp & Newby, 2015).

Nursing students enter the profession with the intention of extending the attributes of collegiality, caring, and compassion, which are the defining characteristics of the nursing profession. However, conflicting feelings created by power inequities and incivility may propel these students to explore other career-based programs, further perpetuating nursing shortages. Should the student persist to graduation, the newly graduated nurse may determine that the idea of post-graduate employment at the training

site may be repugnant, furthering both the shortage at the training facility. As an outcome, poor return on the educational site's investment may be realized.

The following research questions will guide this study:

1. What behaviors in the clinical environment did associate degree nurses perceive as incivility during their nursing school clinical experience?

2. How do new graduate nurses describe their experiences with incivility when they were nursing students?

3. To what extent did exposure to incivility in the clinical environment impact employment choices post-graduation?

Potential Significance of the Study

The majority of research documented on incivility has been completed with licensed nursing personnel. A gap in the empirical research exists as to the identification and understanding of the experiences of nursing students who had encountered incivility in the clinical environment. The potential significance of this study resided in its contributions to the body of existing knowledge of how incivility experiences during the clinical training of student nurses impact persistence and retention of graduates. Both the nursing profession and employment opportunities at the host hospital-based institutions are at risk for worsening nursing shortages if the problem of incivility is not addressed.

The insight gained from this research identified causes and sources of uncivil behaviors which may provoke action to eliminate incivility on all levels throughout the clinical training experience. Improvements in nurse clinical training environments may increase persistence and employment of nurse graduate candidates in the hospital-based institutions (Ward-Smith, 2011).

Definitions of Terms

Aggression – behavior that is intended to harm another individual who does not wish to be harmed (Baron & Richardson, 1994).

Bullying – an "offensive, abusive, intimidating, malicious or insulting behavior, or abuse of power conducted by an individual or group against others, which makes the recipient feel upset, threatened, humiliated or vulnerable, which undermines their self-confidence, and which may cause them to suffer stress. Bullying is behavior which is generally persistent, systematic and ongoing" (Task Force on the Prevention of Workplace Bullying, 2001, p. 10).

Civility – an authentic respect for others that requires time, presence, the will to engage in genuine discourse, and intention to seek common ground (Clark, 2013).

Horizontal Violence – a hostile, aggressive, and harmful behavior toward a coworker via attitudes, actions, words and/or behaviors (Thobaben, 2007).

Incivility – any action that degrades a person's dignity, causing loss of self-respect, is injurious, and occurs in any setting at any time from any person(s) (Clark, 2013).

Lateral Violence – a deliberate and harmful behavior demonstrated in the workplace by one employee toward another (Christie & Jones, 2014).

Mentor – an experienced employee who provides support and guidance to enhance the success and career development of less-experienced employees (Roberts, 2000).

Novice Nurse – a nurse with little or no experience in the situations in which they are expected to perform; often lacking confidence to demonstrate safe practice and requires continual verbal and physical cues (Benner, 1984).

Nurse Preceptor – an experienced nurse who works with a novice/student nurse in a specific role that facilitates and expands the clinical education of the novice/student by sharing experiences in patient care, technology, and other subject matter, with the intent to develop novice/student nurses' clinical reasoning and critical thinking skills. (Billings & Halstead, 2012).

Orientee – any person who is new to a nursing unit or department; requiring an orientation or specific training to gain knowledge of the operation and functions of the assigned environment (Di Leonardi & Ryan, 2006).

Orientor – one who assists a newcomer in adjusting to a social situation or to the local routine (Merriam-Webster, 2017)

Resonant Leadership – A relationally-focused leadership style associated with positive work environments which promotes employee engagement and results in greater work satisfaction and productivity (Uhl-Bien, 2006).

Vertical Violence – any act of violence, such as yelling, snide comments, withholding pertinent information, and rude, ignoring, and humiliating behaviors, which occur between two or more persons on different levels of the hierarchical system and that prohibit professional performance or satisfaction in the work environment (Cantey, 2013).

Chapter Summary

Chapter 1 provided an overview of the problem of incivility among nurses, explored the theoretical construct, and presented a framework to guide this study. Incivility in health care has been related to diminished health status of employees, care-giver burnout, poor patient outcomes, and lost productivity (Lewis & Malecha, 2011). Additionally, the purpose of this study is to explore an existing gap in the literature regarding how incivility experienced during clinical training impacts student nurses, retention of graduate nurses as employees, and post-graduation employment choices

Chapter 2 explores the review of the empirical literature. Following the review of the literature, research design and methodology are discussed in Chapter 3. The results of the research are disseminated in Chapter 4. Chapter 5 provides a discussion of the findings and recommendations based on the analysis of the data collected.

Chapter 2: Review of the Literature

Introduction and Purpose

The historical underpinnings of the nursing profession, as well as the multi-level effects of incivility in the nursing profession, are the focus of this literature review. Seminal studies garnered from empirical research, insights into the causation of incivility, nurse-to-nurse and nurse-to-novice behaviors as well as the implications of incivility relating to patient care ratios and patient outcomes are discussed. The literature highlights the importance of understanding how incivility impacts the vibrancy of the nursing profession and the health care industry.

Evolution of the Nursing Profession

The discipline of nursing slowly evolved from the traditional role of women, apprenticeship, humanitarian aims, religious ideals, intuition, common sense, trial and error, theories, and research, as well as the multiple influences of medicine, technology, politics, war, economics, and feminism (Brooks & Kleine-Kracht, 1983; Gorenberg, 1983; Jacobs & Huether, 1978; Keller, 1979; Kidd & Morrison, 1988; Lynaugh & Fagin, 1988; Perry, 1985). Florence Nightingale (1820-1910) is known as the mother of modern nursing. Nightingale opened the first school of nursing in London in 1860. Similar to the Hippocratic Oath for physicians, Lystra Gretter represented her view of nursing by formulating the Nightingale Pledge for the Nursing Profession. At some point, most nursing students ascribe to and pledge the Nightingale oath, which attempts to connect the nursing professional historically to present-day practices. The pledge reads:

I solemnly pledge myself before God and in the presence of this assembly, to pass

my life in purity and to practice my profession faithfully. I will abstain from

whatever is deleterious and mischievous, and will not take or knowingly

administer any harmful drug. I will do all in my power to maintain and elevate the

standard of my profession, and will hold in confidence all personal matters

committed to my keeping and all family affairs coming to my knowledge in the

practice of my calling. With loyalty will I endeavor to aid the physician, in his

work, and devote myself to the welfare of those committed to my care. (American

Nurses Association [ANA], 2001)

In 1950, the American Nurses Association ascribed to standards and a code of

ethics that hold nurses accountable for various actions and behaviors. The American

Nurses Association established The Code for Professional Nurses with Interpretive

Statements, which has been amended and revised over the past 70 years, with the last

revision in 2015. In total, there are nine provisions that are expected to be upheld by all

nurses. Provision 1 states that the nurse, in all professional relationships, practices with

compassion and the recognition of human dignity and worth that is present in every

individual (ANA, 2015). Provision 1.5 addresses relationships with colleagues and reads:

The principle of respect extends to all those with whom the nurse interacts. The

nurse maintains relationships that are caring and compassionate with a

commitment to fair treatment of others and to conflict resolution. The nurse

serves and functions in many roles and within each of these roles the nurse treats

colleagues, employees, students, and assistants with dignity and respect. This

means that the nurse does not engage in actions that are based on prejudice or

harassment or threatening of others. The nurse also engages in the collaboration

with others to ensure the provision of quality health care services. (ANA, 2015)

The American Association of Colleges of Nurses (AACN) embraces a set of

guidelines, entitled the *AACN Standards for Healthy Work* (ANA, 2001). These

guidelines define incivility as refusal to work with students by faculty members, refusal

to help others by nurses, and making strict disciplinary action should incivility occur.

Incivility in nursing education is defined as "rude or disruptive behaviors which often

result in physiological or psychological distress for people involved and if left

unaddressed, may progress into a threatening situation" (Clark & Ahten, 2011, p. 9).

Simply stated, poor treatment on both sides of the desk, as it involves nurses, patients,

supervisors, and administrators, amounts to incivility. Nursing students are taught and

upheld to the same standards as those of professional nurses.

Nurse-to-nurse incivility. Several empirical research studies exist on the topic of

nurse-to-nurse incivility, which is also known as horizontal hostility. A study completed

by Wilson et al. (2011) concluded that the amount of horizontal hostility experienced by

registered nurses has a statistically significant correlation with intent to leave the job. A

survey sent to 499 registered nurses at a community-based hospital located in the

Southwest United States achieved a response rate of 26% from 130 participating nurses.

This was a retrospective cross-sectional design with a 28-item survey. The higher the

incidence of incivility, the more likely the nurses were to express intent to leave their

current positions. Survey results indicated that 40% of registered nurses responded that

they were definitely going to leave their current position or were considering leaving

their current position because of incivility. Since intent to leave has been demonstrated as

a predictor of those who actually do leave, the authors concluded that the community hospital could face an annual turnover cost ranging from $3.7 to nearly $5 million related to horizontal hostility.

Incivility not only affected the persons involved, but the behavior costs organizations in lost productivity. A study completed by Lewis and Malecha (2011) examined the impact of workplace incivility on staff nurses related to cost and productivity. The study used a nonexperimental, correlational, comparative, and predictive model design using a survey method, and it was completed in the state of Texas. The researchers obtained a mailing list from the State Board of Nursing from which 2,160 licensed registered nurses (RNs) were randomly selected. Although the initial response rate was only 8% ($n = 164$), utilizing a snowball approach to obtain a final sample, a total of 659 participants contributed to this study. The survey results found that 84.8% of the nurses had experienced workplace incivility in the last year. Of the responding nurses surveyed, 36.7% admitted to inciting workplace incivility within the past year. Staff nurses working in positive, less-toxic, healthier work environments were found to have lower incidences of workplace incivility. When comparing workplace incivility scores and hospital settings using an analysis-of-variance table, there were no significant differences in the workplace incivility scores of the direct-care nurses working in an academic medical center, community, or rural hospitals. This study also concluded that negative relationships indicate higher incidences of incivility, which in turn, lowered nursing productivity. This study is congruent with Laschinger, Wong, Cummings, and Grau (2014) who indicated that a supportive or healthy work environment is associated

with less incivility. Not only does workplace incivility exist at high rates, but incivility is also costly in terms of lost productivity (Hutton & Gates, 2008).

Hutton and Gates (2008) completed a study examining incivility experienced by direct health care staff in their workplace. Of the 850 employees who were asked to participate, 21% completed and returned the survey. Of the participants 145 were registered nurses, and the other 33 were nursing assistants. According to Hutton and Gates (2008), direct-care workers reported experiencing workplace incivility slightly above the response of *rarely occurs*. However, there was a statistically significant finding with the correlation matrix with incivility related to general environment, direct care staff, supervisor, physicians, and/or patients. Nursing assistants experienced higher levels of incivility than registered nurses. As reported, using the workplace incivility scores by source and job title, registered nurses totaled 49% and nursing assistants totaled 57% with workplace incivility scores.

Laschinger et al. (2014) also researched the value of a positive organizational culture in reducing workplace incivility. The purpose of study was to test a model linking positive leadership approach and workplace empowerment to workplace incivility, burnout, and, subsequently, job satisfaction. Names were provided by regulatory bodies' registry lists from nine participating provinces in Canada. From the list provided, 3,600 nurses, at 400 per province, were mailed surveys. Of the 3,600 surveyed, a total of 1,241 were returned, resulting in 35% response rate. Results of this study showed that, on average, nurses did not rate their immediate supervisors highly on their use of resonant leadership behaviors, which included a low rating of empowering conditions in their work environments. Resonant leadership is defined as relationally-focused leadership

styles associated with positive work environments that promote employee engagement and result in greater work satisfaction and productivity (Uhl-Bien, 2006). However, nurses self-reported exposure to incivility as being very low. Although the test of the original hypothesized model did not meet acceptable model fit requirements, the modification indices suggested a theoretically plausible direct path from resonant leadership to job satisfaction. Resonant leadership had a strong positive direct effect on workplace empowerment, which in turn had a negative effect on coworker incivility. Resonant leadership also had a significant effect on job satisfaction. Nurse leaders play a vital role ensuring a healthy work environment.

A mixed-methods study of 227 nurses, conducted by Walrafen, Brewer, and Mulvenons (2012), reported that the nurses either experienced or promoted horizontal violence, which is another term used to describe incivility. Verbal disrespect among co-workers was reported by 72% of the respondents who either witnessed or participated in uncivil action. Backstabbing was reported by 77%, and non-verbal innuendoes were reported by 72%. The area that was least reported was sabotage at 28%. The participants in the study described negative behaviors as mainly verbal, including aggressive yelling, demeaning remarks, and being dismissive (Walrafen et al., 2012).

Felblinger (2008) discussed the use of shame tactics when victimizing nurses and this, in turn, created a toxic work environment. The implications are that "concurrent eradication" (p. 237) of incivility may control the shame response, providing a way to minimize responses to being victimized, thus providing safe patient care. Felblinger found that when a nurse does not recognize subtle or overt aggression, self-blaming develops. In turn, those targeted as recipients of abuse behavior appeared to lose interest

and had less enjoyment in their work. In addition, this lack of interest and enjoyment could lead to subpar safety practices. Felblinger (2008) provided an algorithm of victimization and revictimization in which incivility and bullying were the beginning of recipient victimization, leading to shame, anger, self-blame, and self-attack, perpetuating a cycle that leads to a hostile workplace.

In 2010, a Canadian study conducted by Orre et al. examined whether incivility at work exacerbated the relationship between stressors and strain for hospital workers. The study was two-group quasi experiment (intervention vs. waiting-list comparison condition), comparing civility, work attitudes, and well-being of a sample of workers from each unit at Time 1 (pre-intervention) and Time 2 (6 months later). From five hospital systems in Canada, 17 units were asked to participate in the survey. Intervention group, Time 1, included $n = 262$, and comparison group, Time 1, represented $n = 216$, for a total Time 1 of $N = 478$, and total Time 2, $N = 361$, post intervention of civility, respect, and engagement at work (CREW). The intervention program known as the CREW was developed by the United States Veterans Hospital Administration (2005) where the program resulted in significant improvement of civility and respect for unit members. In Orre et al. (2010) study, the researchers tested whether the effects of two job stressors (workload and job control) on two indicators of strain (mental health and physical health symptoms) are moderated by the civility norms on the units. At Time 1, civility norms were operationalized by individual measures of (a) coworker incivility, (b) supervisor incivility, and (c) workgroup respect. At Time 2, civility norms were operationalized and put into use by creating a dichotomous incivility measure of high incivility (nine comparison units at Time 2) vs. low incivility (eight CREW intervention units at Time 2).

The intervention units showed a significantly greater reduction in incivility than the comparison units as stated by Orre et al. The study concluded that incivility exacerbates the relationship between existing job-role stressors and strain among health care workers.

Embree and White (2010) performed a concept analysis to identify the characteristics of lateral violence among nurses, and they found them to be gossiping, belittling, bullying, using silent treatment, intimidating, and using any passive-aggressive behaviors that the perpetrator displayed for the target. The actions were overt and covert, resulting in a negative environment where oppression, learned helplessness, lack of empowerment, and lowered self-esteem were experienced by the victims.

Einarsen, Hoel, and Notelaers (2009) hypothesized a negative correlational relationship would exist between an employee's perception of health and well-being and the perceived quality of the work environment. A 22-item questionnaire was distributed to employees at 70 different organizations in Great Britain. A total of 5,288 surveys were returned for an overall response rate of 42.8%. A latent class-cluster analysis was completed to identify and differentiate between groups who reported similar types and frequency of workplace bullying. A total of seven clusters were identified. A Pearson correlation test was done to assess the relationship between health and well-being, and work-related performance outcomes to the amount of perceived bullying. Finally, a mean standardized score was compared for work-related outcomes for the seven clusters. The findings of the study supported the hypothesis with statistically significant and moderately strong correlations between psychosomatic complaints and the amount of perceived bullying. The r value was 0.42, at occasional bullying, to 0.92, with the perception of severe bullying.

Simons (2008) conducted a descriptive-study examining bullying behavior among nurses practicing in the state of Massachusetts with less than 36 months of experience, which studied the relationship between the experience of being bullied and the nurses' intentions to leave the organization. A mailing list provided by the Massachusetts Board of Nursing was used to obtain possible participants. A total of 1,000 surveys were mailed. Data was received from 511 randomly-selected newly-hired nurses who completed the Negative Acts Questionnaire (Einarsen, Hoel, & Notelaers, 2009). The Negative Acts Questionnaire is an instrument that measures perceived exposure to bullying at work. Results showed that 69% reported being bullied and that bullying is a significant determinate in predicting intent to leave an organization. Intent to leave was measured using a subscale of the Michigan Organizational Assessment Questionnaire. A significant correlation was found between the two variables. As bullying scores increased, so did the likelihood to leave the organization.

Lynn and Redman (2005) conducted a descriptive study based on a mailed survey, completed by 787 staff nurses, to examine the relationship among the organizational commitment, job satisfaction, and nurses' intent to leave their current positions and/or the nursing profession as a whole. The instruments used in this study included the first section of six items from the Price and Mueller (1981) studies and a 54-item Satisfaction in Nursing Scale (SINS). The second section included 20 items that included the Organizational Commitment Questionnaire plus five other questions. Traditional demographic questions were also included. Using stepwise multiple regression, six variables were significant predictors, explaining 42% of the variance in the dependent variable, *intent to leave the current position*. Higher levels of the variables

of organizational commitment, professional satisfaction, satisfaction with workload, satisfaction with co-workers, extent to which the nurses like to work, were associated with a lessened likelihood to leave their positions. The researchers concluded that retention programs should focus on enhancing nurses' commitment to the organization and reducing nurses' workloads.

Australian nursing students reported experiencing much the same incivility in the form of aggression and bullying. Curtis, Bowen, and Reid (2007) sampled 152 nursing students, using a questionnaire, and found many of the same characteristics of uncivil behaviors observed in the United States. The Australian students experienced humiliation, being without power, faculty acting as if the students were invisible, and faculty using hierarchy to communicate to students that they had no credibility. Of the total respondents, 51% stated that the experiences resulted in self-doubt (Curtis et al., 2007).

Mould and Laschinger (2014) examined the relationship between nursing students' exposure to various forms of incivility in acute-care practice settings and their experience with burnout. A cross-sectional survey design was used to assess a conceptual model associating fourth-year baccalaureate nursing students' perceptions of their experiences of incivility and burnout in the acute-care environment in Southwestern Ontario, Canada. The entire fourth semester class of 190 students were asked to participate in this study, resulting in 126 participants. Incivility among staff nurses within the clinical environments was reported as the highest, whereas, incivility was not directed toward the nursing students. The lowest reported exposure of incivility was from clinical instructors. Burnout levels were noted as moderate, and emotion exhaustion was reported

as severe. The results from the study support the hypothesis that nursing students'

reported incidences of incivility in clinical environments are related to burnout of nursing

staff. Incivility from staff nurses were associated with both emotional exhaustion and

cynicism—both components of burnout (Mould & Laschinger, 2014).

Nurse-to-novice incivility. From a different perspective, Hunt and Marini (2012)

researched incivility in the practice environment from the clinical teachers' perspectives.

Resulting in a 71% response rate, 37 clinical teachers participated in the survey. The

lowest mean number of uncivil acts reported was 1.5 times per week, and the highest was

5.4 times per week. Participants also responded to open-ended questions, which were

coded. Four subtypes of incivility emerged and included: (a) direct incivility, such as

senior staff belittling new hires; (b) indirect incivility, such as gossiping about a

coworker; (c) reactive incivility, exampled by a nurse yelling at a patient who questioned

her; and (d) proactive incivility. Proactive incivility obtained the lowest number of

responses, but it was described as a power struggle, such as two nurses speaking to one

another in a different language in front of a patient (Hunt & Marini, 2012).

Del Prato (2013) studied the students' lived experience as a barrier to professional

formation in associate degree nursing education from the view of the student. An

interpretive phenomenological design was used to study the lived experience of associate

degree nursing education students. In-depth interviews were conducted with 13

participants of which five participated in second interviews. Faculty incivility comprised

four interrelated experiences, including verbally abusive and demeaning experiences,

described as condescending remarks, constant criticism, and negative feedback.

Demeaning feedback led the students to question their personal capability of becoming

nurses. Favoritism and subjective evaluation, which included biases based on gender, appearance, behavior, race, and violation of due process, was also revealed. Rigid expectations for perfection, such as holding students to a higher standard than professional nurses in a clinical setting, was also a practice and, lastly, the custom of targeting and weeding out nursing candidates was themed as students spoke of not meeting expectations of select faculty. Del Prato (2013) reported faculty incivility included demeaning experiences, subjective evaluation, rigid expectations, and targeting and weeding practices. Faculty incivility hindered professional formation by interfering with learning, self-esteem, self-efficacy, and confidence (Del Prato, 2013).

Likewise, Altmiller (2012) explored the phenomenon of incivility in nursing education from the perspective of undergraduate nursing students and compared it to the perspectives of educators as reported by the literature. This exploratory study used a focus-group method consisting of 24 undergraduate junior and senior nursing students from four universities in the Mid-Atlantic States. The researcher visited the universities and invited the students to discuss their perceptions of incivility. Four focus groups were conducted. The nine themes that were identified and compared to faculty perspectives found in the literature were unprofessional behavior, poor communication techniques, power gradient, inequality, loss of control over one's world, stressful clinical environment, authority failure, difficult peer behavior, and student views of faculty perceptions. The findings provide insight into how students interpret events common to many nursing programs. The themes show key areas of agreement between faculty perceptions, as found in the literature, and student perceptions. The implications for nurse

educators are that students want professors to maintain classroom respect and set the example of civility (Altmiller, 2012).

Marchiondo, Marchiondo, and Lasiter (2010) conducted a descriptive cross-sectional survey study with 152 senior nursing students from two Midwestern United States universities. The study examined the effect of nursing faculty incivility on nursing students' program satisfaction. Descriptive statistics with frequency tables were generated regarding sample population demographics, mean scores for frequency of incivility experienced, and program satisfaction scores. A multiple linear regression analysis was then completed to determine the effect of faculty incivility on the nursing students' satisfaction with the program. Demographic data of age, grade point data, and optimism score were controlled to limit the impact of possible extraneous variables. The linear regression analysis indicated that 22% of nursing students' program satisfaction is explained by nursing faculty incivility.

A research study tested an intervention to build social capital and civility among nursing was conducted in 2013 at a Midwest university in the USA by Jenkins, Kerber, and Woith. Ten student leaders were recruited during a student leadership meeting. Researchers also recruited 25 other junior- and senior-level nursing students by attending classes regularly. Five themes emerged from the qualitative and quantitative results: respect, equality, caring, building relationships, and working together. Participation in the intervention changed students' attitudes and behaviors regarding civility. Students refused to participate in uncivil behavior, helped peers, were supportive, and they tried to prevent or avoid incivility.

In 2011, experiences of nursing students as targets of incivility in clinical settings were explored through a qualitative study by Anthony and Yastik. The researchers recruited 21 students from one private Midwestern university nursing school. Participants attended four focus groups that were audio taped and transcribed verbatim. A line-by-line method of analysis was used to code, categorize, and analyze data. To ensure trustworthiness of the data, member checking was utilized. Results of this study were that incivility fell into three themes that included the term *exclusionary*. Students reported feeling like outsiders or being in the way during their clinical experience. The next theme was termed *hostile or rude*, where students reported that staff members' behavior incited loss of self-confidence, which created the students' questioning the correctness of their professional choice. Lastly, the theme termed *dismissive* was coined when staff just ignored or walked away from the students, creating the feeling of being insignificant or minimalized. Anthony and Yastik (2011) also asked students to express a positive experience with nursing staff. Many reported interactions that gave the students confidence to continue in the profession. The last issue addressed was how students felt faculty addressed incivility, and the responses to this question varied with many different views. Some students seemed resigned to the occurrence of incivility and did not think faculty could do anything to change the situation. Others thought it would have been better to be warned that this was something they might encounter.

Clark and Springer (2010) studied the academic nurse leaders' perceptions of stressors affecting both faculty and students, the uncivil behaviors exhibited by both groups, and the role of leadership in preventing and addressing incivility in nursing education. The research consisted of an exploratory descriptive study completed in a

statewide nursing conference at a Midwestern state in the US. Of the 172 attending, 126 nurses participated, comprising a completion rate of 73.2%. Researchers asked five open-ended questions to gather the nurse leaders' perceptions of stressors impacting faculty and students, incivility exhibited by both, and the role of leadership in preventing and addressing incivility in nursing education. Findings from Clark and Springer's (2010) study were stressors that nursing students' experienced and were perceived by nurse leaders as emerging students juggling with multiple roles, financial pressures, time-management challenges, lack of faculty support and incivility, and mental health issues. Seven themes emerged from asking nurse leaders to describe uncivil behaviors exhibited by students: in-class disruptions, aggressive or bullying behavior, making excuses for poor performance, cheating, entitlement, and blaming or shunning other students. The third question elicited the nurse leaders' perceptions related to faculty stressors. Many themes emerged from this question, such as challenges from demanding workloads, maintaining clinical competence, advancement issues, and perceived lack of administrative support. Other themes also included problematic students, salary, and faculty-to-faculty incivility.

The fourth question Clark and Springer (2010) asked the leaders to describe was uncivil behaviors displayed by faculty. Findings were grouped into seven themes, which were organized into two major categories: uncivil faculty behaviors toward faculty and administrators and uncivil faculty behavior towards students. The incivilities toward faculty and administrators were reduced into two subcategories. The first subcategory revealed overt acts of intimidation, exerting superiority, and failing to perform a share of the workload. The second subcategory identified marginalizing behaviors, refusal to

27

communicate, gossiping, and resisting change. The faculty incivilities toward the students included rude, belittling behaviors, making unreasonable demands, and not appreciating student contributions. Finally, the last question asked nurse leaders about the role in nursing leadership and addressing incivility in nursing education, with the majority of respondents stating that nurse leaders have a responsibility to create a culture of civility and respect in nursing education (Clark and Springer, 2010).

A survey of the nursing faculty on a national level was conducted in the United States by Lashley and De Meneses (2001) to determine the types of student behaviors that were experienced at the time of their research in for the preceding 5 years. Participants were randomly selected from a listing of state-approved schools of nursing in the United States. A survey was sent to 611 nursing programs, with 409 responding, equaling a 67% response rate. The results of this study indicate that inattentiveness, tardiness, and absence from class were the three main behaviors experienced by 100% of the participating nursing communities. Rude behavior was noted by 84.4% of the respondents, and verbal abuse toward an instructor was measured at 52.8%. The lowest scoring was regarding objectionable physical contact with an instructor, where 24.8% of the respondents reported this was problematic. When existing student behavior was compared to the previous 5 years, nearly half of all respondents indicated that the quality of undergraduate nursing work, at their institution, was lower than the previous years. The perceived student preparation for class was at 57% indicating that measure to be poorer in the present day than the 5 preceding years. Lashley and De Meneses (2001) asked respondents to indicate what the consequences would be at their institution for verbal abuse of nursing instructors and objectionable physical contact with instructors.

The responses to the questions for verbal abuse were 84.3% stating that incidents were handled verbally by instructor, whereas 29.2% stated that the first level of consequence was a written warning. Responses for objectionable physical contact were 42.2% initially handled verbally by instructor, whereas 25.7% stated written warning was given. Lashley and De Meneses (2001) stated that the clinical setting is a place where nursing students and nursing programs represent the society they served, and it represented the ultimate mission of nursing.

Global nursing incivility. Research conducted outside the United States suggests that incivility in other countries may be more severe than within the United States. A study conducted in Iran by Khademi, Mohammadi, and Vanaki (2012) of 15 nurses explored the violation of dignity within the workplace. At the conclusion of this study, some of the issues revealed were the use of hidden cameras, mandatory overtime, and being instructed by superiors not to be friendly to other staff members. The 15 participants felt this was coercion and a violation of their autonomy. Participants reported feeling insecure and were subjected to physical attacks. Other participants in this study stated they "would not complain, fearing retribution interfering with their personal lives" (Khademi et al., 2012, p. 328).

Patient ratios and patient outcomes. When the phenomena of incivility, lack of autonomy, stress, low morale, and fear are commonplace in a work environment, burnout occurs. Wilson et al. (2011) explained that nurse burnout will lead to absenteeism, resulting in an increase in the nurse-to-patient ratio for those on duty. When the nurse-to-patient ratio is increased from four to eight patients per nurse, it was found to be associated with five additional deaths per 1,000 patients (Aiken et al., 2002).

Laschinger (2014) conducted a study in Canada investigating the impact of subtle forms of incivility on Canadian nurses' perception of patient safety risk, nurses' assessed quality, and the prevalence of adverse events. Using a random sample of nurses working in Ontario hospitals ($N = 641$), obtained from the College of Nursing provincial registry list, a total of 336 nurses responded to a questionnaire mailed to their homes, equaling a 52% response rate. Results of the study validated that bullying and incivility for nurses, physicians, and supervisors had significant direct and indirect effects on nurse-assessed adverse events and perceptions of patient care quality (Laschinger, 2014).

Workplace incivility was described by Ward-Smith (2011) as occurring when interpersonal interactions are necessary between coworkers or between those in a different position in a hierarchy. The researcher noted that patient safety was a major concern, because a nurse who experiences incivility can be distracted, unhappy, or intimidated. Ward-Smith (2011) found that nurses who experience incivility "often demonstrate traits of being kind, understanding, and even patient with the perpetrators of aggressive behaviors" (p. 257). Ward-Smith suggested that the empowerment begins when a nurse stands up to the perpetrators even though it may feel uncomfortable. By asking a coworker how a specific comment or action came across may open ways for dialogue to take place in a non-threatening manner, and could, according to Ward-Smith (2011) result in safer patient care.

Wilson and Phelps completed a study in 2013 in a 220-bed acute-care community hospital located in the Southwest United States. The objective was to determine if the perceived level of incivility, also referred to horizontal hostility within this study, influenced nurses' behaviors, and if the threat of, or experience with incivility, directly

related to patient safety. The 28-item Lateral Violence in Nursing Survey (Stanley et al., 2007) was distributed to 500 registered nurses, excluding the registry and travel nurses, who were employed by the hospital. Survey participants were provided with definitions of horizontal hostility including descriptors of incivility and bullying.

A total of 130 completed surveys were reviewed and transcribed by the PhD-prepared researcher in lieu of the hospital site. Results of the Wilson and Phelps (2013) surveys stated that nearly 60% ($n = 78$) of participants witnessed a nurse or physician demonstrating bullying behavior at least monthly, with the majority reporting witnessing hostile behaviors at least weekly. The respondents who had experienced horizontal hostility but failed to address the abuser were asked for reasons for not confronting the abuser. Of the 130 respondents, 84 answered this item. Of the responses, 73% ($n = 62$) stated that nothing would have changed if the perpetrator was confronted, and the remaining 27% stated that they were in fear of retaliation. When asked about reporting witnessed hostile behavior, almost half (44%; $n = 46$) of the participants, did not report the behavior. The last question that received the least amount of responses was related to patient safety. Of the 43 responses, 30% noted interpreting an unclear physicians' order without asking for clarification. Instead of asking for assistance, 26% responded to lifting or ambulating heavy patients independently, and 10% of the respondents reported using medical equipment that was unfamiliar to them and they chose to not seek help. When asked about carrying out an order that was not in the best interest of a patient, 11% chose not to challenge the order, 6% reported withholding medications or treatment until the next shift to communicate with an oncoming nurse rather than to discuss treatment with a co-worker on the same shift, and last, 4% reported giving a medication or treatment that

needed clarification rather than calling the physician (Wilson & Phelps, 2013). The study concluded that in addition to personal and professional safety of the nurse, vertical and horizontal hostility poses potential threats to patient safety as well as posing probable hospital legal issues.

A nursing force that is inadequately staffed has been found to have a negative impact on the outcomes related to patient satisfaction. In the same measure, Coshow, Davis, and Wolosin (2009) reported that hospitals that have low nurse turnover register low rates of risk-adjusted mortality and significantly lower rates of prolonged lengths of stay. A met-analysis conducted by Aiken et al., (2010) by the Agency for Healthcare Research and Quality found out that, "the shortage of registered nurses, in combination with an increased workload, poses a potential threat to the quality of care. Increases in registered nurse staffing was associated with a reduction in hospital-related mortality and failure to rescue, as well as reduced length of stays" (American Association of Colleges of Nursing [AACN], 2009).

The Joint Commission report (2008), *Behaviors that Undermine a Culture of Safety*, lists several contributing factors to unacceptable nursing actions. These factors are competitive environments, time commitments, stress, and pressure piled on the nurses in their line of work. Other factors are high expectations in their work and managing of multiple roles.

Quality patient outcomes and patient safety are priority in all health care settings. Nevertheless, due to the current shortage of nursing and other variables, these outcomes are challenging to achieve. Shortages can create organizational pressures. Organizational pressures can cause incivility due to corporate change initiatives, inferior leadership,

increased technology, and compressed deadlines. Individual differences can cause incivility due to gender differences and perceived possession of power (Marlow, 2013).

Retention and incivility. The demand for registered nurses is generally poised to grow. According to a prediction by the U.S. Bureau of Labor Statistics (2011), the demand for registered nurses is expected to grow by 60% margin between 2008 and 2018. Although idealistic logic may argue that a sufficient number of new graduates are likely to fill the demand, Benjamin Isgur (2008) of Price Waterhouse Cooper relied on the projection arguing that this is not sustainable in the long run. Out of the more than 320,000 students who enrolled for nursing in 2008, only 78,000 of these candidates graduated, and only 23% of the graduates by 2008 were serving as nurses (Isgur, 2008). An estimated 30,000 novice nurses stay in the field after graduation; whereas, close to 50% of these graduates leave their first job after 2 years' experience. While examining strategies that improve the retention and effective utilization of aging nurse faculty, Falk and Fischbacher (2002) identified that the increase in the age of the nursing population and their expected retirement compounds the staffing problem.

The results of a Washington State study of registered nurses leaving the workforce reported that the majority abandon their jobs because of job stress and exhaustion (Skillman, Palazzo, Hart, & Keepnews, 2010). The key implication of the results of the study was that the reliance on registered nurses returning to the workplace, after vacating it voluntarily, is not likely to represent an effective strategy for resolving the nurse shortage.

D'Ambra and Andrews (2014) reported that nurse turnover remains problematic for employers because it impacts the quality of patient care. The researchers' review of

the literature examined incivility, retention, and new graduate nurses. They evaluated 16 studies for determinants of incivility. Multiple studies predicted that incivility in the work environment leads to low job satisfaction and low rates of retention. Of the 16 studies, 13 discussed new graduate transition programs. Of the 13 studies, three interventional approaches emerged, which included mentoring through preceptors, residency programs, and workplace empowerment. These studies concluded that reports related to preceptor programs greatly impacted new graduate retention. Residency programs were also confirmed to support new graduate retention. Empowerment and healthy work environment were shown to have a positive effect on new graduate transitions. D'Ambra and Andrews (2014) concluded that new graduates are often the targets of incivility because these novices are at the bottom of the power-related hierarchy associated with the unit culture and, therefore, are often targets of incivility. Although new graduate nurse-transition programs have not been found to directly reduce incivility, these programs might assist new graduates with strategies to address these issues. Residency programs were found to be beneficial to new graduate nurses as they offered the new nurse time, confidence, and support as they adapted to their new work environment.

Laschinger, Leiter, Day, and Gilin (2009) completed a study examining the influences of empowering work conditions and workplace incivility on nurses' experiences and important nurse-retention factors such as job satisfaction, commitment, and turnover intention. Initially, 2,765 surveys were sent to five organizations in two provinces with a 40% return rate, equaling $n = 1,106$. Of the 1,106 participants, 612 were registered nurses, and the research focused just on the registered nurses for the study. Descriptive results show that 77.6% of the nurses reported some level of coworker

incivility, and 67.5% of nurses reported incivility with supervisors. However, a small percentage, 2.7% and 4.4%, reported regular or very frequent exposure to incivility in their workplaces. The nurses in the study were found to report high levels of exhaustion, and almost half (47.3%) scored *severe* burnout, according to the Maslach Burnout Inventory Scale (Laschinger et al., 2009). Cynicism levels for nurses in the study were lower than exhaustion, and nurses reported high levels of job satisfaction, moderate levels of organizational commitment, and lower levels of turnover intention. The researchers concluded that an empowering practice environment and low levels of incivility and burnout were significant predictors of nurses' experiences of job satisfaction, organizational commitment, and their intentions to leave. Limitations were noted of being a cross-sectional study precluding causal effects of incivility (Laschinger et al., 2009).

In a systematic literature review of the nursing shortage and nurses' intention to leave their employment, Chan et al. (2013), from a Hong Kong School of Nursing, recognized that the shortage is a worldwide problem. If the nursing shortage problem is left unaddressed, serious impacts on the provision of quality health care may occur. The Chan et al. study's initial search on this topic provided them with 8,499 research papers distributed over six data bases. Setting the inclusion and exclusion criteria, Chan et al. reviewed 150 research articles of which 31 were selected for the literature review. The 31 articles were selected as the researchers examined different aspects and factors related to the issue of nurses' intention to leave their current position or the nursing profession. Within the organizational factor, five subthemes were identified: work environment, culture, commitment, work demands, and social support. Within the individual factors, three subthemes were identified: job satisfaction, burnout, and demographic factors.

Results from these studies were the diverse measuring instruments, samples and levels of intent to leave caused difficulties in comparing, and synthesizing the findings; however, the factors influencing nurses' intentions to leave were categorized into organizational and individual factors.

Oyeleye, Hanson, O'Connor, and Dunn (2013) conducted an exploratory, correlational study that explored the relationship and differences between workplace incivility, stress, burnout, turnover intentions, and level of psychological empowerment on acute-care nurses in a hospital setting. Four hundred surveys were distributed to a convenience sample of acute-care nurses from three hospitals in the Midwestern United States. The final survey response was 16% with a final sample of 61 surveys. The data collection instruments included five tools measuring stress, burnout, workplace incivility, turnover intentions, and psychological empowerment. Findings in the study support that a heightened level of stress and burnout can lead to workplace incivility. Correlations revealed a statistically significant relationship between stress and incivility, stress and burnout, burnout and incivility, and burnout and turnover intention. In addition, turnover intention and incivility were significantly related.

Chapter Summary

Review of the empirical literature reveals that incivility among nurses within the workplace, and within educational settings exists. Nursing incivility is both widespread and detrimental to both the sustainability of the nursing profession and to patient care delivery.

In order to study the impact of incivility towards retaining nurse graduates as employees at hospital-based nursing programs, qualitative methodology was designed

and conducted. A detailed description of the qualitative approach used to answer the research questions posed is found in Chapter 3 of this dissertation.

Chapter 3: Research Design Methodology

Introduction

This study sought to address a research gap in the literature related to nursing students' encounters with incivility during their clinical education and the impact of perceived incivility on post-graduation choices. Qualitative research methodology, which included in-depth written feedback, in-depth one-to-one interviews, and a focus group was utilized to capture rich, descriptive data to answer the research questions. The research questions were posed to graduate nurses from two hospital-based nursing programs, with less than 12 months of working experience in the nursing profession. The researcher gathered data using qualitative methodology in alignment with the following research questions:

1. What behaviors in the clinical environment did the associate degree graduate nurses perceive as incivility during their nursing school clinical experience?

2. How do new graduate nurses describe their experiences with incivility when they were nursing students?

3. To what extent did exposure to incivility in the clinical environment impact employment choices post-graduation?

Research Context

Purposeful sampling was used to identify and to select the participants for this study. Purposeful sampling is the process of choosing participants for a qualitative project by recruiting individuals who can help inform the central phenomenon of study

(Creswell, 2016). The self-selected participants for this study were registered nurses with less than 12 months of experience working in various hospitals in New York State. These subjects were identified through referrals from nursing faculty and nursing colleagues of the researcher. The nurse participants' workplaces varied representing employment in mental health, medical-surgical units, in ICUs (intensive care units), and in NICUs (neonatal intensive care units). Nurses from state-funded, private-funded, and faith-based organizations were represented in this study. For the purposes of confidentiality and anonymity, the specific health organizations were not identified in this study.

Utilizing a phenomenological approach and a purposeful sampling process, the findings of this study cannot be generalized (Creswell, 2016). Rather, the aim of this study is to provide insight to inform policy for future practice regarding incivility exposure and the impact of retention and employment rates of new graduates in hospital-based nursing programs.

Research Participants

Identification and recruitment of new registered nurses with less than 12 months experience was done through extensive networking with colleagues and faculty members who provided contact information for the participants. The respondents agreed to participate and provided a personal e-mail address to the researcher, whereby expressing interest in study. For this study, two criteria existed for participation: (a) the registered nurse was a graduate with an Associate of Applied Science in Nursing from a hospital-based nursing program, and (b) the newly graduated registered nurse who had been employed less than 12 months.

An e-mail invitation (Appendix A) with the request to provide written feedback to the three research questions (Appendix B) was sent to eight identified potential subjects to secure participation in this study. The respondents were asked to indicate their willingness to continue to explore incivility, associated behaviors of incivility through further participation with in-depth, one-on-one interviews (Appendix C) and a focus group (Appendix D). The goal of this study was to identify and secure five to 10 respondents who both identified with Clark's definition of incivility and had experienced incidences of perceived incivility during their clinical training. Although qualitative studies do not have a required participant number, the researcher must collect enough data to meet saturation. For the purpose of exploring the identified themes more fully, data saturation using the phenomenological method recommends between three to six participants of the population size for a focus group (Englander, 2012; LoBiondo-Wood & Haber, 2010; Mertens & Wilson, 2012).

Prior to identifying specific participants and collecting any data, certification from the Collaborative Institutional Training Initiative (CITI) was obtained (Appendix E). St. John Fisher College (SJFC) Institutional Review Board (IRB) approved this research study (Appendix F). The design of this study was non-experimental in nature and all potential participants were over age 18 years. Participants voluntarily self-selected into this study. The participants were not coerced nor forced to participate. All respondents were informed that withdrawal from the study was permitted at any time without detriment. In the event that emotional support was needed as a participant in this study, debriefing time was allotted after each interview session. All identified self-selected subjects were required to sign an informed consent form (Appendix G) securing

respondents' agreement to participate in this study as well as granting permission to be audio taped throughout the interviewing and focus group session. No monetary compensation for participation was provided, rather the subjects would be provided with an electronic copy of the completed dissertation upon request. All data collected was password protected and kept in a locked cabinet located at the researcher's place of residence. After three years' time, all data will be destroyed.

Qualitative Research Design

Utilizing qualitative research methodology allows for a deeper understanding of the experiences of individuals by generating thick, detailed data that can produce multiple frameworks to help comprehend the phenomena being studied. To understand qualitative research, one must appreciate that meaning of an individual's experience is socially constructed within that individual's interactions with the world. These interactions describe a phenomenon as a fact, occurrence, or circumstance that is observable (Merriam, 1998). These descriptive, detailed conversations allowed the researcher to acquire a keen awareness of how each person made sense of his or her personal experiences within the clinical environment. Qualitative research methodology, which included in-depth written feedback, in-depth, one-to-one interviews, and a focus group was utilized to capture rich, descriptive data to answer the research questions.

In accordance with qualitative research tradition, multiple data sources were utilized. A rich data set was supplied through a triangulation approach using in-depth written feedback responses provided by the participants, in-depth interviews, and a focus group (Denzin & Lincoln, 2005; Merriam, 1998; Stake, 1995; Yin, 2003). Merriam (2009) suggested that open-ended questions allow participants to share their knowledge,

experience, and behavior as well as express their feelings and opinions. Yin (2011) suggested that being non-directive may lead to salient responses by participants. Yin (2011) also indicated that responses may be shorter than desired and that the researcher may need to be prepared to ask probing and follow-up questions.

Procedures for Data Collection

In-depth written feedback. Each participant received an e-mail invitation which included the initial three research questions and Clark's definition of incivility. Directions as to how to complete the written feedback response form and the researcher's e-mail address was included to expedite return (Appendix B). Bowker and Tuffin (2004) suggested that written feedback through e-mail interviewing is potentially empowering for the participants because these subjects can personally control when, where, response length. Written feedback for this study initially engaged the participants in reflections of their experiences, as well as to "give meaning to their lives and capture these meanings in written, narrative . . . forms" (Denzin & Lincoln, 1994, p. 10).

In-depth, one-to-one interviews. One-to-one, in-depth interviews (Appendix C) are common in qualitative research (Denzin & Lincoln, 2005; Merriam, 1998; Stake, 1994; Yin, 2003). The interviews throughout this study were semi-structured, mostly open-ended questions that guided the interview (Flick, 2014). The interaction between the researcher and the participant through the interview was "the establishment of human-to-human relation with the respondent and the desire to understand rather than to explain" (Fontana & Frey, 1994, p. 366). This interpersonal interaction provided flexibility to engage in natural conversation, evoke deeper thinking and solicit valid insight with a greater level of comfort as the participants' reported experiences.

Focus groups. Creswell (2003; 2016) suggested the use of both interviews and focus groups to provide consistent participant investigation of particular topics by utilizing basic introductory open-ended questions. These open-ended questions were aligned with the research questions to gather rich narrative data. After the in-depth, one-to-one interviews were analyzed and coded for themes, more questions surfaced that needed to be answered; therefore, a focus group was formed with a subset of the first interviewees. The focus group subjects were selected based on the similar phenomenological themes generated through the analysis of the interview questions. Further probing through the use of open-ended, general questions (Appendix D) guided the conversations for the focus group (Creswell, 2016; Flick 2014). Typically, a focus group consists of three-five individuals (Creswell, 2003). The number of participants should be small enough for everyone to contribute, yet large enough to share diverse opinions across the whole group rather than fragmenting into smaller parallel discussions (Krueger, 1994). For the purpose of this study, the focus group size was limited to 2-4 participants. The limitation was due impart to honor respondents' potential emotional impact when revisiting the topic of incivility during the clinical experience. The focus group followed a semi-structured outline, allowing the participants to speak up, expanding on ideas as multiple individuals weighing in on the central phenomenon of study (Creswell 2016; Flick, 2014; Krueger & Casey, 2009).

Instruments Used in Data Collection

Utilizing qualitative methodology, the researcher is often recognized as the instrument used in data collection (Creswell, 2016). As such, one-to one interviews and a focus group were conducted by the researcher. Participants' experiences were captured on audiotape throughout the one-to-one interviews and a focus group session. These conversations were by transcribed by Rev.com. Rev.com is a transcription service which employs outside consultants who listen, review, and translate the recorded audio conversation into text for business and educational purposes (Rev.com, 2017). For the purpose of this study, these transcriptions were utilized for data analysis and later to ascertain credibility, reliability and validity through member checking. The researcher took extensive field notes throughout one-to-one interviews and the focus group session. Field notes capture observable moments that cannot be obtained through audio recording. Field notes also assisted the researcher in identifying personal and professional biases during data analysis (Bogdan and Biklen 1982). Additionally, the researcher bracketed personal feelings and knowledge known only to the medical profession within the extensive field notes to explain various participant experiences.

Data Analysis

Basit (2003) stated "data analysis is the most difficult and most crucial aspect of qualitative research" (p. 143). Data from the in-depth written feedback, in-depth one-to-one interviews, and the focus group were coded and analyzed to identify emerging themes, patterns, and categories. Coding was done collaboratively, in that "a research team builds codes and coding builds a team through the creation of shared interpretation and understanding of the phenomenon being studied" (Weston et al., 2001, p. 382). An

expert was identified to collaborate with the researcher to verify the coding best practices and sound coding outcomes.

In-depth written feedback. Each of the six subjects participated in the in-depth written feedback to the posed research questions. The feedback form was completed in the privacy of each participant's environment and was returned to the researcher within a specific time period. Data from these interviews were initially coded. Every written feedback form was analyzed from a within-subject and across-subject perspective, as suggested by Merriam (1998). The within-subject analysis involved looking at the perception of each nursing student interviewed and helped to form a general picture of how exposure to incivility possibly impacts retention rates. The cross-subject analysis involved a comparison of all the students in the study to develop general themes.

In-depth, one-to-one interviews. Every respondent participated in one single one-to-one interview, which was approximately 45 minutes in length. The interviews were conducted at a location convenient to each of the participants which ensured confidentiality. All interviews were audio recorded and transcribed using Rev.com. The interviews involved probing associate-level graduate nurses' perceptions of incivility by recalling perceived encounters with incivility during the clinical training period as a nursing student (Appendix C). Qualitative data from these interviews was analyzed utilizing a multi-step process. The first step was to organize and read through the data, gaining a sense of overall meaning, followed by organizing and coding the data into meaningful groups, themes, and categories. Through the process of analyzing the data through transcript review, open coding opportunities became known to the researcher (Strauss & Corbib, 1990). Open coding allowed for new codes to emerge after reviewing

the data without constraints of preconceived categories. Each interview was analyzed from a within-subject perspective and across-subject perspective, as suggested by Merriam (1998). The within-subject analysis involved looking at the perception of each nursing student interviewed to help form a general picture of how exposure to incivility possibly impacted retention rates and post-graduate employment choices at both hospital-based nursing schools. The cross-subject analysis involved a comparison of all students in the study to develop general themes.

Focus group. The focus group sessions consisted of two participants. The focus group session was approximately 1 hour in length and, to help ensure confidentiality, was held off campus in a private gathering space. The focus group discussions involved open-ended questions that allowed the group to center conversations on the lived experiences of both personal encounters with incivility and those of their peers during clinical training (Morgan & Krueger, 1998). This focus group was audio recorded and later transcribed using Rev.com. This study attempted to capture the essence of the students' experiences through dialogue and extensive field notes. Field notes from both the one-to-one in-depth interviews and focus group were analyzed both within subject and across subject. The intent of conducting phenomenological inquiry is to generate themes through the discovery of new knowledge and meaning from life experiences of the subjects (Creswell, 2003). The identified themes were formed to extrapolate valuable information for this study.

Validity, Credibility, and Reliability

Validity, credibility, and reliability are critical to good research. Validity refers to the truth, the correctness, and the strength of the statement (Brinkmann & Kvale, 2015).

To ensure validity, several processes were implemented within this study. Member checking was utilized. All of the participants were supplied with the transcribed narratives from the interviews and focus group to ensure accurate representation of what was stated (Creswell, 2016, Flick, 2014). Credibility refers to the value and believability of the findings (Lincoln & Guba 1985). Within this study, triangulation of written feedback using in-depth one-to-one interviews and focus group data was completed. Reliability pertains to the consistency and trustworthiness of the research findings (Brinkmann & Kvale, 2015). The researcher established a set of interview questions which guided the interview with each participant. Collection, recording, and transcription of data were consistent with all participants. Reliability and credibility were guaranteed by employing an intercoder agreement. An intercoder agreement is defined as one or more additional coders who analyze a qualitative database, provide codes for the database, and compare the results of the researcher codes towards establishing agreement on the codes (Richards & Morse, 2013). As the transcription from the in-depth written feedback form, one-to-one interviews, and the focus group were analyzed, the researcher initially identified codes and themes which were later verified by a coding expert formulating an intercoder agreement for this study.

Clarification of researcher bias was identified and bracketed. External auditors identified as the dissertation committee and a peer review forum evaluated transcripts and the coding of dialog to ensure validity, reliability, and credibility of the data.

Summary

Chapter 3 described the rationale for selecting a qualitative research method design. Research instrumentation and data analysis methods for this study were discussed. A plan of action and a timeline to complete the study were established.

Chapter 4 reports the results of the data collection. The analysis of the collected data through in-depth written feedback, one-to-one interviews, and a focus group provided insights as to how exposure to incivility affected graduates from two hospital-based nursing programs and, as a result, impacted their retention rates and employment choices.

Chapter 4: Results

Introduction

Recruitment and retention of registered nurses are among the greatest challenges facing the health care industry. Exacerbating the existing deficit of qualified academic and clinical nurses are other factors, such as the complexity of the work environment, culture, commitment, work demands, and social support of the nursing profession (Anthony & Yastik, 2011; Clark, 2013; Del Prato, 2013). These factors can create challenges within the work environment including tension among coworkers. As the workplace stressors rise, the likelihood of incivility also increases (Oyeleye, Hanson, O'Connor, & Dunn, 2013). While much of the research on the topic of incivility has been conducted among licensed professional nurses, little research has been documented on the possible impact of incivility on nursing students who encounter incivility. The purpose of this study was to explore the nature of incivility experienced by hospital-based student nurses as well the impact of incivility on retention of as licensed registered nurses, and on their immediate post-graduation employment choice.

This chapter presents the findings of the study. Qualitative data was derived through extensive probing utilizing qualitative phenomenological research methods, specifically through written feedback, conducting six in-depth one-to-one interviews and one focus group. The research questions, as well as the interview and focus group questions, were designed and aligned to gain a better understanding of the impact of the lived experiences of personal exposure to incivility during nursing school clinical

training. The identified phenomenological themes and sub-themes generated by these sessions will be discussed.

Research Questions

The three broad research questions guided this qualitative phenomenological study. The research questions were:

1. What behaviors in the clinical environment did the associate degree graduate nurses perceive as incivility during their nursing school clinical experience?

2. How do new graduate nurses describe their experiences with incivility when they were nursing students?

3. To what extent did exposure to incivility in the clinical environment impact employment choices post-graduation?

Data Collection, Analysis, and Findings

Participant selection and demographics. The researcher acquired potential participants for this study through referrals from colleagues and faculty at two Upstate New York hospital-based nursing programs. Participant selection was based upon the specific criteria. These participants were registered nurses who attended an associate-degree-granting Upstate New York hospital-based nursing program, and who were employed for less than 12 months as a registered nurse immediately after graduation. Six participants were identified and upon invitation, self-selected into this research study. All the participants were Caucasian. For the purpose of this research, pseudonyms were used to maintain anonymity. Three were females: Tammy, Michelle, and Rebecca. Three males also participated: David, Nate, and Robert. Ages varied between 19 and 45 years

old. Three participants were graduates from Nursing School 1, and three participants were graduates from Nursing School 2.

Data collection and analysis. To answer the research questions posed, a triangulation approach was implemented. Triangulation is defined as utilizing multiple methods of data collection to capture different dimensions of the same phenomenon, rather than cross-validation of data (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). To increase the validity of this research, triangulation was obtained by written feedback, in-depth one-to-one interviews, and a focus group. A series of questions were generated to gain insights from the experiences of the post-graduate nurses who were exposed to incivility during their student nursing clinical training period. The participants provided written feedback via e-mail, answering the three research questions. The interview (Appendix C) and focus group questions (Appendix D) were created by the researcher to be in alignment with the research questions of this study.

Written feedback was collected via e-mail prior to meeting with the participants. As a first step to analyzing the written feedback data, the researcher coded these narratives. Next, the researcher conducted semi-structured in-depth one-to-one interviews with each of the six participants. The researcher then conducted a focus group and coded the data from that source. The researcher used a recording device for both the interviews and the focus group. All audio recordings were transcribed by an outside consultant. Following the interviews and focus group, the researcher maintained extensive field notes that captured the essences of the setting and communication that happened during the data collection. Preliminary coding of all transcripts was completed by the researcher

through a line-by-line within-subject analysis and across-subject analysis. To assist in providing credibility, validity, and reliability of the transcripts, the researcher listened to the audio recordings to correct any discrepancies and to capture data through cues not noted in transcripts (Brinkmann & Kvale, 2015). Internal validity was strengthened through a collaborative review process of interview transcripts, field notes, and comments with each participant throughout the study. After making minor corrections and completing the member-checking process, the preliminary coding was peer reviewed to ensure accuracy, and initial themes were identified.

Findings. Incivility is impacting the learning environment and employment decisions of newly graduated nurses. This study yielded major findings in three areas.

1. Recent graduates from hospital-based nursing programs clearly defined incivility and identified several uncivil behaviors experienced within the clinical environment as nursing students.

2. Recently graduated nurses described many experiences with difficult individuals identified as instructors, cover nurses, staff nurses, aides, and doctors as the perpetrators of incivility in the clinical setting. Each experience negatively impacted the wellbeing of participants as nursing students.

3. Exposure to incivility in the clinical environment had a strong impact on retention and employment choices post-graduation. The majority of the participants related their employment choices to incivility exposure. Upon graduation, three participants left their training organizations, two participants chose not to work on specific units within the organization, and one

participant, despite involvement with incivility, chose to work on the unit of the occurrence for other reasons.

Themes and subthemes emerged from the in-depth analysis of data. These rich stories of lived experiences naturally addressed all three research questions within this study.

"Nurses eat their young." The first theme that emerged from the in-depth analysis, "nurses eat their young," aligned with Research Question 1. The phrase "*nurses eat their young*" refers to the uncivil behaviors exhibited by established nurses in positions of power or influence toward novice nurses. These behaviors include degrading, shaming, and belittling with rob self-confidence of valuable subordinates (Sheridan-Leos, 2008). This theme emerged as a broad, overarching idea when the participants described their encounters with incivility during their nursing school experience. All six participants used this phrase "nurses eat their young" without prompting. This expression is commonly used amongst novice nurses to express poor treatment by senior mentoring nurses.

Clark's definition of incivility was provided to each participant during the invitation process, however, all participants were asked to define incivility in their own words on the initial feedback form, prior to conducting the one-to-one in-depth interviews.

Definitions of incivility. Although Clark's definition of incivility was provided to each participant during the invitation process, all the participants were asked to define incivility individually on written feedback responses to the research invitation. True to Clark's definition, most of the participants expressed definitions of professional incivility

which caused internalized personal trauma. Others reflected experiences based on the environment which did not seem to affect these novice nurses on a personal basis.

Tammy, using a confident tone, defined incivility as "any person making another person feel unworthy or disrespected." Other terms used by participants were "emotional" or "mental anguish," "feeling belittled," "degrading," and "loss of personal dignity." Nate, a tall, broad-shouldered man using a tone of disgust stated, "Incivility means creating an environment of hostility through either verbal or physical intimidation." Rebecca, in a very adamant manner, added, "It's kind of like lateral violence, like nurses eating their young . . . you've got this young nurse who is very eager to learn, wants to participate . . . you have nurses [senior nurses] who almost go out of their way to make this new person feel like they don't belong."

The first finding within this study showed that several uncivil behaviors within the clinical environment affect the nursing students' learning experience. The two subthemes identified within this theme include: (a) *missed opportunities*, and (b) "*dreading clinical.*" The participants' descriptions detail the events related to the missed learning opportunities, the communication gaps which remained untold events until after graduation.

Missed opportunities. Schmitz and Schaffer (1995) studied positive and negative relationships between nursing faculty and students and how the relationships affected the learning experience. Many of the learning opportunities, whereas, all the participants stated negative interactions with either instructors and/or participants noted positive interactions with instructors and staff nurses, which created an optimal arena for staff creating an environment for missed learning opportunities. Tammy stated that she cried

in clinical during her clinical rotation. Her voice became angry and her facial expression changed as she reflected:

> I was on an OB delivery floor, and my clinical instructor, who was also
> my teacher at the school, was having me insert my first Foley [urinary
> catheterization]. She came in with me, and I missed [the urethral orifice].
> I put it in the vaginal opening instead. She [my clinical instructor]
> screamed at me in front of the patient and literally pushed me out of the
> way! She proceeded to open a new kit and did it herself, and told me to
> leave the room.

David, with a calm optimistic demeanor, had a negative experience that turned into a positive reinforcement for him. He stated:

> I went ahead and discussed meds with the mock charge nurse [student
> leader], prior to actually going to the patient and giving the meds. She
> [my clinical instructor] intercepted me before I started to go through the
> meds with the patient. . . . She [clinical instructor] charged into the room,
> very odd tempered, and you could actually tell on her facial expression
> that she [the instructor] was extremely angry about the situation. I could
> see the fire in her eyes, it looked like her head was about to explode!

David continued to say the rest of his clinical experience was "more positive because it opened my eyes, like, 'okay, what do I need to do to make sure this does not happen again?'" However, David continued adding to his story with a different encounter telling of a students' experience with a well-known doctor commenting:

He [the doctor] charges into a room and threw up his hands in an uproar

at the student, and actually made the student feel so uncomfortable that

she started crying, and ended up leaving the unit to go into a closed room

where we do our conferences, just so she could recollect herself.

Robert, a very animated man, recounted a scenario in a clinical environment where he had made a mistake during a procedure for which he immediately took responsibility. His instructor called him a liar. His hands moved around as he stated:

I asked a few of my classmates, "Right?" within 30 seconds from the

event, and they re-oriented me and corrected me stating, "No, we never

learned that." So, I went back to the instructor within the next minute or

two and apologized. She [my instructor] called me a liar, at that point

and told me I was trying to mislead her.

Rebecca communicated an event she witnessed of a peer asking her cover nurse to assess a patient's bleeding hemorrhoids as this was a new finding for the student nurse. The response from the cover nurse was "Don't bother me with this" as she flipped her hair in her peer's face. Rebecca continued in a confident position and tone: "when you go to somebody and ask them a question, some people are not receptive of discussing it. We only ask because we want to know how to do it the right way." She continued giving an example stating:

If I went to you, and I didn't know, and I said, "Melissa, can we hang LR

[Lactated Ringers] with Zosyn [antibiotic], you know, I'm just not sure?"

And you [the nurse] said something like "I don't have time for your

garbage. Do your job," and "I've got 50 million things going on, and I

don't have time to be dealing with you" versus if you said, "You know,

I'm really busy, but you can look on Micromedex [pharmaceutical

database] just to make sure that they're compatible. Do you know how to

do that? If not, I can show you." The next time that person needs

something they're going to be like "Oh, she was really helpful." Or the

person is going to be like "Well, I'm not going to ask her," and these

people wing it, and that's when patients' safety is compromised because

they're afraid to reach out and ask, because they're made to feel like

they're an idiot.

Nate spoke of an incident with his cover nurse. He was advocating for his

patient's pain control post operatively. His cover nurse told him, "I don't have time for

this, figure it out on your own." Nate continued his story shaking his head from side to

side as he said:

When this nurse is your cover nurse, you're scared to ask questions, you

[the student] are scared to say, "Can we go over my shift assessment so I

can work on my assessment skills?" . . . On that day, when it [student

was advocating for patient's pain medication and cover nurses dismissed

his concern] was about pain medication. I didn't even ask to go over my

shift assessment. I just steered clear. It's sad because the clinical

environment is where most of our jobs are and where we [the students]

learn the most.

Michelle spoke in a frustrated tone about a cover nurse who demanded she hang an IV antibiotic. Michelle couldn't administer any medication without an instructor present. She began telling about her encounter with her cover nurse, stating very angrily:

> She [the cover nurse] basically threw it at me saying, "Here, hang this."
>
> I told her, "I'm not allowed to do that without my instructor." She [the
>
> cover nurse] was yelling at me in front of the patient. I [the student]
>
> didn't fully learn things. There were times where I [the student] was
>
> afraid to reach out and look for learning experiences, which goes against
>
> everything that I was trying to get out of nursing school.

Michelle also had a negative experience with a clinical instructor appearing almost defeated as she retold this event:

> She [the instructor] deliberately went out of her way to cause me [the
>
> student] emotional distress in the clinical setting. My prior clinical
>
> instructor had e-mailed her [the instructor] and told her how wonderful I
>
> was, she [the instructor] didn't agree and didn't see what that clinical
>
> instructor had seen. It made me feel like maybe I should take some time
>
> off, or even, I think at that point, I had a lot of questions surrounding the
>
> incident. Did I want to be in nursing school? Do I want to finish this
>
> out?

Once exposed to incivility, the participants spoke to the second subtheme that emerged from the data, which was "*dreading clinical*" training. They spoke to the feelings of not wanting to be there on the clinical unit. Half of the participants experienced the feeling of "*dreading clinical.*"

"Dreading clinical." Every participant's perception of nursing school was different. Half of the participants' discussions centered on feelings of not wanting to return to clinical after an incident with incivility. The clinical setting is a mandatory portion of the curriculum, and it is where application of learning theory happens. Sharif and Masoumi (2005) reported that the clinical experience was the most anxiety-producing part of the student clinical experience. Tammy stated when she was exposed to incivility, she was "heartbroken." She continued, with her hand covering her heart, stating:

> I had a professional career. I left my professional career because I was extremely motivated and felt I had a real pull toward nursing. It was heartbreaking. It made me dread going to clinical. It made me not want to go to her class.

> Rebecca stated with a tone of repulsion, "Honestly, I didn't even want to go to the floor anymore." Nate, added with defeat in his voice, stating, "Because that was actually my first time of incivility, it struck me so hard. I just didn't want to do it anymore; I didn't want to come back the next day. It was horrible."

There were two themes that emerged from Research Question 2. First, *unsafe zone*, identified as a time during clinical education that the participants felt they could not speak up. The second theme identified from the second research question was *patients first*. Amongst all the hustle and bustle of the clinical environment, all the participants reported that advocating for patients was a priority. Adding to this finding, the focus group participants felt students advocated for patients adamantly when having no voice to advocate for themselves.

Unsafe zone. This theme that emerged from the data analysis revealed the feeling that students felt unsafe while they were in the clinical learning environment. This finding aligns with the second research question. The subthemes identified include: "*keep your mouth shut,*" and *disempowerment*. There is a prevalent notion that students have no voice and little power or little control over what is happening in this setting. Due to the inequitable paradigm, student nurses may be particularly vulnerable to incivility (D'Ambra & Andrews, 2014).

"Keep your mouth shut." Communication is an essential component in nursing, yet the majority of the participants stated they felt that they had no voice during nursing school. All participants concurred that nursing students were "silenced" in clinical practice, and that learners are unable to make their voices heard, even when witnessing poor nursing practice (Bradbury-Jones, Irvine, & Sambrook, 2011). Nate reflected, with the look of horror that he was too scared to speak up saying, "I was terrified." Tammy added, with her hands in a zipping her mouth shut gesture:

> During my exit interview with the dean, I made sure that she knew of the
> things that were going on, but I didn't let them know until I was safe that
> I was graduating. I made sure she [the dean] knew who the instructors
> were, specifically, that were treating the students that way. I think you're
> so scared at nursing school that you just keep your mouth shut.

Michelle added in a less confident tone:

> I just really wanted to just slide by under the radar, if I could, and just pass
> because I knew that that was something I was never going to go back to. I was
> just going to learn what I had to learn and get through.

Robert, pounding his hand on the table, stated that he tried communicating with his instructor:

So, I [the student] did not feel it was resolved, and some others [students] felt that they had similar situations, not necessarily like that, but issues with this particular instructor. And so, we had escalated it above the instructor. We [the students] had a formal meeting with the director at the time. It was said to be, of course, between us— confidential, where we could air our thoughts to the director in private. Unfortunately, shortly after that, the instructor came up to each of us individually and made reference to bits of that private meeting that was supposed to be private. So, we [the students], as a collective group, felt that that was not a private meeting or confidential by any means. So, from that point on, we [the students] decided not to escalate any issues because we felt that the resolution was not confidential, nor did it happen.

The focus group data that was collected supported and added to the findings. Participants were probed with additional questions to obtain a deeper understanding regarding the conversation of *"keep your mouth shut."* One stated:

I [the student] think I kind of went through a situation like that where I wanted to say something about situations that were going on, but at the same time, I just don't want to make things worse for myself. I just want to keep my mouth shut, get through it, get to graduation, move past it. I definitely would advocate for my patients, but I wouldn't advocate for

myself. I was just, like, you know, pick and choose your battles and, like

I said, keep your mouth shut and get through it.

Another focus group participant went on to say:

You learn to advocate, what it means, how to do it, and they teach you

how to do it for your patients, and for yourself, but the minute you try to

advocate for yourself in school, then you feel the retaliation of doing

that. Anything you say is falling on deaf ears anyway. Nothing is ever

going to change. Even if you were brave enough to actually say

something that was wrong, you fear what might happen if you say

something . . . I'm not actually saying anything until I get my diploma in

my hand. I don't trust for a second that they won't find half a point to

hold me back or something.

David had a different approach. He spoke of writing about the incivility in his reflective

paperwork. With a mature tone, he stated:

At that time, it was in a mutual zone. It was a quiet area. There were no

other factors. It was just her [my instructor] and myself, so you know, we

were both able to go through what we both explained the situation in our

own eyes, and then we were able to work things out.

All the participants spoke about having to keep their mouths shut and related to

these experiences to the feelings of *disempowerment*, the hierarchy of the positions

within the nursing profession. We were "just students" many said.

Disempowerment. The second subtheme under the category of *unsafe zone* is

disempowerment. There is a natural vulnerability in the student/teacher relationship. Hurt,

Scott, and McCroskey (1978) suggested that, in an educational setting, "a certain degree of teacher power is always present" (p. 125). However, all six of the participants spoke to the idea of power with a degree of fear. The feelings of fear expressed by the participants surfaced after the act of incivility had been experienced. Instructors and staff nurses are in a unique position of mentoring the student nurses. Being involved in acts of incivility created a negative learning environment. Tammy spoke about not communicating with instructors for fear of retaliation, stating in a frightened tone:

She [my instructor] was also grading my class work, so there was no way I [the student] was going to say anything and have it affect my papers. I think there was a hierarchy, as opposed to looking at us [the students] as equals. They [the instructors] almost felt that because they had more knowledge, they were better than us. As opposed to teaching us, if you did something wrong, you were scolded, as opposed to taking the opportunity to teach us. I think a lot of instructors choose a person, right from the get-go, one or two people [students], they would be the people [students] they [the instructor] were most harsh on. Sometimes, it was even the people [students] struggling the most. They [students] were just the people they [instructors] were going to haze. I saw so many people [students] leave in tears. They [instructors] really control your grades so that fear is there, lean on your peers as much as you can because they [instructors] have the power to fail you.

Tammy, with an irritated tone to her voice, added:

> I was furious . . . the way she treated me was completely unprofessional.
>
> It made me feel incompetent, like I didn't know what I was doing. I was
>
> crying, and I avoided her . . . she definitely made me second guess
>
> whether I was going to be able to do the tasks I needed to do.

Michelle stated, in a submissive tone, "I didn't want any retaliation, and I didn't want to draw any more attention. I just wanted to make sure I was doing everything by the book so that she never had anything on me." Michelle continued stating:

> I felt like she [the instructor] was almost talking out of both sides of her
>
> mouth because it was in the infant/maternal rotation. We [students] were
>
> doing an infant assessment for the first time. I went in there, and I was
>
> clear inside, I don't have kids of my own, and this makes me a little
>
> nervous. I have underlying anxiety. I like to clear the air about that. She
>
> [the instructor] made me feel like everything is going to be fine,
>
> everything is going to be okay. It was myself and another student
>
> working as a team doing an infant assessment, and she's [the instructor],
>
> like, "Oh, you can't hurt the baby, you can't do anything, you know
>
> they're fine, they're not breakable." One second, we're looking at the
>
> infants' feet and she [the infant] had spit up and she [the instructor] was,
>
> like, "What are you doing? You're just going to let that baby choke?"
>
> It's, like, well, one second ago, you [the instructor] told me not to worry
>
> and, like, I said on top of already being upset, having cleared the air, and
>
> saying I have anxiety, I had a death in the family, which she was aware

of. At that point, I started to get upset and she [the instructor] basically

called me out in front of everybody. It just made me feel worse. It makes

you question, "Maybe I don't belong here, am I [the student] being

unsafe?" Then, it goes right back to "Oh, no, you're doing fine," until

the baby spits up again, and then I'm the worse person in the world. She

made me feel like a horrible person.

David, raising his voice, had similar feelings, stating:

She [the instructor[had a major attitude, and it seemed like she was putting me

down, and making me feel like I was doing it on purpose, that I was going behind

her back and about to do it [medication pass] without acknowledging her first, and

that was not the case. Afterwards, she's [the instructor], like, "I need to talk to

you after," and I'm, like, "okay." And then [we] went into the room, just her [the

instructor] and myself, and she [the instructor] continued to degrade me instead of

listening and allowing me to actually talk to her about the situation, telling her

what I thought the misunderstanding was.

Nate, appearing deflated, stated:

She [the cover nurse] was just very mean, and I feel like this individual liked the

power—a power trip. I want to say, I've noticed that several times, it was the

sense of power over someone. The control. I felt stupid, worthless, that I was

bothersome to everybody . . . it made me feel like I just wanted to quit.

Robert also spoke of being crushed:

As far as the instructor, in that particular case, I think it was felt that she

[the instructor] had to demand some respect or make it known her

position to the nursing students' position. The common theme you hear

about is, "make you feel stupid," you know. I always felt the one thing I

did not have control over was clinical. I always felt that at any point,

something could be said or something could be perceived in an unsafe

manner or something could have prevented me from graduating. You

know that feeling in the bottom of your stomach when you wake up to do

clinical. No matter how much prep work you had done, no matter how

safe you practiced or how many times you went to the lab to do things. I

always had a pit in my stomach that, "This could be the thing that holds

me back."

Rebecca passively added, "I felt belittled. I felt like I wasn't valued, and honestly, I felt

like someone was judging my work ethic."

The focus group conversation supported this theme with statements such as:

It's almost like they put up a front, you know, being the big, bad

instructor. We know they know more than us. Most of us are cognizant

of that, and we look to them for advice and help, not to be belittled. I

think that people have forgotten where they came from, and I think that's

terrible. You should treat people how you would want to be treated and

how you want to be treated when you were going through that.

Students depend on faculty and staff nurses to provide educational experiences

that are supportive, positive, and fair. The environment in which students practice should

be safe. Instructors and staff nurses should be role models for student nurses as they learn

the profession of nursing. From the first day of nursing school, students are taught that

everyone is responsible for the patient. If a patient is ringing the bell, anyone can answer it and let the appropriate person know what is needed.

Patients first. The third theme that emerged from the data analysis within the second research question was *patients first*. Patients are the priority within the hospital setting. However, all the participants in this study recognized, it is common knowledge nurses have extremely busy schedules, high acuity patient loads, under-staffing issues, in addition, to the responsibility of mentoring students. Patients can see and hear everything around them whether nurses realize it or not. The subthemes identified include: (a) *too busy for students*, and (b) *"patients can hear you."* On a busy clinical unit, students can feel lost in the midst of the action. Participants agreed that it is one thing to feel overwhelmed by the sights, noise and responsibility, and it's another to feel shunned and embarrassed by your own mentors in front of patients.

Too busy for students. Three of the six participants spoke to staff being too busy to mentor nursing students during clinical training sessions. For some learners at various intervals of the clinical training rotation, the student/preceptor relationship can be enriching and mutually rewarding. At other times, these novice nurses found the collaboration more stressful and difficult. Either way, there are patients who need to be cared for. Michelle reflected upon a time stating:

> I went to go introduce myself to my cover nurse and say, "Can I get report?" She
> was, like, "I'm busy, you're going to have to run after me." Okay, so I ran after
> her and went into the patients' room that I was receiving.

Rebecca, visibly upset by this reflection with a shaken voice, added:

The issue I had is I went to the nurse because the patient was

complaining of symptoms of a UTI [urinary tract infection], so I looked

in the hat [urinary collection device], and it looked really dark. It looked

kind of bloody, but it wasn't gross hematuria. I went to the nurse and

explained to her what the patient had said, and what I observed with my

eyes and said, "Do they want to run a UA (urinalysis)? What are we

doing with this?" She totally blew me off and didn't want to address it.

It was just about shift change, and I went to the next nurse, and the next

nurse was, like, "Wow—let's figure this out!"

Rebecca continued her reflection, shaking her hands, stating:

Honestly, I mean this person would say very snarky things the whole

time we were there like, "Oh, I can't wait for the students to leave, so I

can sit down." We were always in the way. When you are a student, you

have to kind of tread lightly, and it's almost like you walk on egg shells.

Nate, sounding perturbed, when advocating for his patients' pain medications,

stated:

This nurse kind of like threw her hands in the air like she was frustrated

that she didn't have time for this, even though she was on her cellphone.

She stated she didn't have time for this, and that I needed to figure it out

on my own. I came back the next day, and still the pain medication was

the same, and his pain was still like eight (out of 10) across the board,

and it didn't get changed until that day because it was a different nurse.

Several students verbalized and went to our instructor that this nurse was

just very rude and making remarks, and even [making] remarks about

patients in the med room. It was very sad.

Nate also reflected on nursing assistants stating, "Nursing assistants were asked

for help, [such as] "Can you help me clean this patient up or turn this patient?" and the

reply [was], "No, that's why you grab another student, that's not my job right now," and I

would go grab a friend.

The focus group participants added to this theme stating, "it's not necessary to act

that way. You shouldn't complain about being short staffed, but then when you have

people willing to help you or willing to work with you, dismiss them or make them feel

belittled."

The students felt even worse when such behaviors were acted out in front of

patients. Patients could hear and see what was going on. It shouldn't be burdensome for a

patient to have a student nurse.

"Patients can hear you." The second subtheme that emerged from the analysis of

data aligning with the second research question, *"patients can hear you,"* was revealed

especially when incivility was happening in front of the patients. All the participants felt

that patients felt the impact of incivility and some even experienced negative outcomes.

Some statements like, "she screamed at me in front of the patient and literally pushed me

out of the way . . . told me to leave the room." (Tammy). This patient refused care from

students going forward, reported Tammy, as she looked down feeling ashamed.

Michelle experienced comments made from nursing assistants that irritated her,

such as, "This patient has a student, so don't do anything for them," and she continued

stating "In reality, this patient, if they need help, you should be there to help, not ignore."

Michelle shared the story of a time when she was trying to get a report from her cover nurse, and the cover nurse wanted her to hang an IV antibiotic. When she said she wasn't allowed to complete that task without her instructor, she [the cover nurse] started yelling at me in front of the patient, "Well what can you do? This needs to be hung right now." She reported another incident when the same nurse went to tell her she had a patient whose IV was complete. She said, "'Well, why don't you do anything about it?' "Basically, [she] just started yelling loudly for everyone to hear."

David spoke to the impact of patients' exposure to incivility. He passionately stated:

> If a patient sees it, and then they mention it or ask, "Is she going to be
>
> ok?" then it definitely impacted the way they saw it. I mean if they don't
>
> say anything at all and you see their facial expressions, where they
>
> actually don't say something about it, I mean that's actually stronger.
>
> Sometimes it's the ones that don't say anything at all, those are the ones
>
> that are impacted the most.

The focus group supported this theme:

> So as a patient, what do you think? "The student doesn't know what
>
> they're doing." That just makes you [the student nurse] feel stupid and
>
> then I [the student nurse] have to be with the patient for the next two
>
> shifts, and now they [the patient] think I'm an idiot.

All participants spoke of just getting through it, trying to make the best of it. Some participants stated some interactions with incivility made them push harder to complete the nursing program successfully. These participants truly believed that each

could become an active member of a more professional, collaborative nursing team which could make a positive contribution to the nursing profession and contribute to the wellbeing of patients. These ideals propelled the subjects forward despite the abhorrent learning climate.

Future nurses. The fourth and final theme that emerged from the data analysis answered Research Question 3. The theme is *future nurses*. The subthemes identified include *resilience* and *retention*. Many of the participants alluded to the idea that one can get through anything that is time limited. Due to the ongoing shortage, graduates have choices of employment opportunities. The environments that these students, now graduates, were once exposed to during clinical training sessions become an option (or not) of employment choice. Each participant addresses the issue of exposure to incivility had on individual retention and employment choices.

Resilience. Nursing school is often very demanding. The expectations are high. Students must complete both theory and clinical components with satisfactory grades, allowing each to progress forward to the ultimate goal of graduation. Adding exposure to incivility at any point of a student's nursing school experience tested their ability to bounce back from adverse experiences. All six participants reported *resilience* as a factor that related to their experience with incivility while in nursing school.

Tammy stated with positive energy, "It made me want to just help out, so when I see students now, I want to help them and let them know just get through it, just push through, lean on your peers to help you." Michelle questioned many times if she should have complete school, stating:

I had a lot of questions surrounding did I want to be in nursing school?

Do I want to finish this out? I was at the halfway point. I went home and

discussed it with my family, and said "I'm going to finish this out, I am

going to do it despite her." I think that's what drove me after that. I

think coming from that situation so recent[ly], I think it's important to let

students know you're not here to be anybody's slave. You are here to

learn and you're here to take care of your patients—no matter what

anybody tells you.

David added that he turned his exposure to incivility into a positive learning

experience. He stated with absolute assurance, "I think it was more of a positive, because

then it opened up my eyes into what I needed to do to make sure this does not happen

again." Rebecca added very confidently:

I'm a very loud and outspoken. I want to be professional, and I want to

be polite and kind, but I'm going to say what I think or what I hear. Like

it or not, if it comes to my patient. Unfortunately, other people are very

timid, and they don't feel empowered to say, "You know what? This is

wrong, and we need to do something about it" because of the way the

other nurses treat them. I know that it can be intimidating to go to

people, but you can't let that become a barrier to good patient care. Our

job as an RN is to advocate for our patients. Sometimes, that means

ruffling peoples' feathers, and if they don't like it, that's okay. They

don't have to like it. At the end of the day, you need to know that you

did everything you could to care for your patient.

Nate started describing what a busy day looks like and how he is mindful of students' feelings:

Working as a nurse, it's busy, and I can see where some nurses might snap because there's instances where I'm running around, and I've been interrupted so many times just trying to hang an antibiotic, and someone comes to talk to you, and you just want to snap and say, "I don't have time for this right now, I need to do this." I've learned not to do that, especially through orientation, I've learned to nicely say, "Oh, just one moment; I just, I'll be right with you, I just have to hang this antibiotic real quick. I promise I'll be right back." I've had students; I've had lots of students, and sometimes I get a lot of questions, and I try to use those instances of incivility to better my practice with the students, because I don't want to be that nurse that . . . you know they're really mean. You know? I always try to go over my shift assessments with all the students and teach them all, so definitely those incidents of incivility have—I have reflected on and try, I really try, my hardest not to be rude, make remarks, or throw my hands in the air. I try to be, use constructive criticism, and I try to be pleasant to be around, even though I do see that sometimes you can be completely overwhelmed.

Robert added his new perspective with an empowered tone:

If I saw something happen now, I would wait until the situation was over, then I would probably approach the person who was treated badly and just talk to them. I would assist them, give them advice, or maybe

talk through it with them and see what they wanted to do. I would give

support.

The focus group finding differed from the interview finding in that one participant felt that incivility reaches beyond the medical field:

I think it might go a little bit deeper than nursing. I think that today's

society is breeding people that never lose, that never get disciplined, that

never find out that they're wrong, so when they go to a secondary

school, and they are told that they're doing something wrong it's . . . .

They might not take it correctly and it's hard. So, I think, to an extent,

people do need either discipline or guidance and direction beyond what

they're used to. I don't think it should come in the form of incivility, but

I think the way that some people take criticism or constructive criticism,

they're not used to it so they might not know how to take it, so they

might take that as incivility. So, not to tolerate it, but I don't know,

what'd we say? Pick your battles before, would you say? But it's hard

because everybody's going to be different, and there is incivility out

there. I think the bigger question is, can somebody be in charge of that in

nursing, if we're talking about nursing here, at a higher level, an

individual, an instructor that can advocate for students, that can see

incivility from the student's eyes, especially when they get repeated

complaints from certain professors, instructors, nurses.

All the participants were asked approximately how many times they were exposed to, witnessed, or were an active participant in incivility during their clinical experience.

The numbers ranged from several times a semester to hourly. The last question asked each to each participant pertained to incivility and post-graduation job choice. *Retention* is the final subtheme that emerged from the data.

Retention. Retention of graduate nurses is optimal for hospital-based nursing programs. Most hospital-based programs rely on students staying as full-time registered nurses. However, 50% of participants adamantly express that exposure to incivility during nursing school deterred application to the host institutions upon graduation. Both institutions depend on theses qualified graduates whom were trained on their sites to be a source of human capital to alleviate existing nurse shortages within the organization. Two participants stated neither would apply to units in the organization where incivility was commonly occurred during training. One participant continued working on the unit where incivility occurred for scheduling reasons. Tammy very adamantly stated:

> I wanted nothing to do with [name] hospital, nothing to do with them at all. Actually, when I graduated, they [school] want you to sign something so they can follow you [student] and see your career progressing, and I didn't. I don't want my success to be affiliated with them [school]. I thought the program and the clinical experience I gained was fantastic, but I think the teachers and their hierarchy and just the line between student and teacher really turned me off.

> Tammy continued speaking to the likelihood of ever applying at the training

hospital stating: "Highly unlikely, it would have to be my last possible option, if I was unemployed."

Michelle had recently left a position at the hospital where she was trained, which was directly related to the incivility she encountered on a particular unit. She recalled

why she took the position stating, "I think I chose the unit that I chose to work on because I thought it was going to be the best place for a brand-new nurse." The researcher asked Michelle, "Did leaving the unit have anything to do with incivility?" Her response was:

> I think the main orienteer [preceptor] on the unit, I've seen behaviors. I observed her and my nurse manager talking about orientees [newly employed nurses] behind their back. I also caught her talking about me behind my back. Just in general, I didn't feel welcome by her. I went to my nurse manager and said I would like to have things more consistent, and I would like to work with the orienteers [precepting senior nurses employed by the hospital] that I have been working with. She refused to switch me to a different orienteer [preceptor], so I decided to move on.

When asked about the likelihood of returning to that institution, Michelle stated "as of right now, probably unlikely."

David chose a different organization to work with at based on management and personal growth reasons. He spoke to organizational change and personality conflicts stating:

> I could see everything, the changes that were happening . . . . The one floor that I really, really wanted to go on, the manager, I guess, was questionable, which was very unfortunate. But then again, to match them up with the managers that I have now, there is no comparison whatsoever. And the benefits definitely came along with it, so honestly,

when it came down to my personal decision, it came to management and

benefits for what was going to benefit my family the most.

When asked the likelihood of returning to his institution of training, his response was:

Honestly, probably right now, I'd still say no . . . . I'm really focusing and making

sure that I learn everything I can here and get a good solid basis so that I can

continue to grow and expand.

Rebecca stayed at the institution of training. She confidently stated:

I purposefully didn't apply to either of the two floors where I found

[there] to be a large attitude problem, because I didn't want to deal with

it. I was excited to be a nurse, and it's something that I've always wanted

to do, and in that type of environment, nobody is happy. I don't want to

spend my time feeling like I need to look over my shoulder.

Nate also stayed at the hospital of his training. Despite his encounter with

incivility, he chose to work on the unit that the incivility occurred. He stated:

The unit I chose, actually, after my second semester, I took a nursing

assistant job there. That helped a little bit just to know the floor and

know the staff; you know how the staff acts sometimes so . . . regret, not

regrettably, but really if I had, the manager offered me days and that's

really what I wanted, and at the time when I was applying, all the other

floors were offering nights. I worked nights all through nursing school as

a nursing assistant, I worked almost full time, so I was a little burnt out,

right, so she offered me days, and I took it. Now, let's say, if another

unit, there was one unit I really wanted to work on, I had clinical there;

my preceptorship was there; I really enjoyed my time on this certain unit.

The nurses there were really supportive. I never had a problem there as a

student or even working there; I worked there a lot, picked up a lot of

time, and if they offered me days, I probably would have gone to that

unit in a heartbeat. But, the unit I work on was the only floor to offer me

days, and it worked around my schedule for, I'm going back to school,

getting my bachelor's, so it was almost, schedule wise, almost too good

to be true. I couldn't skip up on that. That was a huge factor in me

working there.

Robert also worked at his training hospital after graduation. He added with

confirmation, "As nursing students, we all had different floors we had practiced on that

we said we would probably not apply toward such floors."

Connections Between the Study Findings and the Theoretical Framework

There is overwhelming strong evidence in this study that supports findings of

incivility in three major areas. Each of these findings connects directly to the theoretical

foundation and purpose of this study. Participants reported a variety of behaviors and

experiences that breached all three components of the theoretical framework

underpinning this study: social exchange theory, peace and power theory, and human

caring theory.

Homans (1961) social exchange theory is a model for interpreting interpersonal

communication as a series of interactions between people that are based on estimates of

perceived or actual rewards and punishments. Social exchange theory tells us that either a

positive (reward) or negative(punishment) outcome will result from every social

interaction. Participants in this study reflected upon negative social exchanges between themselves and staff that inhibited their learning experience.

Wheeler and Chin (1984) peace and power theory reinforces the idea that although hierarchy power is innate, conflict resolution can lead to peaceful outcomes. This theory can be used as a means of creating healthy group interactions and promoting health by reducing stress and distress created by a hostile conflict. Participants in this study spoke to the degree of power instructors and staff had, resulting in feelings of disempowerment after uncivil encounters. Meanwhile, participants offered suggestions to promote peaceful encounters that would build more positive relationships in the clinical environment.

Watson's (1979) theory of caring defines the attribute of caring as an interpersonal process that occurs between two people and which involves both the provider of care and the receiver of care. Watson suggests that the caring moment transcends the relationship for better or for worse depending on the nature of the relationship. Participants in this study commented frequently that caring is at the heart of all nursing practice. However, this study's findings reveal numerous uncaring interactions amongst professionals in this setting. In an ideal, healthy clinical setting, civil encounters (i.e. positive social exchanges) lead to a peaceful working environment and enhance the caring component of the working relationship. On the other hand, incivility creates a negative social exchange leading to power struggles that compromise or destroy the caring component of the working relationship.

In conclusion, Table 4.1 summarizes the findings, themes, and subthemes as addressed by the research questions. This study concludes that incivility is present and

widespread within the clinical training environments and is being perpetrated by instructors, cover nurses, aides, and doctors. Additionally, incivility behaviors impact post-graduation employment choices.

Table 4.1 *Summary of Findings, Themes, and Subthemes*

Findings	Theme	Subtheme
1. Uncivil behaviors exist within the clinical environment.	"Nurses Eat Their Young"	Definition Missed Opportunities "Dreading Clinical"
2. Uncivil experiences with individuals, such as instructors, cover nurses, aides, and doctors, impact the students' nursing clinical experience.	Unsafe Zone Patients First	"Keep Your Mouth Shut" Disempowerment Too Busy for Students "Patients Can Hear You"
3. Incivility in the clinical environment has a strong impact on retention and employment choices post-graduation.	Future Nurses	Resilience Retention

Summary of Results

The purpose of this qualitative phenomenological study was to explore the impact of incivility on hospital-based student nurses, retention as licensed registered nurses, and these RNs' post-graduation employment choices. The three major findings that emerged as a result of the data analysis were, first, recent graduates from hospital-based programs identified several uncivil behaviors with the clinical environment that affected their learning experience. Second, recently-graduated nurses described many experiences with different individuals in the clinical setting that they described as uncivil encounters that impacted them as nursing students. Participants identified instructors, cover nurses, staff nurses, aides, and doctors as the perpetrators of incivility. The final major finding was that exposure to incivility in the clinical environment had a strong impact on retention

and post-graduation employment choice. All of the participants related their employment choices to incivility exposure. Three participants left their training organization, two participants chose not to work on specific units within the organization, and one participant, despite involvement with incivility, chose for other reasons to work on the unit of occurrence.

Incivility not only impacted the work environment and patient care, but also the retention and post-graduation choice for the new graduates. All themes and subthemes were relevant to the lived experiences of registered nurses graduating from an associate degree hospital-based nursing program with less than 12 months experience reflecting upon exposure to incivility during nursing school.

Chapter 5 will explore the implications of the results of this study. In addition, limitations of the study, as well as recommendations resulting from this research, will be discussed.

Chapter 5: Discussion

Introduction

Incidences of incivility within the nursing profession are reported in the literature as problematic, systemic and widespread on a global proportion (Altmiller, 2012; Clark and Springer, 2010; Del Prato, 2013; Hunt and Marini, 2012; Hutton and Gates, 2008; Johnson, 2009; Khademi, Mohammadi and Vanaki, 2012). Incivility impacts both the retention of skilled nurses and the persistence of student nurses in the profession, catapulting the already existing shortage of nurses (Isgur, 2008; Wilson and Phelps, 2013). Without adequate nursing staff, the quality of patient care and safety are compromised (Laschinger, 2014). The findings in this study are consistent with the literature on incivility within the clinical environment. With the nursing shortage expected to escalate and the demand for nurses increasing, incivility is a critical factor that needs to be addressed within the nursing profession.

This chapter provides a review of the research methodology, discussion of the implications of the findings, several recommendations, including the need for future research, limitations of the study, and conclusions of the research.

Review of the Research Methodology

The purpose of this qualitative phenomenological study was to explore the impact of incivility on hospital-based student nurses, retention as licensed registered nurses at the hospital-based host site, and these participants' post-graduation employment choices as newly graduated and newly licensed registered nurses. Participant selection criteria

included: (a) graduating from a hospital-based nursing program within New York State and (b) having less than 12 months of working experience as a post-graduate registered nurse. Six participants consisting of three males and three females, from two different hospital-based associate degree nursing schools who met these criteria, were initially asked to provide written feedback to the research questions. All six later self-selected into this research study and participated in one-to-one interviews. Two of the six later participated in a small focus group.

This study adds to the body of knowledge by identifying the experiences of registered nurses reflecting on their student nursing experiences of perceived incivility while in the clinical portion of training. The findings of the study were derived from the guiding research questions:

1. What behaviors in the clinical environment did the Associate Degree graduate nurse perceive as incivility during their nursing school clinical experience?

2. How do new graduate nurses describe their experiences with incivility when they were nursing students?

3. To what extent did exposure to incivility in the clinical environment impact employment choices post-graduation?

Many themes and subthemes emerged from the analysis of the data. The four main themes incorporated elements related to the experience these participants had as nursing students during their clinical portion of nursing school: (a) *"nurses eat their young,"* (b) *unsafe zone*, (c) *patients first*, and (d) *future nurses.* These themes encompassed a spectrum of factors leading to exposure or witnessing incivility during clinical training.

The first theme, *"nurses eat their young,"* emerged as a broad, overarching category when the participants defined and described their encounters with incivility during their nursing school experience. The two subthemes identified from this main theme were *missed opportunities*, and *"dreading clinical."*

The second theme, *unsafe zone*, emerged from the data analysis. Unsafe zone depicted how these graduates as students felt in the clinical environment. The two sub-themes were identified including: *"keep your mouth shut,"* and *disempowerment*. The third theme that emerged from the data analysis was *patients first*. Two subthemes were identified from the *patients first* theme: *too busy for students*, and *"patients can hear you."* The fourth and final theme that emerged from the data analysis was *future nurses*. The subthemes from *future nurses* were identified as *resilience* and *retention*.

The participants noted fear of retribution when expressing honest feedback on the required graduate exit survey. Respondents spoke of communication challenges throughout their clinical experiences with instructors and staff. These respondents were encouraged to advocate for their patients, but collectively believed there was no safe pathway to advocate for themselves as nursing students without retribution. Additionally, participants noted several times during their clinical experience that incivility resulted in compromising patient safety.

Implications of Findings

The findings of this study indicated that widespread uncivil behavior exists in the clinical portion of nursing education and concurs with the literature research that incivility is a common behavior in the nursing profession holistically. These negative, uncivil behaviors clearly violate all three theoretical underpinnings of this study:

Homans' (1961) social exchange theory, Wheeler and Chin's (1984) peace and power theory and Watson's (1979) human caring theory. Furthermore, the stories of incivility captured in this qualitative study reflect a breach of both the long-standing Credo of The Nurse's Pledge and the American Nurses Association's (2015) expectations and standards for professional conduct. These standards provide clearly communicated expectations of professional conduct which are incongruent with hospital interpersonal professional relationships at these two hospital-based nursing schools represented in this study.

Throughout the data collection process, incivility was self-defined by all participants. In conjunction with the literature review, too many definitions for incivility exist. As such, the act of incivility seems to be often misinterpreted and dismissed (Clark, 2013 & Lachman, 2015).

The vulnerability of being a student is a factor as to why incivility was not being reported during the clinical training sessions. Consistent with the findings from Walrafen, Brewer, and Mulvenon (2012), indeed, all graduates described themselves as victims of incivility during clinical training. When nursing students experienced incivility, and were fearful of reporting it, an atmosphere of silence, anger, trauma, humiliation, and stress was created. Consequently, participants reported being stripped of self-confidence and began to question their role as a learner, their competency level as soon-to-be graduates, and their individual sense of belonging in the nursing profession.

Incivility within the clinical setting reported by participants is happening as frequently as hourly to a few times during a semester (16 weeks). Consistent with the findings of Del Prato (2013), perpetrators were primarily college paid clinical instructors

and hospital paid cover nurses. The phrase "*nurses eat their young*" was a common statement among these participants and this response was unanimous without prompting from the researcher. Participants compared the meaning of "*nurses eat their young*" to the same characteristics as lion cubs that are vulnerable to elimination by the father lion, so as to establish his own dominance by eliminating the weakest of the species. Only the strong survived by adhering to a strong survival instinct and sound survival tactics. Likewise, all the participants referred to *"nurses eat their young"* as a professional moniker of their nursing training. This concept is counterintuitive to the caring profession and this practice threatens to abort the next generation of nursing professionals.

Congruent with the Altmiller (2012) study, participants also stated the feelings of dreading attending clinical training which heightened sensitivity to the expectation of abuse. In an atmosphere of learning where questioning is the norm, participants reported adopting a survival tactic of detachment, and deemed some clinical floors as an *unsafe zone*. As a response, students actively decided to avoid these units and missed crucial learning opportunities during their training and later, avoided these floors as employment options.

All participants of this study spoke to the need for resilience and wisdom gained from incivility encounters as a student nurse. Consistent with Jenkins, Kerber and Woith (2013), all participants mentioned civility as respect, caring, teamwork, and a positive working environment. All respondents' demeanors and facial expressions, hand gestures, and tone of voice dramatically changed when speaking of positive interpersonal interactions with some nursing preceptors during clinical training. Additionally, all participants stated that, if able, the friendly and approachable cover nurses and clinical

instructors became their go-to faux mentors in lieu of the assigned clinical instructor/cover nurse.

Respondents concurred with Laschinger's 2014 study regarding student nurses' concern for quality patient care and the learner's role in assisting and providing quality care. Nursing staff was often too busy to provide guidance, supply proper patient history, and next step care-planning for the patients students were assigned to. Students reported feeling disempowered by the miscommunication and high expectations which often led to missed assessments and unasked questions. A graduate reported reluctance to seek out a cover nurse to review patient assessment for fear of further uncivil treatment. Failure to communicate could have led to poor patient outcomes.   After exposure to incivility, patients were reported to lose trust in the care administered by students. Patients then refused to receive basic care from nursing students. Therefore, the consequences of incivility continue to impact the quality of patient care during the learning opportunity due in part to less frequent visits from any nursing provider, including nursing students.

The future of the nursing profession is dependent on nursing students. The shortage in nursing is only expected to rise with baby boomers retiring and the need for healthcare increases (Falk and Fischbacher, 2002). Incivility has a major impact on retention rates and post-graduation employment choice. Consistent with D'Ambra and Andrews (2014) study, participants of this study stated that many graduates left the organization as a direct result of incivility. Focus group participants generated the idea that students bind together, protecting each other from perceived incivility that was happening on specific units. The group of learners banded together to create a tribe of individuals who further vowed not to apply to identified uncivil units upon graduation.

Retaliation to avoid further abuse perpetuates the staffing shortage issues of those nursing units and may contribute to the nurses' shortage in these hospitals holistically.

Similar to the subjects in Anthony and Yastik (2011), recently graduated nurses also reported inconsistencies when learning about incivility and the behaviors being modeled by the instructors and staff nurses. The concept of civility or respect may be taught, but these behaviors are reserved only for the patient, not for novice learners.

Recommendations

The researcher has several recommendations that make practical use of the findings in this study. These include formulating an accepted definition of incivility, revisions to policy and shared governance, changes in the education of future nurse leaders and other areas for further research.

Formulation of accepted definition of incivility. Many definitions of incivility exist which may lead to varying interpretations of uncivil behaviors and lack of reporting. Creating a common definition of incivility would help with identifying behaviors and as a result, may evoke policy changes towards establishing best practices in the nursing profession.

Policy change and shared governance. Anthony (2004) reported shared governance models were introduced to improve the nurses' work environments, satisfaction and retention. Shared governance within the nursing profession attempts to connect new emerging ideas to establish and evaluate best practices within the field. Shared governance is often charged with reviewing policies. American Nurses Association's Code of Ethics for Nurses with Interpretive Statements mandates that nurses are required to "create an ethical environment and culture of civility and kindness,

treating colleagues, co-workers, employees, students, and others with dignity and respect" (ANA, 2015, p. 4). Similarly, nurses must be afforded the same level of respect and dignity as other professionals. However, the ANA, who also incorporates nursing student concerns, is clearly not able to enforce these statutes as incivility incidences are not reported. A pathway must be constructed or better defined as a method to report incivility on all levels. In addition, a disciplinary action protocol for uncivil behaviors must be identified, established, with meaningful punitive measures in place, as well as protection to whistleblowers must be ensured. As one of many recognized governance bodies for registered nurses, the ANA must collaborate with other nursing organizations to create a standardized definition of incivility, promote education on this topic and act on reports of incivility incidences in order to create positive nursing environments.

In this research study, shared governance is a complex entity. The nursing schools are institutionally embedded with educational policies and procedures, yet the nursing schools utilize hospital settings fraught with a strong, longstanding medical culture of hierarchical rankings and traditions. These two stakeholders must develop ways to work collaboratively towards establishing positive professional conduct among its constituents. Established shared governance committees should consist of members from the educational and medical institutions to establish protocol of acceptable/unacceptable behavior, including a "no tolerance" of incivility policy. This policy must be adopted and enforced by both the medical organization and the nursing profession holistically to include students.

Conversations among hospital administrators and the nursing school administrators regarding the cost of novice nurse attrition and return on investment (ROI)

might also spur action. According to Jones (2005, 2008) the cost of recruiting nurses is staggering. Hospital-based nursing schools exist in part, to channel graduate novice nurses back into the host hospital to offset shortages of floor nurses. Of the participants in this study, 50% did not apply to their host site. As learners, these novice nurses were oriented to the mission, the vision and the culture of the host institutions. Having received this extensive training, these novice nurses are less expensive to hire and are more able to acclimate to responsibilities and demands more quickly than are those who are prospected and hired from outside entities.

As a further recommendation, student voice must be participatory and function as a pro-active entity. When shared governance is at its very best, every person has a voice. Every student's voice should be heard without fear of retaliation. Of the six participants in this study, only the one male student approached the subject of incivility with his instructor. Clinical post-conferences should incorporate professional behaviors students witnessed or engaged in to allow the conversation of incivility to be incorporated into daily practice. Students need a safe space to allow critical conversations to be forefront.

Student nurses should be invited to key committees to give voice to novice nurse practice and performance as learners. These conversations might be best served if students were members of a 'student life committee' with a faculty advisor. The faculty advisor would be tasked with communicating various students concerns to the college faculty and administration. Participants within this study reported the current college policy that requires soon-to-be graduates to complete an exit-survey prior to graduation. Although many colleges ask students to complete an exit interview prior to graduation, many participants feared retribution and refrained from providing honest feedback.

Therefore, these participants recommended that the colleges should administer the exit-survey as a post-graduation practice. These surveys would then provide a more accurate reflection of the nursing students' learning experiences without these students being fearful of retaliation. However, knowledge of behavioral problems and other issues that thwart learning would be best addressed in a committee setting at the time of the occurrence rather than after-the-fact is fear was no longer a concern.

Shared governance is a social justice tenet. The theory of caring should be the core of education and healthcare practice. However, the peace and power theory and social exchange theory explain inequitable behaviors that often occur in the workplace. The human need for reward and punishment as a method defining acceptable and unacceptable behavior is often aligned with the creation of policy and procedures which guide healthcare practitioners. However, positive interpersonal relationships are the innate need for collaboration in a healthy working environment. The core tenets of the theory of caring should be the catalyst and the desired outcome of every shared governance opportunity in healthcare.

These research findings uncover several social injustices that must be addressed. Giving voice to others is paramount. Whereas the incidents of incivility in the study did not occur with diverse ethnic populations, diversity is increasing in the local population where this study occurred. Research shows that as the ethnic demographic changes, there is a positive impact on diversity training with includes benefits to the nursing profession (Beheri, 2007). As both the patient population and the population at large is becoming more heterogeneous, recruitment efforts need to reflect these changes in the working environment. Therefore, recruitment efforts in nursing need to change to embrace those

professionals who are best able to identify all patients' needs. Diversity in both students and educators is needed to better communicate these cultural variances. Diversity in gender, ethnicity, and religion need to be better represented in the nursing profession.

Education of future nurse leaders. In the shared governance model, academic and clinical nurse leaders could have a deep impact on changing the culture of the nursing profession through promoting a more civil clinical and classroom environment. Resonant leadership endorses a positive work environment that promotes employee engagement and results in greater work satisfaction and productivity (Uhl-Bien, 2006). To adopt this style of leadership, nurse leaders will require ongoing organizational development training to encourage positive behaviors among all healthcare constituents. Training should include incorporating The Five Practices of Exemplary Leadership (Kouzes and Posner, 2012). The Five Practices of Exemplary Leadership are identified as: (a) Modeling the Way, (b) Inspired a Shared Vision, (c) Challenge the Process, (d) Enable Others to Act, and (e) Encouraging the Heart.

Modeling the way. Nurse leaders need to be mentors who set the example of professionalism by identifying various workplace behaviors, being approachable and open, take appropriate action as needed, open dialog towards problem solving, and identifying methods of promoting a healthy work environment.

Inspire a shared vision. Nurse educators need to enlist all nursing professions to create an accepted definition of incivility and further work to eliminate these damaging behaviors in the healthcare arena. In addition, nurse leaders need to have the vision of wellness in the workplace and inspire learning and collaboration with established practices that enhance and elevate the nursing profession.

Challenge the process. Leaders would accept the challenge to change the current substandard nursing condition of every member responsible to create a more civil environment. Incivility cannot be tolerated. A zero-tolerance for uncivil behavior needs to be enforced. This will promote civility in the nursing profession. Precepting policies and the patient care load need to be reevaluated so that nursing students receive adequate attention and enhanced learning experiences.

Enable others to act. Nurse leaders should be flexible and able to adapt innovation. Encouraging collaboration will provide opportunities for new ideas sparking change. For example, assessments for both nursing students and staff preceptors should be created to provide feedback after every clinical rotation. Information garnered from these assessments would create a catalyst for necessary changes as well as helping to and identify blind spots in practice. Nursing educators should consider collaborating with floor nurses to develop training manuals for each clinical rotation. Including frequently asked questions (FAQs), common medical terminology, pharmacology, various procedures and exams, and other patient or floor concerns would create a resource tool available both to students and novice nurses. This resource may empower students and new staff for the demanding role of a profession nurse.

Encouraging the heart. Leaders should be encouraged to show genuine acts of caring to other faculty, staff, and students. These individuals should be viewed as valued team members and partners towards achieving established hospital outcomes and excellence in patient care practices. Students and hospital administrators should acknowledge the extra work preceptors are performing for the nursing profession and for the hospital. Students should be encouraged to express gratitude to the preceptors and

nursing staff by providing examples of positive learning moments and celebrating end of training experience with staff members.

Future research. This study has begun a process of investigating and describes a phenomenon that has far-reaching implications for the health care industry. There are many opportunities and possibilities for future research.

1. Identify best practices of promoting civility in the academic and clinical setting for nursing students.

2. Replicate this study in a wide variety of programs with sites that have identified problematic behaviors or those who have remediated problematic behaviors.

3. Develop a method to match the preceptor and the nursing student in the clinical environment.

4. Conduct a study of the same cohort for attrition in a hospital-based nursing program to explore and identify other reasons for attrition.

5. Develop a study regarding the patient perspective of incivility in the clinical environment that host students.

Nursing research on the topic of incivility should be ongoing, dynamic, and relevant towards establishing positive learning and working environments. The ensuing discourse can ignite novel ways to evoke change.

Limitations

The complexity of this study over the duration of an abbreviated timeframe of 28 months provided several limitations. These limitations were related to sample size, IRB

constraints, lack of respondents' availability to conduct research, and potential researcher bias.

This small sample size resulted from marketing the opportunity by using word of mouth invitation through networking with colleagues and faculty. The initial word of mouth referral method was chosen due to the last-minute decision of one hospital-based nursing school who later decided not to grant IRB approval for this study. In retrospect, an open invitation approach through the use of a student record database to both hospital based-nursing programs may have increased the number of participants. Whereas this small sample size limits the generalizability of the study, the small sample was also a benefit or a de-limitation. Due to the small sample size, the researcher was able to focus deeper with fewer subjects which yielded rich descriptions of lived experiences which may not have been possible with a larger sample size.

Graduate nurses' lack of availability to schedule the focus group was a deterrent to focus group size. Due to the nature of the nursing job demand of working multiple shifts to provide patient care, it was difficult to coordinate a sizable focus group.

Researcher bias was a concern as the researcher's status as an experienced nurse educator may have impacted the designing of the questions, analysis of the data, and interpretation of the findings. Although the participants seemed comfortable relating their experiences, a non-nursing researcher who is not involved with the caring profession may have collected, coded, and analyzed data from a different perspective. The researcher attempted to identify personal and professional bias by bracketing data that could influence the outcome. The one-to-one interviews and focus group were emotionally charged sessions which often evoked tears, frustration, and regret.

Conclusion

The problem of uncivil behaviors and the implications of incivility should be kept in the forefront in both classroom and clinical nursing education experiences. Raising awareness through inclusion in shared governance opportunities, continued education and education development on the topic of incivility, organizational development training for nurse leaders, creating and monitoring policies as a pathway for reporting uncivil behaviors, and social justice tenets should become priorities towards the remediation of hostile work environments that impede nurse persistence. All nurses should be encouraged to nurture each other and to "nurture their young" by positively embracing resonant leadership characteristics and as outlined by Kouzes and Posner (2012). As an outcome, all ranks of nursing professionals will flourish through gaining maturity in the profession with the goal of impacting the existing nurse shortage.

As the nursing profession faces the continuous challenges of the nursing shortage, due in part to an aging baby-boomer population of nursing professionals and an aging population with increasing need for acute and chronic health care services, the health care environment is stressed. These factors and other issues create a greater demand for nursing students' persistence. Any issue that negatively impacts the longevity of this profession, including incivility, needs immediate attention and correction.

References

Aiken, L., Sloane, D., Cimiotti, J., Clarke, S., Flynn, L., Seago, J., Smith, H. (2010). Implications of the California Nurse Staffing Mandate for Other States. *Health Services Research, 45*(4), 904-921

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., & Silber, J. K. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *The Journal of the American Medical Association, 288*(16), 1987-1993. doi:10.1001/jama.288.16.1987

Altmiller, G. (2012). Student perceptions of incivility in nursing education: Implications for educators. *Nursing Education Perspectives*, *33*(1), 15-20. doi:10.5480/1536-5026-33.1.15

American Association of Colleges of Nursing. (2009). *Advancing higher education in nursing: 2009 annual report.* Washington, DC: AACN.

American Nurses Association. (2001). *Code of ethics for nurses with interpretive statements.* Retrieved from http://nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsfor Nurses/2110Provisions.aspx

American Nurses Association. (2015), *Code of ethics for nurses with interpretive statements*. Silver Spring, MD: Nursebooks.org.

Anthony, M. (2004). Shared governance models: the theory, practice, and evidence. *Online Journal of Issues in Nursing*, *9*(1), 13p.

Anthony, M., & Yastik, J. (2011). Nursing students' experiences with incivility in clinical education. *Journal of Nursing Education*, *50*(3), 140-144. doi:10.3928/01484834-20110131-04

Auerbach, D. I., Buerhaus, P. I., & Staiger, D. O. (2007). Better late than never: Workforce supply implications of later entry into nursing. *Health Affairs, 26*(1), 178-185.

Baron, R. A., & Richardson, D. R. (1994). *Human aggression* (2nd ed.). New York, NY: Plenum Press.

Basit, T. (2003). Manual or electronic? The role of coding in qualitative data analysis. *Educational Research*, *45*(2), 143-154.

Beheri, W. (2007). Nursing diversity: the knowledge of cultural diversity and its impact on the interaction level within the nursing workforce. *Nursing Diversity*, 194.

Benner P. *From Novice to Expert: Excellence and Power in Clinical Nursing Practice.* Menlo Park, CA: Addison-Wesley; 1984

Billings, D. M., & Halstead, J. A. (2012). *Teaching in nursing: A guide for faculty.* St. Louis, MO: Elsevier/Saunders.

Bogdan, R., & Biklen, S. K. (1982). *Qualitative research for education: An introduction to theory and methods*. Boston, MA: Allyn and Bacon.

Bowker, N., & Tuffin, K. (2004). Using the online medium for discursive research about people with disabilities. *Social Science Computer Review, 22*(2)*,* 228-241.

Bradbury-Jones, C., Sambrook, S., & Irvine, F. (2011). Nursing students and the issue of voice: A qualitative study. *Nurse Education Today, 31*(6), 628-632. doi:10.1016/j.nedt.2010.10.030

Brinkmann, S., & Kvale S. (2015). *InterViews : Learning the craft of qualitative research interviewing* (Third ed.). Los Angeles, CA: Sage Publications

Brooks, J. A., & Kleine-Kracht, A. E. (1983). Evolution of a definition of nursing. *Advances in Nursing Science, 5*(4), 51-63.

Bureau of Labor Statistics, US Department of Labor. (2011). *Occupational outlook handbook, 2010-11 library edition*. Washington, D.C.: U.S. Government Printing Office

Cantey, S. W. (2013). Recognizing and stopping the destruction of vertical violence. *American Nurse Today*, *8*(2).

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The Use of Triangulation in Qualitative Research. Oncology Nursing Forum, 41(5), 545-547. doi:10.1188/14.ONF.545-547

Chan, Z. C., Tam, W. S., Lung, M. K., Wong, W. Y., & Chau, C. W. (2013). A systematic literature review of nurse shortage and the intention to leave. *Journal of Nursing Management*, *21*(4), 605-613. doi:10.1111/j.1365-2834.2012.01437.x

Chinn, P. L. (2013) *Peace & power: New direction for building community* (8th ed.). Burlington, MA: Jones and Bartlett Learning.

Chinn, P. L., & Falk-Rafael, A. (2015). Peace and power: A theory of emancipatory group process. *Journal of Nursing Scholarship, 47*(1), 62-69. doi:10.1111/jnu.12101

Christie, W., & Jones, S. (2014). Lateral violence in nursing and the theory of the nurse as wounded healer. *Online Journal of Issues in Nursing, 18*(4), 1-1. doi:10.3912/OJIN.Vol19No01PPT01

Clark, C. (2011). *Why civility matters. Reflections on Nurse Leadership.* Retrieved from:http://www.reflectionsonnursingleadership.com/pages/vol36_1_clark2_civility.aspx

Clark, C. (2013). Reflections on incivility and why civility matters. In C. Hall (Ed.). *Creating & Sustaining Civility in Nursing Education* (pp. 1-15). Indianapolis, IN: Sigma Theta Tau International.

Clark, C. M. & Ahten, S. M. (2011). Beginning the conversation: The nurse educator's role in preventing incivility in the workplace. *RN Idaho*.

Clark, C. M., & Springer, P. J. (2010). Academic nurse leaders' role in fostering a culture of civility in nursing education. *Journal of Nursing Education, 49*(6), 319-325. doi:10.3928/01484834-20100224-01

Coshow, S., Davis, P., & Wolosin, R. (2009). The 'big dip': Decrements in RN satisfaction at mid-career. *Nursing Economic$, 27*(1), 15-18.

Creswell, J. W. (2003). *Research design: qualitative, quantitative, and methods approaches*. Thousand Oaks, CA: Sage Publications.

Creswell, J. W. (2016). *Essential skills for the qualitative researcher*. Thousand Oaks, CA: Sage Publications.

Curtis, J., Bowen, I., & Reid, A. (2007). You have no credibility: Nursing students' experience of horizontal violence. *Nurse Education in Practice, 7*(3), 156-163. doi:10.1016/j.nepr.2006.06.002

D'Ambra, A. M., & Andrews, D. R. (2014). Incivility, retention and new graduate nurses: an integrated review of the literature. *Journal of Nursing Management, 22*(6), 735-742. doi:10.1111/jonm.12060

DeCamp, W., & Newby, B. (2015). From bullied to deviant: The victim-offender overlap among bullying victims. *Youth Violence & Juvenile Justice, 13*(1), 3-17. doi:10.1177/1541204014521250

Del Prato, D. (2013). Students' voices: The lived experience of faculty incivility as a barrier to professional formation in associate degree nursing education. *Nurse Education Today, 33*(3), 286-290. doi:10.1016/j.nedt.2012.05.030

Denzin, N. K., & Lincoln, Y. S. (1994). Introduction: Entering the field of qualitative Research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The handbook of qualitative research* (pp. 10-15). London, England: Sage Publications.

Denzin, N. K., & Lincoln, Y. S. (2005). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Handbook of Qualitative Research* (pp. 1-32). Thousand Oaks, CA: Sage Publications.

Di Leonardi, B. C., & Ryan, L. (2006). A Proactive Approach to Orienting with a Preceptor. Retrieved from: https://lms.rn.com/getpdf.php/1789.pdf.

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

Embree, J., & White, A. (2010). Concept analysis: Nurse-to-nurse lateral violence. *Nursing Forum*, *45*(3), 166-173. doi:10.1111/j.1744-6198.2010.00185.x

Englander, M. (2012). The Interview: Data Collection in Descriptive Phenomenological Human Scientific Research. *Journal of Phenomenological Psychology, 43*(1), 13-35.

Falk, A & Fischbacher, (2002). 'The Economics of Reciprocity: Evidence and Theory', in RB Freeman (ed.), Inequality Around the World. New York, NY: Palgrave Macmillan.

Felblinger, D. (2008). Incivility and bullying in the workplace and nurses' shame responses. *JOGNN: Journal of Obstetric, Gynecologic & Neonatal Nursing, 37*(2), 234-242. doi:10.1111/j.1552-6909.2008.00227.x

Flick, E., (2014). *An introduction to qualitative research* (5th ed.). Thousand Oaks, CA: Sage Publications.

Fontana, A., & Frey, J. H. (1994). Interviewing: The art of science. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 361-376). Thousand Oaks, CA: Sage Publications.

Freire, P. (1970). *Pedagogy of the oppressed* (M. B. Ramos, Trans.). New York, NY: The Seabury Press.

Gorenberg, B. (1983). The research tradition of nursing: An emerging issue. *Nursing Research, 32*(6), 347-349.

Hogh, A., Hoel, H., & Carneiro, I. G. (2011). Bullying and employee turnover among healthcare workers: A three-wave prospective study. *Journal of NursingManagement*, *19*(6), 742-751. doi:10.1111/j.1365-2834.2011.01264.x

Homans, G. C. (1961). *Social behavior*. New York, NY: Harcourt Brace.

Hunt, C., & Marini, Z. A. (2012). Incivility in the practice environment: A perspective from clinical nursing teachers. *Nurse Education in Practice*, *12*(6), 366-370. doi:10.1016/j.nepr.2012.05.001

Hurt, H. T., Scott, M. D., & McCroskey, J. C. (1978). *Communication in the classroom*. Reading, MA: Addison-Wesley

Hutton, S., & Gates, D. (2008). Workplace incivility and productivity losses among direct care staff. *AAOHN Journal*, *56*(4), 168-175.

Isgur, B. (2008). *What works: Healing the healthcare staffing shortage.* Presented at National Conference of Nursing Workforce Leaders, June 11, 2008, Denver, CO.

Jacobs, M. K., & Huether, S. E. (1978). Nursing science: The theory practice linkage. *Advances in Nursing Science, 1*(1), 63-78.

Joint Commission for the Accreditation of Health Care Organizations. (2008). Behaviors that undermine a culture of safety. *Sentinel Event Alert, Issue 40.*

Jenkins, S. D., Kerber, C. S., & Woith, W. M. (2013). An intervention to promote civility among nursing students. *Nursing Education Perspectives*, *34*(2), 95-100.

Jones, C. (2005). The costs of nurse turnover: Part 2. *Journal of Nursing Administration, 35*(1), 41-49.

Jones, C. (2008). Revisiting nurse turnover costs: adjusting for inflation. *Journal of Nursing Administration*, *38*(1), 11-18.

Johnson, S.L. (2009) International perspectives on workplace bullying among nurses: a review. *International Nursing Review, 56*, 34–40

Keller, M. C. (1979). The effect of sexual stereotyping on the development of nursing theory. *American Journal of Nursing, 79*(9), 1584-1586.

Kidd, P., & Morrison, E. (1988). The progression of knowledge in nursing: A search for meaning. *Image, 20*(4), 222-224.

Khademi, M., Mohammadi, E., & Vanaki, Z. (2012). Nurses' experiences of violation of their dignity. *Nursing Ethics*, *19*(3), 328-340. doi:10.1177/0969733011433926

Kouzes, J. M., & Posner, B. Z. (2012). The leadership challenge (5th ed.). San Francisco, CA: John Wiley & Sons.

Krueger R. A. (1994). Focus groups: A practical guide for applied research. Thousand Oaks, CA: Sage Publications.

Krueger, R. A., & Casey, M. A. (2009). *Focus groups: A practical guide for applied research*. Los Angeles, CA: Sage Publications.

Lachman, V. D. (2015). Ethical Issues in the Disruptive Behaviors of Incivility, Bullying, And Horizontal/Lateral Violence. *Urologic Nursing, 35*(1), 39-42

Lachman, V. D. (2012). Applying the ethics of care to your nursing practice. *MEDSURG Nursing*, *21*(2), 112-116.

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

Laschinger, H., Leiter, M., Day, A., & Gilin, D. (2009). Workplace empowerment, incivility, and burnout: Impact on staff nurse recruitment and retention outcomes. *Journal of Nursing Management*, *17*(3), 302-311. doi:10.1111/j.1365-2834.2009.00999.x

Laschinger, H. S., Wong, C. A., Cummings, G. G., & Grau, A. L. (2014). Resonant leadership and workplace empowerment: The value of positive organizational cultures in reducing workplace incivility. *Nursing Economics*, *32*(1), 5-44.

Lashley, F., & De Meneses, M. (2001). Student civility in nursing programs: A national survey. *Journal of Professional Nursing*, *17*(2), 81-86.

Lewis, S. P., & Malecha, A. (2011). The impact of workplace incivility on the work environment, manager skill, and productivity. *Journal of Nursing Administration, 41*(1), 41-47. doi:10.1097/NNA.0b013e3182002a4c

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.

LoBiondo-Wood, G., & Haber, J. (2010). Nursing research: Methods and critical appraisal for evidence-based practice (7th ed.). St. Louis, MO: Elsevier.

Lynaugh, J. E., & Fagin, C. M. (1988). Nursing comes of age. *Image, 20*(4), 184-190.

Lynn, M. R., & Redman, R. W. (2005). Faces of the nursing shortage: Influences on staff's intentions to leave their positions or nursing. *Journal of Nursing Administration, 35*(5), 264-270.

Marchiondo, K., Marchiondo, L. A., & Lasiter, S. (2010). Faculty incivility: Effects on program satisfaction of BSN students. *Journal of Nursing Education, 49*(11), 608-614. doi:10.3928/07484834-201000524-05

Marlow, S. (2013). *Academic incivility in nursing education* (Doctoral dissertation). Retrieved from Digital Commons @ Gardner-Webb University database. (Paper 71)

Merriam, S. B. (1998). *Qualitative research and case study applications in education*. San Francisco, CA: Jossey-Bass.

Merriam, S. (2009). *Qualitative research a guide to design and implementation*. San Francisco, CA: Jossey-Bass.

Mertens, D. M. and Wilson, A. T. (2012), *Program Evaluation Theory and Practice: A Comprehensive Guide*, Guilford Press, New York .

Morgan, D. L., & Krueger, R. A. (1998). *Focus group kit.* Thousand Oaks, CA: Sage.

Mould, Y., & Laschinger, H. S. (2014). Effects of incivility in clinical practice settings on nursing student burnout. *International Journal of Nursing Education Scholarship, 11*(1), 145-154. doi:10.1515/ijnes-2014-0023

Nightingale, F. (1969). *Notes on nursing: What it is, and what it is not*. New York, NY, Dover Publications.

Orientor. 2017. In *Merriam-Webster.com*. Retrieved July 30, 2017, from https://www.merriam-webster.com/dictionary/orientor

Orre, D., Leblanc, D., Day, A., Leiter, M., Laschinger, H., Price, S., & Latimer, M. (2010). When respect deteriorates: Incivility as a moderator of the stressor-strain relationship among hospital workers. *Journal of Nursing Management, 18*(8), 878-888 11p. doi:10.1111/j.1365-2834.2010.01139.x

Oyeleye, O., Hanson, P., O'Connor, N., & Dunn, D. (2013). Relationship of workplace incivility, stress, and burnout on nurses' turnover intentions and psychological empowerment. *Journal of Nursing Administration, 43*(10), 536-542. doi:10.1097/NNA.0b013e3182a3e8c9

Perry, J. (1985). Has the discipline of nursing developed to the stage where nurses do 'think nursing'? *Journal of Advanced Nursing, 10*(1), 31-37.

Price, J., & Mueller, C. (1981). A causal model of turnover for nurses. *Academy of Management Journal (pre-1986), 24*(3), 543.

Richards, L., & Morse, J. M. (2013). *Readme first for a user's guide to qualitative methods* (3rd ed.). Thousand Oaks, CA: Sage.

Roberts, A. (2000). Mentoring revisited: A phenomenological reading of the literature. *Mentoring and Tutoring, 8*(2), 145-170. doi:10.1080/713685524

Schmitz, K., & Schaffer, M. (1995). Ethical problems encountered in the teaching of nursing: Student and faculty perceptions. *Journal of Nursing Education, 34*(1), 42-44.

Sharif, F., & Masoumi, S. (2005). A qualitative study of nursing student experiences of clinical practice. *BMC Nursing, 4*(6).

Sheridan-Leos, N. (2008). Understanding lateral violence in nursing. *Clinical Journal of Oncology Nursing, 12*(3), 399-403.

Simons, S. (2008). Workplace bullying experiences by Massachusetts registered nurses and the relationship to intention to leave the organization. *Advances in Nursing Science, 31*(2), 48-59.

Skillman, S., Palazzo, L., Hart, L., & Keepnews, D. (2010). The characteristics of registered nurses whose licenses expire: Why they leave nursing and implications for retention and re-entry. *Nursing Economic$, 28*(3), 181-189.

Stake, R. E. (1995). *The art of case study*. Thousand Oaks, CA: Sage Publications.

Stanley K., Martin M., Michel Y., Welton M., Nemeth S. (2007). Examining lateral violence in the Nursing workplace. *Issues in Mental Health Nursing, 28*(11), 1247-1265.

Strauss, A. L., & Corbin, J. M. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage Publications.

Task Force on the Prevention of Workplace Bullying. (2001). *Report of the task force on the prevention of workplace bullying: Dignity at work–the challenge of workplace bullying*. Dublin, Ireland: Health and Safety Authority. Retrieved from https://www.djei.ie/en/Publications/Publication-files/Report-of-the-Expert-Advisory-Group-on-Workplace-Bullying-2005-.pdf

Thobaben, M. (2007). Horizontal workplace violence. *Home Health Care Management and Practice, 20*(1), 82-83.

Uhl-Bien, M. (2006). Relational leadership theory: Exploring the social processes of leadership and organizing. *The Leadership Quarterly, 17*(6), 654-676.

Walrafen, N., Brewer, M., & Mulvenon, C. (2012). Sadly caught up in the moment: An exploration of horizontal violence. *Nursing Economics, 30*(1), 6-49.

Ward-Smith, P. (2011). Let's leave bullying on the playground! *Urologic Nursing, 31*(5), 257-263.

Watson, J. (1979). *Nursing: The philosophy and science of caring*. Boston, MA: Little Brown.

Watson, J. (2005). *Caring science as sacred science*. Philadelphia, PA: F.A. Davis Company.

Watson, J. (2012). *Human caring science*. Sudbury, MA: Jones & Bartlett Learning.

Weston, C., Gandell, T., Beauchamp, J., McAlpine, L., Wisemen, C., & Beauchamp, C. (2001). Analyzing interview data: The development and evolution of a coding system. *Qualitative Sociology, 24*(3), 381-400.

Wilson, B., Diedrich, A., Phelps, C., & Choi, M. (2011). Bullies at work; The impact of horizontal hostility in hospital setting and intent to leave. *The Journal of Nursing Administration*, *41*(11), 453-458.

Wilson, B. L., & Phelps, C. (2013). Horizontal hostility: A threat to patient safety. *JONA's Healthcare Law, Ethics & Regulation, 15*(1), 51-57. doi:10.1097/NHL.0b013e3182861503

Wheeler, C. E., & Chinn, P. L. (1984). *Peace & power: A handbook of feminist process* (1st ed.). Buffalo, NY: Margaretdaughters, Inc.

Xerri, M. (2013). Workplace relationships and the innovative behavior of nursing employees: A social exchange perspective. *Asia Pacific Journal of Human Resources 51*(1), 103-123.

Yin, R. K. (2003). *Case study research design and methods*. Thousand Oaks, CA: Sage Publications.

Yin, R. K. (2011). *Qualitative research from start to finish.* New York, NY: Gilford Press.

Appendix A

Introductory E-mail Invitation

Dear Graduate Nurse,

My name is Melissa Di Natale. I am a doctoral candidate in the Ed.D. program in Executive Leadership at Ralph C. Wilson, Jr. School of Education at St. John Fisher College and an Assistant Professor at Pomeroy College of Nursing. To satisfy my dissertation research, I am investigating the topic of incivility within the clinical setting as a nursing student and the potential impact on post-graduation employment choice.

I am examining graduate nurse's exposure to incivility as nursing students either as a witness or as a participant within the clinical environment. The goal of the research is to achieve a better understanding of the impact incivility has on student nurses, the retention of graduate nurses as employees, and on post-graduation employment choices.

As part of this study, I am asking for your participation of an initial written feedback responses answering my three research questions which will take about fifteen minutes of your time. Please forward written responses to e-mail address provided on top of survey within a week. I will be inviting participants to partake in an in-depth one-to-one interview which will take about forty-five minutes of your time, at a time and location of your convenience. Once data is analyzed, I may ask you to return to participate in a focus group, which is typically one hour in length. All the information gathered from the written feedback responses and one-to-one interviews will be held in strict confidence; however, anonymity and confidentially cannot be guaranteed during the use of focus groups. The researcher will take the following steps to ensure privacy and confidentiality in the body of the published research. All files will be locked on a flash drive that is password protected, all participants will be identified by a code known only by the researcher, and all audio tapes will be transcribed by software and assessable only by the researcher. All data will be in a locked cabinet in the researcher's home office. All data will be destroyed after 3 years. All published results will ensure participants' confidentiality. Although there is no anticipated risk to you as a participant, the topic can be emotionally charged and debriefing will be available to participants if required.

As compensation for your participation, the researcher will provide the results of this data to requesting participants through an electronic version of the dissertation.

Should you decide you would like to participate, please contact me by e-mail or phone. My contact information is provided below. I deeply appreciate your participation and interest.

The results of this study will help to increase the knowledge base of incivility within the student clinical environment and how incivility may impact retention rates. Research will conclude April 30th, 2017.

Should you have any questions, please contact me: (315) 663-6338 or mad05842@sjfc.edu.
Dissertation Chair, Dr. Cynthia Smith, at (585) 293-3192 or csmithedd@gmail.com.

Thank you for your time and consideration.

Melissa A. Di Natale
St. John Fisher School of Education Executive Leadership Doctoral Candidate

Appendix B

Initial Written Feedback Responses

Please answer the following questions about your nursing school clinical experience with incivility. Elaborate with as much detail as possible. Please return completed form to mad05842@sjfc.edu within one week.

Are you a registered nurse with less than 12 months working experience? Yes_____ No_____

Did you graduate from a hospital-based nursing program with an Associate Applied Science of Nursing Degree? Yes_____ No_____

Incivility - An action that degrades a person's dignity causing loss of self-respect, is injurious, and is occurring in any setting at any time from any person(s) (Clark, 2013).

1. What behaviors in the clinical environment did you perceive as incivility during your

   nursing school clinical experience?

2. How do you describe your experiences with incivility when you were a nursing student?

3. To what extent did exposure to incivility in the clinical environment impact your

   employment choice post-graduation?

Would you be willing to participate in a one-to-one interview?

Yes _____

No _____

Contact information:

Name_____ phone # _____

e-mail address_____

All information obtained is strictly confidential.

Appendix C

List of Research/Interview Questions

<u>**Research Question One**</u>

1. What behaviors in the clinical environment did the Associate Degree nurse perceive
    as incivility during their nursing school clinical experience?

Interview Questions:

    1. How do you define incivility?

    2. Tell me about an uncivil encounter you have experienced during your nursing
        school clinical experience.

<u>**Research Question Two**</u>

2. How do nurse graduates describe their experiences with incivility when they were
    nursing students?

Interview Questions:

1. Approximately how many incidences of incivility were you exposed to as a
    nursing student during your clinical experience?

2. What were the positions of the persons involved in this instance of incivility?

    a. (staff nurse, instructor, physician, peer, other)

    b. In your opinion what might have prompted the person who committed the
        act of incivility to behave this way?

3. How did you feel when this happened?

4. What did you do in response to the incident?

5. Upon reflection, how do you wish you had responded?

6. How did these experiences impact your clinical learning experience?

Research Question Three

3. As an Associate Degree nurse, to what extent did exposure to incivility in the clinical environment during nursing school impact employment choices post-graduation?

Interview Questions:

1. How do these experiences impact your feelings about being a nurse?

2. Tell me how exposure to incivility may impact your decision about working on particular units of the hospital.

3. Tell me how this experience influences your perception of the hospital as a potential place of employment upon graduation.

4. How likely are you to apply for a position at the hospital?

5. Are there any other reasons as to why you might not apply for a position at this hospital upon graduation?

Appendix D

Focus Group Questions

1. Tell me why you became a nurse.

2. Given Clark's definition of incivility, what addition comments do you want to add to

 the definition?

3. How did being exposed to incivility make you feel as a nursing student?

4. How does incivility impact patients?

5. Is there something you would say to students who feel they have no voice?

6. How is incivility perceived as new nurses?

7. Why are students afraid to report incivility?

Appendix E

Collaborative Institutional Training Initiative (CITI Program)

COMPLETION REPORT – PART 1 OF 2 COURSEWORK REQUIREMENTS*

*NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details.
See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Melissa Di Natale (ID: 5667564)
- **Email:** mad05842@sjfc.edu
- **Institution Affiliation:** St. John Fisher College (ID: 3316)
- **Institution Unit:** education
- **Phone:** 3156636338
- **Curriculum Group:** Social & Behavioral Research – Basic/Refresher
- **Course Learner Group:** Social & Behavioral Research
- **Stage:** Stage 1 - Basic Course
- **Report ID:** 20258945
- **Completion Date:** 11-Aug-2016
- **Expiration Date:** 11-Aug-2019
- **Minimum Passing:** 80
- **Reported Score*:** 96

REQUIRED AND ELECTIVE MODULES ONLY DATE COMPLETED SCORE

Belmont Report and CITI Course Introduction (ID: 1127) 11-Aug-2016 3/3 (100%)
History and Ethical Principles - SBE (ID: 490) 11-Aug-2016 5/5 (100%)
Defining Research with Human Subjects - SBE (ID: 491) 11-Aug-2016 5/5 (100%)
The Federal Regulations - SBE (ID: 502) 11-Aug-2016 5/5 (100%)
Assessing Risk - SBE (ID: 503) 11-Aug-2016 5/5 (100%)
Informed Consent - SBE (ID: 504) 11-Aug-2016 5/5 (100%)
Privacy and Confidentiality - SBE (ID: 505) 11-Aug-2016 5/5 (100%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680) 11-Aug-2016 5/5 (100%)
Research with Children - SBE (ID: 507) 11-Aug-2016 5/5 (100%)
Research in Public Elementary and Secondary Schools - SBE (ID: 508) 11-Aug-2016 5/5 (100%)
Internet-Based Research - SBE (ID: 510) 11-Aug-2016 5/5 (100%)
Vulnerable Subjects - Research Involving Workers/Employees (ID: 483) 11-Aug-2016 4/4 (100%)
Conflicts of Interest in Research Involving Human Subjects (ID: 488) 11-Aug-2016 5/5 (100%)
Unanticipated Problems and Reporting Requirements in Social and Behavioral Research (ID: 14928) 11-Aug-2016 5/5 (100%)
Cultural Competence in Research (ID: 15166) 11-Aug-2016 5/5 (100%)
Consent and Subject Recruitment Challenges: Remuneration (ID: 16881) 11-Aug-2016 2/5 (40%)

**For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution
identified above or have been a paid Independent Learner.**

Verify at: https://www.citiprogram.org/verify/?0eb5e52f-e7b9-4fa4-ae62-363219d86a08

CITI Program
Email: support@citiprogram.org
Phone: 888-529-5929
Web: https://www.citiprogram.org

St. John Fisher College IRB Approval

January 31, 2017

File No: 3664-121516-23

Melissa Di Natale
St. John Fisher College

Dear Ms. Di Natale:

Thank you for submitting your research proposal to the Institutional Review Board.

I am pleased to inform you that the Board has approved your Expedited Review project, "The Impact of Incivility on Hospital-based Student Nurses, Retention as Licensed Registered Nurses and Their Post-Graduation Employment Choices."

Following federal guidelines, research related records should be maintained in a secure area for three years following the completion of the project at which time they may be destroyed.

Should you have any questions about this process or your responsibilities, please contact me at irb@sjfc.edu.

Sincerely,

Eileen Lynd-Balta

Eileen Lynd-Balta, Ph.D.
Chair, Institutional Review Board

ELB: jdr

Appendix G

St. John Fisher College

Informed Consent Form

Title of study: The Impact of Incivility on Hospital -Based Student Nurses, Retention as Licensed Registered Nurses, and Their Post-Graduation Employment Choices: A Phenomenological study

Name of researcher: Melissa A Di Natale   Phone for further information: (315) 663-6338.

Faculty Supervisor: Dr. Cynthia Smith   Phone for further information: (585) 293-3192.

Purpose of study: The purpose of this study is to gain additional understanding of how incivility experienced during clinical training may be contributing to post-graduation employment considerations and the impact it may have on retention rates.

Place of study: Central New York
Length of participation: 1-2 hours

Risks and benefits: The expected risks and benefits of participation in this study are explained below: Although there is no anticipated risk to you as a participant, the topic can be emotionally charged. A debriefing time will be allotted for all participants. The results of this study will contribute to scholarship and professional practice as a nurse.

Method for protecting confidentiality/privacy: All the information gathered from the one-to-one interviews will be held in strict confidence, however anonymity and confidentially cannot be guaranteed during the use of focus groups. The researcher will take the following steps to ensure privacy and confidentiality in the body of the published research. All files will be password protected, all participants will be identified by a code known only by the researcher, and all audio tapes will be transcribed by software and assessable only by the researcher in a locked cabinet in the researcher's home office. All data will be destroyed after 3 years. All published results will ensure participants' confidentiality.

Your rights: As a research participant, you have the right to:

1. Have the purpose of the study, and the expected risks and benefits fully explained to you before you choose to participate.
2. Withdraw from participation at any time without penalty.
3. Refuse to answer a particular question without penalty.
4. Be informed of the results of the study.

I have read the above, received a copy of this form, and I agree to participate in the above-named study.

Print name (Participant)_____ Signature _____Date_____

Print name (Investigator) _____Signature _____Date_____

If you have any further questions regarding this study, please contact the researcher listed above.

The Institutional Review Board (IRB) of St. John Fisher College has reviewed this project. For any concerns regarding this study and/or if you experience any physical or emotional discomfort, you can contact Jill Rathbun by phone at 585.385.8012 or by e-mail at: irb@sjfc.edu

Audio Tape Consent Form

I consent to being audio taped during this study.

_____

Print name (Participant)   Signature   Date

Researcher statement: I certify that I obtained the consent of the subject whose signature is above. I understand that I must give a signed copy of the informed consent form to the subject, and keep the original in my files for 3 years after the completion of the research project. At the end of three years, this research will be destroyed.

_____

Print name (Researcher)   Signature   Date