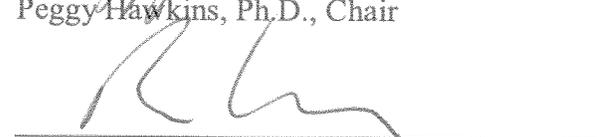
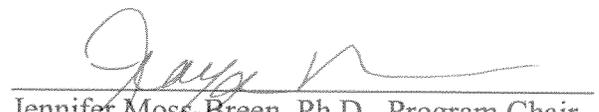


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NURSES' PERCEPTIONS OF WORKPLACE INCIVILITY ON HOSPITAL TEAMS

By
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A DISSERTATION IN PRACTICE

Submitted to the faculty of the Graduate School of Creighton University in Partial
Fulfillment of the Requirements for the degree of Doctor of Education in
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Abstract

Workplace incivility, or bullying, experienced by nurses has been shown to adversely affect nurses and the care they provide patients. As such, nurses' roles are being challenged in the healthcare environment. Such negative outcomes exist despite the support provided to teams in which these nurses work. This research study hypothesizes that higher levels of team performance have an inverse relationship with workplace incivility or bullying. The Team and Team Dynamics survey used in this study revealed the results of 128 nurses in two medical centers in the northeast. These nurses believed that teamwork was an important facet to success in the workplace. Ninety-five percent of nurses were in agreement that a team approach is an effective method for providing quality patient care. Ninety-eight percent of respondents believed that a team approach fosters better patient care. Furthermore, 67% of respondents revealed a higher than average score when indicating the prevalence of specific constructs of leadership, trust, and communication. Thirty-one percent of respondents reported that they were bullied at least 2-3 times per month while 53% of nurses experienced others being bullied at the same frequency. The results of the Team and Team Dynamics survey revealed a small but statistically significant correlation between levels of leadership, trust, and communication and levels of workplace incivility. An awareness and education campaign is proposed to enhance the levels of teamwork and decrease the levels of workplace incivility.

Keywords: Teamwork, workplace incivility, leadership, trust, communication

Dedication

This dissertation is dedicated to my wife, Jo Ellen, who offered me the encouragement needed to enter into a doctorate program and has made numerous sacrifices so that I could focus on my studies and dissertation. I will always be grateful for her sacrifice.

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I would like to thank a number of individuals who have offered so much time and encouragement in the dissertation process. First, I would like to thank Dr. Peggy Hawkins, chairperson of my Dissertation in Practice, who has provided unwavering support during this entire dissertation process. I would also like to thank Dr. Rob Koonce who has provided much needed guidance and resources to assist this journey. I would like to thank all the faculty and staff that I have worked with at Creighton University as the entire staff has made my experience in this doctoral program nothing short of spectacular. A thank you is in order to Dr. D. Michael Malone, University of Cincinnati, who has provided considerable time and encouragement to help with the dissertation process. Thank you to Dr. Isabelle Cherney for showing me what servant leadership truly means and for her guidance throughout my doctoral journey. A special thank you goes to all my family, my wife Jo Ellen, my son Tyler, my daughter Kristina, and soon to be daughter-in-law Katie. Each of my family members has provided enduring love and support through this process and has truly inspired me to “reach for the stars”.

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NURSES' PERCEPTIONS

CHAPTER ONE: INTRODUCTION

Background of the Problem

In healthcare systems, nurses play a significant role in the delivery of quality care. Unfortunately, nurses are also faced with the challenge of workplace incivility or bullying that influences the delivery of such quality care. According to the American Nurses Association, (2015), such incivility accounts for 21% of nursing turnover. Current literature describes various causes (Croft & Cash, 2012), scope (Laparell, 2011; Leiter, Price, & Laschinger, 2010), and to a less extent, the effect of such incivility on the quality of care provided (Murray, 2009; Smith, Andrusyszyn, & Laschinger, 2010). The cost of replacing one nurse in the U.S. can cost up to \$88,000 (American Nurses Association, 2015).

Workplace incivility is now considered an epidemic affecting hundreds of thousands of nurses internationally (Rodwell, Demir, & Theol, 2013). Furthermore, nurses are often positioned toward the bottom of the team hierarchy within healthcare institutions as subordinates to doctors, administrators, regulators, and patients (Croft & Cash, 2012). As a result, nurses feel a sense of powerlessness and frustration which may result in aggressive manners (Croft & Cash, 2012). One must also note that both nurses and nurse leaders may lack the assertiveness or negotiation skills needed when disruptive behavior takes place (Lachman, 2015).

Collaborative teams represent a key tool in the provision of quality healthcare (Bajnok, Puddester, MacDonald, Archibald, & Kuhn, 2012). However, additional research is needed to examine the influence such workplace incivility has on teams. One might posit, if a direct link is drawn between incivility and teamwork, potential solutions

to combat such workplace incivility may be developed to enable nurses to provide better quality care for patients.

The importance of teamwork in nursing is well documented (Bajnok et al., 2012; Buljac-Samardzie, van Wijngaarden, van Wijk, & Exel, 2011; Leggat, 2007). As effective teamwork wanes, patient risk increases (Leonard & Frankel, 2011). Effective teamwork is recognized as a central focus for improved patient care (Sargeant, Loney, & Murphy, 2008). One of the factors affecting the importance of teamwork for nurses is the passing of the Affordable Health Care Act (Taplin, Foster & Shortell, 2013). All healthcare providers, including nurses, must now act to ensure patient satisfaction scores are high. Low scores can affect the level of reimbursement to institutions through Medicare (Murphy, 2015). In essence, effective teamwork must be provided within healthcare institutions. Leadership, trust, and communication are frequently mentioned constructs that enhance and foster effective teamwork.

Introduction and Statement of the Problem

The terms workplace incivility and bullying are often used interchangeably. According to the Workplace Bullying Institute (WBI, 2014), the term bullying is defined as a “systematic campaign of interpersonal destruction”. The phenomenon of bullying has been recognized since the 1980s (Aggervold, 2007). Research has also noted the magnitude of incivility in the workplace. The 2014 (WBI) concluded that 27% of adult Americans have experienced abuse. Further statistics by the WBI revealed that 48% (including witnesses) have been affected by abuse. Seventy-two percent of the American public are aware of the problem and of those who are aware, 93% want some type of law to protect victims of such incivility (WBI, 2014).

Workplace incivility also occurs in the nursing profession (McCabe & Sambrook, 2013; Moore, Leahy, Sublett, & Lanig, 2013; Murray, 2009). This incivility increases employee turnover, reduces job satisfaction, and reduces patient safety due to poor communication (Khadjehturian, 2012). As a result of the prevalence of bullying, fewer individuals are entering the nursing profession (Leiter, Price & Laschinger, 2010). The effect on nurses is not limited to the United States (Jackson & Daly, 2004; Malinauskiene, Leisyte, Malinauskas, & Kirtiklyte, 2011).

Solutions have been offered to help diminish the prevalence of workplace incivility. Solutions include empowering nurses to work more effectively, especially as it pertains to teamwork (Nursing Standard, 2010). Such teamwork in the healthcare environment has been associated with a higher level of job satisfaction and a higher quality of care (Kalisch, Curley, & Stefanov, 2007). Other solutions include training nursing managers to utilize negative affectivity and political skills tests to help determine whether a potential employee is a threat to cause abuse (Harris, Harvey & Booth, 2010). Fritz (2009) stated the importance of managers modeling appropriate guidelines and ensuring that managers “walk the talk” (p. 191) and ensure that managers enforce breaches of civility. The WBI urges stronger legislation at both the national and local levels. Still further suggestions include enhancing teamwork by cross training teams using skills development, role play, and simulation (Kalisch et al., 2007).

Overall, empirical research highlights the influence effective teams may have in the workplace. Given the increasing importance of teams in the workplace, the occurrence of workplace incivility in the nursing community represents a significant concern. The current research study posed the question of how workplace incivility

affects teams of nurses and their delivery of quality care within two hospitals located in the same county in the northeastern U.S.?

Purpose of the Study

The purpose of this study was to investigate perceived workplace incivility (bullying) and the influence on leadership, trust, and communication reported by nurses working on hospital teams.

Research Question(s)

The following questions guided this research.

Research Question 1: What relationship exists between communication (behaviors) of nurses and workplace incivility among nurses in two hospitals in the northeastern U.S.?

Hypothesis 1: A relationship exists between communication (behaviors) of nurses and workplace incivility among nurses in two hospitals in the northeastern U.S.

Null Hypothesis 1: There is no relationship between communication (behaviors) of nurses and workplace incivility among nurses in two hospitals in the northeastern U.S.

Research Question 2: What relationship exists between trust (behaviors) of nurses and workplace incivility among nurses in two hospitals in the northeastern U.S.?

Hypothesis 2: A relationship exists between trust (behaviors) of nurses and workplace incivility among nurses in two hospitals in the northeastern U.S.

Null Hypothesis 2: There is no relationship between trust (behaviors) of nurses and workplace incivility among nurses in two hospitals in the northeastern U.S.

Research Question 3: What relationship exists between workplace incivility among nurses and team performance among nurses in two hospitals in the northeastern U.S.?

Hypothesis 3: A relationship exists between workplace incivility among nurses and team performance among nurses in two hospitals in the northeastern U.S.

Null Hypothesis 3: There is no relationship between workplace incivility among nurses and team performance among nurses in two hospitals in the northeastern U.S.

Research Question 4: What relationship exists between leadership (behaviors) of nurses and workplace incivility among nurses in two hospitals in the northeastern U.S.?

Hypothesis: A relationship exists between leadership (behaviors) of nurses and workplace incivility among nurses in two hospitals in the northeastern U.S.

Null Hypothesis 4: There is no relationship between leadership (behaviors) of nurses and workplace incivility among nurses in two hospitals in the northeastern U.S.

The qualitative portion of the survey provided survey respondents with the option of utilizing “free text” to address these four questions. For the purpose of gaining greater insight and depth into respondent answers, a section on teamwork characteristics allowed respondents to add additional comments.

Significance of the Study

The phenomenon of workplace incivility threatens an increasing number of employees worldwide (Neall & Tuckey, 2014). Such a threat also affects nurses in the workplace environment. The problem is compounded by a growing shortage of nurses who are entering the profession (Leiter, Price, & Laschinger, 2010). The phenomenon of workplace incivility has been studied in the healthcare arena with vivid descriptions of its influence on the nursing profession. For example, research suggests that such workplace incivility or bullying is pushing nurses out of the profession (Luparell, 2011). Given the importance of nurses in the healthcare industry, it seems relevant that solutions to

workplace incivility need to be developed and delivered. A need exists to develop new solutions that can improve and enhance the chances of making an acceptable work environment for such nurses.

More scholarly research is needed to further explore the magnitude of workplace incivility for nurses, and also to examine its correlation with team performance. By taking a closer look at workplace incivility and its influence on teamwork and specific team constructs, one may uncover potential solutions to help diminish such incivility. Such solutions may help foster new policies and procedures ensuring more productive workplace environments.

Aim of the Study

The aim of this study was to develop an evidence-based solution to workplace incivility. Clear, more targeted solutions, may help diminish the problem.

Methodology Overview

A purposive nonprobability sampling technique was used to identify nurses in two hospitals in the northeastern U.S. A purposive nonprobability sampling technique can be defined as a biased form of sampling whereby the researcher selects specific groups for their knowledge of the topic being studied (Kingery, Bryant, Palmer, & Araghi, 1989). This type of sampling was used for its practicality. A detailed demographic survey, along with attitudes about teamwork and workplace incivility, was assessed through an online questionnaire. Responses to the teamwork questions were based on a 5-point Likert scale (ranging from 1 for strongly disagree to 5 for strongly agree) or a 1-6 scale (1 indicating low prevalence and 6 indicating a high prevalence). The workplace incivility responses measured the frequency of occurrence of a particular characteristic. Each question

assessed the attitudes of nurse participants toward teamwork and workplace incivility. A letter of the study's intent and its promise of anonymity to all volunteer participants preceded the survey. Questions in the survey focused on three distinct areas:

- Demographic data
- Questions focused on perceptions and prevalence of teamwork
- Questions regarding workplace incivility

Definition of Relevant Terms

The following terms were used operationally within this study.

Workplace Incivility: Implies an ambiguous disregard and rudeness toward others. Specifically, workplace incivility demonstrates a violation of norms for mutual respect and in turn negatively affects cooperation and motivation (Pearson, Andersson, & Porath, 2000).

Bullying: Using strength or influence to intimidate someone, typically to force him or her to do what one wants (Webster's Dictionary). It is considered an interaction by the sender using verbal and/or non-verbal communication that is characterized as negative or aggressive towards its subject over a prolonged period of time (Agervold, 2007).

Closed-loop communication: a communication technique used to avoid misunderstandings. Such communication acts as a three-step process. A message is generated by the sender, a receipt of the message by a receiver, and is followed by a check-in by the sender to ensure the message was both received and understood (McComb & Hebdon, 2013).

Team: “Two or more individuals with specified roles interacting adaptively, interdependently, and dynamically toward a common and valued goal” (Salas, Sims, & Burke, 2005, p. 562).

These terms will be used throughout this dissertation. Such definitions will provide better insights into the application of the terms and how these terms relate to the subject matter. In this dissertation, the term workplace incivility and bullying will be used interchangeably.

Assumptions

The assumptions made in this dissertation were two-fold. First, it was assumed that nurses performing on high-functioning teams would be less likely to experience workplace incivility first-hand within their respective teams. Secondly, it was assumed that the majority of survey respondents would not personally experience workplace incivility.

Delimitations and Limitations

The delimitations of this study include the following:

- The online survey included two-medium sized hospitals located within ten miles of each other in the northeastern U.S.
- The study targeted only nurses

Leader's Role and Responsibility in Relation to the Problem

Leadership plays an important role in the Dissertation in Practice. Constructs of teamwork, including trust and communication, are integral to effective leadership. Each construct has a direct influence on the paradigm through which a leader operates. The Dissertation in Practice raises awareness of workplace incivility with the focus of

providing solutions for nurses experiencing such incivility in the workplace. Part of a leaders' role is to ensure a safe and productive work environment for its employees hence, research illuminating factors negatively influencing the workplace become important leadership insights. Such insights for leaders have potential to positively influence the workplace.

Summary

The healthcare industry can be a stressful environment for nurses to work. For some nurses, the work environment entails life and death situations for patients often resulting in increased stress levels. Unfortunately, workplace incivility has taken a toll on healthcare providers, including nurses. Most organizations pay tribute to the importance of teamwork in the workplace. When looking at the constructs of effective teams, leadership, trust, and closed-loop communication are frequently mentioned. Due to a lack of current research, however, little has been written regarding the potential influence of workplace incivility on teams and teamwork.

The Dissertation in Practice was designed to examine the relationship between workplace incivility and nurses who work as a team within a hospital. Furthermore, the Dissertation in Practice was designed to closely examine the link between workplace incivility and the specific constructs of leadership, trust, and communication. The significance of such research should theoretically provide links, while offering potential solutions on how best to diminish workplace incivility.

Overall, the Dissertation in Practice was designed to view workplace incivility in a new light. Such a shift in paradigm incorporated the element of teamwork and the specific behaviors of leadership, trust, and communication. The intent was to identify

any potential link between incivility and teamwork. As such, the potential for new and improved solutions exists by which healthcare workers can operate in a healthier work environment while contributing to a more productive workplace.

CHAPTER TWO: LITERATURE REVIEW

Introduction

The incidence of workplace incivility, or bullying, as it applies to nurses has been well documented. Although the extant literature describes the prevalence, influence, and scope of bullying, little focus has been applied toward the influence or consequences of this on effective team dynamics. The same can be said about the dearth of research as it applies to the influence of effective teams on bullying. As such, a review of effective teamwork and the behaviors that build such teams is needed. Further, although the literature addresses a number of constructs that contribute to effective teamwork such as collaboration (Bajnok, Puddester, MacDonald, Archibald, & Kuhl, 2012, Leggat, 2007) cohesion (Salas, 2005) or agreeableness (Bradley & Baur, 2013), bullying and its effect on the team constructs of leadership, trust, and communication will be considered here. These three particular constructs were chosen due to the frequent mention of each of them in literature pertaining to effective team dynamics. The goal was to investigate the connection between effective team constructs and bullying in the workplace.

Due to rising costs and increased technological complexity in modern healthcare environments, a need has arisen to identify and coordinate scarce human and financial resources to ensure appropriate patient outcomes (Mickan & Roger, 2005). Healthcare institutions need to understand the importance of providing high levels of service/quality care for their patients. Such institutions rely heavily on the quality care provided to fund the value-based incentive payments under the Affordable Care Act (ACA) (Patient Protection & Affordable Care Act, 2010). The challenge for healthcare institutions partially centers on nurses being placed in complex work environments

loaded with numerous stressors such as intense workloads all while handling life-and-death decision making (Croft & Cash, 2012). The effect of incivility/ bullying on nurses places greater stress in the work environment. Of note, workplace incivility has been shown to lead to poor teamwork, low morale, distrust and decreased job performance (American Nursing Association, 2015). Such stress highlights the challenges of ensuring appropriate patient care.

There is a need for high work performance from all healthcare personnel. Such performance dictates the importance for employees to function efficiently and effectively. It is reasonable to posit that effective teamwork is an essential job requirement for any nurse working within a hospital setting (Leonard & Frankel, 2011). For many nurses, this skill is paramount to successfully perform their job duties. Unfortunately, teams within the healthcare environment are often faced with the challenge of workplace incivility/bullying. This particular phenomenon is well researched, especially as it applies to nurses in institutional settings (Becher & Visovsky, 2012; Demir & Rodwell, 2012; Moore, Leahy, Sublett, & Lanig, 2013). The direct influence of workplace incivility on teams appears to be less researched.

Purpose Statement

The purpose of this study was to investigate perceived workplace incivility (bullying) and the influence on leadership, trust, and communication reported by nurses working on hospital teams.

Aim of the Study

The aim of this study was to develop an evidence-based solution to workplace incivility. Clear, more targeted solutions, may help diminish the problem.

Teamwork

To provide a clear picture of effective teamwork, one needs to examine the definition of *team*. Teams may be defined as a small number of people with an ability to provide complementary skills and who are also committed to a common purpose and goal (Lerner, Magrane, & Friedman, 2009). In addition, teams hold themselves collectively responsible for such goals (Mickan & Rodger, 2005). Salas et al., (2005) highlighted the importance of thoughts, actions, and feelings of each team member. Salas et al., (2005) stressed that thoughts, actions, and feelings “[...] combine to facilitate coordinated, adaptive performance and task objectives resulting in value-added outcomes” (p. 562). A variety of descriptions are provided for teamwork, but gaps in the definition still exist. A clear definition of teamwork continues to be elusive.

Teamwork is now an essential part in a healthcare organization's quest to deliver quality care (Leonard & Frankel, 2011; Lerner, et al., 2009; McComb & Hebon, 2013). The Affordable Care Act (ACA) has added additional stress on such institutions to deliver the best possible healthcare services. The ACA will give further impetus to the growing importance of teams in the healthcare arena (Taplin, Foster, & Shortell, 2013). As a result of the ACA going into effect, nurses will need to foster a higher level of responsibility as it pertains to patient safety (Khadjehturian, 2012). Differences exist on a performance level between individuals and teams. In essence, well-performing teams tend to produce better health care outcomes than do individuals alone (Hays, 2014). It should be noted that teamwork does not inherently come to fruition simply by placing various people together. These members will likely need training to learn how to work together and to understand their professional roles and responsibilities (Lerner et al.,

2009). Overall, teams have a desire for leaders to better understand both teamwork and team development in the workplace (Bajnok et al., 2012).

Leadership. Leadership frames an important construct of team effectiveness (Leggat, 2007; Mickan & Rodger, 2005). Strong leadership on a team provides the ability to influence team dynamics in a positive manner (Muller-Judge et al., 2014; Salas et al., 2005). In the healthcare environment, it is believed that leadership should exist at two levels within the organization, senior leadership and clinical leadership (Leonard & Frankel, 2011). As Leonard and Frankel (2011) further suggested, leadership is not often taught in healthcare. The consequence of poor leadership can result in higher errors made by medical staff (Reed, 2015). Hence, developing effective leadership in healthcare environments may be more challenging.

Leaders who feel more enthusiastic and energetic themselves are more likely to energize their followers. The reverse is true as well, meaning that hostile leaders are likely to negatively affect their followers (Brief & Weiss, 2002). A closer review of Salas's theory of the Big Five of Teamwork revealed that leaders of a team have a direct influence whether or not such a group has a team orientation (Reed, 2015). Furthermore, Reed (2015) alluded that effective team leadership provides a team with stronger adaptability to change.

Abusive Supervision

Interpersonal style is an important element in determining the effectiveness of the leader (Reed & Olson, 2010). One potential consequence of ineffective leadership is abusive supervision or toxic leadership. Such leaders often reveal a lack of respect towards subordinates (Reed, 2004). What is known about relationships in the workplace

is that the relationship between employees and their immediate supervisors is the most important (Tepper et al., 2009). It should be noted that abusive supervision generally refers to a sustained display of nonphysical hostility (Tepper, 2007). Supervision is defined as an individual who directs and controls the duties and activities of subordinates (Estes, 2013). Defined differently, abusive supervision focuses the lens on subordinates' perceptions of their supervisors' display of prolonged verbal or non-verbal hostile behavior (Rodwell, Brunetto, Demir, Shacklock, & Farr-Wharton, 2004). Common manifestations of abusive supervision include angry outbursts, taking credit for subordinates' success and ridiculing (Tepper, 2007).

Studies reveal that such abusive supervision affects nearly 14% of US workers in general (Tepper, Moss, Lockhart, & Carr, 2007). Abusive supervision can chronically damage an employee psychologically (Lin, Wang, & Chen, 2013). One of the challenges with abusive supervision is the employees who report only an incident when it is perceived that the act is effective yet, not too personally costly (Tepper et al., 2007).

Oftentimes abusive leaders suffer from narcissistic behaviors indicating such leaders are selfish, self-serving, egotistical, manipulative, and exploitative (Doty & Fenlason, 2013). Such leaders lack emotional intelligence and in essence, turn the emphasis and focus on themselves (Doty & Fenlason, 2013). Perhaps Tepper (2000) best described abusive supervision as leaders whose behaviors isolate subordinates. Examples includes a supervisor giving an employee the silent treatment or not allowing an employee to interact with colleagues.

Toxic leaders by definition reveal a lack of respect to subordinates (Reed, 2004). Abusive supervisors may mistreat subordinates to accomplish objectives (Tepper, 2007).

One challenge for subordinates is the fear of revenge and retaliation by supervisors caused by power differentials (Tepper et al., 2009). Such toxic leaders can instill a serious negative effect on followers and even entire societies that they lead (Lipman-Blumen, 2005). Injustices by supervisors may translate into depression and hence greater incidences of abuse as reported by the subordinates (Tepper, Duffy, Henle, & Lambert, 2006). Such leaders may deliberately harm others to enhance themselves (Lipman-Blumen, 2005). Furthermore, Lipman-Blumen (2005) listed specific characteristics of the destructive behaviors of such toxic leaders:

- leaving followers worse off
- violating basic human rights
- consciously feeding followers illusions that enhance the leader's power
- playing to the basest fears and needs of followers
- misleading followers through untruths. (p.19)

As a result of such destructive behaviors, victims of abusive supervision tend to create psychological or physical distance between themselves and the perpetrator (Tepper et al., 2007). Furthermore, subordinates who are abused by their supervisors tend to be less committed to their jobs and place less trust in their coworkers (Tepper et al., 2006).

It should be noted that differences exist between abusive supervision and bullying in that the former is exclusively hierarchical (Estes, 2013). At risk are nurses who perform in a high-risk group for a range of antisocial behaviors in the workplace (Rodwell et al., 2004). Nurses are at risk because abusive supervision may lead to poor employee well-being whereby nurses experience a lower job satisfaction (Lin et al.,

2013). It seems logical to posit that abusive supervision has potential to harm constructive team dynamics and may, in essence, encourage further workplace incivility.

Trust. The effectiveness of teamwork depends on the level of trust among team members (Lerner , Magrane, & Friedman, 2009; Suddick & DeSouza, 2007). In simple terms, trust can be defined as an expression of confidence between parties in an exchange of some type (Jones & George, 1998). Trust is also described as a willingness of an individual to be vulnerable to actions of another party based on a perceived outcome, regardless of the individual doing the trusting being able to monitor or control the other individual (Jones & George, 1998).

It is known that in both interpersonal relationships and group interactions, within the work environment, trust is considered a highly important factor (Sheng & Tian, 2010). Due to the multi-dimensional nature of trust, it can be difficult to define (McCabe & Sambrook, 2013). Trust has been described, however, as a fragile commodity that is threatened by conflict (Jones & Jones, 2011). What McCabe and Sambrook (2013) illuminated is that trust is not only fragile but can be easily destroyed.

Additionally, what is known about trust is that when individuals who perceive that past performance of another individual meets specific qualifications, there is a tendency for the two individuals to trust each other (Sheng, Tian, & Chen, 2010). Such trust developed on an intra-team level can moderate conflict within a team (Jones & Jones, 2011). Of note, during the first stages of a social encounter within a team, each individual on the team does not automatically assume that the other team member is trustworthy but rather each individual tends to suspend belief that the other's values may be different from their own (Jones & George, 1998).

It should also be noted that mutual trust forms one of the key relationships among teamwork concepts (Reed, 2015). In addition, one of the prerequisites to effective performance monitoring is the development of a trusting and cohesive team climate (Salas et al., 2005). Put in a slightly different light, to work effectively on an interprofessional team, trust is considered a key element (Van Schaik et al., 2014). In order to develop a productive and safe working environment, collegial trust becomes essential (Jones & Jones, 2011).

It has been noted in the healthcare environment, nurses are more likely to instill trust with managers who have an open style of communication and who are approachable (McCabe & Sambrook, 2013). McCabe and Sambrook (2013) further stated attributes such as openness, communication, and being kept informed, all positively influenced trust. Increased collegiality, along with participative safety and innovative working practices between disciplines, has been demonstrated with increased levels of trust (Jones & Jones, 2011). To determine trustworthiness, individuals need to perceive past role performance and determine the reliability that the individual meets professional qualifications. If viewed favorably, then team members will trust each other (Sheng & Tian, 2010).

Viewed from a different lens, declining levels of trust may negatively influence teams. Such declines in trust may precipitate when participants believe that an unclear role definition exists (Kilpatrick, Lavoie-Tremblay, Ritchie, Lamothe, & Doran, 2011). Loss of trust tends to lead to declining levels of morale, commitment, and organizational performance which in turn, increases stress (Lencioni, 2002; McCabe & Sambrook, 2013;

Reed, 2015). It stands to reason that workplace incivility or bullying may also lead to declining levels of trust.

Communication. A variety of characteristics and constructs can be identified as important elements of effective teamwork. In literature, communication, trust, and leadership are some of the most commonly mentioned constructs (Leonard & Frankel, 2011; McComb & Hebdon, 2014; Van Schaik, O'Brien, Almeida, & Adler, 2014). Each of these parameters has an influence on the accomplishment of team goals and objectives. Each construct provides a frame through which to support effective teamwork.

Effective team communication is essential for improved patient care and safety (Bajnok et al., 2012; Frakes, 2009). In essence, communication helps facilitate teamwork (Biggers & Ioerger, 2001). Effective communication skills, along with an ability to foster and demonstrate cohesive teamwork, are expected of newly graduated nurses (Thistlethwait & Dallest, 2014). Specifically, effective communication on teams is labeled as closed-loop communication (McComb & Hebdon, 2013). Closed-loop communication acts as one means to ensure effective communication. Biggers and Ioerger (2001) described six types of communication demonstrated within teams to ensure successful coordination:

- synchronization: common and compatible flow: teams should progress through various stages at a consistent pace. All team members should flow through these six stages at a consistent pace. One individual on the team should not get ahead of the other team members or else failure is likely.
- disambiguating a shared responsibility: if a given shared responsibility has ambiguity, there is a possibility of multiple team members attempting to execute the same task

- simultaneously. In the long-run this can hinder efficiency because excess work is being performed. As such, communicating to resolve ambiguity of shared responsibilities is important to the success of the team.
- alerting of failure: the importance of alerting the team of impending failures. If such a message is not sent, other team members may strive to accomplish a goal in vain.
 - assistance offers or requests between team members: individual becomes overwhelmed or lacks resources to complete a given task. Individual reaches out to ask others to help.
 - information requests and distribution: proactively transferring information whenever there are updates, and allowing team members to request more detailed status updates whenever needed.
 - ambiguous information resolution: individual attempts to resolve conflict by someone who knows the answer or polls the team as a whole to uncover the truth.(p. 883)

Essentially, effective communication needs to flow through these six phases in order to enhance teamwork. Of note, healthcare institutions need to keep both patients and colleagues informed while placing emphasis on the content of the message itself (Siassakos et al., 2013).

To provide quality care, individual caregivers are needed who can quickly diagnose a problem and provide a solution. However, the solution needs to be communicated to team members in an expeditious manner or patients may suffer negatively. Nurses are expected to take patients' history, present a case, and confer with colleagues, all of which require strong oral and written communication skills (Clark, 2014). Healthcare teams utilizing clear communication may enhance their caregiving

ability. As noted by Bumann and Youkin (2012), communication skill can create enormous influence on processes and outcomes in the healthcare environment. One potential solution to increasing effective communication includes team-building exercises. Such activities have been shown to result in greater staff communication (Kalisch et al., 2007). It must also be noted that the transferal of effective messaging relies heavily on repetition (Kalisch et al., 2007).

Workplace Incivility/Bullying

Recent research on workplace bullying, points to the usage of the term coming to fruition in the 1980s. During this period, researcher Henrik Leymann revealed that the emphasis of bullying should be placed on the frequency and duration of the phenomenon (Agervold, 2007). Lim (2011) further added to the description of bullying as a social interaction. Such interaction highlights individual attacks by one or more individuals almost on a daily basis and for periods of many months. Leymann further argued that the duration of bullying had to occur more than six months to be labeled bullying (Lim, 2011). Leymann and colleagues in Sweden studied the frequency and consequences of bullying and later developed the questionnaire on bullying which is commonly known as the LIPT or Leymann Inventory of Psychological Terror (Agervold, 2007). This questionnaire consisted of forty-five different actions described as bullying. Agervold (2007) was quick to point out a difference between bullying and conflict with bullying involving longer durations of negative behavior.

Definition

Workplace incivility/bullying is described by a variety of different terms. In reviewing literature regarding the subject, one finds terms such as professional incivility,

mobbing, aggression, petty tyranny, harassment and organizational deviance (Fritz, 2013). Regardless of the term, the actual act itself describes behavior in the workplace that depicts unreasonable repeated acts by one individual, or a group of individuals, towards another individual. Generally, these acts are employed to intimidate the individual being attacked (Department of Labor and Industries, 2008).

In terms of aggressive behavior, bullying has been described as a type of social interaction whereby the sender uses verbal and/or non-verbal communication on a regular basis for at least six months (Agervold, 2007). The interactions are characterized by negative and aggressive elements. This aggression is focused towards the personality and self-esteem of the intended receiver (Agervold, 2007). In fact, bullying has been described as abusive and intimidating behaviors whereby the recipients feel humiliated and potentially vulnerable (Eager, Cowin, Gregory, & Firtko, 2010).

Looking more closely, one sees that the act of bullying often results as a misuse or abuse of power (Department of Labor and Industries, 2008). When defining bullying, four characteristics are described as essential elements: frequency and duration, the reaction of the target, the balance of power, and lastly the intent of the perpetrator (Agervold, 2007).

From a different perspective, other authors define bullying or, in this particular definition, workplace incivility as “[...] deviant behavior with an ambiguous intent to harm the target” (Smith, Andrusyszyn, & Laschinger, 2010, p. 1007). Agervold (2007) defined bullying as having two parts: an objective identification of the particular activities that one needs to recognize as bullying and secondly, a subjective part which focuses on the person’s perception of being bullied. Still others define workplace

bullying as “health-harming mistreatment of one or more persons” and describe it as “verbal abuse” and “offensive conduct” (Pomeroy, 2012, p. 5).

Other definitions include the perspective of repetitive abuse, intimidating or humiliating behaviors, threats, and other verbal abuse that essentially interferes with an employee’s job performance (Murray, 2009). Much research refers to an overall abuse of power, but it must be noted that bullying is not limited to a boss/subordinate relationship. In essence, abusive supervision differs from bullying in that abusive supervision is solely hierarchical (Estes, 2013). Indeed, well-documented in the workplace is employee to employee bullying (Becher & Visovsky, 2012; Eagar et al., 2010).

According to the Society for Human Resource Management (SHRM), there are four types of bullying behavior. These types include verbal bullying, physical bullying, gesture bullying (threatening gestures), and exclusion where an employee is excluded from a work group on purpose (SHRM, 2013). Each of these types of bullying can negatively influence an employee causing a drop in morale and productivity in the workplace (Pomeroy, 2012).

Regardless of the definition, it becomes apparent that a variety of deviant behaviors constitute some form of the concept of bullying. Individuals faced with such inappropriate behavior are placed in a challenging environment in the workplace. These challenges can have negative repercussions throughout an organization (Malinauskiene, Leisyte, Malinauskas, & Kirtiklyte, 2011).

Impact

One challenge employees who experience bullying often have in common is that bullying behaviors are not always openly aggressive. Indeed, the acts of bullying are

generally more subtle and very often go unnoticed by those employees affected by the act. Therefore, it is difficult to document such occurrences (Pomeroy, 2012). In the long-run, employees become more isolated in their job, further decreasing their engagement and subsequent productivity (Murray, 2009; Pomeroy, 2012).

The tactics involved in bullying may involve leaders who provide employees with unreasonable workloads. This in turn, may limit career opportunity (Hutchinson, 2010). Excluding the victim from important communication is another common tactic (Hutchinson, 2010). In some cases, employees may be denied “due process” in meetings, limiting opportunity to work in a suitable environment, and a denial of sick leave.

As has been mentioned, nurses perform their duties in complex environments where stressors such as challenging workloads and a hectic pace are frequently prevalent (Croft & Cash, 2012). Such high job demands may lead to high levels of work stress. These demands impede effective teamwork (Gevers, van Erven, de Jonge, Mass, & de Jong, 2010).

The actual effect in the workplace varies depending on the severity and consistency of the bullying. As Fritz (2013) alluded, there are significant implications to organizations which can include employee turnover, lowered productivity, and stress to the employee. As one reflects on workplace incivility and its influence on employees, it stands to reason that employee turnover rates would be higher than more positive encouraging environments. Twenty-one percent of nursing turnover can be related to incivility in the workplace (American Nurses Association, 2015). Specifically focusing on nurses, hospitals are faced with negative consequences when bullying is allowed in the institution. In particular, hospitals are concerned with the cost of replacing a nurse. It is

estimated that a recently graduated nurse costs the hospital \$88,000 to replace (Smith, Andrusyszyn, & Laschinger, 2010). Viewed from a different lens, however, collaboration and teamwork can lead to both reduced healthcare costs and increased job satisfaction (Bajnok et al., 2012).

Scope

Workplace incivility is a pervasive problem in the United States (Carbo, 2009). In the workplace, a majority of employees have been exposed to workplace bullying in some manner (Harris, Harvey, & Booth, 2010). Luparell (2011) reported that 24.1% of nurses stated they were verbally abused either by a nurse manager or nurse colleague. As emphasized by Leither, Price, Spence, and Laschinger (2010), the nursing profession faces a growing shortage of nurses. Further research indicates that generational differences exist and affect both workplace relationships and social environments leading to burnout (Leiter et al., 2010). These generational differences describe a decided problem for healthcare institutions because statistics suggest that between 35% - 61% of new nurses may leave the profession within the first year of professional practice (Leiter et al., 2010). Research also pointed out that those nurses who fall prey to bullying are more likely to quit their job (Luparell, 2011). Lachman (2015) reported that 39% of newly graduated nurses witnessed some type of bullying and 31% personally experienced bullying. Any one of the concerns noted can be a challenge to the effective and efficient operation of health care institutions.

Perhaps it is best to state that identifying the incidence may be an even harder task than identifying the prevalence. Of significance, the process of identifying the incidence of bullying has major methodological problems which start with trying to define the

problem (Rayner, 1997). The emphasis shifts to bullying in the workplace and in particular, the nursing profession.

A survey in 2006 by the American Association of Critical-Care Nurses (AACN) revealed that 24.1% of nurses reported being abused by a nurse colleague or a nurse manager (Luparell, 2011). In a more recent survey, Duffin (2012) revealed that nearly 42% of nurses stated that they had experienced bullying in the workplace. The same research revealed that in 2011, the rate was only half the 2012 number, or 22 percent. Rates of incivility affecting Certified Nurse Anesthetists (CRNAs) revealed that more than 80% experienced some type of aggression (Elmblad, Kobjebacheva, & Lebeck, 2014). According to a SHRM poll conducted in 2011, 51% of employees who responded to a survey reported incidences of bullying in their workplaces (Binney, 2012). It must be noted that these results were not exclusive to nursing. These results do, however, highlight the significant prevalence of workplace incivility/bullying.

In terms of prevalence, it has been shown that certain individuals are more prone to the actual act of bullying than others. In particular women, ethnic minorities, and the lower level employees are more likely to experience bullying (Pomeroy, 2012). Equally compelling, Pomeroy (2012) revealed that women are more likely to bully than are men. Utilizing a different lens, results from the 2007 Workplace Bullying Institute survey revealed the following:

- 35% of workers have experienced bullying firsthand (53.5 million Americans)
- 58% of targets of bullying are women
- Bullying is four times more prevalent than illegal harassment

Of note, this survey defined bullying as “repeated health harming abusive conduct committed by bosses and coworkers” (Workplace Bullying Institute, 2007).

In comparison, overseas research estimated that 3.5% of the workforce in Sweden experienced bullying and in one Austrian hospital, a rate of 27% was reported (Agervold, 2007). Research indicated that regardless of the rate, bullying creates a stressful and less than desirable workplace.

Potential Causes

There are a number of reasons hypothesized as to why bullying in the workplace occurs. Unfortunately, the origin and propensity for incivility are unknown (Luparell, 2011). There are a number of rather practical explanations as to the rationale for why one individual bullies another individual. One hypothesis posited by Murray (2009) was the need for the bully to be in control of his or her work environment. Murray (2009) further stated that the bully may have a personality disorder or flaw. Fritz (2013) formulated further explanations for what she termed an increase in “incivility in the workplace” and advanced the theory that it may be part of a climate of informality in the workplace combined with an increase in cultural and generational diversity. Such diversity strains communication and thus prompts misunderstanding. Fritz (2013) also examined the influence of increasing workloads on all employees along with the increase in productivity demands. All of which can lead to a more stressful environment making it easier to express such stress levels through the form of bullying.

Pomeroy (2012) believed that organizations with highly competitive cultures where employees competed against each other helped to feed the problem. Croft and Cash (2012) posited that frenetic pace, lack of power for nurses, lack of management

skills, and generational differences can lead to workplace incivility. It is also postulated that workplace incivility is the result of stress and overwork (Elmblad et al., 2014) Pomeroy (2012) further revealed that organizations that lack accountability and or policies regarding workplace bullying, helped open the door to an environment where bullying can take place freely. In many instances, there are no consequences for those who choose to bully despite hospitals instituting specific policies against such incivility.

The focus group from the British Columbia Nurses Union (BCN) and the Union of Psychiatric Nurses (UPN) identified what they defined as four themes and key contributors to bullying (Croft & Cash, 2012):

1. Economy and workload. This theme was derived because of the down-turn in the economy and the inherent stress it has placed on employees, especially nursing staff.
2. Lack of interpersonal skills. Although the focus argues that lack of interpersonal skills is not a “root cause” of bullying but more a “cultural subjugation”. One instance reflects nurses hiding resources making it difficult for other nurses to get their job completed.
3. Lack of management skills. In the nursing profession in particular, nurses are often elevated into positions of authority more out of seniority than skill level. In fact, many of the nurse managers lack any formal training in such areas as conflict management.
4. Hierarchical nature of nursing work. Much of the conflict may arise because “older” nurses were trained differently than younger nurses. (p. 230).

Effects/Consequences

The ill effects of bullying in the workplace may be displayed in a number of manners. Research has demonstrated that those who suffer from bullying may suffer a lowered work performance, sleep disorders, loss of concentration, anxiety and depression (Pomeroy, 2012). As an employee begins to endure these difficult symptoms, a loss of engagement at work becomes more likely. This very lack of engagement can lead to a loss in productivity. According to Hutchinson (2010), equally disturbing is that bullying remains an under researched phenomenon. As long as there is a lack of focus on this issue, there will continue to be a problem in the workplace.

It has been demonstrated that bullying can damage an employee's professional identity (Hutchinson, 2010). Hutchinson (2010) further noted that this damage to identity leaves employees feeling "down-graded" and oftentimes in such an environment, limited career opportunities exist. The ramifications for individuals who are bullied are well documented. Much research points to the significant physical and mental health problems experienced by the victims of bullying. These health problems include musculoskeletal problems, phobias, sleep disturbances, digestive problems, and even high stress; post-traumatic stress disorder (PTSD) (Dept. of Labor and Industries, 2008).

As has been mentioned, the negative ramifications of bullying include a decrease in productivity, morale, collaboration, and an increase in stress levels. Hutchinson (2010) revealed that bullying is recognized as the most concerning form of aggression. Croft (2012) clarified that bullying has been a reality for the nursing profession for at least three decades. Further research reinforces the seriousness of bullying for nurses. It has

been noted that an abusive workplace results in poor job satisfaction, as well as, poor retention culminating in adverse patient outcomes (Murray, 2009).

Negative Affectivity

Looking through a different lens, negative affectivity may play a role in the bullying process because individuals with high levels of negative affectivity tend to dwell on their shortcomings and may resort to abusive behaviors (Harris, Harvey, & Booth, 2010). Importantly, the authors noted that employee's personality is directly related to coworker abuse. As such, negative affectivity was positively associated with abuse, making it important for managers to use skill tests as tools for identifying candidates in the hiring process.

The effect of nurses enduring bullying in the workplace can lead to confusion in areas such as medication administration, patient allocation, and workload (Eagar, Cowin, Gregory, & Firtko, 2010). The authors suggested that such circumstances may leave nurses feeling not only bullied, but stressed and harassed. An unfortunate consequence of workplace incivility points to higher turnover rates along with diminished job satisfaction leading to decreased communication and patient safety (Kadjehturian, 2012). Adding further to this challenge, the ACA has increased nurse responsibility for patient safety (Khadjehturian, 2012).

Bullying Effect on Teamwork Constructs

Relevant research has demonstrated that in order for team members to provide a safe environment for patients, effective individual teamwork behaviors must be demonstrated (Gevers, van Erven, de Jong, Maas, & de Jong, 2010). Gevers et al., (2010) further stated such behaviors included anticipating others' needs and

communicating in closed loops. Strain in the workplace is hypothesized to influence effective teamwork behaviors including coordination, performance monitoring, and backup behavior (Gevers et al., 2010). Unfortunately, research does not directly link the effects of team constructs such as communication, trust, and leadership on workplace incivility.

Looking at each construct individually, one might consider the effect of bullying on such parameters. It stands to reason that closed-loop communication channels will be negatively influenced by bullying as such negative behavior tends to isolate nurses. It also seems reasonable that communicative responses to problematic relationships will need to be handled individually as opposed to applying a universal approach as a universal approach may be ineffective. Thus, addressing the bullying behavior on an individual level might provide a more prudent application.

The same can be said regarding both trust and leadership. Both traits act as important constructs to effective teamwork. A lack of one or both of these constructs will most likely negatively affect either patient care or service. Trust is often formed within the nurses' immediate ward and can be significantly influenced by the role of a line manager (McCabe & Sambrook, 2014). Given the importance of workplace relationships as it pertains to trust, it appears that damage to this construct will fracture relationships in the workplace (Jackson et al., 2010).

Self-efficacy theory

Applying an existing theory against a known problem may be a helpful approach. One such theory may provide insights into improving interpersonal effectiveness within teams. The self-efficacy theory sheds light into improving such factors. Self-efficacy is

defined as individuals who believe in their ability to succeed when it comes to attaining their goals (Bandura, 2010). Creating positive healthcare relationships is designed to facilitate positive outcomes (Bumann & Younkin, 2012). The authors further described healthcare workplaces as having three factors affecting human interactions. Such factors included individual differences, group dynamics, and conflict (Bumann & Younkin, 2012).

Utilizing the self-efficacy lens, it is more apparent that individuals who possess a stronger belief in their skills and abilities enable such employees to make a more positive effect in the workplace. Thus, for nurses operating on teams, this attribute may be a critical element to enable them to navigate interactions in healthcare environments more effectively (Bumann & Younkin, 2012). Self-efficacy theory weaves a common bond between teamwork and bullying. Research findings indicate that it is difficult to maintain high self-efficacy while simultaneously exhibiting bullying behavior. In theory, teams possessing high levels of self-efficacy among its members may exhibit stronger team constructs.

Summary

Given the potential influence of bullying on team constructs, it is prudent to examine the relationship more closely. As such, rather than looking at bullying and its effect on teamwork, one may need to change perspective and measure the affect that high performing teams have on bullying behavior. Essentially, teams with effective closed-loop communication, high levels of trust, and strong leadership may be able to create an environment where the engagement in bullying is greatly reduced or eliminated. As

such, training such healthcare providers in the essentials of teamwork could help establish a more desirable work environment.

In short, there are options available for nurses and nursing managers to help eliminate workplace bullying. First, it seems relevant for nurse managers to establish a working environment where nurses feel empowered and supported in the workplace. One option suggested by Harris et al., (2010) was for managers to use negative affectivity and political skills tests to help hire appropriate nurses who will be less likely to commit workplace bullying.

Lastly, research findings discussed suggest healthcare institutions need to create an environment open to teaching the importance of teamwork. It seems intuitive that such training be taught for all levels of employees in the healthcare environment enabling the concept to better inculcate the entire institution. Employees' ability to feel prepared for their jobs may well be influenced to the extent by which the training for teamwork is imbedded in professional development (Malone, Gallagher, & Long, 2001).

Research is necessary to provide concrete metrics for developing effective teams that are cognizant of bullying and the subsequent consequences of such behavior. More importantly, research needs to generate ideas for teaching nurses how to enhance the various constructs of effective teamwork. In particular, ideas need to be generated on how to utilize effective communication, maintain high levels of trust, and exhibit strong leadership to help minimize and diminish potential bullying in the workplace. Closer analysis needs to focus on both the effect of bullying on any and all constructs of effective teamwork and the influence effective teams have on the prevalence of bullying.

The nursing profession is a high stress work environment that can ill afford the negative effect of bullying. More research on the link and consequences between bullying and effective team constructs needs to be performed. By emphasizing teamwork, focusing on essential team constructs, and ensuring effective training programs, nurses will be better equipped to effectively manage their high demand careers (Geevers et al., 2010). The end result will be high performing teams focused on providing high quality healthcare.

CHAPTER THREE: METHODOLOGY

Introduction

This study was conducted utilizing mixed methods research. Specifically, an online survey was utilized to measure the levels of teamwork and workplace incivility existing on nursing teams in two hospitals in the northeast. Quantitative research methods were chosen to provide a larger pool of respondents from which to answer the research questions. Qualitative open text responses were used to provide deeper context. Participants were also asked to evaluate their perceptions of teamwork and any experience with workplace incivility either personally or observed on other team members within the hospital. This study was conducted to measure both the level of teamwork present among the respondents and the level of workplace incivility. The goal was to assess any potential influence the level of incivility played on specific constructs (leadership, trust, and communication) of teamwork.

Purpose

The purpose of this study was to investigate perceived workplace incivility (bullying) and the influence on leadership, trust, and communication reported by nurses working on hospital teams.

Aim of the Study

The aim of this study was to develop an evidence-based solution to workplace incivility. Clear, more targeted solutions, may help diminish the problem.

Baseline Assessment Information

The current state of workplace incivility points to the idea that teams working within the healthcare environment are often plagued with such incivility (Moore, Leahy,

Sublett, & Lanig, 2013). Workplace incivility is identified from a variety of sources all illuminating the idea that such a phenomenon negatively influences the provision of effective healthcare (Becher & Visovsky, 2012; Demir & Rodwell, 2012; Moore et al., 2013).

Research Questions

Specific questions relating to the relationship of workplace incivility and teamwork provide a new lens from which to view the overall phenomenon of workplace incivility. These questions include the following:

Research Question 1: What relationship exists between communication (behaviors) of nurses and workplace incivility among nurses in two hospitals in the northeastern U.S.?

Research Question 2: What relationship exists between trust (behaviors) of nurses and workplace incivility among nurses in two hospitals in the northeastern U.S.?

Research Question 3: What relationship exists between workplace incivility among nurses and team performance among nurses in two hospitals in the northeastern U.S.?

Research Question 4: What relationship exists between leadership (behaviors) of nurses and workplace incivility among nurses in two hospitals in the northeastern U.S.?

The overarching hypothesis is that a negative association between levels of teamwork and workplace incivility exists. In essence, as high levels of teamwork are exhibited, low levels of workplace incivility will exist.

Method Rationale

A purposive nonprobability sampling technique was utilized in the Team and Team Dynamics survey. Such a technique was used to gain a broader perspective of nurses' perception on teamwork and workplace incivility. Two hospitals in the northeast

were surveyed utilizing the technique. A purposive nonprobability sampling technique is defined as a “[...] a judgmental form of sampling in which the researcher purposely selects certain groups or individuals for their relevance to the issue being studied” (Kingery et al., 1980, p. 50). A detailed demographic survey, along with attitudes about teamwork and workplace incivility, offered the opportunity to assess a broader scope of participants. The Team Characteristics Survey (TCS) (Malone, 1995) provides a global assessment of an individual’s perception of the performance of a team on which she or he serves (See Appendix B). Additionally, the TCS allowed respondents an open-text box to elaborate answers regarding perceptions on teamwork. The 12 questions regarding workplace incivility, Negative Intention Questionnaire, (NIQ) (See Appendix B, questions 21-32) were aimed at assessing the quality of the work environment and employee well-being. Workplace incivility questions were drawn from Einarsen and Raknes’ (1997) Negative Acts Questionnaire and contained 12 items generally characterized by any type of negative intent (Agervold, 2007).

The Chief Nursing Officer invited participants via email. As part of the invitation email, all respondents were given a timeline to complete the online survey and were assured of anonymity and confidentiality. As such, all data were secured via a password protected laptop computer. A total of 128 people participated in the thirty-seven question survey.

Participants

Participants were nurses working on teams within one of two northeastern hospitals, each hospital between 250 and 300 beds. Nurses working on teams, regardless

of position, were invited to complete the online questionnaire. Participants were allotted six weeks to complete the survey.

The Team and Team Dynamics survey yielded 128 nurse respondents. Eighty-seven percent of the survey respondents were female (Figure 1). This percentage is representative of the nursing profession in the U.S. where approximately 10% of nurses are male (Tanner, 2015). Furthermore, 82% worked within their team between one and fifteen years. Nearly half of respondents (44%) were fifty years of age or older with 84% being forty years of age and older (Figure 2). According to the National Council of State Boards of Nursing and the Forum of State Nursing Workforce Centers (2013), 55% of nurses in the workforce are age 50 or older. Only 3% had been with the particular medical center for less than one year. Seventy-five percent had been in the nursing profession sixteen years or more (Figure 3).

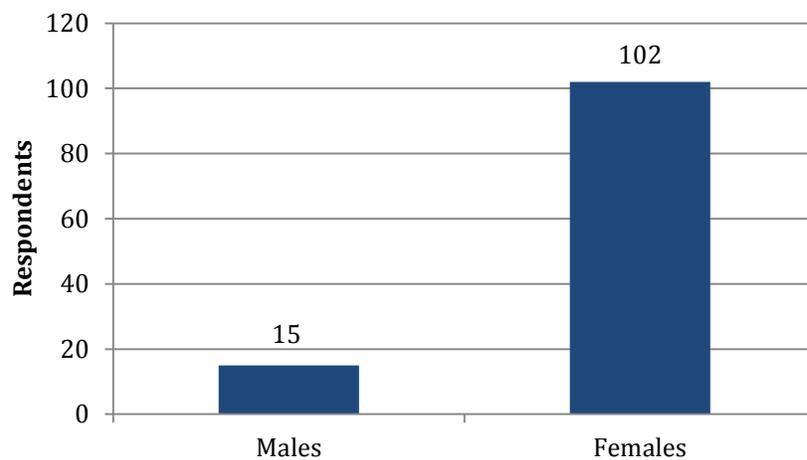


Figure 1. Gender of Respondents

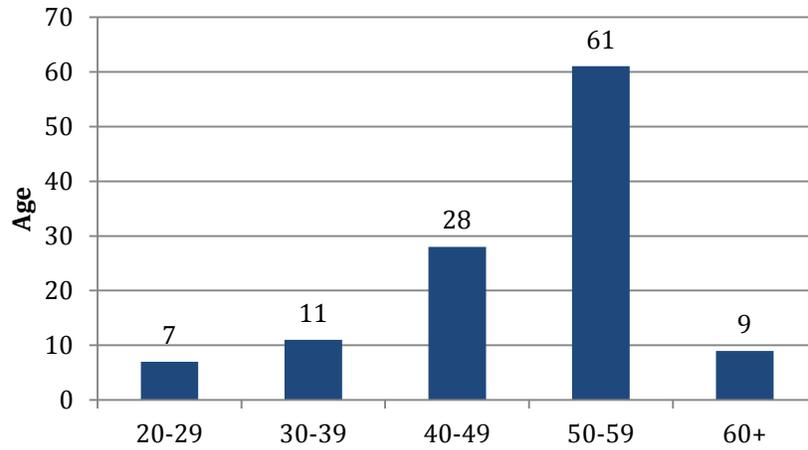


Figure 2. Respondent's age.

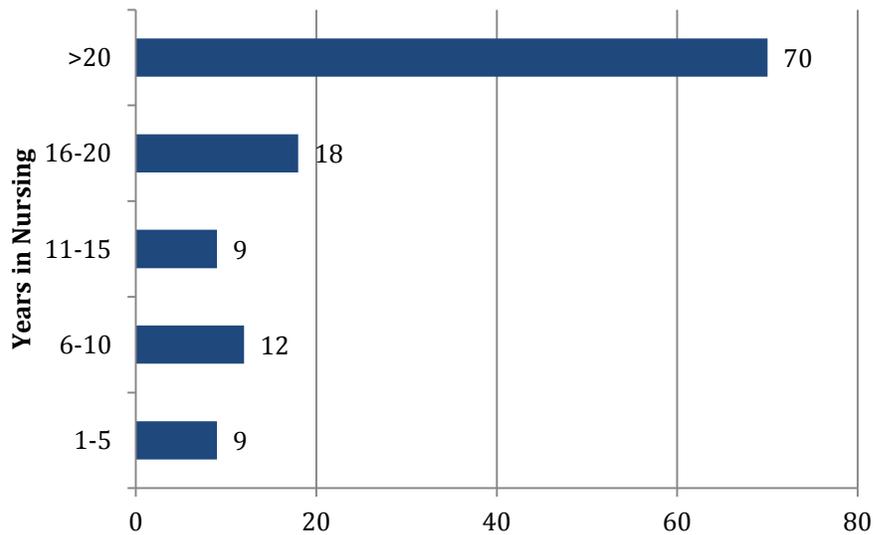


Figure 3. Respondent's years in nursing

Instrumentation

The quantitative survey utilized was based on a teamwork survey developed by Natvig and Malone (1992). The “Attitudes about Teamwork Survey” (AATS) was a 13-item questionnaire that addressed one’s acceptance or favorable regard of the team process in planning and implementing. Although the survey was adapted from a children with disabilities survey, the survey’s emphasis on teamwork provided a good framework

from which to measure attitudes about teamwork as it related to nurses in the workplace. As such, the tool served as a guide for teamwork questions designed to measure nurses' perceptions regarding teamwork. The Team and Team Dynamics survey eliminated three questions from the AATS to better streamline the survey and match the intended audience of nurses. The responses were based on a 5-point Likert scale [range = 1 (strongly disagree) to 5 (strongly agree)]. Essentially, the range of summary scores (sum of 10 items divided by 10) for the Attitudes About Teamwork Survey is 1 (low regard) to 5 (high regard) (Natvig & Malong, 1992) The Teamwork Characteristics (TCS) section consisted of ten questions. The Negative Intention Questionnaire (NIQ) section was based partly on Einarsen and Raknes' (1997) Negative Acts Questionnaire and contained 12 questions. (See appendix A for the complete survey)

Instrument Reliability and Validity

To effectively survey respondents, a reliable instrument needed to be utilized. The content validity, construct validity, and the internal consistency reliability have been established for the teamwork instrument (Natvig, 1993). The Perceptions of bullying questionnaire was based partly on Einarsen and Raknes' (1997) Negative Acts Questionnaire (NAQ). This questionnaire contained 12 items which were generally perceived by negative intent. Agervold (2007) revealed that the Cronbach alpha coefficient for the scale utilized in the questionnaire was 0.79. As such, the level of internal consistency among questions in the Agervold questionnaire was high.

Variables

The predicting variable in this online survey was the behavior of leadership, trust, and communication. Workplace incivility was the outcome variable measured.

Procedures

This online survey (Survey Monkey) was distributed utilizing Chief Nursing Officers (CNOs) at two northeastern hospitals. Each CNO disseminated the link via email. The potential respondents included approximately 750 nurses. One hundred and twenty-eight respondents were full-time nurses working within one of the two selected hospitals. Recipients had six weeks to complete the survey. The return rate for this survey was 17%. It should be noted that all nurses in one hospital were offered access to the survey while a smaller number of nurses in the second medical center had access to the survey. The smaller number of nurses gaining access to the survey may have been related to a quicker time frame for nurses to complete the survey. This researcher discovered that the link was not distributed to the entire nursing staff in the same time frame at the second hospital.

Nurses were asked to complete three sections in the survey. Sections included questions on teamwork, workplace incivility, and demographics. Data were collected and stored utilizing the Survey Monkey tool. Data were also stored on this researcher's password protected laptop computer.

Data Analysis Plan

This mixed-method survey consisted of three sections addressing attitudes about teamwork, team characteristics and perceptions of bullying. Means and standard deviation was calculated on all survey questions (Appendix B, C, and D). The AATS, TCS, and NIQ were analyzed using Pearson's r . According to Cohen (1988) correlations of .10, .30, and .50 are, respectively, small, medium and large (pp. 77-81). Hemphill (2003), however, suggested that such guidelines at least for large correlations, might be

conservative. An analysis utilizing Cronbach alpha was applied to ratings of AATS, TCS, and NIQ. Qualitative responses were examined for negative, neutral, or positive tone as well as general descriptive content.

Ethical Considerations

The main consideration for this Dissertation in Practice was to maintain confidentiality of all participants. As such, all demographic information on the nurses including position, number of years in the hospital institution, and gender were kept confidential. No identifying information has been shared. All data collected has been stored in a secure location where only this researcher has had access. Consent from nurses was obtained by nurses proactively completing the survey. Prior to the survey administration, a conversation was held with one of the CNOs to ensure all hospital protocol standards were met. All Creighton University IRB standards were followed.

Summary

Overall, the Dissertation in Practice served as a tool to measure the influence of workplace incivility on nursing teams and the teamwork constructs of leadership, trust, and communication. This Dissertation in Practice sought potential insights to enable hospitals to better train nurses for handling workplace incivility. Ignatian Values served as the framework surrounding the research for this dissertation thus, ensuring strict ethical guideline adherence. The hope is that insights gained from this Dissertation in Practice will serve the nursing community to better ensure high performing teams focused on providing high quality healthcare.

CHAPTER FOUR: RESULTS

Introduction

The descriptive statistics for the AATS and TCS are presented in Tables 1 and 2. The descriptive statistics for the NIQ are presented in Table 3. Overall, respondents had a favorable view of teamwork and its importance to the contribution of providing quality healthcare. The overall prevalence of bullying or any of its characteristics was low.

Results for Survey Questions on Teamwork

AATS Ratings

The AATS consisted of 10 questions utilizing a Likert Score of 1-5. The average mean score for the questionnaire was 3.7. The Cronbach alpha coefficient for this scale was 0.72. Nearly all respondents (95% - 99%) agreed or strongly agreed that a team approach is an effective method to provide patient care; the team approaches provides better care; each member needs to take time to make the team work; formal and informal communication is essential. Sixty-nine percent agreed or strongly agreed that each member of the team should have equal decision making power.

Seventy-seven percent agreed or strongly agreed that goals and objectives should be developed by individual team members prior to the team meeting while 53% agreed or strongly agreed in terms of individuals implementing team decisions even when the respondent did not believe it was the preferred conclusion. Six percent of respondents agreed or were neutral that conflict on a team should be ignored, compared to 94% who disagreed or strongly disagreed. Likewise, 14% agreed or were neutral in the belief that it is permissible for team members to revise a patient's health care plan without notifying other members of the team while 86% disagreed or strongly disagreed. Eighty-seven

percent agreed or strongly agreed that follow-up of a patient's progress is part of each team member's responsibility.

TCS Ratings

The Teamwork Characteristics section was composed of 10 constructs of teamwork. The Cronbach alpha coefficient for this scale was 0.93. Nurses were asked to rate the prevalence of occurrence with individual constructs. The scale indicated that a (1) was low and a (6) was high. The average total score for the TCS was 4.0. Three of the constructs, leadership, trust, and communication, indicated an above average score for prevalence in the workplace. In particular, nearly half (49%) of nurses indicated strong leadership in their hospital (Rating 5-6); 41% rated trust as high; and 39% rated communication as high. On the other hand, 18% rated trust as low, or less than average (Rating 1-2). This difference is statistically significant (40.1% vs. 59.3%; $Z = 2.00$; $p = 0.0497$). Of note, 17% rated communication as low/very low (1-2).

The average rating for the prevalence of cooperation was 4.3 with 48% rating the prevalence as a 5-6 with 34% rating prevalence of Balance and Participation as a 5-6 with an average score of 4.0. The prevalence of Role Clarity was rated a 5-6 by 39% of respondents with an average score of 4.1 and the prevalence of Frequent Barriers had an average score of 4.0 with 36% rating the prevalence at 5-6. Twenty-eight percent rated the prevalence of Conflict Resolution a 5-6 with an average score of 3.5 and twenty-seven percent rated the prevalence of Equal Power as 5-6 with 33% rating the prevalence as 1-2 and an average score of 3.4. Thirty-four percent rated the prevalence of Giving/Receiving Input and Feedback as a 5-6 with an average score of 3.7.

NIQ Ratings

The Cronbach alpha coefficient for this scale was 0.91. Sixty nine percent of respondents reported they rarely or never experienced acts of bullying (Table 4). Nearly all respondents (90%) reported they had never or rarely experienced anyone at work making fun of them and or their private life and 79% reported they had never or rarely experienced being made fun of in front of others. In contrast, 39% stated they had been ignored at least 2-3 times per month when asking someone a question. Fifty-four percent reported that at least 2-3 times per month they had witnessed others being bullied in the previous six months while 30% stated they had personally experienced the act of bullying in the previous six months.

Relationship between AATS and TCS

Only three of the Attitudes about Teamwork Survey (AATS) had a significant correlation (Table 5). The AATS characteristic that each team member should spend time and energy to make the team work had a statistically significant correlation with the prevalence of communication ($r = -.233$; $p = .010$) and each team member should spend time and energy to make the team work and frequent barriers ($r = -.219$; $p = .018$). The AATS item that it is permissible for each team member to revise a patient's healthcare plan without notifying the other team members, showed a significant correlation with the prevalence of equal power ($r = -.211$; $p = .021$). The AATS question regarding follow-up of a patient's progress is part of each team member's responsibility showed a significant correlation with the prevalence of frequent barriers ($r = .202$; $p = .029$). No other statistically significant correlations occurred.

Relationship between AATS and NIQ

A statistically significant relationship existed between five of the AATS and NIQ variables (Table 6). An inverse relationship between withholding information and the importance of the team approach existed ($r = -.238$; $p = .009$). The same inverse relationship existed between those experiencing others dealing with bullying in the previous six months and respondents agreeing with the importance of teamwork ($r = -.250$; $p = .007$) and that each team member needs to spend time and energy to make the team work ($r = -.186$; $p = .048$). An inverse relationship existed between those who had experienced others bullied in the workplace and those believing it is permissible to revise a healthcare plan without asking others ($r = -.189$; $p = .043$), and the idea that follow up of patient progress is the responsibility of each nurse ($r = -.236$; $p = .011$).

Relationship between TCS and NIQ

A statistically significant correlation existed between 66% of possible TCS and NIQ variables (Table 7). The teamwork variable of prevalence of Conflict Resolution had 10 of the 12 items correlate with the NIQ. In contrast, the teamwork characteristic of prevalence of Frequent Barriers was significantly correlated with only three items in the NIQ: you are made fun of it front of others ($r = -.188$; $p = .046$); someone ignores or makes fun of your attitudes or opinions ($r = -.201$; $p = .027$); your attitudes are ignored or made fun of ($r = -.223$; $p = .019$). No correlation existed between the concept of being made fun of and or one's private life and any of the TCS characteristics. Two TCS variables, prevalence of cooperation and frequent barriers, showed a significant correlation with the NIQ variable that someone ignores or makes fun of one's attitudes

and opinions ($r = .207$; $p = .025$ and $r = .207$; $p = .027$). Few correlations existed between being made fun of in front of others and TCS characteristics. A significant correlation existed between the prevalence of leadership and most (9 of 12) of the NIQ parameters. The same holds true for Trust (8 of 12) and Communication (9 of 12).

Qualitative Responses

An “open text” box was provided in the TCS. Comments were analyzed with particular focus on the constructs of leadership, trust, and communication. Leadership comments indicated an array of results from, “We have great leadership” to “Too many people are able to strong arm current leadership resulting in ineffective management”. Overall, comments regarding leadership were balanced with an equal number of positive statements and negative statements.

Comments on trust took on a more negative connotation. Comments included, “I feel that there are many of my co-workers who would ‘throw me under the bus’ to hide their own shortcomings or simply because they are mean and vengeful” and “No one wants to bring problems to the attention of leaders because the perception is that it makes things worse”. Not all respondents believed that trust was illusive. One respondent noted, “I feel trusted by those who know me best and that trust must be earned and sometimes previous misconceptions obscure trust”.

Less positive comments regarding communication were more prevalent than were positive comments. Comments ranged from “I think this (communication) is improved over the past year, however, it still needs work from the management to the staff”, to “Fear interferes with communication”. One respondent related the importance

of trust on communication, “Effective communication will not occur when trust is lacking. People hold back when trust is not established”.

Some comments in the “open text” box revealed some underlying discontent as evidenced by:

- “Nurses are extremely busy, high patient acuity and census, as well as, short staffing effect patient care and team dynamics”
- “Our unit is having difficulty with teams”
- “Management does not address conflict”
- “Staff do not feel that they are in control of anything or having a say in what the team should have as goals”

Other more positive comments included:

- “Excellent clinical leads”
- “We have great leadership”
- “People in my group always pull together for the good of the person”
- “The majority of staff is able to resolve conflict at the appropriate time in a professional manner. There are some (that) are not capable at this time”

Summary

Overall, most respondents agreed with the team approach and its effectiveness for patient care. Nearly all believed that there is a need to spend time and energy to make the team work and most agreed that goals and objectives should be developed by individuals before attending meetings. Nearly all respondents believed that team conflict should not be ignored.

Nearly half of respondents believed their institution had strong leadership. Trust, as it pertained to the respondent's team, rated high by less than half of respondents. Communication was also rated high by less than half of the respondents. Conflict resolution rated lowest in terms of prevalence with less than one-third rating it as high.

A majority of respondents reported having never or rarely been bullied. During the previous six months, over half of respondents reported seeing others bullied at least 2-3 times per month. Less than one-third stated they had personally been bullied on a frequency of at least 2-3 times per month.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

Introduction

In the Team and Team Dynamics survey, most nurses revealed their understanding of the importance of teamwork in their work environment. As such, most of the respondents indicated teamwork's importance as an effective method to provide patient care. Of note, most respondents agreed that the team approach results in overall better patient care.

Furthermore, most nurses in the study had not personally experienced workplace incivility in their institutions, however, over half observed others experiencing such incivility on a basis of at least 2-3 times per month. In general, the Team and Team Dynamics survey revealed a small but statistically significant correlation among leadership, trust, and communication and levels of incivility. In general, higher levels of leadership, trust, and communication related to lower levels of workplace incivility. An important finding from the Team and Team Dynamics survey was that nearly one-third of nurses responded that they personally experienced incivility a minimum of two to three times per month. This number is similar to the Workplace Bullying Institute findings (2007) at 35% but slightly lower than Duffin (2012) revealed at 42%. Any level of workplace incivility is likely considered unacceptable by hospitals. In turn, viable solutions on how to reduce such incivility in the workplace need to be determined. Such will be the focus of this final chapter.

Summary of the Study

The Team and Team Dynamics survey was distributed to nurses within two medical centers in the northeast. The results of the Team and Team Dynamics online

survey revealed that respondents agreed with the importance of teamwork as it applies to the healthcare environment. As mentioned, the majority of respondents believed that the team approach would result in overall better patient care. Such insight is consistent with other healthcare teamwork related research (Bajnok et al., 2012; Hays, 2013; Leonard & Frankel, 2011). A majority of nurses agreed that both informal and formal communication is essential to team functioning and that it is the responsibility of each nurse to follow up on patient progress.

The prevalence of leadership, trust, and communication within nurses' respective institutions was rated higher than average by the majority of respondents, indicating a more favorable view of these constructs versus an unfavorable view. Based on survey scores, however, there is room for improvement for increased levels of leadership, trust, and communication within teams in these two hospitals. Open text comments, in the TCS, revealed slightly more negative comments in terms of leadership and trust than positive comments. Comments regarding communication were generally neither positive nor negative.

Workplace incivility questions revealed that a small percentage of individuals personally experienced negative behaviors on an almost daily basis. A larger percentage of respondents reported personally experiencing such negative behavior on a basis of at least 2-3 times per month. When asked if they had seen others experiencing workplace incivility, a small percentage responded that they had seen it on a daily basis while over half stated that they had seen others experience it at least two to three times per month. Overall, there was a small but statistically significant correlation between higher levels of teamwork and lower levels of incivility. More research, however, needs to be conducted

to establish an even stronger correlation between the two variables. The purpose of this research was to review and investigate the potential influence that workplace incivility had on team performance as it pertained to healthcare providers, specifically nurses.

The aim of the research was to provide evidence-based solutions to workplace incivility in the hopes of adding practical solutions to help minimize and/or diminish such incivility.

Solutions

Based on the negative consequences of workplace incivility, it is important to identify practical solutions that can be implemented in healthcare institutions. The foundation of such solutions centers on awareness and education. The audience includes all nursing staff within a medical center. The research results from the Team and Team Dynamics survey revealed the importance that nurses place on teamwork while simultaneously exposing the degree of workplace incivility. In order to further enhance team performance and potentially diminish workplace incivility, one needs to identify practical and enduring solutions to be implemented in appropriate medical centers and institutions. One such practical solution is to begin an Awareness and Education Campaign (A&E Campaign) to provide both awareness and educational opportunities throughout the calendar year for nurses and staff.

The opportunity for awareness starts with a medical center's anti-bullying policies. It is likely that all medical centers have current policies addressing workplace incivility. Equally relevant, it is likely most, if not all, nurses are aware of the existence of such a policy. As such, reinforcing the relevance of the policy starts with senior leadership within the medical centers, specifically the Chief Nursing Officer (CNO). The

CNO needs to reinforce the policy and potential repercussions of violating such a policy. Additionally, nurse directors and managers need to reinforce the policy. This would ensure that all nursing personnel are aware of the policy, and more importantly, the consequences of violating the policy. Such communication needs to be incorporated as part of the yearly compliance training all employees must undertake in medical centers. Ideally, mid-year reviews would be held with all healthcare providers in the hospital. Most importantly, however, hospitals need to maintain strict adherence to penalties if violations occur. Without such strict adherence, some employees may demonstrate a lack of regard for the policy. Furthermore, without such adherence, the consequences will likely lead to the loss of nurses, increased errors, and decreased patient satisfaction (Eagar, Cowin, & Firtko, 2010).

A second solution for enhancing effective teamwork is providing nurse directors and managers training on engaging in crucial conversations. Crucial conversations are defined as a discussion between two or more individuals where the stakes are high, opinions vary, and emotions run strong (Patterson, Grenny, McMillan, & Switzler, 2012). Often, employees lack the ability for handling crucial conversations. Such a break-down in communication may precipitate even further incivility (Croft & Cash, 2012). In contrast, proper execution of crucial conversations may help diminish strained relationships in medical centers. Perhaps such crucial conversations may lead to more agreeableness among nurses. Such agreeableness has been shown to be one of the best predictors of team performance (Bradley, Baur, Banford, & Postlethwaite, 2013).

Furthermore, nurses may lack both interpersonal skills and management skills (Croft & Cash, 2012). Thus, courses in teambuilding and relationship skills offer a third

solution. Further development of such skills helps keep the focus on teamwork and team dynamics and ideally keeps the concept in the forefront of healthcare professionals' minds. A renewed awareness in teamwork combined with reliable processes of care may lead to better team dynamics and ultimately lead to better patient care (Leonard & Frankel, 2011). Additionally, for CNOs, nurse directors, and nurse managers, a 360 degree feedback on leadership should be provided (Goldman, 2009). This instrument enables those evaluated to gain better perspective on their effectiveness in a team environment.

Workplace incivility can precipitate from all levels within a hospital. In terms of addressing abusive supervision, Sipe and Frick (2009) defined various roles to enhance leadership in groups. Three such roles are defined below:

- *Mediator*: intervenes in disputes and forms resolutions for the work group
- *Keeper of Conscience*: places the work of the team within the context of the beliefs and values of the team
- *Process Watcher*: observes the group process and leadership roles and works to rectify any malfunctions or deficiencies. (p. 87)

Incorporating each of these roles into the nursing community has relevance. Each role can enhance leadership within the group, while simultaneously enhancing overall team performance. Of note, such roles may also provide another avenue to inhibit the prevalence of workplace incivility. By encouraging and supporting effective teamwork, there is opportunity to improve the quality of patient care and diminish burnout among healthcare professionals (Lerner, Magrane, & Friedman, 2009).

Reed (2015) provided another viable solution by suggesting that nurse managers, as well as administrators, need to consider various ways to improve teamwork by utilizing educational opportunities on communication and conflict resolution, team building exercises, and leadership development. Her suggestion was focused on charge nurses, but it seems reasonable to posit that such an idea is relevant to all nurses within the medical center. As has been discussed—leadership, trust, and communication are three constructs within the teamwork frame that have been identified as frequently discussed in literature. Providing educational opportunities for nursing staff could enhance all three constructs. Such educational opportunities should be provided to nurses on an annual basis. Placing emphasis on educational opportunities on an annual basis will foster positive team dynamics and inculcate the importance of teamwork into the medical center culture. This awareness is likely to have a positive effect on diminishing workplace incivility. By doing such, higher performing teams become more the norm. Such teams, when functioning well, may implement fundamental changes geared to enhance quality care (Taplin, Foster, & Shortell, 2013).

Overall, the educational opportunities reviewed, provide a starting place for nurses to build a framework that enhances teamwork and team performance. As a consequence of better teamwork, nurses are more likely to experience improved job satisfaction (Bajnok et al., 2012). Importantly, stronger teamwork also enhances team performance resulting in better outcomes for patients (Bajnok, et al., 2012; Hays, 2013; Leonard & Frankel, 2011).

Purpose of the Study

The purpose of this study was to investigate perceived workplace incivility (bullying) and the influence on leadership, trust, and communication reported by nurses working on hospital teams.

Aim of the Study

The aim of this study was to develop an evidence-based solution to workplace incivility. Clear, more targeted solutions, may help diminish the problem.

Implementation of Solution Processes and Considerations

To properly implement the A&E Campaign, Chief Nursing Officers (CNOs) must take accountability to begin the process. The ultimate responsibility for all nursing staff lies with the CNO. It is likely the CNO will need to begin by prompting a discussion with Human Resources to gain buy-in for the campaign. Once such buy-in is confirmed, it is the responsibility of the CNO to foster a team meeting with nurse directors and managers. During the meeting, the CNO must provide a thorough overview of the campaign and importantly must illuminate the benefits of such a program. Moving forward, the “grass roots” execution of the initiative must lie with the nurse managers. Such managers work closely with the nursing team on a daily basis and can measure the level of success on a more frequent basis.

Roles and Responsibilities of Key Players in Implementation

Three positions within the hospital are integral to the success of integrating the A&E Campaign within the medical center. First, the CNO provides senior leadership and instills guidance and direction for the entire nursing staff within the institution. Second, nursing directors are an integral part of the campaign, as such individuals are responsible

for direction to all nurse managers. Lastly, nurse managers are an important element, as these lower level managers have direct day-to-day influence on the nursing staff and are closest to daily activities. In order for effective execution of the A&E campaign, each level of leadership must first understand the importance of the educational opportunities and secondly, ensure “pull-through” from subordinates. Overall, the CNO must generate enthusiasm for such educational opportunities and each subsequent level of leadership will then follow the lead of the CNO.

Leader's Role in Implementing Proposed Solution

As mentioned previously, leaders on all levels are important to the A&E campaign. If all levels of leadership are operating with the same mindset, the likelihood for success increases. One consideration all leaders must take into account is that a percentage of subordinates will not agree or “buy into” the concept. Leaders themselves may be skeptical that such educational opportunities are just the latest “fad” that is being delegated by hospital administrators. In order to overcome such an objection, nurse leaders must ensure that all subordinates have the appropriate tools necessary to successfully engage in the campaign. Nurse leaders must consistently make this campaign a focal point through both words and actions throughout the year. Once the program is fully engaged with employees, it will then be the leader's job to ensure follow-up and understanding with all subordinates. At such a stage, it has been shown that interpersonal channels involving face-to-face exchange are more important at the persuasion stage when it comes to the innovation-decision process (Rogers, 2003).

Evaluation and Timeline for Implementation and Assessment

The timeline to ensure successful implementation of these specified educational opportunities will be six months. While some of the opportunities such as reviewing medical center harassment policies and delivering team building activities could be accomplished in a relatively short period of time, other initiatives such as procuring a training vendor to deliver workshops on crucial conversations would take a longer period of time. Six months should allow sufficient time. In essence, not all initiatives would be delivered simultaneously. Therefore, it is relevant to begin the process with the awareness portion of the campaign whereby a review of the medical center's harassment policy is provided.

Central to the A&E Campaign's success to bolster teamwork and diminish workplace incivility, is the idea that components of the initiative must be simple to implement. In line with this idea is keeping educational costs to a minimum. It should also be noted that success depends on "buy-in" from all levels of leadership within the medical center. Essentially, this is top-down driven and, as mentioned, begins with the CNO.

The first step in the process is Human Resources meeting with the CNO to ensure "buy-in" on the relevance of the initiative. It is imperative that the CNO provides full support in order for the initiative to be successfully implemented with nurse directors, nurse managers and all nursing staff. As a second step, the CNO meets with nurse directors within the institution to gain additional support. Subsequently, nurse directors meet with their nurse managers with the eventual outcome being nurse managers meeting with all subordinates.

Within the first six weeks, nurse directors and nurse managers need to ensure that the 360 degree feedback is implemented. Teambuilding exercises should be delivered within this six week period of time as well.

<u>Initiative</u>	<u>Timeline</u>
Human Resources to meet with CNO to discuss initiative	Within one month of start of initiative
Nurse directors/nurse managers to review medical center harassment policy with all subordinates	Within one month of start of initiative
360 degree assessment held for nurse directors and nurse managers	Within one quarter of start of initiative
Team Building Exercises	Within one quarter of start of initiative
Workshop on Crucial Conversations	Within 6 months

Figure 4. Awareness & Education Campaign Timeline

To ensure the success of the campaign, an appropriate assessment/evaluation plan must be implemented. As such, Human Resources needs to incorporate team work, communication skills, and crucial conversations, as part of the annual performance evaluation. All levels of nurses should be evaluated on such characteristics and be held accountable to meet required standards. Human Resources will need to “spot-check” performance evaluations to ensure that appropriate emphasis is being placed on the initiative. Additionally, the CNO and nurse directors should ensure the same level of adherence.

Convincing Others to Support the Proposed Solution

The first step in the process of gaining support for this initiative is convincing senior leadership that workplace incivility exists in their institution. Such individuals may readily admit that workplace incivility exists in other institutions but not their own. It should be noted that the same skepticism may be present at all levels of nursing. In such situations, results from the Team and Team Dynamics survey, as well as other relevant research, would need to be reviewed. Such results would need to be shared with all appropriate nursing staff.

For those senior leaders who agree that workplace incivility exists in their institution, the focus shifts to gaining buy-in on the campaign. Once such leadership, especially the CNO, is convinced of the viability of the solution, the process can begin to be inculcated within the institution. As mentioned, the process starts at the top and moves through the various layers of leadership until it reaches all nurses within the institution. CNOs need to be passionate and committed to the process and ensure that all nurse directors instill the same passion and commitment. The same holds true for nurse managers. Ultimately, it becomes the nurse managers' job to ensure the passion and commitment is part of the culture within their respective teams. It should be noted that resistance needs to be addressed at all levels by re-emphasizing the importance of high performing teams to the overall goal of effective patient care. To be successful, leadership must decrease the level of uncertainty for nurses while at the same time communicate the *relative advantage* of the initiative. Relative advantage illuminates a ratio of the expected benefits versus the cost of adopting the initiative (Rogers, 2003).

Internal and External Implications for the Organization

The passage of the Affordable Care Act highlights the importance of patient satisfaction scores, readmission rates, and length of stay guidelines for hospitalized patients. Each of these guidelines affects the reimbursement rate for the hospital. The better the score the medical center achieves, the better the reimbursement rate (Murphy, 2015). As such, all medical center CEOs, CFOs, and board members are paying close attention to such parameters. Follow-through on an initiative geared to enhance employee teamwork, especially as it applies to nurses, makes fiscal sense. More importantly, it makes sense from a patient perspective, as patient care is likely to be bolstered. If medical centers rate high on patient satisfaction scores, the end result for hospitals is a lower tier status which ultimately provides patients a lower co-pay premium or deductible.

Implications and Considerations for Leaders Facing Implementation of Proposed Solution

There are two considerations that the CNO must take into consideration to employ this A & E campaign. First, the CNO must consider the financial cost. As mentioned, in order to educate the nurse directors and managers, an outside subject matter expert would likely need to be brought in to run workshops. It becomes the CNO's responsibility to convince the appropriate personnel to secure funding. Secondly, the CNO needs to consider the time necessary on the part of nurse directors and managers to fully implement this program. As the adage states, "time is money". As such, the CNO will need to justify the importance of such an educational opportunity to the CEO and CFO. Furthermore, from a time standpoint, the CNO must recognize that most nurse directors

and managers have busy schedules and likely have little time to spare for new initiatives. Therefore, the CNO must ensure the proper prioritization of tasks for both nurse directors and managers.

Evaluation Cycle (or Evaluation Cycle Outcome If Implemented)

The frequency by which an assessment of progress is made, would be determined by the formality of the discussion. Informal sessions with leaders' direct reports would be held on a weekly basis during regularly scheduled group meetings. During such meetings, the focus of the group discussion would be on the opportunities and challenges regarding the educational campaign. Such check-ins allow the leader frequent benchmarks as to the progress and acceptance of the initiative. Weekly discussion allows the leader to make early course corrections should such corrections be warranted.

Weekly discussion points:

- Common goals for the group (patient satisfaction scores, length of stay, re-admission rates, etc.)
- Progress on teambuilding and roles within the team
- Input from team: opportunities/challenges

Formal discussions held with the leader and one subordinate (one-on-one sessions) would be held quarterly. During these sessions, the leader would begin discussion based on observable behaviors. Likewise, during mid-year Performance Evaluations and Annual Performance Evaluations, leaders would assess progress made by the subordinate in achieving team objectives.

Quarterly/mid-year/Annual one-on-one discussion points:

- Role on team

- Job performance as it applies to teamwork
- Achievement towards group goals

Summary of the Study

Much of the research that existed before this Team and Team Dynamics survey alluded to the importance of effective teamwork, especially as it applies to nurses providing quality patient care (Bajnok et al., 2012; Hays, 2013; Leonard & Frankel, 2011). The Team and Team Dynamics survey verified that the team approach is an effective method to provide better patient care. There was strong agreement that each member of the nursing staff must commit to time and energy to make the team function. Such responses indicate a level or degree of accountability taken by nurses in this survey. Of note, there was less agreement that each member of the nursing staff should have the same decision-making power. This may be indicative of a belief in a hierarchal alignment versus a horizontal alignment.

As might be intuitive, nurses believed that both informal and formal communication is essential to team performance. It is imperative that the entire nursing staff fosters a belief that effective teamwork is important. Such a belief enhances the work environment and may diminish workplace incivility. Equally important, higher team performance leads to better patient experience and care (Hays, 2013; Taplin, Foster, & Shortell, 2013). Also illuminated in this research, nurses felt there is room for improvement in the areas of leadership, trust, and communication. This survey further revealed that frequent barriers need to be removed. In particular, one nurse stated that communication barriers existed and that such a lack of communication was “dangerous”.

While the nursing staff believed that such team constructs were prevalent, room for development still exists.

In terms of workplace incivility, the Team and Team Dynamics survey verified that bullying exists in these two medical centers. Fortunately, the majority of respondents stated that occurrences were rare. Based on survey results, one can draw the conclusion that more work needs to be done in these medical centers to improve teamwork and team performance. Such enhancements will likely diminish the incidents of workplace incivility.

Implications for Action/Recommendations for Further Research

As discussed, workplace incivility threatens a growing number of employees worldwide (Neall & Tuckey, 2014). This threat is relevant in the nursing community as well, which is the impetus behind this Team and Team Dynamics survey. The effect of workplace incivility, as it pertains to nurses, ranges from a loss in productivity, diminished patient care, and a growing shortage of nurses entering the profession (Leiter, Price, & Laschinger, 2010). As such, the Dissertation in Practice provides potential solutions to aid in a more productive nursing environment. The survey provides a linkage between workplace incivility and its influence on effective teamwork. By exploring the relationship between workplace incivility and teamwork, potential solutions have been offered for medical centers to increase awareness of workplace incivility and bolster nurse teamwork. Ideally, increased awareness and educational opportunities will decrease the likelihood of such incivility in the medical center. Future studies in this arena, done on a broader scale, would serve to further solidify the relationship between teamwork and incivility, while continuing to raise the level of awareness regarding workplace incivility.

Summary

The Dissertation in Practice has reviewed nurses' responses as they pertain to teamwork and workplace incivility. The results regarding teamwork are consistent with current literature. In essence, these select nurses understand the importance of good teamwork and its positive correlation to providing effective healthcare. Results also revealed that nurses working in environments where acceptable teamwork is present are less likely to experience incivility. While the number of nurses directly experiencing incivility on a daily basis was small in this research, a substantial number of nurses did experience workplace incivility indirectly as it pertained to colleagues. Given the results of this survey, it is imperative that medical centers not only increase the awareness level of such incivility, but provide educational opportunities where nurses can learn the dynamics of effective teamwork, enhance their collaboration skills, and engage in critical conversations. Each of these learning opportunities will enhance nurses' ability to effectively function on high performing teams. Such education will likely enhance employee engagement, bolster morale, and make a contribution to positive healthcare provision. In the long-run, nurses will provide the framework where medical centers will not only survive but will thrive, well into the 21st century.

References

- Agervold, M. (2007). Bullying at work: A discussion of definitions and prevalence, based on an empirical study. *Scandinavian Journal of Psychology* 48, 161-172. doi: 10.1111/j.1467-9450.2007.00585.
- American Association of Colleges of Nursing (2014). Nursing shortage. Retrieved from: www.aacn.nche.edu
- American Nurses Association (2015). Taking a stand: Creating an incivility-free nursing environment. Retrieved from <http://eo2.commpartners.com/users/anan2/session.php?id=16394>
- Bajnok, I., Puddester, D., MacDonald, C. J., Archibald, D., & Kuhl, D. (2012). Building positive relationships in healthcare: Evaluation of the teams of inter professional staff interprofessional education program. *Contemporary Nurse*. 42, 76-89. Retrieved from <http://eds.b.ebscohost.com.cuhs1.creighton.edu/ehost/resultsadvanced?sid>
- Bandura, A. (2010). Self efficacy. In *The Corsini encyclopedia of psychology* (4th Ed. pp. 1534-1536). Hoboken, NJ: John Wiley & Sons.
- Becher, J. & Visovsky, C. (2012). Horizontal violence in nursing. *MEDSURG*. 21, 210-214. Retrieved from <https://www.amsn.org/sites/default/files/documents/practice-resources/healthy-work-environment/resources>
- Biggers, K. E., Ioerger, T. R. (2001). Automatic generation of communication and teamwork within multi-agent teams. *Applied Artificial Intelligence*. 15, 875 – 916. doi:10.1080/088395101753242679

- Binney, E. (2012). Experts recommend workplace bullying policies. Retrieved from <http://www.shrm.org/hrdisciplines/employeerelations/articles/pages/experts-recommend>
- Bradley, B. H., Baur, J. E., Banford, C., & Postlethwaite, B. E. (2013). Team players and collective performance: How agreeableness affects team performance over time. *Small Group Research*. doi:10.1177/1046496413507609
- Brief, A. P., & Weiss, H. M. (2002). Organizational Behavior: Affect in the workplace. *Annual Review of Psychology*. 54, 279-307. Retrieved from <http://www.annualreviews.org/doi/abs/10.1146/annurev.psych.53.100901.135156>
- Buljac-Samardzic, M., van Wijngaarden, J. D. H., van Wiljk, K. P., & van Exel, N. J. A. (2011). Perceptions of team workers in youth care of what makes teamwork effective. *Health and Social Care in the Community* 19, 307-316. doi: 10.1111/j.1365-2524.2010.00978.x
- Bumann, M., & Youkin, S. (2012). Applying self-efficacy theory to increase interpersonal effectiveness in teamwork. *Journal of Invitational Theory and Practice*. 18, 11-18.
- Carbo, J. (2009). Strengthening the healthy workplace act—Lessons from title VII and IIED litigation and stories of targets' experiences. *J. Workplace Rights*. 14, 97-120. doi:10.2190/WR.14.1.f
- Chen, C. C. (2010). Leadership and teamwork paradigms: Two models for baseball coaches. *Social Behavior And Personality* 38, 1367-1376. doi: 10.2224/sbp.2010.38.10.1367

- Clark, P. G. (2012). Narrative in interprofessional education and practice: Implications for professional identity, provider-patient communication and teamwork. *Journal of Interprofessional Care*. 28, 34 – 39. doi:10.3109/13561820.2013.853652
- Croft, R. K., & Cash, P. A. (2012). Deconstructing contributing factors to bullying and lateral violence in nursing using a postcolonial feminist lens. *Contemporary Nurse* 42, 226-242. doi:10.5172/conu.2012.42.2.226
- Demir, D., & Rodwell, J. (2012). Psychological antecedents and consequences of workplace aggression for hospital nurses. *Journal of Nursing Scholarship* 44, 376 – 384. doi:10.1111/j.1547-5069.2012.01472.x
- Department of Labor and Industries (2008). Workplace Bullying: What everyone needs to know. Retrieved from <http://www.lni.wa.gov/SAFETY/RESEARCH/Files/Bullying.pdf>
- Doty, J., Fenlason, J. (2013). Narcissism and toxic leaders. *Military Review*.55-60. Retrieved from <http://www.au.af.mil/au/awc/awcgate/milreview/doty-fenlason.pdf>
- Duhigg, Charles (2012). *The power of habit: Why we do what we do in life and business*. New York, NY: Random House.
- Eagar, S. C., Cowin, L. S., Gregory, L., & Firtko, A. (2010). Scope of practice conflict in nursing: A new war or just the same battle? *Contemporary Nurse* 36, 86-95. Retrieved from <http://eds.b.ebscohost.com.cuhs1.creighton.edu/ehost/resultsadvanced?sid=458ce3>
- Elmblad, R., Kodjebacheva, G., & Lebeck, L. (2014). Workplace incivility affecting CRNAs: A study of prevalence, severity, and consequences with proposed

- interventions. *AANA Journal*. 82, 437 – 445. Retrieved from
<http://www.aana.com/newsandjournal/20102019/Workplace-incivility-1214.pdf>
- Estes, B. C. (2013). Abusive supervision and nursing performance. *Nursing Forum*. 48, 3 – 16. doi:10.1111/nuf.12004
- Frakes, P., Neely, I., & Tudoe, R. (2009). Effective teamwork in trauma management. *Emergency Nurse* 17, 12-7. Retrieved from
<http://www.pubfacts.com/detail/20043426/Effective-teamwork-in-trauma-management>
- Fritz, J. M. (2009). Rudeness and incivility in the Workplace: A work psychology perspective. Pargrave MacMillan, New York, NY: Routledge.
- Fritz, J. M. (2013). *Professional civility: Communicative virtue at work* New York, N.Y: Peter Lang.
- Gevers, J., van Erven, P., de Jong, J. Maas, M., & de Jong, J. (2010) Effect of acute and chronic job demands on effective individual teamwork behavior in medical emergencies. *Journal of Advanced Nursing* 1573- 1583. doi:10.1111/j.1365-2648.2010.05314.x.
- Goldman, A. (2009). *Transforming toxic leaders*. Stanford, CA: Stanford University Press.
- Harris, K. J., Harvey, P., & Booth, S. L. (2010). Who abuses their coworkers? An examination of personality and situational variables. *The Journal of Social Psychology*. 150, 608-627. doi:10.1080/00224540903365489
- Hays, R. (2013). Learning and teaching about teamwork. *The Clinical Teacher* 10, 269-271. doi:10.1111/tct.12081

- Hutchinson, M., Vickers, M. H., Wildes, L., Jackson, D. (2010). A typology of bullying behaviors: The experiences of Australian nurses. *Journal of Clinical Nursing*. 19, 2319 – 2328. doi:10.1111/j.1365-2702.2009.03160.x
- Jackson, D., Daly, J. (2004) Current challenges and issues facing nursing in Australia. *Nursing Science Quarterly*. 17, 352-355. doi:10.1177/0894318404269389
- Jackson, D., Peters, K., Andrew, S., Edenborough, M., Halcomb, E., Luck, L., & Wilkes, L. (2010). Trial and retribution: A qualitative study of whistleblowing and workplace relationships in nursing. *Contemporary Nurse*. 36, 34-44. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/21254821>
- Jones, A., & Jones, D. (2011). Improving teamwork, trust and safety: An ethnographic study of an interprofessional initiative. *Journal of Interprofessional Care*. 25, 175 – 181. doi:10.3109/13561820.2010.520248
- Jones, G. R., & George, J. M. (1998). The experience and evolution of trust: Implications for cooperation and teamwork. *Academy of Management Review*. 3, 531 – 546. Retrieved from http://web.mit.edu/jrankin/www/teamwork/teamwork_Jones.pdf
- Kalisch, B. J., Curley, M, Stafanov, S. (2007). An intervention to enhance nursing staff teamwork and engagement. *JONA*. 37, 77 – 84. Retrieved from <https://scholar.google.com/scholar?q=an+intervention+to+enhance+nursing+staff+teamwork+and+engagement>
- Khadjehturian, R. E. (2012). Stopping the culture of workplace incivility in nursing. *Clinical Journal of Oncology Nursing* 16, 638-639. Retrieved from

<http://search.proquest.com/openview/8a5597be41d1c8b0f68e1440e68d1462/1?pq-origsite=gscholar>

Kilpatrick, K., Lavoie-Tremblay, M., Ritchie, J. A., Lamothe, L., & Doran, D. (2011).

Boundary work and the introduction of acute care nurse practitioners in healthcare teams. *Journal of Advanced Nursing*. 68, 1504 – 1515. doi:10.1111/j.1365-2648.2011.05895.x

Kingery, D. W., Bryant, L. D., Palmer, L. K., & Araghi, F. A. (1989). *A handbook of survey research*. The University of Georgia, Athens: Survey Research Center, Institute of Behavioral Research.

Lachman, V. D. (2015). Ethical issues in the disruptive behaviors of incivility, bullying, and horizontal/lateral violence. *Urologic Nursing*. 35, 39 – 42. Retrieved from <https://scholar.google.com/scholar?q=ethical+issues+in+the+disruptive+behaviors+of+incivility+bullying+and+horizontal/lateral+violence>

Leggat, S. G. (2007). Effective healthcare teams require effective team members: defining teamwork competencies. *BMC Health Services Research* 1-10. doi: 10.1186/1472-6963-7-17

Leiter, M. P., Price, S. L., & Spence Laschinger, H. K. (2010). Generational differences in distress, attitudes and incivility among nurses. *Journal of Nursing Management* 18, 970-980. doi:10.1111/j.1365-2834.2010.01168.x

Lencioni, P. (2002). *The five dysfunctions of a team: A leadership fable*. Hoboken, NJ: Wiley

- Leonard, M. W. & Frankel, A. S. (2011). Role of effective teamwork and communication in delivering safe, high-quality care. *Mount Sinai Journal Of Medicine* 78, 820-826. doi:10.1002/msj.20295
- Lerner, S., Magrane, D., & Friedman, E. (2009). Teaching teamwork in medical education. *Mount Sinai Journal of Medicine* 76, 318-329. doi:10.1002.msj.20129
- Lim, J. J. (2011). A cross-cultural comparison and examination of workplace bullying in Singapore and the United States. An unpublished master's thesis, University of Houston, Houston, TX.
- Lin, W., Wang, L., & Chen, S. (2013). Abusive supervision and employee well-being: The moderating effect of power distance orientation. *Applied Psychology: An International Review*. doi:10.1111/j.1464-0597.2012.00520.x
- Lipman-Blumen, J. (2005). Toxic leadership: When grand illusions masquerade as noble visions. *Leader to Leader*. 29 – 36. doi:10.1002/ltl.125
- Luparell, S. (2011). Incivility in nursing: The connection between academia and clinical settings. *Critical Care Nurse* 31, 92-95. doi:10.4037/ccn2011171
- Malinauskiene, V., Leisyte, P., Malinauskas, R., & Kirtiklyte, K. (2011). Associations between self-rated health and psychosocial conditions, lifestyle factors and health resources among hospital nurses in Lithuania. *Journal of Advanced Nursing* 67, 2383-2393. doi:10.1111/j.1365-2648.2011.05685.x
- Malone, D. M. (1995). *Team characteristics survey*. (Available from D. M. Malone, Early Childhood Education and Human Development Program, University of Cincinnati, Cincinnati, OH 45221-0105).

- Malone, D. M., Gallagher, P. A., & Long, S. R. (2001). General educators' attitudes and perceptions of teamwork supporting children with developmental concerns. *Early Education and Development* 12(4), 577-592. doi:10.1207/s15566935eed1204_5
- McCabe, T. J. & Sambrook, S. (2013). The antecedents, attributes and consequences of trust among nurses and nurse managers: A concept analysis. *International Journal of Nursing Studies*. 51, 815-827. doi:10.1016/j.ijnurstu.2013.10.003
- McComb, S., & Hebdon, M. (2013). Enhancing patient outcomes in healthcare systems through multidisciplinary teamwork. *Clinical Journal of Oncology Nursing*. 17, 669-670. doi:10.1188/13.CJON.669-670
- Mickan, S. M., & Rodger, S. A. (2005). Effective health care teams: A model of six characteristics developed from shared perceptions. *Journal of Interprofessional Care*. 19, 358-370. doi:10.1080/13561820500165142
- Moore, L. W., Leahy, C., Sublett, C., & Lanig, H. (2013). Understanding nurse-to-nurse relationships and their impact on work environments. *MEDSURG* 22, 172-179.
Retrieved from
<http://search.proquest.com/openview/6edb275cac2759069ac5fd75112681b3/1?pq-origsite=gscholar>
- Muller-Juge, V., Cullati, S., Blondon, K. S., Maître, B., Vu, N. V., Savoldelli, G. L., & Nendaz, M. R. (2014). Interprofessional collaboration between residents and nurses in general internal medicine: A qualitative study on behaviours enhancing teamwork quality. *Plos One*. 9, 1-8. doi:10.1371/journal.pone.0096160
- Murphy, M. (2015). HCAHPS: The true impact of patient satisfaction. *Medical Scribe Journal*. Retrieved from

<http://scribeamerica.com/blog/hcahps-true-impact-patient-satisfaction/>

Murray, J. (2009). Workplace bullying in nursing: A problem that can't be ignored.

MEDSURG Nursing, 18, 273 – 276. Retrieved from

https://www.amsn.org/sites/default/files/documents/practice-resources/healthy-work-environment/resources/MSNJ_Murray_18_05.pdf

Natvig, D. A., & Malone, D.M. (1992). *Attitudes about teamwork scale*. (Available from D.M. Malone, Early Childhood Education Program, University of Cincinnati, Cincinnati, Ohio, 45221-1015).

Natvig, D. A. (1993). *The interdisciplinary approach to decision-making about the use of psychotropic medication for individuals with mental retardation*. Unpublished dissertation, Medical College of Georgia, Augusta, GA.

Neall, A. M., & Tuckey, M. R. (2014). A methodological review of research on the antecedents and consequences of workplace harassment. *Journal of Occupational and Organizational Psychology*, 87, 225 – 257. doi:10.1111/joop.12059

Nursing Standard (2010). Empowerment is the solution to workplace bullying. *Nursing Standard*, 25 (15-17), 8. Retrieved from <http://connection.ebscohost.com/c/articles/57290035/empowerment-solution-workplace-bullying>

Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

Patterson, K., Grenny, J., McMillan, R., Switzler, A. (2012). *Crucial conversations: Tools for talking when stakes are high*. New York, NY: McGraw Hill.

Pearson, C. M., Andersson, L. M. Porath, C. L. (2000). Attacking workplace incivility. *Organizational Dynamics*, 29, 123 – 137. Retrieved from

http://www.researchgate.net/publication/228079608_Assessing_and_attacking_workplace_incivility

Pomeroy, E. C., (2012). The bully at work: What social workers can do. *Social Work*, 58, 5-8. doi:10.1093/sw/sws055.

Rayner, C. (1997). The incidence of workplace bullying. *Journal of Community & Applied Psychology*, 7, 199-208. Retrieved from [http://onlinelibrary.wiley.com/doi/10.1002/\(SICI\)1099-1298\(199706\)7:3%3C199::AID-CASP418%3E3.0.CO;2-H/abstract](http://onlinelibrary.wiley.com/doi/10.1002/(SICI)1099-1298(199706)7:3%3C199::AID-CASP418%3E3.0.CO;2-H/abstract)

Reed, G. E. (2004). Toxic leadership. *Military Review*, 67-71. Retrieved from <http://www.au.af.mil/au/awc/awcgate/milreview/reed.pdf>

Reed, G. E., Olsen, R. A. (2010). Toxic leadership: Part deux. *Military Review*, 58 – 64. Retrieved from <http://oai.dtic.mil/oai/oai?verb=getRecord&metadataPrefix=html&identifier=ADA531886>

Reed, J. (2015). When nursing teamwork suffers. Retrieved from <http://nursejournal.org/community/when-nursing-teamwork-suffers>

Rodwell, J., Brunetto, Y., Demir, D., Shacklock, K., Farr-Wharton, R. (2004). Abusive supervision and links to nurse intentions to quit. *Journal of Nursing Scholarship*, 46, 357 – 365. doi:10.1111/jnu.12089

Rodwell, J., Demir, D., & Theol, P. S. (2013). Psychological and organizational impact of bullying over and above negative affectivity: A survey of two nursing contexts. *International Journal of Nursing Practice* 19, 241-248. doi:10.1111/ijn.12065.

Rogers, E. M. (2003). *Diffusion of innovations*. New York, NY: Free Press.

- Salas, E., Sims, D. E., & Burke, C. S. (2005). Is there a "big five" in teamwork? *Small Group Publication* 36, 555-599. doi:10.1177/1046496405277134
- Sargeant, J., Loney, E., & Murphy, G. (2008). Effective interprofessional teams: "Contact is not enough" to build a team. *Journal of Continuing Education in the Health Professions*, 28, 228-234. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1002/chp.189/abstract>
- Sheng, C. W., Tian, Y. F., & Chen, M. C. (2010). Relationships among teamwork behavior, trust, perceived team support, and team commitment. *Social Behavior and Personality*. 38, 1297-1306. doi:10.2224/sbp.2010.38.10.1297
- Siassakos, D., Fox, R., Bristown, K., Angouri, J., Hambly, H., Robson, L., & Draycott, T. J. (2013). What makes maternity teams effective and safe? Lessons from a series of research on teamwork, leadership and team training. *Obstetricia et Gynecologica*, 92, 1239-1243. doi:10.1111/aogs.12248.
- Sipe, J. W., & Frick, D. M. (2009). *Seven pillars of servant leadership: Practicing the wisdom of leading by serving*. New York, NY: Paulist Press.
- Smith, L., Andrusyszyn, M. A., & Laschinger, H. K. (2010). Effects of workplace incivility and empowerment on newly-graduated nurses' organizational commitment. *Journal of Nursing Management*, 18, 1004-1015. doi: 10.1111/j.1365-2834.2010.01165.x
- Society for Human Resources (2013). Workplace-bullying laws on the horizon? Retrieved from <http://www.shrm.org/hrdisciplines/safetysecurity/articles/pages/workplace-bullying-laws.aspx>

- Suddick, K. M. & De Souza, L. H. (2007). Therapists' experiences and perceptions of teamwork in neurological rehabilitation: critical happenings in effective and ineffective teamwork. *Journal of Interprofessional Care*, 21, 669-686. doi: 10.1080/13561820701722634
- Taplin, S. H., Foster, M. K., & Shortell, S. M. (2013). Organizational leadership for building effective health care teams. *Annals of Family Medicine* 11, 279-281. doi: 10.1370/afm.1506
- Tanner, L. (2015). Women dominate nursing field, yet men make more. USA Today Network. Retrieved from www.usatoday.com/news/nation
- Tepper, B. J. (2000). Consequences of abusive supervision. *Academy of Management Journal*. 43, 178 – 190. doi:10.2307/1556375
- Tepper, B. J., Duffy, M. K., Henle, C. A., Lambert, L. S. (2006). Procedural injustice, victim precipitation, and abusive supervision. *Personnel Psychology*. 59, 101-123. doi:10.1111/j.1744-6570.2006.00725.x
- Tepper, B. J. (2007). Abusive supervision in work organizations: Review, synthesis, and research agenda. *Journal of Management*. 33, 261 – 289. doi: 10.1177/0149206307300812
- Tepper, B. J., Moss, S. E., Lockhart, D. E., & Carr, J.C. (2007). Abusive supervision upward maintenance communication, and subordinates' psychological distress. *Academy of Management Journal*. 50, 1169 – 1180. doi:10.1111/j.1464-0597.2012.00520.x

- Tepper, B. J., Carr, J. C., Breaux, D. M., Geider, S., Hu, C. & Hua, W. (2009). Abusive supervision, intentions to quit, and employees' workplace deviance: A power/dependence analysis. *Organizational Behavior and Human Decision Processes*. 109, 156 – 167. doi:10.1016/j.obhdp.2009.03.004
- Thistlethwaite, J., Dallest, K. (2014). Interprofessional teamwork: Still haven't decided what we are educating for? *Medical Education*. 552 – 560. doi: 10.1111/medu.12471
- Van Schaik, S. M., O'Brien, B. C., Almeida, S. A., & Adler, S. R. (2014). Perceptions of interprofessional teamwork in low-acuity settings: a qualitative analysis. *Medical Education* 48, 583-592. doi:10.1111/medu.12424
- Workplace Bullying Institute (2014). Retrieved from <http://www.workplacebullying.org/wbiresearch/wbi-2007/>

*Appendix A***Directions for survey:**

Thank you for participating in a research study from the Creighton University graduate studies. This research study is designed to measure your attitudes about teamwork in general and about specific elements of teamwork, namely leadership, trust, and communication. The purpose of this study will be to investigate the relationship between team performance and workplace incivility/bullying among healthcare teams. As such, the survey will measure your perceptions of not only teamwork but also workplace incivility (bullying) and the prevalence and impact in the workplace.

This questionnaire is completely anonymous and as such you will not be identified. The hope is that such research will provide insights into enhancing the work environment for nurses working in healthcare institutions.

Note that as a nurse, you likely work on more than one team. In answering questions regarding teamwork, please refer to the team with which you work and spend that greatest portion of your day.

Please complete the survey by _____(Date)_____

Thank you for taking the time to complete this survey.

Email Directions for CNO to staff:**Email to Chief Nursing Officer:**

My name is Todd Logan and I am a doctorate student at Creighton University researching teamwork and team dynamics. I have attached a link for a short, 37 question, the survey is on Survey Monkey. My request is for you to send the link along with a short note (written below) to nurses working in your medical center. The survey will run from Tuesday, February 17 to Tuesday, March 17. Please note, all responses will be confidential. Thank you in advance for helping with this research.

Email from CNO to nurses:

Hello Nursing Team:

Please find a URL link to an important survey regarding teamwork and workplace dynamics. The survey is being conducted by a graduate student at Creighton University for the purpose of better understanding teamwork and team dynamics. All responses will be confidential! The survey will need to be completed by Tuesday, March 17. Thank you in advance for your participation.

Appendix B

Survey

Questions 1-10 adapted from Malone, D. M., & Natvig, D. A. (1992).

Questions 11-20 adapted from Malone, D. M. (1995).

Questions 21-32 adapted from Agervold, M. (2007).

Directions: Thank you for taking the time to provide input on your perceptions regarding teamwork. Please base your responses on your general/overall experiences working on healthcare teams. Your responses will be kept confidential.

	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
1. The team approach is an effective method to provide patient care.					
2. The team approach results in overall better patient care.					
3. Each member of the team should have as much decision-making power as any other team member.					
4. Each team member needs to spend time and energy to make the team work.					
5. Both formal and informal communication is essential to effective team functioning.					
6. Goals and objectives should be developed by individual team members prior to the team meeting.					
7. Sometimes the decisions made by the team may not be the same as the decision that some individual team members would have preferred. When this happens, team members should implement the decisions made by the team regardless of their personal preference.					
8. If conflict occurs among team members, it should be ignored so that the team meetings will run smoothly.					
9. It is permissible for team members to revise a patient's health care plan without notifying the other members of the team.					
10. Follow-up of a patient's progress is part of each team member's responsibility.					

Please rate the prevalence of each characteristic.

Low/Not at all Characteristic = 1.....6 = High/Extremely Characteristic

11. Leadership

1 (Low)	2	3	4	5	6 (High)
Comments:					

12. Trust

1 (Low)	2	3	4	5	6 (High)
Comments:					

13. Effective Communication (Verbal, written, and or non-verbal)

1 (Low)	2	3	4	5	6 (High)
Comments:					

14. Cooperation

1 (Low)	2	3	4	5	6 (High)
Comments:					

15. Balance/Participation

1 (Low)	2	3	4	5	6 (High)
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Comments:

16. Role Clarity

1 (Low)	2	3	4	5	6 (High)
Comments:					

17. Frequent Barriers

1 (Low)	2	3	4	5	6 (High)
Comments:					

18. Conflict Resolution

1 (Low)	2	3	4	5	6 (High)
Comments:					

19. Equal Power

1 (Low)	2	3	4	5	6 (High)
Comments:					

20. Giving/Receiving input and feedback

1 (Low)	2	3	4	5	6 (High)
Comments:					

Please indicate the frequency of each of the following:

	Almost Daily	2-3 times per week	2-3 times per month	Rarely/ Never
21. Someone willfully withholds information making it difficult for you to perform your work properly.				
22. Someone unjustly criticizes your work performance.				
23. You experience unjustified verbal abuse.				
24. You are made fun of in front of others.				
25. Someone ignores or makes fun of your attitudes and opinions.				
26. Someone makes fun of you and or your private life.				
27. Your attitudes are ignored or made fun of.				
28. Being ignored when asking someone a question or when trying to talk to them.				
29. You feel social exclusion from co-workers.				
30. You sense that someone is slandering or spreading rumors about you.				
31. During the previous six months, did you witness anybody being bullied at your workplace?				
32. During the previous six months have you been subjected to bullying at your workplace?				

Please indicate the following:

Gender	Female	Male				
Age	<20	20 – 29	30-39	40-49	50-59	60+
Number of years working in this institution	<1 year	1-5 years	6 – 10 years	11-15 years	16 – 20 years	>21 years
Number of years working on the team with which you spend the most time	<1 year	1-5 years	6-10 years	11-15 years	16 – 20 years	>21 years
Number of years in the profession	<1 year	1 – 5 years	6 – 10 years	11-15 years	16 – 20 years	>20 years
Position in hospital	Nurse	Nursing Supervisor	Nursing Director	Nurse (Other)		

Table 1.

Descriptive Statistics For The Attitudes About Teamwork Survey (AATS)

Item #	Item Excerpt	Mean	SD
1	The team approach is an effective method to provide patient care	4.5	0.73
2	The team approach results in overall better patient care	4.57	0.59
3	Each member of the team should have as much decision making power as any other team member	3.79	1.06
4	Each team member needs to spend time and energy to make the team work	4.59	0.58
5	Both formal and informal communication is essential to effective team functioning	4.53	0.6
6	Goals and objectives should be developed by individual team members prior to the team meeting	3.89	0.92
7	Team members should implement decisions regardless of their personal preference	3.67	1.09
8	If conflict occurs, it should be ignored so that the team meetings will run smoothly	4.39	0.67
9	It is permissible for team members to revise a patient's healthcare plan without notifying other members of the team	4.24	0.85

10	Follow-up of a patient's progress is part of each team member's responsibility	4.11	0.79
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Table 2.

Descriptive Statistics for the Team Characteristics Survey (TCS)			
Item #	Description	Mean	SD
1	Leadership	4.31	1.36
2	Trust	3.99	1.44
3	Communication	4	1.43
4	Cooperation	4.3	1.18
5	Balance/Participation	4	1.18
6	Role Clarity	4.13	1.25
7	Frequent Barriers	4.02	1.23
8	Conflict Resolution	3.55	1.37
9	Equal Power	3.39	1.43
10	Giving/Receiving Input & Feedback	3.79	1.36

Table 3.

Descriptive statistics for Negative Intention Questionnaire (NIQ)

Item #	Item Excerpt	Mean	SD
1	Someone willfully withholds information	3.26	0.94
2	Someone unjustly criticizes your work performance	3.25	0.93
3	You experience unjustified verbal abuse	3.35	0.95
4	You are made fun of in front of others	3.7	0.65
5	Someone ignores or makes fun of your attitudes and opinions	3.52	0.81
6	Someone makes fun of you and your private life	3.86	0.44
7	Your attitudes are ignored or made fun of	3.58	0.73
8	Being ignored when asking someone a question or when trying to talk to them	3.41	0.84
9	You feel social exclusion from co-workers	3.63	0.71
10	You sense that someone is slandering or spreading rumors about you	3.56	0.75
11	During the previous six months, did you witness anybody being bullied at your workplace?	3.25	0.86
12	During the previous six months, have you been subjected to bullying at your workplace?	3.57	0.75

Table 4

<i>Prevalence of bullying</i>					
The following questions describe various acts which may be perceived as bullying. Have you been exposed to any of these acts at work during the last six months?	Almost daily (%)	2-3 times a week (%)	2-3 times a month (%)	Never/Rarely (%)	Total (%)
Someone willfully withholds information, making it difficult for you to perform your work properly?	6.7	12.6	26	54.6	100.0 n = 119
Someone unjustly criticizes your work performance?	7.4	11.5	28.9	52	100.0 n = 121
Unjustified telling off/verbal abuse?	8.3	9.1	20.8	61.6	100.0 n = 120
You are made fun of in front of others?	2	3	15.2	78.8	100.0 n = 118
Someone ignores or makes fun of your attitudes and opinions?	4	7	20.1	68	100.0 n = 119
Someone makes fun of you and/or your private life?	0.8	1	7.5	89.9	100.0 n = 119
Your attitudes are ignored or made fun of?	2	6	20	70.4	100.0 n = 115
Being ignored when asking someone a question or when trying to talk to them?	4.2	10.9	24.3	60.5	100.0 n = 119
Social exclusion from co-workers?	2.5	5.9	16.9	74.5	100.0 n = 118
You sense that someone is slandering or spreading rumors about you?	1.6	10.8	16.9	74.5	100.0 n = 120
During the previous six months, did you witness anybody being bullied at your workplace?	6	9.4	37.9	46.5	100.0 n = 116
During the previous six months, have you been subjected to bullying at your workplace?	3.3	4.9	22.3	69.4	100.0 n = 121

Table 5

Correlation Between Attitudes About Teamwork Survey (AATS) And Team Characteristics Survey (TCS)

	TCS1	TCS2	TCS3	TCS4	TCS5	TCS6	TCS7	TCS8	TCS9	TCS10
AATS1	-.021	-.057	-.135	-.048	-.061	-.029	.109	.029	-.017	.014
AATS2	.004	-.023	-.152	-.023	-.057	-.020	-.023	-.038	-.132	-.149
AATS3	-.070	-.149	-.233*	-.134	-.117	-.019	-.042	-.045	-.124	-.116
AATS4	-.030	-.012	-.122	.011	.025	-.059	-.014	-.028	-.086	-.144
AATS5	-.010	-.058	-.176	-.060	.023	-.057	.047	-.133	-.157	-.047
AATS6	-.033	-.024	-.037	.027	-.042	.017	.004	-.042	.026	-.129
AATS7	.111	-.043	-.219*	-.009	0.78	-.150	.038	-.002	.036	.202*
AATS8	-.093	-.139	-.123	-.119	-.107	.007	.048	-.129	-.162	-.119
AATS9	-.066	-.090	-.170	-.035	-.022	.130	-.006	-.169	-.211*	-.115
AATS10	-.068	-.050	-.067	-.025	-.058	.017	-.054	-.065	-.095	-.167

**Correlation is significant at the 0.01 level (2-tailed)

*Correlation is significant at the 0.05 level (2-tailed)

Table 6

Correlation Between Attitudes About Teamwork Survey (AATS) And Negative Intention Questionnaire (NIQ)

	AATS1	AATS2	AATS3	AATS4	AATS5	AATS6	AATS7	AATS8	AATS9	AATS10
NIQ1	-.238**	-.129	-.084	-.089	-.094	.033	-.139	-.104	-.095	-.132
NIQ2	-.043	-.020	.066	-.003	-.020	.000	.002	.000	-.003	.023
NIQ3	-.112	-.041	-.072	-.119	-.029	.102	-.045	-.006	.016	-.126
NIQ4	-.082	.087	.001	-.027	-.035	.043	.079	-.050	-.061	-.040
NIQ5	-.060	.062	.116	.037	-.100	.007	.082	.024	-.074	-.071
NIQ6	.075	.166	.119	.088	-.106	.103	-.033	-.012	-.122	.039
NIQ7	-.040	.039	.045	.049	-.073	.150	.062	.066	-.159	-.006
NIQ8	-.179	.072	-.048	-.038	-.058	-.027	.006	.038	-.041	-.145
NIQ9	-.084	-.128	-.023	-.130	-.100	-.068	.164	.136	.011	-.074
NIQ10	-.150	-.020	-.034	-.122	-.019	-.054	-.005	-.013	-.046	-.128
NIQ11	-.250**	-.067	-.077	-.186*	-.121	-.055	-.112	-.178	-.189*	-.236*
NIQ12	-.146	.038	-.031	-.099	-.158	.000	-.056	-.047	-.157	-.124

**Correlation is significant at the 0.01 level (2-tailed)

*Correlation is significant at the 0.05 level (2-tailed)

Table 7

Correlation Between Team Characteristics Survey (TCS) And Negative Intention Questionnaire (NIQ)

	TCS1	TCS2	TCS3	TCS4	TCS5	TCS6	TCS7	TCS8	TCS9	TCS10
NIQ1	.241**	.261**	.352**	.341**	.356**	.251**	-.012	.344**	.308**	.267**
NIQ2	.194*	.212**	.281**	.343**	.285**	.238**	-.011	.202*	.292**	.258**
NIQ3	.355**	.270**	.406**	.426**	.387**	.266**	-.117	.359**	.258**	.262**
NIQ4	.166	.086	.166	.178	.198*	.112	-.188*	.202*	.127	.176
NIQ5	.098	.127	.169	.207*	.131	.094	-.207*	.103	.118	.124
NIQ6	.135	.084	.074	.112	.120	.040	-.109	.128	.076	.067
NIQ7	.223*	.237*	.283**	.325**	.245**	.249**	-.223*	.194*	.220*	.245**
NIQ8	.194*	.152	.273**	.223*	.189*	.159	-.133	.252**	.159	.169
NIQ9	.220*	.233*	.225*	.188*	.183*	.147	-.044	.248**	.193*	.169
NIQ10	.313**	.259**	.258**	.233*	.225*	.199*	-.171	.294**	.280**	.171
NIQ11	.280**	.287**	.349**	.368**	.387**	.294**	-.176	.361**	.354**	.274**
NIQ12	.308**	.254**	.276**	.292**	.285**	.267**	-.105	.297**	.278**	.206*

**Correlation is significant at the 0.01 level (2-tailed)

*Correlation is significant at the 0.05 level (2-tailed)