



# The Impact of Workplace Incivility on the Work Environment, Manager Skill, and Productivity

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**Objective:** The objective of the study was to investigate the impact of workplace incivility (WPI) on staff nurses related to cost and productivity.

**Background:** Healthful practice environments are one of the goals of the American Organization of Nurse Executives 2010 to 2012 Strategic Plan. Healthy work environments are linked to patient safety and quality.

**Methods:** A postal survey was sent to 2,160 staff nurses ( $n = 659$  completed) and included the Nursing Incivility Scale and Work Limitation Questionnaire.

**Results:** Although almost 85% ( $n = 553$ ) reported experiencing WPI in the past 12 months, nurses working in healthy work environments (defined as Magnet®, Pathway to Excellence, and/or Beacon Unit recognition) reported lower WPI scores compared with nurses working in the standard work environment ( $P < .001$ ). Workplace incivility scores varied between types of unit. Nurses' perception of their manager's ability to handle WPI was negatively associated with WPI scores ( $P < .001$ ). Lost productivity

as a result of WPI was calculated at \$11,581 per nurse per year.

**Conclusions:** Not only does WPI exist at high rates, but also it is costly. Nursing leaders play a vital role ensuring a healthy work environment.

Workplace violence can be viewed as a continuum from low-level nonphysical workplace violence to physical violence.<sup>1</sup> Physical violence in the workplace makes the headlines; however, the more insidious forms of workplace violence, such as workplace incivility (WPI), can have long-lasting effects on an organization. Workplace incivility is defined as "low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. Uncivil behaviors are characteristically rude and discourteous, displaying a lack of regard for others."<sup>2</sup> Until this decade, the topic of WPI had rarely been mentioned; however, an interest has developed because of the evolving understanding of the importance of creating and sustaining a healthy work environment. Workplace incivility, usually occurring under the radar, is thought to be benign and frequently is not apparent to the leaders of the organization.

In nursing, a healthy environment is defined as a hospital with Magnet® designation or Pathway to Excellence designation<sup>3</sup> from the American Nurse Credentialing Center as well as the Beacon Award for Critical Care/Progressive Care Unit Excellence from the American Association of Critical-Care Nurses (AACN).<sup>4</sup> The forces of Magnetism are aligned with the concepts of a healthy work environment, especially the force of interdisciplinary relationships and autonomy. The Pathway to Excellence program also

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supports a healthy work environment in that it ensures professional satisfaction of nurses and the best places to work.<sup>3</sup> The Beacon Award for Critical Care Unit Excellence from the AACN promotes a healthy, professional work environment that ensures quality patient outcomes based on the evidence.<sup>4</sup>

Effective work relationships are necessary for a healthy work environment. Kramer and Schmalenberg<sup>5</sup> state that staff nurses want a collaborative interdisciplinary and nurse-physician relationship, which is one of the attributes of a satisfying and productive work environment. This collaborative relationship is described as “one based on mutual trust, power, and respect between parties.”<sup>5(p58)</sup> The relationship between the nurse and the nurse’s manager and peer relationships are critical to healthy work environments. The role of the manager sets the tone of the environment and impacts retention.<sup>6</sup> Positive relationships with colleagues are as important as the relationship with the unit/department manager.<sup>6,7</sup>

## Workplace Incivility

Most of the WPI research has focused on the business or nonhealthcare setting.<sup>8-13</sup> Recent research has focused on the target, witnesses, and outcomes of WPI and found that WPI has major ramifications on the workforce leading to absenteeism, reduced productivity, and turnover.<sup>8,9,11</sup> The literature on WPI is relatively new in the field of nursing science with one published WPI state-of-the-science article<sup>14</sup> and a limited number of nursing research studies on WPI.<sup>6,7,15</sup>

Hutton and Gates<sup>15</sup> explored the frequency of incivility experienced by nurses and nonlicensed assistive personnel and its impact on productivity and costs to the organization. Two instruments, the Incivility in Healthcare Survey and the Work Limitations Questionnaire (WLQ),<sup>16</sup> were used. These researchers modified the Nursing Incivility Scale (NIS) developed by Guidroz et al<sup>17</sup> into a frequency instrument measuring source-specific WPI in the healthcare setting. The authors found that the lowest reported incivility was from the direct supervisor and the greatest incivility was from the general environment. The direct care staff rated WPI at a mean of 2.12, which is just above “rarely occurs.” There was a correlation between WPI from direct supervisors and productivity ( $r = 0.284$ ,  $P = .001$ ) and WPI from patients and productivity ( $r = 0.204$ ,  $P = .006$ ). Incivility from physicians, coworkers, and the general environment was not statistically significant. Logistic regression found no significance between employment characteristics and demographics and WPI. The analysis did find a significant relationship between incivility and decreased productivity ( $F = 4.04$ ,  $P =$

.0017,  $R^2 = 0.1046$ ). Each factor was run against incivility, and only 2 factors were significant, direct supervisors ( $F = 15.65$ ,  $P = .0001$ ,  $R^2 = 0.0808$ ) and patients ( $F = 7.69$ ,  $P = .0061$ ,  $R^2 = 0.0361$ ). The authors also found that the annual cost of the decreased productivity for the sample was \$264,847.34, with the mean nursing assistant lost productivity costs at \$1,235.14 and \$1,484.03 for a nurse. A  $t$  test found that there was a significant difference between nurses and nursing assistants in the level of reduced productivity for the cumulative WLQ. Incivility had a greater impact on productivity than on the frequency of WPI. The limitation of this study was the small sample size, with a response rate of 22%.<sup>15</sup>

Laschinger et al<sup>6,7</sup> recently published two studies exploring WPI. The first study used the Workplace Incivility Scale of Cortina et al.<sup>8</sup> This study examined the influence of workplace empowerment, manager and coworker incivility, and burnout on retention, job satisfaction, organizational commitment, and turnover intent. Incivility from supervisors was experienced by 67.5% of the nurses, whereas 77.6% reported coworker incivility. A small percentage of nurses reported ongoing incivility (bullying) of 4.4% from supervisors and 2.7% from coworkers. Supervisor incivility, empowerment, and cynicism most strongly predicted job dissatisfaction and low organizational commitment ( $P < .001$ ), whereas the major predictors of turnover intent were emotional exhaustion, cynicism, and supervisor incivility ( $P < .001$ ).<sup>6</sup> The second study was designed to examine supportive professional practice environments, civility, and empowerment on graduate nurses experience with burnout. Incivility was measured using 4 items from the ICU Nurse-Physician Questionnaire of Shortell et al.<sup>18</sup> Graduate nurses reported relatively positive scores for civility in the workplace. Laschinger et al<sup>7</sup> found that the combination of a supportive practice environment ( $\beta = -0.221$ ,  $P = .004$ ), civility ( $\beta = -0.18$ ,  $P = .003$ ), and empowerment ( $\beta = -0.245$ ,  $P = .001$ ) contributed to less emotional exhaustion leading to burnout in graduate nurses. The lower scores of emotional exhaustion explained 28% of the variance of burnout.<sup>7</sup>

## Study Objectives

This impetus for this study was to add to the nursing science literature on organizational factors that influence WPI and the impact of WPI on cost due to lost productivity.

The aims of this study were to (1) determine if there were differences in reported WPI between healthy work environments and the standard work environment, (2) determine if there is a difference in WPI scores between hospital settings (academic

medical center, community, and rural), (3) evaluate the impact of WPI on cost and productivity of staff nurses in the hospital setting, (4) determine if there is a relationship between WPI subscales and productivity subscales, (5) examine the relationships between the manager's skill (manager's awareness and ability to handle WPI) and WPI, (6) determine if there are differences between the type of unit/department and WPI scores, and (7) determine if there were organizational factors that predict WPI in the hospital setting.

## Methods

This study is a nonexperimental, correlational, comparative, and predictive model design using a survey methodology with institutional review board approval. The setting for this study was in the state of Texas. Initially, the investigators obtained a mailing list of active RNs employed in the state of Texas from the Board of Nursing (BON) of Texas. The investigators selected only active RNs who were in a staff nurse role. The population of active staff nurses as of January 2, 2009, was 95,195 licensed staff nurses in Texas (personal communication, Texas BON, January 2009).

The investigators randomly selected 2,160 RNs for the sample and mailed a packet consisting of a cover letter, a hard copy of the survey, and a return postage-paid envelope. Each participant had the option of completing and returning a hard copy of the survey or completing the survey online using PsychData. By May 2009, the investigators had a response rate of 8% ( $n = 164$ ). A revised approach was used to increase the sample size. The snowball sampling function was activated in the PsychData survey to allow a staff nurse to forward the survey to other colleagues. Additionally, the investigators contacted key resources at 15 professional organizations in Texas and requested that the organization leaders electronically mail their members the PsychData URL link. The final sample size was 659 completed surveys.

## Instruments

Three instruments were used in this study: the NIS,<sup>17</sup> the WLQ,<sup>16</sup> and a demographic component designed by the investigators. The NIS is an agreement scale survey that measures source-specific (coworkers [nurses], supervisor, physicians, patients/visitors, and the general environment) incivility. This 43-item instrument has demonstrated reliability, with internal consistency  $\alpha$ 's ranging from .88 to .94 for each of the subscales. The subscales represent 2 general incivility factors (inappropriate jokes, hostility/rudeness), 3 nursing factors (free-riding, gossip/rumors, inconsid-

erate), and 1 factor for patients/visitors, supervisor and physician scales. A 5-point Likert scale is used in the NIS.<sup>17</sup>

The WLQ, designed by The Health Institute at Tufts Medical Center, is a 25-item instrument designed to measure productivity by the degree of interference an individual has in performing one's job role. The components of the WLQ include time management, physical demands, mental-interpersonal demands, and output demands. Responses range from "difficult at all times" to "not difficult at all." The WLQ index is calculated to indicate overall productivity. The WLQ possesses excellent scaling properties as well as content, construct, and criterion validity.<sup>16</sup> For this study, the Cronbach  $\alpha$  range for the subscales was .88 to .94.

The WLQ Productivity Loss Score indicates the percentage reduction in work output due to a work-related limitation (incivility). The WLQ Productivity Loss score determines the estimated percent difference in output compared with those who do not have the work-related limitations (experience with WPI).<sup>16</sup> To calculate the cost of WLQ Productivity Loss, the investigators followed the process outlined by Hutton and Gates.<sup>15</sup> The percent productivity loss is multiplied by the mean annual salary of the direct care staff nurse. The investigators used salary data from Keefe and O'Brien,<sup>19</sup> who conducted a national survey of 4,553 nurses from August through September 2008. The average salary range for a staff nurse in Texas was \$60,000 to \$64,999. The inpatient direct care staff nurse base pay in Texas was \$30.54 per hour.

## Findings

The sample included 659 direct care nurses, with a mean age of 46.38 years and 92% ( $n = 597$ ) being female. The ethnic/race distribution of the sample was diverse. Almost half of the sample (48%) had a baccalaureate degree in nursing (BS/BSN), and the majority of the sample (85.7%) had more than 6 years' experience as a nurse. The work environment was described by the work setting, type of unit, and special designations associated with healthy work environments. An academic medical center was the work setting for 38.6% of the nurses, whereas 37% were employed in a community hospital. Only 8.1% of the nurses identified themselves as working in a rural setting. Eleven percent of the nurses described themselves as working in an urban setting. Magnet designation, Pathway to Excellence, and Beacon status for critical care and progressive care units are recognition awards associated with healthy work environments with excellence in nursing. Thirty-eight percent of the nurses ( $n = 251$ ) worked in Magnet hospitals, and 31% ( $n = 200$ ) worked in Pathway to

Excellence hospitals. Only 6.4% of the sample (n = 42) identified themselves as employed in a Beacon Unit. The type of unit varied, with the highest percentage being the operating room (OR) (30%), followed by medical-surgical (MedSurg) units (16.4%) and ICUs at 14.6%. The emergency department (ED) and women's services were similar at 6.6% and 6.5%, respectively.

A large majority of the nurses in the sample experienced WPI in the last year (84.8%, n = 553). Interestingly, 36.7% (n = 239) of the nurses in the sample indicated that they had instigated WPI to another person in the last year. The sample demographics can be seen in Supplemental Digital Content 1, <http://links.lww.com/JONA/A38>.

### Work Environments and Nursing Incivility

Research question 1 asked: Is there a difference in reported WPI between healthy work environments and the standard work environment? A difference was found between healthy work environments and the standard work environment in respect to WPI. Staff nurses working in healthy work environments were found to have lower WPI scores than nurses working in the standard work environment ( $P < .001$ ) in all subscales except the patient/visitor (Table 1). The investigators followed with research question 2: Is there a difference in WPI scores and hospital setting? An analysis-of-variance (ANOVA) statistic indicated the means to be very close, with no significant difference in the WPI scores of direct care nurses working in academic medical center, community, or rural hospitals.

### Productivity, the Cost of Lost Productivity, and WPI

Research question 3 asked: Does WPI among staff nurses impact productivity and costs? The WLQ

productivity loss score estimates the percentage difference in output compared with those not experiencing the limitation (WPI). Lost productivity was calculated to be a mean of 0.19 or 20% (SD, 3.21). The WLQ index is multiplied by \$30.54 (average hourly base salary for staff nurses in Texas, which calculates to an annual salary of \$63,523.00). Subtracting nonproductive time of a 3-week vacation and 8 days of holidays computes to \$11,581 per nurse per year of lost productivity as a result of WPI. The investigators went on to ask if there was a difference in lost productivity related to WPI between healthy work environments and the standard work environment. An ANOVA was performed to determine whether the means between groups were different. The means were close; therefore, there was no difference in lost productivity scores between healthy work environments and the standard work environment. This finding indicates that the presence of any WPI impacts productivity, and the costs are the same. The investigators followed with question 4: Is there a relationship between the WPI and the productivity? Table 2 depicts a correlation between general environment, nurse, supervisor, and patient/visitor and the time management, mental/interpersonal skill, and output subscales. There was a negative relationship indicating that the higher the incivility, the lower the productivity. The physical subscale of the work limitation questionnaire has no correlation with WPI.

### Organizational Factors and WPI

Research question 5 asked: Is there a relationship between manager's skill and WPI scores? There was no correlation between the direct care nurses' perception of their manager's awareness of WPI on their unit/department. Conversely, direct care nurses' perception of their manager's ability to handle WPI was

**Table 1.** Is There a Difference Between Healthy Work Environments and the Standard Work Environment and NIS Scores?

Nursing Incivility Subscales		Healthy Work Environment	Mean (SD)	F/df/P
General environment	No	293	3.36 (0.734)	6.102/639/<.001
	Yes	348	3.07 (0.815)	
Nurse	No	292	3.36 (0.816)	1.129/634/<.001
	Yes	344	3.03 (0.852)	
Direct supervisor	No	292	2.32 (1.07)	5.206/633/<.002
	Yes	343	2.07 (0.99)	
Physician	No	290	3.14 (1.03)	.182/628/<.001
	Yes	340	2.75 (1.04)	
Patient/visitor	No	287	2.02 (0.826)	.153/624/.112
	Yes	339	2.13 (0.875)	

**Table 2. Is There a Relationship Between WPI and Productivity?**

Subscales	General Environment	Nurse	Direct Supervisor	Physician	Patient/Visitor
WLQ time management					
R	-0.212 <sup>a</sup>	-0.292 <sup>a</sup>	-0.263 <sup>a</sup>	-0.257 <sup>a</sup>	-0.309 <sup>a</sup>
P (2-tailed)	.000	.000	.000	.000	.000
N	603	603	603	603	603
WLQ physical					
R	0.064	0.084 <sup>b</sup>	0.088 <sup>b</sup>	0.044	0.134 <sup>a</sup>
P (2-tailed)	.117	.039	.031	.276	.001
N	602	602	602	602	602
Mental interpersonal skill					
R	-0.284 <sup>a</sup>	-0.319 <sup>a</sup>	-0.293 <sup>a</sup>	-0.268 <sup>a</sup>	-0.312 <sup>a</sup>
P (2-tailed)	.000	.000	.000	.000	.000
N	601	601	601	601	601
WLQ output					
R	-0.195 <sup>a</sup>	-0.234 <sup>a</sup>	-0.253 <sup>a</sup>	-0.217 <sup>a</sup>	-0.265 <sup>a</sup>
P (2-tailed)	.000	.000	.000	.000	.000
N	600	600	600	600	600
WLQ productivity index					
R	-0.252 <sup>a</sup>	-0.307 <sup>a</sup>	-0.295 <sup>a</sup>	-0.278 <sup>a</sup>	-0.305 <sup>a</sup>
P (2-tailed)	.000	.000	.000	.000	.000
N	599	599	599	599	599

<sup>a</sup>Correlation is significant at the .01 level (2-tailed).

<sup>b</sup>Correlation is significant at the .05 level (2-tailed).

negatively associated with WPI scores in general environment, nurse, supervisor, and physician subscales of the NIS ( $P < .001$ ). The patient/visitor subscale was not significant. Direct care nurses who demonstrated lower WPI scores were associated with a perception of their manager being able to handle WPI in the unit/department (Table 3).

Research question 6 explored the impact of WPI on the type of unit. The investigators asked: Is there a difference in type of unit/department (ICU, MedSurg, OR, ED) and WPI scores? An ANOVA was performed to determine whether there were differences between means ( $F_{12,641} = 4.27$ ,  $P < .001$ ). Post hoc Bonferroni tests were performed to determine where the significant differences existed. For the general environment subscale, the OR was different than the ICU and MedSurg ( $P < .001$ ). The ICU and MedSurg

units had lower incivility scores. The ICU was also different from the ED ( $P < .002$ ). For the nurse subscale (lateral hostility), the ICU and MedSurg units were significantly different than the OR ( $P < .001$ ). Again the WPI scores were lower in the ICU and MedSurg area. For the direct supervisor subscale, the OR was significantly different than the ICU and MedSurg units ( $P < .001$  and  $P < .003$ , respectively). For the physician subscale, the OR was significantly different from the ICU ( $P < .001$ ), MedSurg ( $P < .001$ ), and ED ( $P < .002$ ). ICU, MedSurg, and ED all demonstrated lower incivility scores than the OR staff. For the patient/visitor subscale, the OR was significantly different than the ICU, MedSurg, and ED ( $P < .001$ ). Conversely, the OR demonstrated the lowest incivility scores for the patient/visitor subscale than the other 3 departments.

**Table 3. Is There a Relationship Between Manager Skills and WPI?**

Subscales	General Environment	Nurse	Direct Supervisor	Physician	Patient/Visitor
Manager's awareness of WPI					
R	0.063	0.088 <sup>a</sup>	-0.076	0.073	-0.159 <sup>a</sup>
P (2-tailed)	.111	.026	.055	.067	.000
N	641	636	635	630	626
Manager's ability to handle WPI					
R	-0.353 <sup>b</sup>	-0.417 <sup>b</sup>	-0.462 <sup>b</sup>	-0.326 <sup>b</sup>	-0.054
P (2-tailed)	.000	.000	.000	.000	.175
N	638	633	632	627	623

<sup>a</sup>Correlation is significant at the .05 level (2-tailed).

<sup>b</sup>Correlation is significant at the .01 level (2-tailed).

## Organizational Factors Predicting WPI

The investigators asked research question 7: Are there organizational factors that predict WPI? The manager's awareness of WPI was a statistically significant ( $z = 23.896$ ,  $P < .001$ ) predictor of the manager's ability to handle WPI. A participant who agrees that their manager is aware of WPI is 7 times more likely to agree on the ability of the manager to handle WPI. Furthermore, the type of unit was significantly associated with the manager's ability to handle WPI ( $R^2 = 34.51$ ,  $P < .001$ ). With the OR as a reference group, ORs differ from ICUs ( $z = 23.049$ ,  $P < .001$ ) in predicting the manager's ability to handle WPI. A participant from the ICU is 4.5 times more likely to agree that their manager is able to handle WPI than participants from the OR. Similarly, participants from MedSurg are 3.29 times more likely to agree that their manager can handle WPI than those from the OR. The ED staff demonstrated no significant difference from the OR.

## Discussion

This study supports the work of Hutton and Gates,<sup>15</sup> demonstrating that incivility has an impact on productivity as well as the cost of lost productivity. Furthermore, this research is congruent with the work of Laschinger et al<sup>7</sup> indicating that a supportive or healthy work environment is associated with less incivility. To date, investigators measuring WPI in nursing have used a variety of surveys.<sup>8,15,17,18</sup> Finding the best instrument to measure incivility will be beneficial to the science related to WPI.

This investigation clearly indicates the importance that nursing leaders have in setting the tone and expectations of the work environment. Creating an environment with heightened mindfulness or awareness of the effects of incivility is essential, given how it has become a normative behavior in our society. The Joint Commission launched a sentinel event alert in July 2008 stating that disruptive behaviors undermined a culture of safety<sup>20</sup> and that zero-tolerance policies need to be implemented and enforced. Nurse leaders who actively manage incivility in the work environment are noticed and appreciated by staff nurses.

To support a healthy work environment, staff and management can jointly develop a code of conduct to set expectations and hold staff accountable for their actions and behaviors (Figure 1). Frequent rounding by nurse executives and managers is

Code of Conduct
➤ Be respectful of others
➤ Respect the privacy and confidentiality of others
➤ Call people by their name
➤ Accept equitable share of workload
➤ Help others
➤ Teach others
➤ Listen to others and seek clarification for understanding
➤ Do not talk about a coworker with another coworker
➤ Provide constructive feedback in a private place
➤ Be aware of nonverbal behaviors and tone of voice
➤ Support collaborative relationships
➤ Focus on solutions and positive outcomes
➤ Demonstrate congruence in words and actions
➤ Seek a mentor and mentor others

Figure 1. Sample code of conduct.

designed to role model and observe staff interactions with coworkers, other department personnel, physicians, and patients/visitors.<sup>21-24</sup> Reviewing WPI scenarios in staff meetings and discussing strategies for handling each situation will help staff develop the communications skills needed to respond to WPI and other disruptive behaviors.<sup>21</sup> Interdisciplinary shared governance councils, quality improvement teams, and collaborative learning opportunities are excellent vehicles to promote a healthy work environment. An excellent Web site with links to communication exercises to enhance one's skills using a newsletter approach is at [www.vitalsmarts.com](http://www.vitalsmarts.com).<sup>25-28</sup>

Further research and process improvement projects can be developed to determine strategies that foster healthy work environments and evaluate the effectiveness of interventions used to counteract and respond to negative behaviors in the workplace. Healthy work environments are crucial to the future of healthcare organizations.<sup>29</sup> Workplace civility can influence our organizations in positive ways, resulting in employee engagement, enhanced productivity, minimal absenteeism, and low turnover. The research is clear that a healthy collaborative practice environment is the ideal setting for nurses to flourish and patients to be safe. Civility matters!

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