RESEARCH ARTICLE

# WORKPLACE INCIVILITY AMONG NURSES IN A NATIONAL TERTIARY HOSPITAL

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## Abstract

Incivility creates an environment of hostility among healthcare providers in the workplace, and undermines a culture of patient safety. Although this phenomenon is pervasive in the profession, nurses tolerate or ignore its occurrence due to inadequate knowledge, fear and lack of institutional policies. There are no empirical studies in the local context which explore incivility among nurses in the hospital setting. This study examined the sources and forms of incivility among nurses working in a hospital according to nurse-related variables. A descriptive, cross-sectional design was utilized. Respondents were asked to answer Nurse's Profile and Nursing Incivility Scale. A stratified random sampling was used. A sample of 280 nurses from different clinical nursing units in a national tertiary hospital completed the questionnaire. Incivility outcome was analyzed using One-way Analysis of Variance (ANOVA) according to nurse-related variables such as nursing designation, practice setting, type of clinical nursing unit and length of hospital work experience. Post-hoc analysis was performed using Tukey's Honestly Significant Difference. Data were collected from September to October 2017.

Majority of the participants are female (78 %) and single (50 %) with an average age of 36 years old (SD= 9.96, range 21-62). They are employed in the hospital for an average of 9 years (SD = 8.82). Most of the sample works in general clinical nursing units (68 %) in a service/ charity setting (57 %). More than half of the respondents are staff nurses (67%) who provide direct care (Nurse I/II) followed by charge nurses (Nurse III) (19%) and head and chief nurses (IV/VI) (13%). Significant incivil interactions were reported between nurses and their colleagues at work, physicians and patients and their families according to the nursing designation, practice setting, type of clinical nursing unit and length of work experience. The moderately incivil interactions were exhibited in the forms of inconsistent behaviors, hostile climate and displaced frustrations.

Nurse-related variables have significant impact on incivil interactions in the hospital setting. Understanding the sources and forms of incivility is of paramount importance in mitigating its impact on healthcare delivery and patient outcomes, and developing relevant policies and interventions that protect the welfare of nursing workforce.

***Keywords:*** nursing incivility, workplace incivility

## Introduction

A culture of respect in a workplace free from incivility optimizes patient health outcomes, and promotes a positive work environment for nurses (American Nurses Association, 2015). Incivility is a critical issue affecting the welfare of nurses as well as the quality of care being delivered (Johnson, 2009). Incivility is part of a complex phenomenon of harmful actions such as bullying and violence in the workplace. It is a low-intensity, deviant behavior that demonstrates a lack of regard for other workers that results to psychological or physiological distress (Hutton & Gates, 2008). It is characterized by disruptive behaviors such as discourtesy, sarcasm, humiliation, hostile stares, verbal intimidation, gossiping and abusing other's privileges.

Incivility in healthcare settings has potential detrimental effects on patient safety and the entire organization (Elmblad, Kodjebacheva & Lebeck, 2014). Its negative impact transcends not only the victims themselves, but also peers, stakeholders, clients and organizations. It leads to erosion of professional competence as well as increased sickness, absenteeism, decreased job satisfaction, reduced organizational commitment, and employee

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attrition (Chipps&McRury, 2012; Porath& Pearson, 2013). It harms the victims' self-worth and confidence resulting to stress-related physical symptoms and psychosocial conditions (Townsend, 2012). Such circumstances may impair nurse's clinical judgment to the extent that the performance of duty is affected. It can lead to dysfunctional patient care, medication and safety errors and increased direct and indirect healthcare delivery costs (Holloway &Kusi, 2010).

Strategies to promote a respectful, civil and safe environment is a must. It is incumbent upon nurse administrators, policy-makers and front-line nurses to initiate measures that seek to address workplace incivility. However, nurses tolerate or ignore workplace incivility due to lack of knowledge and awareness, fear and inadequate institutional policies and support (Adeniran et al., 2016). It is important, therefore, to first recognize the existence of incivil behaviors in the workplace in order to prevent them from occurring.

Although workplace incivility has been prevalent in nursing, there is a limited empirical evidence exploring this concept among hospital nurses in the local setting. To the best of our knowledge, this is the first study to examine the nature of workplace incivility among Filipino nurses in the local context. This study aimed to describe the perceived sources and forms of workplace incivility, and identify the differences when grouped according to nurse-related variables. It is hoped that the outcomes of this study shall inform institutional policies governing work climate to implement mechanisms that eliminate incivility in its various sources and forms.

### *Theoretical Framework*

Healthcare environment is more susceptible to incivility due to stressful conditions, challenging and difficult work situations and diversity of interactions (Hunt & Marini, 2012). Nurses are situated in complex environments like hospital setting that have many stressors such as overwhelming workloads, hierarchal organizational structures and highly charged emotions due to life and death decision-making (Croft & Cash, 2012).

Betty Neuman's Systems model (1982) is the theoretical framework that was used to understand the nature of workplace incivility. The model posits that human being is unique, a composite of factors and characteristics, an open system within a given range of responses to stressors. The client variables are physiological, psychological, sociocultural, developmental and spiritual (Fawcett, 2005). Stressors are intra-, inter-, and extra-personal in nature, and arise from the internal, external, and created environments. Stressors occur within and outside the client system boundary, and have an impact to the system. The goal of the systems model is stability and integrity through elaborate circles of protection and defenses (Meleis, 2012). When stressors invade the system, a degree of reaction, entropy and reconstitution occur. Nursing interventions are targeted to these stressors in varying levels such as primary, secondary and tertiary modes.

In the study, incivility is conceptualized as a stressor operating within the workplace of the nurse. It arises during interactions with hospital personnel, nurse colleagues, direct supervisor, physicians and patients, families and visitors. Client variables, as identified in the Neuman's model, are factors that affect workplace incivility. It should be noted that the occurrence of incivility happens in a broader context that includes influences from interpersonal, community, environmental, and policy sources. Supported by empirical studies, we hypothesized that certain nurse-related variables will have significant impact on workplace incivility. These nurse-related factors are nursing designation, practice setting, clinical nursing unit and length of hospital work experience.

## Methodology

### *Design and Setting*

The study utilized descriptive, cross-sectional design. The study was conducted in different clinical nursing units in a national tertiary hospital. These units are further classified according to the types of patients such as service/ charity, pay and those with health insurance (i.e., Philhealth). Units which are involved in training, research and managerial functions are categorized as administrative units. Data were collected from September to October 2017.

### *Sampling*

A stratified random sampling technique was used. Inclusion criteria were (1) registered nurses with a designated plantilla position assigned in different nursing units; and (2) must have at least six-month stint in the current area of assignment at the conduct of the study. Exclusion criteria were those registered nurses working under a job order item, and those who were employed not on a staff nurse or nurse managerial position.

### *Sample size*

Sample size requirement was calculated based on estimates of confidence interval, chance for Type 1 error, population size and effect size. The online sample size calculator by Raosoft Inc. (2004) was used to compute for the sample size. To achieve a confidence level of 95%, error rate set at 5 % in a 1,000 population size, a minimum sample size of 278 is required. The study had a sample of 280. Response rate was recorded at 83.83 %.

### *Research Instruments*

The following research instruments were utilized in the study:

1. Nurse's Profile. This tool described the socio-demographic

characteristics of nurses in terms of age, sex, highest educational attainment, civil status, nursing designation, practice setting, length of hospital work experience and clinical nursing unit.

2. Nursing Incivility Scale (NIS). The NIS is a five-point scale, 42-item tool designed to assess hospital nurses' experiences with incivility according to specific sources namely hospital personnel in general, physicians, direct supervisors, coworkers, patients, families and visitors. The tool is further divided into eight subscales indicating the forms of incivility such as hostile climate, inappropriate jokes, inconsiderate behavior, gossip/rumors, free riding, abusive supervision, lack of respect, and displaced frustration. The Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree) measures the level of agreement on behaviors in different types of interactions at work. Scores are averaged to compute for source-level and form-specific incivility. To compute for subscale scores, individual item scores should be summed and averaged. Higher score indicates higher degree of workplace incivility.

The tool was chosen for its ease of use and its ability to provide a baseline assessment on the sources and forms of workplace incivility specific in nursing. The survey took approximately 10-15 minutes to complete. The NIS has been utilized in previous studies conducted in other Asian countries such as Iran, China, Singapore, Malaysia and Korea. Previous psychometric tests reported that the NIS has a good internal consistency with a Cronbach's alpha ranging from 0.88 to 0.94 and excellent construct and discriminant validity (Guidroz et al., 2010). In the study, the Cronbach's alpha of the NIS in general was 0.94 with each subscale ranging from 0.88 to 0.92.

### Data Collection Procedures

After the protocol has been approved by the ethics review board, the researchers coordinated with the head nurse and chief nurse in each clinical nursing unit about the conduct of study. They were informed about the purpose and duration of the study and procedures to be observed during data collection. Likewise, pilot-testing of research instruments was conducted prior to actual data collection. Data collectors were given an orientation regarding the processes involved in the protocol.

Over a month period, respondents were recruited and screened using the inclusion/exclusion criteria. Announcement regarding the need for respondents in the study was posted in the bulletin board in each nursing unit, and disseminated during endorsements and meetings. The questionnaire was handed to the respondent in an envelope. All answered questionnaires were returned to the data collectors sealed in an envelope. Data obtained from the questionnaire were entered into statistical software by the researchers. A statistician assisted the researchers in data processing, presentation and analysis.

### Ethical Considerations

The University of the Philippines Manila Research Ethics Board provided ethical clearance to conduct the study. Voluntary participation was emphasized in the recruitment of respondents. Each respondent received a full disclosure of the study in a cover letter with corresponding informed consent attached in the questionnaire. The data collector explained the study purpose, procedures and rights of the respondents. All respondents signed a written consent form indicating participation in a study. Moreover, they were assured that answered questionnaires were kept privately in a locked cabinet in the researchers' office, and anonymity was observed. Likewise, permission to use the research instruments from copyright holders and developers was sought through electronic mail.

### Statistical Considerations

Descriptive statistics was used to present nurse's characteristics. Normality of data was determined using Shapiro-Wilk test. A one-way Analysis of Variance (ANOVA) was used to determine differences between nurse-related variables and sources of incivility. Post-hoc analysis was performed using Tukey's Honestly Significant Difference (HSD). The level of significance was set at 0.05, two-tailed test. Data were analyzed using Statistical Package for the Social Sciences (SPSS) version 23 software. Data sets were compared for completeness, inconsistency and accuracy.

## Results

### Sample Characteristics

Majority of the participants are female (78 %) and single (50 %) with an average age of 36 years old (*SD*= 9.96, range 21-62). They are working in the hospital for an average of 9 years (*SD* = 8.82). Most of the sample works in general clinical nursing units (78.20 %) under a service/ charity setting (57 %). More than half of the respondents (67.50 %) are bedside nurses who private direct care (Nurse I/II) followed by charge nurses (Nurse III) (19.30 %) and head and chief nurses (IV/VI) (13.24 %).

### Sources of Workplace Incivility

Source of incivility is medium when interacting with hospital personnel in general and physicians. Low incivility was reported when dealing with fellow nurses and patient, family and visitors. Relationship with direct supervisor is the least incivil.

### Forms of Workplace Incivility

Inconsistent behaviors, hostile climate and displaced frustration are the most common forms of incivility reported. Additionally,

gossip/ rumors, free riding, lack of respect, abusive supervisor and inappropriate jokes are also identified as other actions showing incivility in a lesser extent.

**Table 1.** Socio-demographic characteristics of sample.

| Characteristics | Summary Measures |
|---|---|
| Age in years | 36 ± 9.96 |
| **Gender** | |
| *Male* | 61 (21.79%) |
| *Female* | 219 (78.21%) |
| **Civil status** | |
| *Single* | 140 (50%) |
| *Separated* | 7 (2.50%) |
| *Married* | 129 (46.07%) |
| *Widowed* | 4 (1.43%) |
| **Highest Educational Attainment** | |
| *Bachelor of Science in Nursing degree* | 224 (80%) |
| *Currently enrolled in Master's degree* | 46 (16.43%) |
| *Master's degree (MA/MS)* | 8 (2.86%) |
| *Currently enrolled in Doctoral Degree* | 2 (0.71%) |
| **Nursing Designation** | |
| *Nurse I (Staff Nurse)* | 21 (7.50%) |
| *Nurse II (Staff Nurse)* | 168 (60%) |
| *Nurse III (Charge Nurse)* | 54 (19.29%) |
| *Nurse IV (Head Nurse)* | 31 (11.07%) |
| *Nurse VI (Chief Nurse)* | 6 (2.14%) |
| Length of hospital work experience | 9 ± 8.82 |
| **Practice setting** | |
| *Service/ Charity* | 160 (57.14%) |
| *Pay/ PhilHealth* | 56 (20%) |
| *General/ Mixed* | 50 (17.86%) |
| *Administrative* | 14 (5%) |
| **Type of Clinical Nursing Unit** | |
| *Specialized* | 75 (26.79 %) |
| *General* | 191 (68.21 %) |
| *Administrative* | 14 (5 %) |

**Table 2.** Mean scores on the sources of workplace incivility.

| Sources of Incivility | Mean Scores/ Standard Deviation |
|---|---|
| All individuals | 2.56 ± 0.82 |
| Other nurses | 2.30 ± 0.86 |
| Direct supervisors | 1.69 ± 0.77 |
| Physicians | 2.50 ± 0.89 |
| Patients, family, visitors | 2.26 ± 0.88 |

**Table 3.** Means scores on the forms of workplace incivility.

| Forms of Workplace Incivility | Mean Scores/ Standard Deviation |
|---|---|
| Hostile Climate | 2.65 ± 0.50 |
| Inappropriate Jokes | 1.94± 0.25 |
| Inconsistent Behaviors | 2.76±0.29 |
| Gossips and Rumors | 2.40±0.38 |
| Free Riding | 2.23± 0.13 |
| Abusive Supervisor | 2.04 ±0.51 |
| Lack of Respect | 2.15 ± 0.35 |
| Displaced Frustrations | 2.46±0.28 |

The nature of incivil interactions when grouped according to nursing designation did not differ when interacting with hospital personnel in general and direct supervisor. Significant differences were observed when dealing with fellow nurses ($F(2, 277) = 5.82$, $p = 0.003$), physician ($F(2, 277) = 9.43$, $p = 0.001$), and patients, families and visitors ($F(2, 277) = 6.67$, $p = 0.001$).

Post-hoc Tukey HSD analysis showed that incivil behaviors among staff nurses were significantly higher when compared among head/chief nurses when interacting with fellow nurses, physicians and patients and their loved ones ($p = < 0.01$). In addition, incivility scores were significantly higher among staff nurses when compared among charge nurses in a nurse-physician interaction ($p = < 0.05$).

**Table 4.** Source-specific incivility mean scores according to nursing designation.

| Source of Incivility | Nursing Designation | | | F statistic | p-value |
|---|---|---|---|---|---|
| | *Staff Nurse* | *Charge Nurse* | *Head/ Chief Nurse* | | |
| Hospital personnel in general | 2.62 (0.82) | 2.41 (0.87) | 2.48 (0.71) | 1.61 | 0.202 |
| Nurse colleagues | 2.41 (0.87) | 2.17 (0.84) | 1.92 (0.73) | 5.82 | 0.003** |
| Direct supervisor | 1.72 (0.81) | 1.74 (0.73) | 1.46 (0.58) | 1.98 | 0.140 |
| Physicians | 2.64 (0.84) | 2.30 (0.92) | 2.03 (0.89) | 9.43 | 0.001** |
| Patients, family and visitors | 2.36 (0.85) | 2.21 (0.99) | 1.80 (0.73) | 6.67 | 0.001** |

### Practice Setting

Incivility behaviors between nurses and hospital personnel, nurse colleagues and direct supervisors did not significantly differ with regards to practice setting. However, incivil interactions between nurses and physicians ($F(3, 276) = 6.04$, $p = .001$) and patients and loved ones ($F(3, 276) = 2.97$, $p = 0.032$) significantly differ according to practices setting.

Post-hoc analysis revealed that incivil behaviors in dealing with patients and their loved ones were comparatively higher among nurses who work in service and pay/ Philhealth settings as compared those who are in administrative posts ($p = < 0.05$). Further, nurses assigned in the pay/Philhealthand general/ mixed type of patients had significantly higher incivility outcome with physicians when compared those nurses in the service area ($p = < 0.05$).

### Type of Clinical Nursing Unit

When classified according to the type of clinical nursing unit (i.e., nature of patient care services being rendered as to general, specialized and administrative), incivil interactions did not significantly differ except when dealing with patient, families and visitors ($F(2, 277) = 5.21$, $p = 0.006$). Post-hoc Tukey HSD analysis indicated that incivil behaviors were significantly higher among those nurses assigned in non-specialty areas than those who are in administrative positions ($p = < 0.01$).

### Length of Hospital Work Experience

Significant differences in incivility when interacting with fellow nurses ($F(3, 275) = 3.01$, $p = .031$), physician ($F(3, 275 = 4.01$, $p = .008$) and patients and loved ones ($F(3, 275) = 6.12$, $p = 0.001$) were identified when grouped according to the length of the nurse's hospital work experience. Incivil behaviors with hospital personnel and direct supervisors did not significantly vary according to years of service.

**Table 5.** Source-specific incivility mean scores according to practice setting.

| Source of Incivility | Practice Setting | | | | F statistic | p-value |
|---|---|---|---|---|---|---|
| | *Service* | *Pay/ Philhealth* | *General/ Mixed* | *Administrative* | | |
| Hospital personnel in general | 2.54 (0.80) | 2.47 (0.88) | 2.72 (0.85) | 2.59 (0.59) | 0.87 | 0.457 |
| Nurse colleagues | 2.45 (0.85) | 2.10 (0.80) | 2.46 (0.96) | 1.94 (0.58) | 2.69 | 0.051 |
| Direct supervisor | 1.73 (0.81) | 1.60 (0.67) | 1.77 (0.87) | 1.33 (0.43) | 1.66 | 0.176 |
| Physicians | 2.14 (0.91) | 2.43 (0.79) | 2.22 (1.17) | 2.49 (0.89) | 6.04 | 0.001** |
| Patients, family and visitors | 2.29 (0.88) | 2.37 (0.80) | 2.25 (0.96) | 1.60 (0.67) | 2.97 | 0.032** |

**Table 6.** Source-specific incivility mean scores according to clinical nursing unit.

| Source of Incivility | Type of Clinical Nursing Unit | | | F statistic | p-value |
|---|---|---|---|---|---|
| | *General/ Non-specialty area* | *Specialty area* | *Administrative* | | |
| Hospital personnel in general | 2.54 (0.85) | 2.61 (0.79) | 2.59 (0.59) | 0.22 | 0.804 |
| Nurse colleagues | 2.30 (0.87) | 2.36 (0.88) | 1.94 (0.58) | 1.42 | 0.243 |
| Direct supervisor | 1.67 (0.78) | 1.81 (0.78) | 1.33 (0.43) | 2.50 | 0.084 |
| Physicians | 2.54 (0.91) | 2.43 (0.79) | 2.22 (1.17) | 1.06 | 0.349 |
| Patients, family and visitors | 2.34 (0.87) | 2.18 (0.90) | 1.60 (0.67) | 5.21 | 0.006** |

**Table 7.** Source-specific incivility mean scores according to clinical work experience.

| Source of Incivility | Clinical Work Experience (in years) | | | | F statistic | p-value |
|---|---|---|---|---|---|---|
| | *1-2 years* | *3-5 years* | *6-10 years* | *11 years and above* | | |
| Hospital personnel in general | 2.63 (0.83) | 2.75 (0.79) | 2.52 (0.84) | 2.46 (0.81) | 1.56 | 0.200 |
| Nurse colleagues | 2.47 (0.81) | 2.49 (0.92) | 2.28 (0.86) | 2.13 (0.84) | 3.01 | 0.031* |
| Direct supervisor | 1.56 (0.61) | 1.83 (0.86) | 1.71 (0.83) | 1.68 (0.77) | 1.05 | 0.373 |
| Physicians | 2.63 (0.93) | 2.73 (0.69) | 2.57 (0.87) | 2.28 (0.93) | 4.01 | 0.008** |
| Patients, family and visitors | 2.33 (0.73) | 2.66 (0.90) | 2.26 (0.95) | 2.04 (0.85) | 6.12 | 0.001** |

Post-hoc analysis reported that those who has a hospital work experience of 3-5 years had significantly higher incivil interactions with physicians, patients and their loved ones and nurse colleagues than those who have spent at least 11 years and above of service to the hospital ($p= < 0.05$).

## Discussion

This preliminary study offers evidence on the sources and forms of workplace incivility among nurses in a national tertiary hospital. Incivility was analyzed according to nurse-related variables such as nursing designation, practice setting, type of clinical nursing unit and length of hospital work experience. These personal and organizational factors are valuable in understanding and predicting certain workplace behaviors such as incivility.

It was revealed that nurses encountered moderate incivility when dealing with hospital personnel in general and physicians. They reported low incivility when interacting with nurse colleagues at work and patients and their loved ones assigned under their care. Relationship with their direct supervisor has been found out to be least incivil. Empirical studies supported this finding which showed that incivility was low with supervisors and co-workers in contrast to anecdotal reports about high levels of co-workers incivility in healthcare settings (Laschinger, Leieter, Day &Gilind, 2009). The finding is consistent with the prevalence of incivility among certified registered nurse-anaesthetists which indicated that the respondents experienced moderately high levels of incivility from hospital employees in general and physicians, moderate levels of incivility from nurse colleagues, and low levels of incivility from supervisors (Elmblad, Kodjebacheva & Lebeck, 2014). However, there are contrasting evidences which reported that incivility occurs more frequently from superiors, followed by co-workers and subordinates (Lim & Lee, 2011). Guidroz et al (2010) who developed the Nursing Incivility Scale identified that the highest incivility occurs in the general working environment. The findings supported the tenets of social power theory which argued that those having more perceived social authority and resources tend to exert greater coercive and reward power on those with less resources and authority creating incivility (Lim & Lee, 2011). The conflicting evidence on the extent of incivility varies among organizations because each institution has its own unique culture, values and philosophy.

Inconsistent behaviors and hostile climate are the most common forms of incivility as perceived by the nurses. Displaced frustrations, gossips and rumors, free riding and lack of respect occur in a lesser extent. Abusive supervisor and inappropriate jokes were identified as the least forms of incivility. Inconsistent behaviors such displaying offensive body language (i.e, eye rolling, crossed arms, pinpointing fingers), taking things without asking and talking too loudly in the workplace permeate incivil actions. Hostile climate, on the other hand, encompasses a range of adversarial relationship among personnel leading to a working environment of threat, intimidation and verbal attacks. Budin and colleagues (2013) concluded that verbal abuse is the most common form of disruptive behavior experienced by professional nurses. This includes gossip and rumors from co-workers and supervisor, lack of respect and inappropriate jokes. Abusive supervision from physician is a recurring problem of incivility that leads to intimidation and neglect of duty due to fear of verbal abuse. Displaced frustration from expectations to services and facility, on the other hand, may be directed to the nurses in most cases because they are the ones the patient and visitor interact with most of the time (Gillian, 2015). It must be noted that although forms of incivility vary, the cumulative effects derange collaboration and teamwork in a healthcare team, and negatively affects patient care outcomes.

Staff nurses exhibited higher incivil interactions with nurse colleagues, physician and patients and their families than nurse supervisors due to more frequent interactions, increased patient workloads, burn-out, physical fatigue and emotional displacement. This finding is substantiated by prior studies which reported that younger, front-line nurses with fewer years of experience are more vulnerable to work-related disruptive behaviors, aggression and abuse due to their lack of experience in the work environment (Budin, Brewer, Chao & Kovner, 2013). The nature of practice setting where a nurse is assigned has impact on incivility. In this study, practice setting refers to patient classification according to the mode of payment to hospital service which includes service/ charity, pay, Philhealth and general/ mixed. Administrative units are those not directly involved in patient care, but rather in training, research and managerial functions. It was noted that nurses in the service and pay/Philhealth nursing units registered significantly higher incivility scores with patients and their families because they have more time of exposure to patients in bedside care in an 8-hour duty shift. Additionally, nurses in the pay/ Philhealth and areas with mixed type of patients have higher incivil interactions with physicians than those in the service areas due to the expectations and demands of patients and healthcare providers.

Incivil interactions of nurses with patients and their loved ones differ according to type of clinical nursing unit. The study findings indicated that nurses in the general clinical nursing units have significantly higher incivil behaviors than those in administrative position because they are more exposed to patients being in the frontline of service. Extant literature supported this finding where it was ascertained that those assigned in general medical and surgical wards have higher perceptions of incivil behaviors than those assigned in specialty areas such as oncology units and operating room and post-ansethesia care units (Knippschild, 2012). Significantly, nurses in emergency and trauma departments experienced higher levels of incivility because of tension from higher health demands for life-threatening

conditions (Ryan &Maguirre, 2006). Similarly, acute care work settings have higher incidence of disruptive behaviors than those in outpatient settings (Vessey, Demarco, Gaffney &Budin, 2009). Kreitzer and colleagues (1997) hypothesized that situational factors inherent in high stress and high activity areas may predispose nurses to verbal abuse and disruptive behaviors. The general clinical nursing units in the study setting have diverse and complex patient acuity levels because of the influx of patients being admitted. These high activity areas predispose nurses to incivil interactions because of overwhelming workloads and care expectations.

Incivil behaviors when dealing with nurse colleagues, physicians and patients and loved ones significantly differ according to years of hospital work experience. In the study, nurses who have spent at least 3-5 years of hospital work had comparatively higher incivil interactions than those who have been working for more than a decade. Length of working experience (5 years), nature of job (part-time) and age (20-39 years old, above 60 years old) have been found to be statistically significant predictors of incivility (Nikstaitis& Coletta Simko, 2014; Knippschild, 2012; Budin, Brewer, Chao & Kovner, 2013). The finding can be explained by the work acculturation and adjustment in developing interpersonal relationship with hospital personnel and patients as a function of time and maturation.

In summary, this study found out that nurses when grouped according to designation, practice setting, type of clinical nursing unit and length of hospital work experience reported significant incivil interactions with nurse colleagues, physicians and patients and their families. These incivil acts are usually exhibited as inconsistent behaviors, hostile climate and displaced frustrations.

## Limitations

Study design and data collection procedures are research imitations. The descriptive design doesn't warrant the establishment of causal relationships between variables. The sampling technique limits the generalizability of the findings. Since data were gathered cross-sectionally, interpretation of findings should look into the interplay of situational variables and nature of work climate inherent to each nursing unit.

## Conclusion and Recommendation

The study ascertained that nurses have significant incivil interactions with nurse colleagues, physicians and patients and families according to their designation, practice setting, type of clinical nursing unit and length of hospital work experience. Relationship with direct supervisor has been found out to be least incivil. The moderately incivil interactions are manifested in inconsistent behaviors, hostile climate and displaced frustrations. The preliminary findings provide evidence on the nature of workplace incivility among nurses in a hospital setting in the local context. Understanding the sources and forms of incivility is of paramount importance in mitigating its impact on healthcare delivery and patient outcomes, and developing relevant policies and interventions that protect the welfare of nursing workforce.

Administrators should carefully review existing policies on promoting safe and healthy working environment for nurses, and must adopt a zero-tolerance policy for incivility. Nursing policies should explicitly address measures and processes in dealing with incivility alongside with bullying and violence in the workplace. Since nurses usually encounter lateral incivility among colleagues at work, nurse managers should develop a nurturing leadership style and creative conflict management skills to address incivil encounters particularly among the vulnerable ones.

Innovative strategies need to be tailored to promote teamwork in the inter-professional relationship among nurses and colleagues in the healthcare team particularly with physicians. There is a need to further strengthen team cohesiveness development programs particularly between physicians and nurses. It has been reported that nurse-patient relationship is oftentimes marred with incivility. Training and debriefing programs for nurses should focus on personality development, composure behaviors, therapeutic communication techniques, enhancing intrapersonal and interpersonal relationships, conflict management and handling diverse types of patients.

Lastly, further studies are needed to explore the impact of staff burn-out, understaffing, patient workload, leadership styles and organizational climate on workplace incivility using other research methodology such as qualitative to capture the unique experiences. Likewise, nurse's interactions with student-nurses, nurse-trainees, clinical instructors, and other members of healthcare team need to be investigated.

**Conflict of Interest:** We declare no conflict of interest.

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