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Creating an Educational Intervention to Combat Nursing Incivility Benchmark Study

Kathleen P. Melancon
University of Texas at Tyler, kmelancon@patriots.uttyler.edu

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Contents

Acknowledgments

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Executive Summary

When most people reflect on the nursing as a profession, the term compassionate typically comes to mind. The association with compassion is no surprise as nursing is considered to be the most compassionate profession in the world. Nurses, by trade and in all areas of practice, have an ethical and professional responsibility to create and uphold an environment of mutual respect and civility. However, the notion of "nurses eat their young" and the behaviors that stem from this mindset are causing detrimental effects not only to those organizations employing nurses but to patients and the nurses themselves.

Over the last few years, the labor and delivery unit at the benchmark project site has seen a trend in the number of incidences where new graduate nurses feel they are being bullied, gossiped about, made fun of, and humiliated in front of patients, peers, and physicians. Most of these incidences are the result of nurse to nurse interactions. Currently, the hospital's Code of Conduct addresses behaviors like those mentioned above that are unsuitable for the workplace (bullying, gossiping, name calling, disrespect, etc.) and states those behaviors will not be tolerated. More specifically, being the perpetrator of uncivil behaviors could result in progressive discipline or termination depending on the severity of the incident. Unfortunately, the negative behaviors are not always reported and therefore are allowed to continue. Regardless of the reasoning for the behaviors going unreported, the effects of those behaviors are seen in the number of nurses leaving the unit to seek positions elsewhere within the hospital or leaving the hospital all together to pursue a different venture that perhaps may not be nursing. From an organizational perspective, the results of uncivil behaviors among the nursing staff can be very costly and affect the overall bottom line.

The current practice of strictly relying on the Code of Conduct policy to guide and oversee the way nurses on the labor and delivery treat one another as well as fostering a culture of "sweeping it under the rug" when those behaviors present themselves is no longer acceptable. Further training and education regarding the definition of uncivil behavior, how to recognize those behaviors, and how to appropriately respond when presented with an uncivil situation is an optimal first step in combating nursing incivility. Furthermore, incorporating cognitive rehearsal into that educational model is recommended.

1. Rationale for the Project

First, it is important to define incivility in context with this discussion. The American Nurses Association (ANA) defined incivility as "one or more rude, discourteous, or disrespectful actions that may or may not have negative intent behind them" with bullying being defined as "repeated, unwanted, harmful actions intended to humiliate, offend, and cause distress in the recipient" (ANA, 2015). According to a national survey conducted by the Workplace Bullying Institute, 93% of the nurses surveyed stated that they had witnessed uncivil behaviors with 85% of the respondents reporting being victims of uncivil behaviors themselves (Razzi & Bianchi, 2019). While incivility among nurses is common throughout various nursing experience levels, it is more common with new graduate/novice nurses regardless of their specialty.

Workplace incivility, bullying, and lateral violence are only a few of the terms used to describe these problematic behaviors. For those nurses who have been exposed, incivility can cause physical and emotional problems such as decreased sense of well-being, sleep disturbance, depressive symptoms, burnout, stress, frustration, loss of productivity, intention to leave, absenteeism, medication and documentation errors, decreased job satisfaction, and an overall decreased commitment to the nursing organization as a whole (Smith, et al., 2018; Palumbo,

2018; Razzi & Bianchi, 2019). Essentially, these nurses suffer from post-traumatic stress disorder at the hands of unaddressed incivility.

From an organizational standpoint, the side effects of incivility come at a staggering cost. Stoddard (2017) found that when looking at nursing turnover directly, incivility results in a 33% turnover rate with the financial burden of on and off-boarding nursing staff falling on the organizations themselves with a cost of about 125% of the nurse's salary. For those nurses who do not leave the organization, lost productivity related to incivility alone can reach up to $12,000 per nurse annually (Stoddard, 2017). At the benchmark project site specifically, the average cost to on-board and train a new nurse during a 20-week orientation period is roughly $35,000. This does not include the cost of interviewer time or human resource time allocation. The most recent new hire group consisted of 15 new graduate nurses equaling a total of $525,000 in on-boarding costs. This group signed out of their orientation period roughly 1.5 months ago and already have voiced experiencing workplace incivility at the hands of nurses on the unit.

With the rising costs of hiring/onboarding new employees and the effects nursing incivility can have on nurses and patients as a whole, something must be done to ensure the newly hired, novice nurses are given the information and tools they need to recognize uncivil behaviors and respond to them appropriately. Nursing administrators have a responsibility to create and maintain a healthy work environment for new and established nurses alike. By doing so, administrators can work to decrease turnover, improve commitment to the organization, improve patient care, and decrease the extensive costs associated with turnover, absenteeism, and decreased productivity as a result of incivility (Stoddard, 2017).

1.1 Project Goals

The goal of this benchmark capstone project was to attempt to address nursing incivility as it relates to the labor and delivery unit at the benchmark project site by utilizing an educational intervention and cognitive rehearsal. This project would not only educate staff on the definition of incivility but also how to recognize it and respond to it appropriately. The current culture of the unit suggests relying only on a hospital policy without upholding employees to the expectations of that policy can further foster an environment where incivility can not only occur but can grow. In addition, this benchmark project could provide newly hired/novice nurses with the tools needed to feel empowered at the bedside and on the unit. Increasing resilience and decreasing incivility can benefit not only the nurse but the patient and the organization as a whole while creating a healthy environment conducive to extraordinary patient care.

2. Literature Discussion to Support Project

A review of literature presented multiple articles and studies discussing nursing incivility and nursing interventions designed to address it. Of those articles and studies, most used some form of cognitive rehearsal in conjunction with an in-person educational experience or an e-module. Cognitive rehearsal is defined as "a technique used in behavioral science whereby individuals work with a skilled facilitator to discuss and rehearse effective ways to address a problem or social situation" (Clark & Gorton, 2019, p. 691). Clark and Gorton (2019) in a mixed methods study explored the use of cognitive rehearsal, Heartmath, and simulation to effect nursing resilience and ability to address incivility in upper division, pre-licensure nursing students. This particular study was beneficial as the population was similar to that of the benchmark project population. They had no prior experience in nursing and had not been exposed to the hospital culture. The study revealed the combined use of cognitive rehearsal,

Heartmath, and simulation allowed for participants to reveal uncivil situations they had experienced, describe hypothetical experiences, and ultimately report the ability to apply what was learned in the intervention into practice.

Clark and Griffin (2014) completed a literature review again exploring the use of cognitive rehearsal and its effect on recognition and response to incivility. The authors investigated three studies by Griffin (2004), Stagg et al. (2011), and Clark, Ahten and Macy (2013, 2014). Griffin's study yielded results that show newly hired nurses witnessed lateral violence in their respected units, half of the study respondents reported being victims of direct violence, and finally those nurses who utilized the cognitive rehearsal method reported a stoppage of negative behaviors against new nurses following implementation. Stagg et al. (2011) reported majority of participants witnessing uncivil behaviors, participants changed their own behaviors following the educational intervention, and a small percentage were able to respond to the bullying at the time it occurred prompting the need for further management and intervention. Finally, Clark, Ahten, and Macy (2013, 2014) reported that the teaching scenarios involving cognitive rehearsal were effective for preparing them to respond and recognize incivility and increased feelings of empowerment among the staff. The literature review also discussed using scripted scenarios as an educational tool.

When discussing scenario-based learning, Abedina and Parvisy (2019) in a mixed method explanatory study used scenarios in an educational intervention to explore the effect on perceived levels of incivility. This study was conducted with 81 2nd and 3rd year nursing students. The results of this study were supportive of scenario-based learning in that there was a significant decrease in the perceived level of incivility following the intervention as well as a

significant effect on behavior (decrease in disruptive behavior, discriminating comments towards others) and the occurrence rate of incivility among the population.

Finally, Howard and Embree (2020) completed a mixed method, quasi-experimental study that focused on a provider directed, e-learning activity and the effect of this activity on participants ability to implement conflict management strategy as well as their response to the Workplace Incivility Index (WCI). This study was one of two that contained an experimental and control group within the literature review. The authors found that of the 49 persons in the experimental group, 21 of those individuals were able to effectively perform at least one positive conflict management strategy. In addition, those in the experimental group showed an increase in the WCI meaning that they were more aware of incivility when it occurred following the intervention.

The studies listed above show support for not only the use of a nursing intervention to combat nursing incivility, but they also give support for the use of cognitive rehearsal and scenario-based learning as a tool to incorporate into the nursing intervention. The final study by Howard and Embree (2020) provided support for the use of an e-learning activity to address incivility. Due to COVID-19 and social distancing restrictions, an e-learning module consisting of guided/recorded scenarios and questions may be the best option for future implementation, and this piece of literature provides the basis of support for such an intervention.

3. Project Stakeholders

When considering stakeholders for any project or idea, it is crucial to consider those who would be directly impacted as well as those who could be indirectly impacted. For a nursing intervention utilizing cognitive rehearsal to combat incivility, the number one stakeholder would

be the nurses who are experiencing the behaviors. For the project to be well received and completed as efficiently as possible, buy-in from the nursing staff is crucial. However, nurses alone are not the sole stakeholders in this project. As mentioned above, incivility affects the organization as a whole as well as the individual. So, from an organizational standpoint, department managers and directors as well as nursing educators would be stakeholders in the project as the results of the project could directly affect staffing, quality of work environment, and department budgeting. Also, the managers and directors are vital for the project to be implemented and successful. Higher on the organizational chart, the Chief Nursing Officer would be a crucial stakeholder as they could speak to the project in a manner that could achieve organizational buy in versus only departmental.

Due to the high costs of turnover associated with incivility, accountants and those responsible for the hospital and departmental budgets would be stakeholders in this project. If the project deems to be successful and turnover and retention are positively affected, it would create a savings of hundreds of thousands of dollars in onboarding/offboarding costs (especially in the benchmark project site). Finally, the ultimate stakeholder in this equation would be the patients receiving care in the organization. Incivility affects nurses and nurses care for patients. If the benchmark project could prove to be successful and there could be a workplace culture shift from incivility to trust and respect, patient care will be directly affected.

4. Implementation

Due to the cancellation of the project, many steps in the implementation/planning stage were unable to be completed to the fullest. However, each step will be discussed with the fullest intention of successful completion. The first step of implementation would be to meet with the departmental management (director, nurse manager, educator) to discuss the need for the project,

the evidence supporting it, and the overall potential benefit of implementing the project. This step is crucial as approval and assistance will be needed throughout the creation and implementation of the project. The second step of implementation would be to gather anonymous, real-life scenarios where incivility was prevalent. This information ideally would be gathered from staff nurses willing to share their experiences. Again, these individuals would be kept anonymous. Following scenario gathering, another meeting would be arranged with department management. However, this meeting will also involve human resource representatives, social services, and nurse educators with the hope of dissecting each scenario and creating appropriate responses to be used in the cognitive rehearsal component of the educational tool.

Once the project has been approved and the appropriate parties have completed the scenario-based learning component, a meeting will be arranged with the director of education. This individual is responsible for creating all hospital-wide educational tools. The goal of this meeting would be to create a hospital approved e-learning module consisting of basic definitions of incivility, what it looks like in the nursing realm, the effects of incivility, and the overall effect it can have on the organization as a whole. Following this definition component, the e-module will then break off into an e-simulator with the approved scenarios broken down in sections with multiple choice options for how to respond to each scenario. This component of the implementation could prove to be lengthy and will require a longer amount of time than previous steps. Once the e-module is approved and completed, the Chief Nursing Officer will be presented with the project for overall approval. As this is a nursing-based intervention in an active hospital, the CNO must approve the content.

Assuming that the previous steps will be completed without difficulty, the newly hired nurses as well as those who have been hired within the last year will be approached regarding the project. The project will be completely voluntary, so it is crucial at this stage to really engage the nurses and get buy-in. This will not only ensure participation, but it will ensure meaningful, value added participation. For those nurses who agree to participate, they will be given the Workplace Incivility Scale (Appendix A) as adopted from Nikstaitis (2014). This pretest will be completed prior to the start of the project. Once the pre-test is completed, the nurses will then have access to the e-module. A period of two weeks will be given for completion of the e-module as the nurses will need to complete it on company time. Paid in-service time will not be allowed for this project.

The nurses will be given the Workplace Incivility Scale again as a post-test 10 weeks following completion of the e-module. The scores from this post-test will be compared to that of the pre-test to test for any type of significance. Also, descriptive data will be gathered from the nurses with regard to scenarios they experienced and the relevance of the intervention to help them in recognizing and responding appropriately to those incidences.

For longevity purposes, this e-module would be completed by the newly hired, novice nurses first and then would be available to the experienced nurses. After one year, the turnover rates would be compared to that of the previous year to test for any type of significance in turnover related to incivility as a reason for terminating employment.

5. Evaluation Design

Evaluation of the nurses who agree to participate in the e-learning module will be given a pre and post-test to gain baseline information as well as information following the intervention. The tests will be scored appropriately and compared for significance. With regard to the e-

module, there will be several components: definition, real-world examples, organizational affect, and finally the e-simulation/cognitive rehearsal component). The e-module will not be graded but will provide feedback to the answer choices chosen by the participants. For example, if the "wrong" choice is chosen, there will be information present that will explain why the option they chose may not be the best option when handling the situation being referenced.

6. Timetable/Flowchart

The timetable/flowchart below lists the steps for creating this benchmark project. In previous semesters, the initial question was asked, "What can be done to combat incivility in the new graduate nurses?". Following guidance from professors, the PICOT was solidified and approved. Following PICOT approval, a literature review was performed to find support for the question of whether a nursing intervention containing cognitive rehearsal could affect incivility recognition and response in new graduate nurses over an 8-week period. While there is not a vast amount of strong evidence (randomized controlled trials, mixed methods with experimental and control groups), there is evidence to support the use of the intervention in this capacity.

Unfortunately, due to COVID-19, this is the point where the project had to cease. The project plan from this point on will be discussed as the project will hopefully be initiated in the future. Originally, this project was meant to be an in-person training. However, as restrictions are still in place, the project will be moved from in person to e-module. The 8-week time frame will be extended to account for project quality and scheduling.

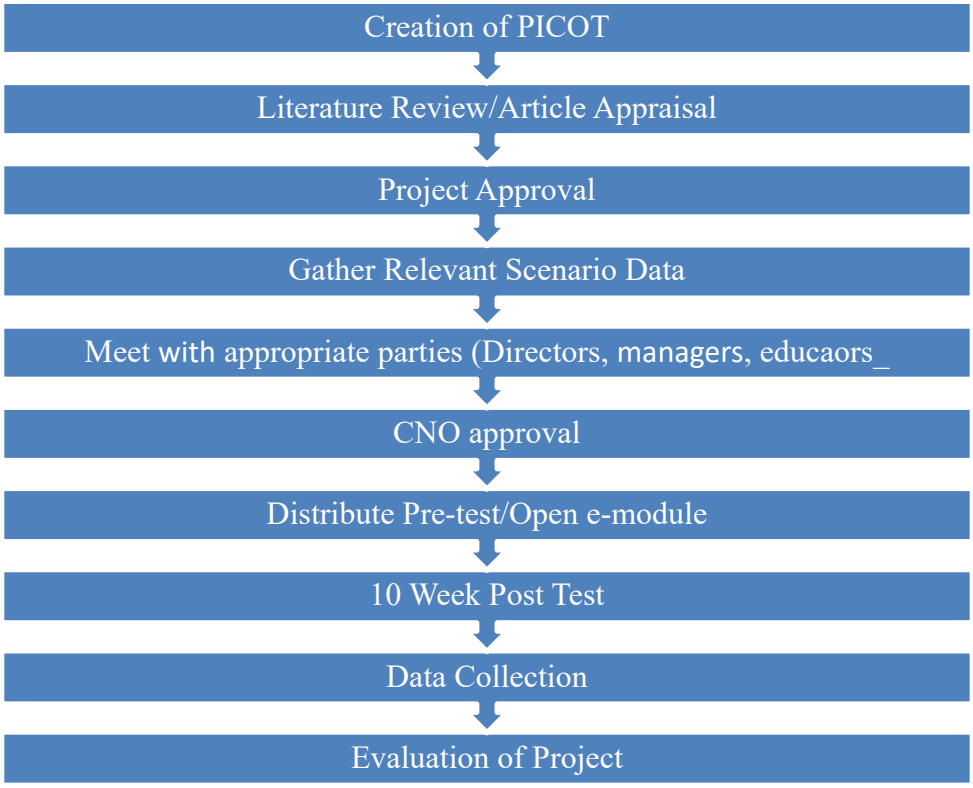
Project approval from the department administration could take roughly one to two weeks to allow for initial presentation and addressing of action items/questions from the initial meeting. There is a scheduled meeting between the administration on Thursdays, and this information could be presented in that meeting.

The anticipated time frame for scenario data collection from staff will be roughly 2-3 weeks. There is a clinical nurse leader on site 24/7 who could conduct interviews for data collection. This timeframe could be shorter depending on participation and quality of scenarios given.

Meeting with the appropriate parties could take anywhere between 4-6 weeks as this timeframe involves e-module development and educator/director/manager approval of the final product. Also, during this time, the e-module will be completed by the creators to test for any errors. Included in this 4-6 week timeframe will be the approval of the CNO following developmental completion.

Distribution of the pretest will last roughly 2-weeks. Again, the pretest and e-module must be completed during work hours. Depending on patient ratio and staffing, the participants may need more time to complete the module. Once the module is complete, each participant will be given a 10-week window to exercise what they learned in the e-module and apply it to real-life scenarios. Following the 10-week period, the post-tests will be administered. Again, a period 2-weeks will be given for this as there will be descriptive data gathered as well.

Data collection and evaluation will be discussed in the next section, but overall this project has an anticipated start to completion time of 25 weeks. Ideally, if this was to be implemented as the Capstone project for this course, it would need to be condensed into an 8-week time frame. However, as this project is now benchmark, more time will be allocated to allow for higher quality of the project.



7. Data Collection Methods

The benchmark project site utilizes a program called Healthstream. This is an electronic database that facilities the educational needs of the hospital. Through this program, authorized users are able to see the status of completion for those who are participating in the e-module. For example, employee A is assigned the pre-test/e-module to their Healthstream account on January 1, 2021. As an authorized user, it is possible to view the date the assignment was opened, progress status, and completion status. Unfortunately, this intervention is designed to create a change in social culture as incivility is a social dilemma. Therefore, there is no way to definitively track the progress of use during the 10-week period where the tools gained from the e-module should be implemented into practice.

The pre-test and post-test will provide valuable information to the effectiveness (or ineffectiveness) of the intervention. This data will be collected by the clinical nurse leaders and

clinical educators, scores will be calculated, and a paired-t test will be completed to hopefully show statistical significance. In addition, the descriptive data and feedback from the participating nurses will be collected by the clinical nurse leaders and the clinical educators in an interview style setting. Themes will be identified among the feedback and results will be gathered from the emerging themes.

8. Discussion of Evaluation

Unfortunately, as this project has not been completed due to restrictions in the benchmark project site, there are no results to discuss. However, the idea for the project has been discussed with members of the management team as well as some of the nurses on staff. The feedback from both parties has been positive and will hopefully be reflective of the overall participation when the project is implemented in the future.

9. Costs/Benefits

Costs associated with this project will include the time and effort it will take to create the e-module. Ideally, this module could be created during business hours as it would be considered a need for the department. However, for discussion purposes, budged cash will be noted in terms of cost effort. Cost effort will be defined as the amount of time per workday this project will require and the compensation needed to allow for participation. See the table below for potential cost breakdown:

Clinical Nurse Leader Hourly rate $30.00 Works 3 days per week (12-hour shifts)	Will need to devote 25 weeks to this project in addition to other projects; roughly 4 hours per day: $120 x 3 x25= $9,000 cost effort
Clinical Educator	Will need to devote time initially to the

Hourly Rate: $32.00 Works 5 days per week (8-hour shifts)	development of the project (3-4 meetings at 1.5 hours in length) and time toward the end for analysis of data (1 hour per day for 2 weeks): $512 cost effort
Manager of Education Unknown Hourly Rate Co-creator of actual e-module	Along with the Clinical Nurse Leader, the Manager of Education would be a high cost effort for this project. Anticipated budgeted cost: $5,600 cost effort
	Total anticipated budget: $15,112 of cost effort

Looking at the anticipated cost of this project, it could be said that something so new with limited strong evidence to support it may not be worth the investment. However, there is evidence out there to support using cognitive rehearsal to decrease incivility. As mentioned above, the projected site for this project holds a cost of $35,000 per new hire to go through orientation. The facility does not require the new hires to sign a contract devoting a certain amount of employed time to the facility. Basically, if the employee is hired, graduates from orientation, and decides to quit, they are allowed to do so. When this happens, the facility not only loses the cost of orientation but also loses the cost of off boarding the employee. When turnover is high, more employees must be hired, and the cost continues to rise.

The goal of this project is to decrease some of the turnover experienced by the facility in hopes of providing cost savings as well as culture change. In addition to affecting the organizational bottom line, another goal is to foster an environment that is conducive to mutual respect, learning, and optimal patient care. Addressing incivility with something as an e-module

could be the first step in a huge nursing cultural change. Plus, word of mouth is a great tool for advertisement for new employees. If the hospital is known as being a great place to work, nurses will be more inclined to apply increasing the quality and caliber of nurse applicants. This also will affect patient care by increasing the quality of care given. Although the project comes with a $15,000 price tag, if the project deems to be successful, it could be worth the investment.

Conclusions/Recommendations

Incivility has been tolerated in the nursing arena as a rite of passage and is continuously referred to as "nurses eat their young". However, literature states that these uncivil behaviors are exactly the opposite of the character-building exercise many considered them to be in the past. It is time for a change as organizations are seeing turnover, absenteeism, and other costly effects of incivility. In addition, those subjected to the negative behaviors are suffering mentally, emotionally, and physically, and ultimately the patients suffer from these detrimental behaviors.

The next steps for this project will be to gain official approval from the department administration and set a start date for project implementation. However, a start date is not in the near future as the hospital recently increased meeting restrictions and allocated dollars for education are not currently being used for new projects. Preliminary work can begin on the project by gathering scenario data from staff members.

A recommendation for the management staff as well as the staff participating in the project would be to have an open mind and consider the potential effects a project like this could have on the overall unit environment. Also, be mindful that the effects of the project may not be seen directly as everyone's experiences are different and vary. This project may need to be implemented multiple times to truly gather data that shows a fiscal effect.

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Appendix A

Evaluation Tool

Workplace Incivility Scale

Nursing Incivility Scale						
We would like to know the type of interactions held between people you work with. For each item below, consider those individuals you interact with at work (nurses, MD's, support staff, etc.)						
		NEVER	RARELY	SOMETIMES	OFTEN	VERY OFTEN
	Do basic disagreements turn into personal or verbal attacks on other employees?	1	2	3	4	5
	Are there violent outbursts or heated arguments in my workplace?	1	2	3	4	5
	Do hospital employees scream at other employees?	1	2	3	4	5
	Do people raise their voices when they get frustrated?	1	2	3	4	5
	Do hospital employees blame others for their mistakes or offenses?	1	2	3	4	5
	Do people, in this hospital, make jokes about minority groups?	1	2	3	4	5
	Do people, in this hospital, make jokes about religious groups?	1	2	3	4	5
	Do coworkers make inappropriate remarks about other people's characteristics (race, gender)	1	2	3	4	5
	Do hospital employees spread bad rumors around here?	1	2	3	4	5
	Do hospital employees bad mouth others in the workplace?	1	2	3	4	5
	Do individuals gossip about their supervisor at work?	1	2	3	4	5
	Do some hospital employees not stick to an appropriate noise level? (speaking too loudly?	1	2	3	4	5
The following items ask about interactions with other direct care staff. How often do other direct car staff…						
	Argue with each other frequently?	1	2	3	4	5
	Take things without asking?	1	2	3	4	5
	Claim credit for your work?	1	2	3	4	5
	Gossip about one another?	1	2	3	4	5
	Take credit for work they did not do?	1	2	3	4	5
Consider interactions with your direct supervisor and indicate how strongly you agree with the following behaviors						
	Is verbally abusive	1	2	3	4	5
	Yells at me about matters that are not important	1	2	3	4	5
	Shouts or yells at me for making mistakes	1	2	3	4	5
	Takes their feelings out on me (stress, anger, etc.)	1	2	3	4	5
	Does not respond to my concerns in a timely manner	1	2	3	4	5

	Factors gossip and personal information into personal decisions	1	2	3	4	5
This section refers to your interactions with physicians that you work with. How frequently?						
	Is verbally abusive	1	2	3	4	5
	Yells at me about matters that are not important	1	2	3	4	5
	Shouts or yells at me for making mistakes	1	2	3	4	5
	Takes their feelings out on me	1	2	3	4	5
	Does not respond to my concerns in a timely manner	1	2	3	4	5
	Treat me as if my time is not important	1	2	3	4	5
	Treat me in a condescending manner	1	2	3	4	5
**Scale adapted from Workplace Incivility Scale used in Nikstaitis (2014)						