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ADDRESSING NURSE-TO-NURSE INCIVILITY IN AN ACADEMIC HOSPITAL IN GAUTENG PROVINCE TO PROMOTE A RESPECTFUL WORKPLACE CULTURE

By

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Submitted in fulfilment of the requirements for the degree

Masters in Nursing Science (Nursing Management)

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DEDICATION

I dedicate this study to my late grandmother Mirriam Dlamini. Thank you for raising me.

ACKNOWLEDGEMENTS

First and foremost, praises and thanks to the God, the Almighty, for His showers of blessings to complete the research successfully. God your timing is perfect -: When the time is right, I the lord will make it happen – 'Isaiah 66:22 ''

I would like to thank my husband Kgomotso for your support throughout my studies

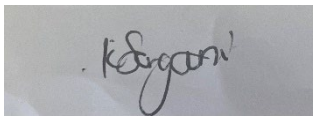
My mother Makepa, my number one supporter; thank you for your endless support.

My daughter Remmogo, my shining star, thank you for being my reason of waking up everyday

My supervisors Prof Leech and Prof Heyns, I was able to reach greater heights due to your guidance and patience.

DECLARATION

I, K.J. Sengani, declare that the dissertation titled “Addressing nurse-to-nurse incivility in an academic hospital in Gauteng province to promote a respectful workplace culture” is my own work and that this work has never been submitted for any other degree at any institution. All sources that have been used or quoted have been indicated and acknowledged by means of complete references.



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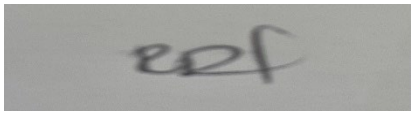

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ABSTRACT

BACKGROUND

Workplace incivility has negative effects on the organizations. Workplace incivility undermines the safety dignity, wellbeing and happiness of workers. Workplace culture is the strongest factor related to incivility because workplace culture structure the way employees perceive, feel and act within the organization.

Workplace incivility reflects an uncaring encounter which has become more visible and prevalent over the years. Incivility is nursing is characterised as the on-going mistreatment of an employee, by one or more peers or leaders. As nurses both individually and collectively, we have a responsibility to demand a healthy workplace which will initiate caring encounters between nurses resulting in quality nursing care for our patients.

Despite the growing interest in incivility, there is still a need for research. We do not how nurses of the organizations perceive, cognitively represent and make sense of this incivility. This information is critical to advance our knowledge of incivility.

AIM AND OBJECTIVE

The aim of the study was to explore nurse to nurse incivility to promote a respectful workplace culture

METHOD

The study was qualitative in nature, -unstructured interviews were conducted with 8 nurses at the designed hospital. By using content analysis five themes were identified 1, conceptualization of nurse to nurse incivility in academic hospital 2, causes of nurse to nurse incivility in an academic hospital 3, consequences of nurse to nurse incivility in an academic hospital 4, ways of coping with nurse to in the academic hospital 5. recommendations to develop a respectful workplace culture to address nurse to nurse incivility in an academic hospital

FINDINGS

Nurses in the designed hospital are aware of the nature of incivility in their workplace, the causes of incivility and consequences. Nurses reacted to incivility by reporting to their managers, seeking professional help or ignoring the incident. Most nurses perceived that incivility had a psychological effect on them which consequently affected their work performance and resulted in poor patient care. Nurses have suggested several recommendations to assist in the management of incivility.

CONCLUSION

Nurses in the designed hospital are exposed to incivility due to work stress, the nature of their jobs and poor working conditions in the hospital. The study has come up with recommendations to promote a safe workplace culture for nurses.

KEYWORDS: nurse to nurse incivility, incivility, workplace culture

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CHAPTER 1 – OVERVIEW

1.1 INTRODUCTION AND BACKGROUND

“An ugly secret in the caring profession” is one of the ways incivility has been described in literature at (Edmonson, Bolick & Lee, 2017:40). Incivility has become a global research problem (Pheko, Monteiro & Segopolo, 2017:572). Although incivility has long existed in health care, the prevalence in the nursing profession has become a widespread challenge (Mothibi, Rankoana & Nel, 2015:146). Incivility posed unsatisfactory work environments, where there is poor communication, disrespect, and abusive behaviours (Abolfazi Vagharseyydin, 2015:116; Boafa & Hancock, 2017:1; Islam, Ahmed & Ali, 2017:3).

Workplace incivility is one form of interpersonal mistreatment in nurses’ workplace environment (Abolfazi Vagharseyyedin, 2015:116). Incivility refers to rude and disruptive behaviours that may progress into threatening situations without intervention (Razzi & Bianchi, 2019:527). Incivility occurs from top down, bottom up and horizontally within an organisation. If nurses are unable to adequately cope with high stress and/or overwhelming emotions, they tend to start to lash at their peers and those in position of lower power (Garth, Todd, Byers & Kuiper, 2018:8).

According to the literature, workplace incivility has negative effects on the health of the individual and organisation. At the individual level, incivility leads to increased anxiety, irritability, and depression which could lead to post traumatic stress (Islam, Ahmed & Ali, 2017:3). At organisation level, nurses have decreased productivity, increased high absenteeism leading to high turnover that the organisation must account for (Garth et al. 2018:8). Workplace incivility undermines the safety, dignity, wellbeing and happiness of workers (Boafa & Hancock, 2017:1).

Workplace culture is an important factor related to incivility (Yuseon, 2016:1) because it structures the way employees perceive, feel, and act within the organisation (Vilas-Boas, 2019:105). Workplace culture refers to the values, beliefs, and norms shared by members of the organisation (Page, Boysen & Arya, 2019:1).

Despite the growing interest in incivility, there is still a need for further research. We still do not know how nurses of the designated hospital cognitively represent and make sense of this incivility. This information is critical to advance our knowledge of incivility (Samosh, 2019:82). Workplace incivility is a sign of an ineffective workplace environment (Abolfazi Vagharseyyedin, 2015:116).

1.2 PROBLEM STATEMENT

Although research on incivility in the workplace abound (Abolfazi Vaghaseyyedin, 2015:116; An & Kang, 2016:235), it is still occurring globally (Islam, Ahmed & Ali, 2017:3). Approximately 90% of nurses are affected by incivility in their workplace (Craft, Schivinski & Wright 2020:41). Incivility has negative influences on the physical, mental, and emotional wellbeing of the nurse, the productivity of the nurse, the wellbeing and productivity of colleagues, and affects the health outcomes of patients negatively (Garth et al. 2018:8; An & Kang, 2016:234).

In the academic hospital where the researcher is currently working, she has observed and experienced nurse-to-nurse incivility as part of the workplace culture e.g. intimidation, offensive language, sarcasm, poor information flow, and rude remarks towards each other. Nurses do not know how to handle incivility as they may find it difficult to stand up to the nurses who portray incivility. This has also been reported by Green (2019:51). Nurses should create a respectful workplace culture where the conditions of employment are conducive to safe and quality health care (Solis, 2019:593). To sustain respectful cultures, nurses must be committed to upholding principles and standards of right and wrong behaviours of conduct (Edmonson, Bolick & Lee, 2017:40).

It is evident in the female medical ward in the designated hospital that nurse-to-nurse incivility has profound impacts, not only on nurses but on the patients and the organisation as well. If the incivility is not addressed it could lead to impaired communication and increase poor patient outcomes due to medication errors and nurse turnover (Garth et al. 2018:8). It has been indicated that if nurse-to-nurse incivility is reduced, health care costs decrease, nurse and patient satisfaction improves, and it enhances patient outcome (Solis, 2019:593).

Research linking workplace culture and incivility is scant (Pheko et al. 2017:572; Islam et al. 2017:3), as most of the studies focused on the frequency of the incivility and the types of incivility. The researcher aimed to explore nurse-to-nurse incivility in the female medical ward in the designated hospital and how it could be addressed to promote a more respectful workplace culture.

1.3 RESEARCH AIM, QUESTION AND OBJECTIVES

1.3.1 Research aim

The aim of the study was to explore how incivility in a medical ward can be addressed to promote a respectful workplace culture

1.3.2 Research question

Based on the research aim, the question to guide the research was:

How can incivility amongst nurses in a medical ward in a designated academic hospital be addressed to promote a respectful workplace culture?

1.3.3 Research objectives

To assist in answering the research question the following objectives were employed to:

- Explore current incivility amongst nurses in a medical ward in a designated academic hospital
- Recommend how a respectful workplace culture can be developed to address nurse-to-nurse incivility in a designated academic hospital.

1.4 DEFINITION OF KEY CONCEPTS

Incivility: Includes rude, discourteous or disrespectful actions or behaviour that may or may not have a negative intent behind them (Craft et al. 2020:1; Islam et al. 2017:3). In this study incivility will be regarded as any insulting behaviour between nurses in the female medical ward in the designated hospital that makes them feel humiliated and degraded.

Workplace culture: “The way things are done around here” (Mckinlay & Williamson 2010:1). The shared values, beliefs, norms shared by members of the organisation (Yuseon 2016:1; Page et al. 2019:1). The workplace culture in this study refers to the way in which things are done and how nurses behave towards each other in the male medical ward in the designated hospital.

Nurse: A nurse is a person who completed a nursing programme (ICN 2012:6) and is seen as a person who is registered with the South African Nursing Council (SANC) as a registered nurse or enrolled as an enrolled nurse or assistant nurse to practice nursing according to the Nursing Act 33 of 2005 (South African Government 2005:6). In this study a nurse will be either a registered nurse, an enrolled nurse, or an assistant nurse working permanently in the female medical ward at the designated hospital and who are registered/enrolled with the SANC.

Nurse-to-nurse incivility: In this study, nurse-to-nurse incivility will refer to any insulting behaviour nurse-to-nurse that makes the receiving nurse feel humiliated and degraded; based on the definition of incivility by Craft et al. (2020) and Islam et al. (2017:1).

1.5 SETTING

This study was conducted in the female medical ward in a designated academic hospital in Gauteng province. The ward has 40 beds and 22 nurses inclusive of one operational manager, seven registered nurses, seven enrolled nurses and seven assistant nurses were working in the ward at the time the study was conducted. Female patients are in general admitted with medical conditions such as respiratory tract infections, cardiac conditions and Human Immuno-Deficiency Virus (HIV) related complications, and for palliative care. The bed occupancy in the ward is consistently 100%.

1.6 ASSUMPTIONS

The research was situated in the pragmatist paradigm. Pragmatism is associated with an abductive reasoning. Pragmatists believe that no two people have exactly the same experiences. They also believe human actions cannot be separated from their experience (Kaushik & Walsh, 2019:3, 4-6). Pragmatists believe that the process of acquiring knowledge happens on a continuum. They also accept that there can be multiple realities to an inquiry (Kaushik & Walsh, 2019:4).

1.6.1 Epistemological assumptions

Each person's knowledge is unique as it is created by his /her unique experience. All knowledge in this world is socially constructed (Kaushik & Walsh, 2019:3). Pragmatists do not view knowledge as reality rather it is constructed with a purpose to better manage one's existence (Kaushik & Walsh, 2019:4). According to Goldkuhl (2012:139, 140) knowledge is viewed as a 'copy' of realty and is constructed to better manage existence and taking part in the world. In the study, the researcher aims to gather knowledge of incivility in the workplace by using the principles of caring conversations. The researcher aimed to attach meaning to the phenomenon through interaction with participants during focus group discussions.

1.6.2 Ontological assumptions

Pragmatists agree that research occur in a social context (Creswell, 2014:32) and believe that the essence of ontology is actions and change that is guided by purpose and knowledge (Goldkuhl, 2012:139).

The researcher assumes that all experience has meaning, whether good or bad. The impact of the phenomenon should be highlighted, and possible strategies explored. Through interactions with participants, the participants will share their experiences which will be

valuable to address the aim of the research. The researcher assumed that each participant viewed the phenomenon in a different way, and that add value to the data collected from them.

1.6.3 Methodological assumptions

Pragmatism orients itself towards solving practical problems in the real world (Kaushik & Walsh, 2019:4). A descriptive qualitative research design was used in the study and individuals' interviews were held to collect data about nurse-to-nurse incivility. The researcher assumed that the participants will be able to reflect on their experiences regarding incivility and verbalize recommendations to address incivility.

1.7 DELINEATION

The study was conducted in only one medical ward at one academic hospital in Gauteng province. The focus was on incivility amongst nurses. Only nurses who were employed permanently in the female medical ward participated in the study. Nursing students and other healthcare professionals were excluded.

1.8 SIGNIFICANCE

The study would contribute to a better understanding of nurse-to-nurse incivility and the way in which nurses deal with incivility. The study came up with recommendations to address incivility among nurses in the designated hospital, which ultimately could create a respectful workplace culture. The findings of the study could assist in improving the quality of work life in the designated hospital.

1.9 RESEARCH DESIGN AND METHODS

The research design and methods and trustworthiness of the study are discussed in Chapter 3.

1.10 ETHICAL CONSIDERATIONS

Ethical considerations were adhered to while conducting the study. Ethics includes what is right and good during the research. The Belmont Report (Polit & Beck 2017:139) articulates the three primary ethical principles as beneficence, respect for human dignity and justice. These principles and its application in the study are discussed in Chapter 3.

1.11 DISSERTATION STRUCTURE

The dissertation is divided into five chapters. Following this introductory chapter, in Chapter 2 a brief overview of the literature and philosophical assumptions are provided. In Chapter 3, the focus is on the research design and methods employed to answer the research question.

In Chapter 4, the research findings are presented and discussed. Conclusions, recommendations, implications, and potential areas for future research are provided in the final chapter.

1.12 SUMMARY

In the first chapter the researcher gave an overview of the research study that was undertaken. The background and rationale of the study, the research problem, research questions and objectives, research design and methodology were outlined. In the second chapter, the researcher will give detailed information regarding the literature integrated.

CHAPTER 2 - LITERATURE REVIEW

2.1 INTRODUCTION

A culture of respect in a workplace free from incivility optimizes the patient health outcomes and promotes a positive work environment for nurses (American Nurses Association, 2015). It is no secret that workplace incivility is an ongoing challenge in the healthcare sector (Bar-David, 2018:2). It is a topic that is gaining attention due to its ability to cause harm not only to nurses but patients too. Incivility can happen anywhere, at any time, such as nurses rolling their eyes at a colleague's story, or making a disparaging comment to another nurse (Bar-David, 2018:2). As there is a risk that workplace incivility may advance to high aggression and physical violence, it is important to strive for a civil workplace environment.

This chapter describes literature found. This enabled the researcher to establish what research has been previously done and to develop a more comprehensive understanding of nurse-to-nurse incivility. A literature review provides a foundation on which to base new evidence and usually is conducted before data collection (Polit & Beck, 2017:54). This section addresses the definition and current knowledge about the study.

2.2 LITERATURE SEARCH STRATEGY

A review of literature was undertaken to summarise existing literature and provide a comprehensive understanding of nurse-to-nurse incivility. Databases such as ResearchGate, Medline and Google Scholar were used to search for relevant sources. The search terms or key words used included: nurse-to-nurse incivility AND incivility in the workplace AND incivility in nursing practice. This search strategy yielded several published articles, and grey literature such as theses and dissertations. Inclusion criteria were that the published material describe research related to incivility and incivility in nursing and were published in English between 1999 and 2022. The full text articles, theses and dissertations were assessed for eligibility according to the criteria.

2.3 LITERATURE REVIEW

In the following section, the researcher provides a brief overview of literature available on the topic. The focus will be on defining the concept of workplace incivility, causes of workplace incivility, sources of workplace incivility, the consequences thereof, how do employees cope with it, and how it is managed in the workplace.

2.3.1 WORKPLACE INCIVILITY

There has been a long tradition of research on workplace mistreatment in the field of health, on constructs such as workplace aggression, workplace bullying, workplace deviance, abusive supervisors and counterproductive workplace behaviours (Schilpzand, De Pater & Erez (2016:S57). However, research on workplace incivility originated with the seminal publication by the two management scholars Andersson and Pearson (1999:457) who defined workplace incivility as "low intensity deviant behaviour, with ambiguous intent to harm the target in violation of workplace norms for mutual respect." In their definition, they emphasise that the uncivil behaviour displayed by the perpetrator includes rudeness, lack of courtesy, and disregard for others.

Literature review done by Schilpzand et al. (2016:S61) shows that workplace incivility is a world-wide phenomenon with adverse outcomes on people and organisations. The types of workplace incivility can be categorized into experienced incivility, witnessed incivility and instigated incivility (Schilpzand et al. 2016:S66). A similar definition is provided by Abolfazi Vagharseyyedin (2015:121) who defines workplace incivility as "a behavior of low intensity and ambiguous intent, which lacks mutual respect and physical assault". In this definition workplace incivility behaviour is differentiated from aggression, violence, and bullying. Estes and Wang (2008:10) argue that although harm might not be intended in the uncivil behaviour, it does not mean harm does not happen because it actually does happen. A similar approach is taken by Akella and Lewis (2019:55) who describe incivility as "bad or rude behavior encompassing impoliteness, with diminished use of basic courtesies such as 'please' and, 'thank you', along with abrupt and curt language when using technological communications with a singular lack of respect for leaders and colleagues." They further argue, similar to Estes and Wang (2008:10), that although this uncivil behaviour can be seen as "mundane" and "minor", they can have devastating consequences.

In their effort to refine the "low intensity" aspect of the definition of incivility, Cortina and Magley (2009:284) argue that it is the incivility target appraisal of the situation that will determine whether their experience is of low-intensity. They therefore propose that the important characteristic of incivility is that it "gives rise to mildly negative appraisals in targets such as appraising the behavior as insensitive, annoying, frustrating, bothersome"; and that the three key features of incivility would therefore be "norm violation, ambiguous intent, and mildly negative appraisal" (Cortina & Magley, 2009:284).

The American Nurses Association (2022) defines incivility as "one or more rude, discourteous, or disrespectful actions that may or may not have a negative intent behind them." This

definition is similar to Andersson and Pearson (1999:457) because it shows the ambiguity of the intent as well as the uncivil behaviour that include rudeness, disrespect and lack of courtesy. Similar to most of the definitions above, Clark (2009:1) defines incivility as “rude and disruptive behavior that, when left unaddressed, may spiral into aggressive or violent behavior.”

Johnson and Indvik (2001:706) describe workplace incivility as “the thousand ‘slings and arrows’ that eat away at the day to day” smooth running of an organisation; and consider incivility to be at the low end of the workplace abuse scale. Some researchers mistakenly use the words ‘workplace incivility’, ‘bullying’, ‘horizontal and vertical abuse’, ‘violence’, and ‘psychological aggression’ interchangeably (Abolfazi Vagharseyyedin, 2015:116).

Several studies have found that examples of uncivil behaviour are, among others, publicly criticizing of a co-worker, gossiping, or backstabbing and yelling or shouting, eye rolling, staring or glaring, making face or excluding someone from a conversation or work activities, having one’s opinion ignored, being excluded from a meeting, use of verbally abusive language, racial slurs, ethnic jokes, not greeting in the morning, sending a nasty and demeaning note, leaving a jammed printer for someone else to fix, (Kisner, 2018:26; Lim & Lee, 2011:95; Felblinger, 2008:237; Johnson & Indvik, 2001:708). Other uncivil behaviour has been found to include not returning phone calls and e-mails, habitually interrupting others, not keeping appointments, and belittling people who think differently from you (Miner, Settles, Pratt-Hyatt & Brady, 2012 :345). These behaviours could be both intentional and unintentional, both subtle and obvious levels of rude and discourteous behaviour, but are characterized by their low intensity (Samosh, 2019:81; Buck-Hooper, 2017:80; Collins & Roger, 2017:564).

2.3.2 CAUSES OF WORKPLACE INCIVILITY

Previous research indicates that co-worker incivility is more prevalent than blatant and overt types of violence such as battery and homicide (Felblinger, 2008:234). According to Vasconcelos (2020:16) a total of 75 % of participants had witnessed workplace incivility from a co-worker taking place during the past year, while 58 % had witnessed supervisor incivility, and 66 % reported that they themselves had instigated incivility towards another during the past year. Similar research findings show that 98% of participants have reported experiencing uncivil behaviour; 71% of employees experienced some form of incivility in the past five years, sometimes in combination with sexual harassment (Porath & Pearson, 2012:1; Cortina, Magley, Williams & Langhout, 2001:70). It is therefore necessary to consider why incivility is occurring at an increasing rate.

Estes and Wang (2008:10) provide a conceptual model that show workplace incivility constructs and causes which include organisational context such as management philosophy and organisational culture; co-worker beliefs, social systems, mental disorders, moral maturity and psychological contract. Some researchers identify factors that cause workplace incivility such as generational differences where there are differences in worldviews of Baby Boomers and Generation Xers (Engelbrecht, 2012:56; Estes & Wang, 2008:10); work pressures resulting from shortage of nursing staff and uncertainties in work life (Mothibi, Rankoana & Nel, 2015:153; Al-Ghabeesh & Qattom, 2019:6; Holm, 2021:23; Johnson & Indvik, 2001:710), lack of communication in the workplace (Johnson & Indvik, 2001:710) and lack of collaborative effort that decreases teamwork and cause organisational chaos (Abid, Khan, Rafiq & Ahmed, 2015:6308).These can be associated with Estes and Wang (2008) social systems construct.

Other triggers include poor coping, lack of support from management and peers and little job autonomy. These triggers can elicit feelings of frustration and powerlessness which leads to high level of stress and emotions boiling over (Craft, Schivinski & Wright, 2020:42; Al-Ghabeesh & Qattom, 2019:7).

Leadership and management styles have also been found to cause workplace incivility. These include abusive supervision (Flink-Samnick, 2016:262; Logan, 2016:50) lack of communication (Johnson & Indvik, 2001:710), laissez-faire leadership style that ignores problems, avoids criticism of others behaviour and have difficulty with providing direction leading to incivility not being dealt with, thereby perpetuating the cycle (Wachs, 2009:88; Green 2019:52) and favouritism (Kisner, 2018:28). Other leadership styles contributing to workplace incivility include not being acknowledged for good performance (Holm, Torkelson & Bäckström, 2016:76). Leadership styles are also associated with an additional cause of incivility, namely; power dynamics, also known as rankism (Lim & Bernstein, 2014:127). Those in powerful positions have been found to easily perpetrate incivility because they can get away with it (Estes & Wang, 2008:13; Cortina et al. 2001:75; Pearson & Porath, 2005:11). The powerful status makes it is easy for these instigators to be uncivil because they can keep people waiting, interrupt meetings, speak in patronizing words and tone and disrupt other employees work and conversations without any consequences because their power positions forms a “protective shield” (Pearson & Porath, 2005:11).This is supported by the study by Lim and Lee, (2011:104) that found that there is a higher likelihood that employees are mistreated by those who occupy higher status at the workplace, followed by co-workers and subordinates.

Mental and personality disorders have been found to cause workplace incivility (Estes & Wang, 2008:7; Jelavić., Aleksić & Braje, 2021:14). Personality factors that have been related to workplace incivility include:

- Agreeableness - Low agreeableness was positively related to experienced workplace incivility, and people low on agreeableness draw attention to become a target. Low levels of agreeableness are associated with mistrustfulness, suspicion, non-cooperation, rudeness and stubbornness. Individuals in agreeableness perceive less interpersonal workplace deviance (Jelavić et al. 2021:3).
- Emotional stability - Emotional stability is the personal trait that includes appropriate reaction and calmness, while neuroticism includes nervousness, worrying, insecurity and impulsivity. Perceived workplace incivility has been proven positivity related with high neuroticism by several researchers (Jelavić et al. 2021:3).
- Openness to experience – Openness to experience is characterised by imagination, open-minded liberalism creativity, introspection and intellect. People open to experience might be more inclined to ascribe the behaviour of others as externally caused and not a priori negative or uncivil because of absence of full evidence (Jelavić et al. 2021:3).
- Extraversion - Extraversion is associated with activeness, self-confidence persistence and assertiveness. Extraverted people are always positive in situations, they are better accepted by other employees and draw less attention as targets of incivility (Jelavić et al. 2021:3).
- Conscientiousness - Conscientiousness is characterized by good organisation skills, diligence, persistence and determination to accomplish tasks and obligation. People who are conscientious may be more likely to observe breaching of civil norms and they appraise incivility in unambiguous situations (Jelavić et al. 2021:3).

Furthermore, organisational culture contributes to workplace incivility as it includes important norms, values, beliefs and responding employee reactions that could provoke workplace incivility. The workplace culture furthermore celebrates certain behaviours that could actually form part of the incivility spectrum and therefore occurs as unpunished and accepted practice. (Jelavić et al. 2021:4). Family pressures have also been found to cause workplace incivility. Family obligations take too much of an employee that they are unable to complete the required tasks at work. A lot of family responsibility are to be fulfilled by an individual, which makes him or her mentally tired. This makes him or her unproductive (Urooj, Jameela & Ahmed, 2019:6).

2.3.3 SOURCES OF WORKPLACE INCIVILITY

Literature reviewed shows that sources of workplace incivility can be categorized into two categories, namely prejudices based on diversity factors and workplace culture. These two categories are discussed in detail below.

Research shows that prevalence of workplace incivility is sometimes based on prejudices or "dispositional target attributes" (Schilpzand et al. 2016:S67; Samad, Memon & Maitlo, 2021:1418; Urooj et al. 2019:3). For example, incivility against female nurses is reportedly greater than males and this could be related to the fact that females are regarded as the oppressed group (Mothibi et al. 2015:153). A study by Cortina, Kabat-Farr, Leskinen, Huerta and Magley (2013:1596) concurs with this and view this "selective incivility" against females as "inconspicuous form of gender discrimination"; while Miner et al. (2012:356) refer to it as "gendered incivility". There are however inconsistent findings of research that assesses the link between gender and incivility experience (Schilpzand et al. 2016:S67). For example, a study by Lim and Lee (2011: 102) found that men experienced greater levels of incivility than women.

Age is also regarded as a factor that has an influence on the occurrence of incivility. Nurses aged 30 years and below felt that their colleagues were uncivil (Dirgar, Tosun and Arslan 2021:221). According to Mothibi et al. (2015:152) younger employees experience higher levels of incivility than their older counterparts. A younger age may reflect lack of job experience, resulting in a nurse's inability to identify or prevent abusive situations (Mothibi et al. 2015:152). This is supported by Lim and Lee (2011:102) who found that younger employees experienced more incivility in the workplace. Contrary to this, the study by Cortina et al. (2013:1597) could however not find the age link even when participants in their study were mostly of a young age.

An additional incivility factor has been found to be race. Cortina et al. (2013:1596) found selective incivility based on racial discrimination. They however acknowledge that patterns of "triple jeopardy", which represents the combined discrimination based on race, gender and age, are also possible with workplace incivility (Cortina et al. 2013:1597).

2.3.4 THE SPIRALLING OF WORKPLACE INCIVILITY

A common reaction to uncivil behaviour is to retaliate in one form or the other (Porath & Pearson, 2012:2). Andersson and Pearson (1999:458) describe how workplace incivility can spread in the workplace and become part of the workplace culture through social exchanges between co-workers, which they dubbed "incivility spirals". They refer to an incivility spiral as

how incivility may spread in the workplace through a social process of reciprocal, interchanging incivilities between co-workers (Andersson & Pearson, 1999:458). An example of how the incivility can spiral is illustrated in Figure 2.1.

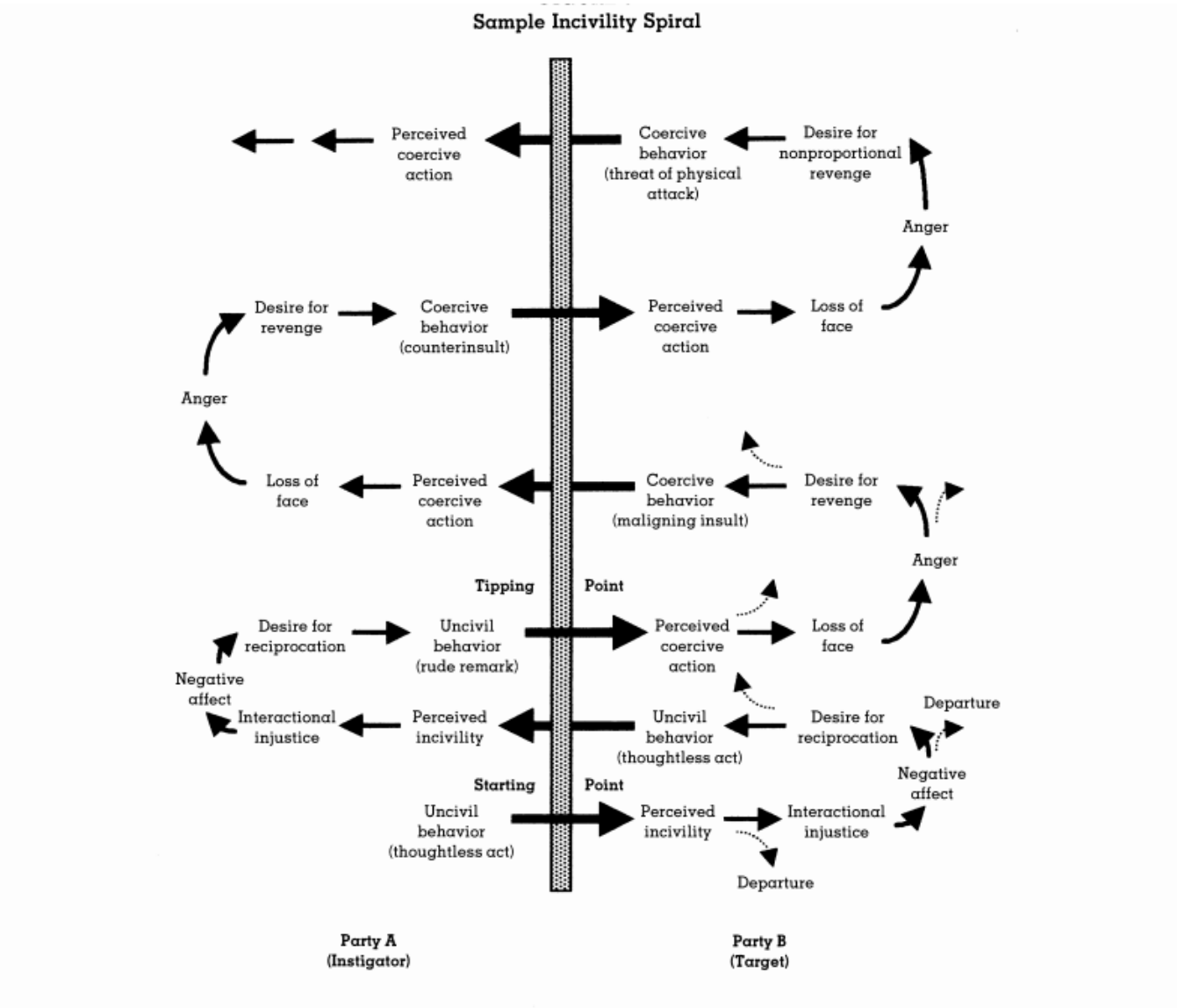

Figure 2.1 Sample Incivility Spiral (Source: Andersson and Pearson 1999:456)

The above figure shows how uncivil behaviour from Party A (the instigator) can be reciprocated by Party B (the target), which then escalates further because of the desire for revenge. This “tit for tat” can ultimately reach what Andersson and Pearson (1999:461) refer to as “the tipping point” or what is commonly known as "the straw that breaks the camel's back" if the involved parties have hot temperament and the culture of the organization perpetuates an escalation. This stage leads to anger and threats of physical attack where an employee can resort to bringing a gun to work (Andersson & Pearson, 1999:462). Bar-David (2018:2) concurs and asserts that incivility breeds incivility, with the spiral effect that can spawn more serious aggressive behaviour and like a common cold, low intensity negative

behaviour can spread easily from one person to another. Even when the level of incivility is mild, there is a risk that interactions may escalate from low intensity to behaviours with explicitly harmful intentions (Dirgar, Tosun, & Arslan, 2021:221). This spiralling of uncivil behaviour is supported by the definition by Clark (2009:1) that warns that if the incivility is not addressed, it will spiral into aggressive and violent behaviour.

2.3.5 DIFFERENTIATING WORKPLACE INCIVILITY FROM OTHER WORKPLACE MISTREATMENT CONSTRUCTS

The definition by Andersson and Pearson (1999:457) provides clear delineation between workplace incivility and other workplace mistreatments. Workplace incivility is differentiated from other forms of mistreatment in organizations, such as aggression, violence, and sexual harassment aggression and bullying that are more severe (Schilpzand, 2016:S57). Andersson and Pearson provide an illustration of how workplace incivility "differs from and overlaps" with the different forms of mistreatments workplace at Figure 2.2.

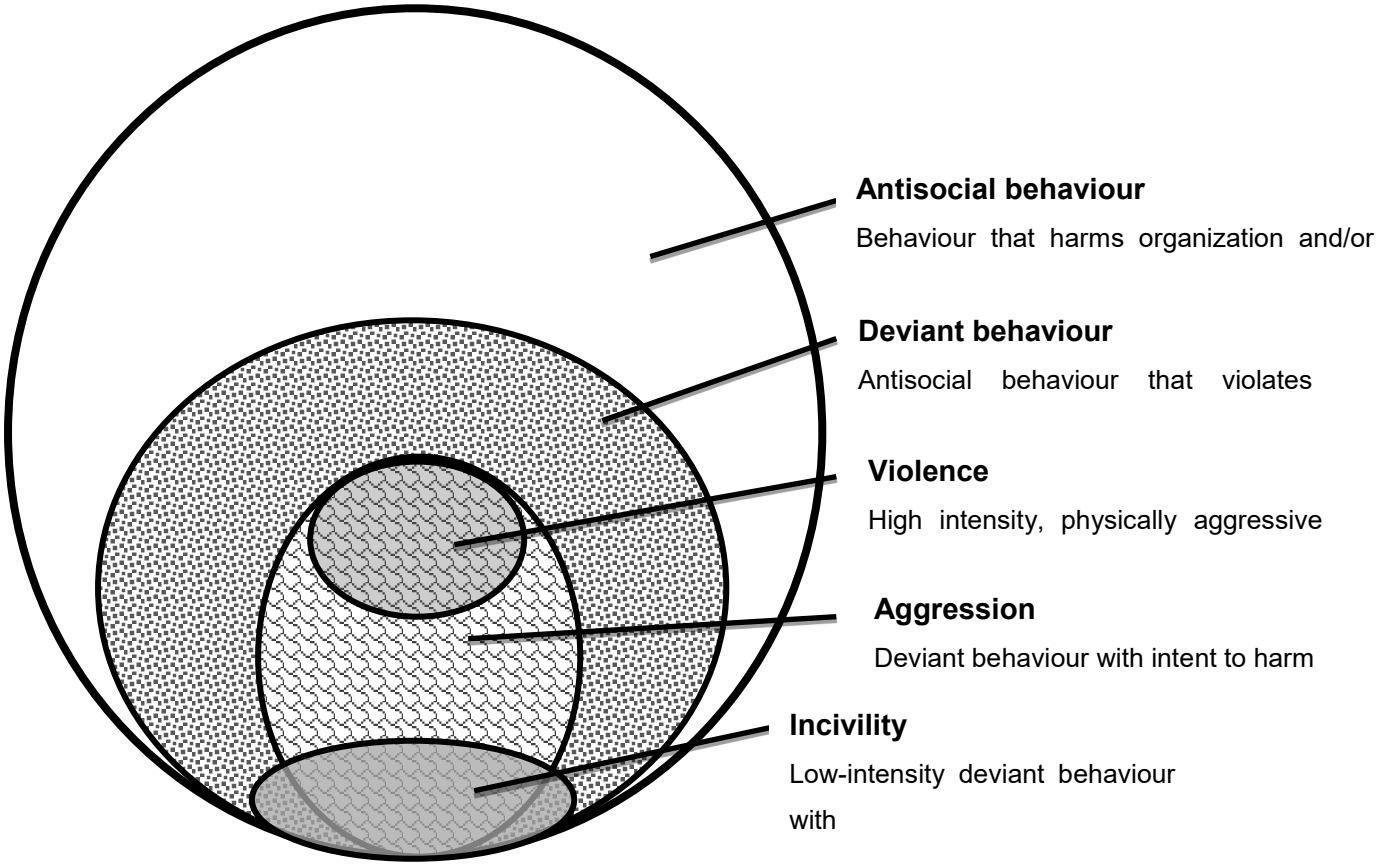

Figure 2.2: Incivility and Other Forms of Mistreatment in Organizations (Source: Andersson and Pearson (1999:456)

In Figure 2.2 it is shown how incivility is at the lower end of aggression because the deviant behaviour is of low intensity; while violence is on the higher end of aggression because the deviant behaviour is high in intensity and physically aggressive.

This therefore means that incivility is, a deviant behaviour similar to aggression but "one that is less intense and ambiguous as to intent to harm". Deviant behaviour is outside the realm of aggression but has some overlaps with incivility (Andersson & Pearson,1999:457).

Workplace bullying and workplace incivility are similar in the way that there may be an overlap in some of the conceptualized negative behaviours, such as neglecting or showing little attention to others' statements, the social exclusion of others, or behaviours that are demeaning and condescending, as well as ridicule and teasing of others. Workplace bullying and incivility are both to some extent associated with similar outcomes, and they have often been measured with similar instruments (Holm, 2021:23). But the constructs can still be differentiated in the way that bullying requires the negative behaviour to persist over a period of time, and that there has to be a difference in power between target and perpetrator.

In a meta-analysis, it was found that workplace bullying was not more strongly related to any outcome than incivility, except for physical well-being, that had a stronger association with workplace bullying than workplace incivility (Holm, 2021:23). Workplace incivility, on the other hand, was more strongly related to turnover intentions than workplace bullying was (Holm, 2021:23; Cortina, Kabat-Farr, Leskin., Huerta & Magley, 2013:1598). This demonstrates that on one hand, the two constructs both share similarity in that their relation to certain outcomes cannot be distinguished from each other, and on the other hand it shows that the constructs are related with different strength to physical well-being and turnover intentions. In other words, although the constructs share several similarities, they are distinct from each other, defined differently, and to a certain degree differently associated with outcomes (Holm, 2021:23).

Bullying is a form of aggression at work that goes beyond incivility. Bullying is more deliberate and repetitive form of behaviour. Bullying more than incivility involves systematic harassment for a long period of time period of time and the instigator desire to control the target. As the target becomes independent, the instigator becomes more in control, the target develops self-blame (Felblinger, 2008:236).

To consider behaviour as bullying, it must occur repeatedly and for a long time at least a month or more in situations where targets find it difficult to defend against and stop abuse. A single event is not considered as bullying but rather conflict (Felblinger, 2008:236).

2.3.6 CONSEQUENCES OF WORKPLACE INCIVILITY

Lim, Cortina and Magley (2008:97) propose a model in Figure 2.3 below that describes constructs that are related to outcomes of workplace incivility among targets and their workgroup members.

Figure 2.3: Effects of workplace incivility Source: Lim et al. (2008:97)

The figure shows that incivility towards the individuals and workgroup affect mental health, physical health, job satisfaction and turnover intentions (Lim et al. 2008:97). The discussion on the consequences of workplace incivility will be linked to this proposed model. The individual effect will also be categorised according to the three types of incivility, namely the experienced, the witnessed and the instigated.

Individual Experienced incivility consequences

Incivility is more common today than decades past. Several studies have found detrimental effects of workplace incivility. For instance, associations have been found between incivility and increased depression, higher levels of sleeping problems, more perceived stress on days of experiencing incivility, and lower levels of well-being, anger, fear and sadness (Holm, 2021:31).

Researchers have confirmed that there is a negative correlation between an uncivil work environment and employee satisfaction, meaning that as incivility among co-workers increases, reports of employee satisfaction decrease (Cortina, Magley, Williams & Langhout,

2001:72); Porath & Pearson, 2012:2). This consequence also affirms the model proposed by proposed by Lim et al. (2008:97).

Other studies also support the mental health, physical health, turnover intentions effects proposed in the Lim et al. model. For example, burnout and its negative effect of anxiety, depression and heart diseases have been found to develop when individual coping strategies are no longer effective. The burned-out nurses may become detached, convey a negative attitude, avoid meaningful relationships, or come across as unapproachable, and consider quitting (Cortina et al. 2001:75; Shi, Guo, Zhang, Xie, Wang, Sun et al. 2018:2; Samad et al. 2021:1481).

Workplace incivility causes reduced job performance of employees, decreases their creativity and fosters their intentions to leave the job. (Ma, Meng, Shi, Xie, Wang, Dong et al. 2018:1; Porath & Pearson, 2012:5). A negative impact on employee well-being for those repeatedly exposed to incivility, includes negative emotions over time, reduced trust (Samad et al. 2021:1418). This finding is supported by Lim et al. (2016:2899) whose study found that daily incivility would be positively associated with feelings of hostility.

Holm (2021:31) found workplace incivility had a negative impact on the target's marital satisfaction and increased family-to-work-conflict, indirectly via the partners' perceived stress transmission of the uncivil experiences. This is supported by the study by Lim et al. (2016:2901) which found that there is a significant positive relationship between daily hostility at work and withdrawn and angry marital behaviours at home This demonstrates that the negative consequences of workplace incivility do not stop at the workplace but can possibly affect the personal life of those targeted by it.

Psychological effects of bullying may include a shame response that results in an "attack-self" phenomenon. When nurses are first victimized by emotionally abusive behaviours (Felblinger 2008:236; Shi et al. 2018:2; Samosh, 2019:84), their immediate response may be one of shame and anger. The nurses' initial shame response to violence can elicit an attack-self coping reaction that is characterized by inner-directed anger (Samosh, 2019:83). When nurses attack themselves and direct their anger inward, they once again become victimized, which is known as revictimization (Samosh, 2019:84).

Witnessed workplace incivility consequences

The literature review study by Schilpzand et al. (2016:S69) found that research on the consequences of workplace incivility has mostly focussed on individuals who experience the workplace incivility. Their study shows that witnesses to workplace incivility are also affected negatively, with consequences such as decreased performance in their task, reduced

creativity, not being helpful towards others. Other consequences to the individuals witnessing the workplace incivility include emotional exhaustion, especially if they were on the side of the one experiencing the incivility; and withdrawal at work (Schilpzand et al. 2016:S69). Porath and Pearson (2012:6) agrees that witnesses to incivility experience negative consequences such as being “less likely than others to help out”.

The above factors that are linked to performance are not featured in Lim et al. (2008:97) proposed model.

Instigated workplace incivility consequences

The literature review study by Schilpzand et al. (2016:S80) found that instigators of workplace incivility feel excluded and distrusted after the instigated incivility.

Work related consequences

Workplace incivility hampers professional nursing practice, and decreases the quality of patient care and the health of the nurses. Patients necessitate from to embrace certain characteristics such as empathy, kindness and caring as some indicators of quality nursing care (Alshehry, Alquwez, Almazan, Namis & Cruz, 2019:4583)

Nurses like other healthcare professional have the primary responsibility of providing care holistically (physical, mental, social, spiritual and emotional) and ensuring patient’s safety. However, if the workplace environment is unsatisfactory and violates their workplace standards, their delivery of care may be affected. The workplace environment could be challenging to nurses as providers of care because of negative workplace experiences (Alshehry et al. 2019:4583).

The well-being of nurses is critical to quality patient care. Nurses who experience incivility do not work as fast, and more likely to make mistake critical errors that can cost a patient’s life or prolong their recovery time (Al-Ghabeesh & Qattom, 2019:7; Porath & Pearson, 2012:2). Nurses often failed to report errors because they feared being gossiped about and receiving punishment (Buck-Hooper, 2017:80). According to Bar-David (2018:2) incivility reduced the amount of information sharing and help seeking behaviour by team members, this led to poor team performance.

The problem with incivility is that not only are nurses wounded but patients as well (Buck-Hooper, 2017:79). Nurses who experience incivility are unable to communicate with patients and visitors (Al-Ghabeesh & Qattom, 2019:7). A nurse who may be mistreated by a peer may in turn bully a patient (Buck-Hooper, 2017:79) especially in high stress wards such as emergency department and psychiatric wards.

Behavioural consequences of workplace incivility

Besides the health and work-related consequences tied to workplace incivility, behavioural outcomes have been the focus of many studies. This has for instance concerned withdrawal behaviours, where individuals withdraw from the organization after having been exposed to workplace incivility (Holm, 2021:30) and in extreme cases it can lead to aggressive and violent behaviour (Pearson and Porath, 2005:10).

When exploring how long the effect persisted, Holm (2021:30) found the relationship to be statistically significant when uncivil interactions between co-workers occurred within the same day, a significant association between being targeted by workplace incivility and exhibiting rude behaviours towards others on a following day, suggesting that there was a carry-over effect from one day to another.

The bystander perspective can be an important addition to the field, to explore possible vicarious impact for those not directly affected by incivility. In order to advance knowledge about how workplace incivility impacts bystanders in the workplace.

Workplace incivility adversely affects new nurses' behaviours and is more likely to generate negative experiences and behaviour. The negative behaviour increases ambiguity and difficulty adjusting to new rules (Ma et al. 2018:7).

2.3.7 COST OF WORKPLACE INCIVILITY

Incivility is expensive, and few organizations recognize or act to curtail it (Porath & Pearson, 2012:2; Craft et al. 2020:40).

Research statistics on the cost of incivility show that about 80% of work time was spent /lost worrying about an uncivil incident, and almost two thirds (63%) of participants lost work time from avoiding an instigator of incivility. In addition, it was found that 38% of participants intentionally decreased work quality, 66% reported performance declines, and 78 % felt less commitment to their organization, 25% admitted to taking their frustration out on customers, 12% said that they left their job because of the uncivil treatment (Holm, 2021:32; Porath & Pearson, 2012:5).

Several studies have found that the hidden costs of incivility include lost or wasted work time, reduced commitment, reduced effort at work, increase in absenteeism and use of sick leave, and high turnover rates (Craft et al. 2020:40; Porath & Pearson, 2012:3; Holm, 2021:32; Al-Ghabeesh and Qattom, 2019:2). Employee turnover is costly to the organisation because it involves hidden costs such as the separation cost, the replacement cost and the training cost (Samadet al. 2021:1422; Logan, 2016:49).

Pearson and Porath (2005:9) compare the cost of incivility with that of sexual harassment which has been estimated to exceed $6 billion per company in absenteeism, lost productivity, and turnover. This, they emphasise, exclude costs associated with of settlement costs, lawsuits and legal fees, legal settlements, the indirect costs of organizational reputational damage, or the time spent managing the situation (Pearson & Porath, 2005:9)

2.3.8 COPING WITH INCIVILITY

The literature on the cost and consequences of workplace incivility above showed the potential devastating impact on the target and witnesses of workplace incivility. It is therefore vital to understand what appropriate coping strategies are effective in dealing with incivility. There are several categories of coping strategies that can be found in literature, namely; problem- vs. emotion-focused, approach vs. avoidance, and cognitive vs. behavioural (Lazarus & Folkman, 1984:141; Cortina & Magley, 2009:273; Skinner, Edge, Altman & Sherwood, 2003:216). Several studies that researched coping strategies to deal with incivility (Cortina & Magley, 2009:273; Holm, 2021:3; Hershcovis, Cameron, Gervais & Bozeman, 2018:165; Welbourne, Gangadharan & Esparza, 2016:731) adopted the transactional model of stress and coping developed by Lazarus and Folkman (1984:141) in their methodology. They define coping as "constantly changing cognitive or behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984:141). The central theory of the transactional model of stress and coping is that targets of incivility are likely to use two methods of coping, namely; problem-focused coping (PFC), and emotion-focused coping (EFC) where they first appraise the situation to determine the extent of the real or possible harm the incivility poses to them before they decide how to react to it. (Cortina & Magley, 2009:273; Holm, 2021:3).

Problem-focused coping relates to ways of dealing with stress through active engagement with the goal to reducing or eliminating its cause; while emotion-focused coping has as its main goal to manage emotions emanating from stress (Hershcovis et al. 2018:165). Two of the most significant factors that determine which coping strategy to use are outcomes of the appraisal and the length of the incivility (Cortina & Magley, 2009:281). For example, some of the threat of incivility can be evaluated by targets as "benign, annoying, frightening or potentially inspiring" (Cortina & Magley, 2009:273).

The literature review revealed several key themes of coping strategies that include 1) conflict avoidance, 2) detachment, 3) minimization, 4) support seeking, and 5) Confrontation (Cortina

& Magley, 2009:281; Lim, Bogossian & Ahern, 2010:29). These strategies are discussed in detail below.

Conflict avoidance

Cortina and Magley (2009:280) identify different conflict avoiders such as prosocial conflict avoiders who involve themselves with high levels of conflict avoidance and informal social support seeking; and assertive conflict avoiders who avoid confronting the instigator most of the time but at some point, do confront the instigator about their inappropriate behaviour. The strategy of conflict avoidance include behaviour such as trying to avoid or stay away from the instigator, just tolerating the uncivil behaviour, trying not to make the instigator angry, and trying not to hurt the instigator's feelings (Cortina & Magley, 2009:279). This coping strategy is the commonly used by targets of incivility as they believe it will neutralise the incivility and control their emotions (Cortina & Magley, 2009:280; Welbourne et al. 2016:732). This however, has the opposite effect because it does not allow the target to "let go" because they have not made any effort to resolve the situation and this may lead to perpetuation of the uncivil behaviour, low levels of "psychological forgiveness" and increased emotional exhaustion (Hershcovis et al. 2018:165)

Minimization

The strategy of minimization includes behaviour such as telling yourself it wasn't important, just trying to forget about it, ignoring the incivility, and assuming that the instigator meant no harm/meant well. Minimizers, as name says, minimize the severity of the incivility and therefore do not attempt to confront the instigator. As with conflict avoidance, this strategy is dominantly used by targets (Cortina & Magley, 2009:283). Although some studies regard emotion-focused strategies such as self-control and minimization to have negative results, these strategies improve the mental health of target nurses (Lim et al. 2010:29).

Detachment

This strategy involves targets pretending that the incivility does not exist and therefore do not even use any real coping strategy. They have several similar characteristics with minimizers in that they occasionally rely on conflict avoidance. This was the most commonly used strategy in the study by Cortina and Magley (2009:282). Although some studies regard emotion-focused strategies such as detachment to have negative results, these strategies improve the mental health of target nurses (Lim et al. 2010:29)

Support seeking

There are several categories of support seeking coping strategies, namely; informal social support seeking strategy, informal organizational support seeking, and formal organizational support seeking (Cortina & Magley, 2009:280; Welbourne et al. 2016:733).

Informal social support seeking strategies include behaviour such as talking with a friend/someone for advice/support, talking about it with someone you trust, and talk with family for understanding/support. This is the most commonly used support seeking coping strategy as most targets turned to informal social networks to cope such as friends, family and the church (Cortina & Magley, 2009:280; Welbourne et al. 2016:733; Lim et al. 2010:29). Social support has also been found to be more beneficial for targets than the emotion-focused coping strategies such as avoidance and detachment (Lim et al. 2010:29).

Informal organisational support seeking strategies include behaviour such as talking with a supervisor/someone in management, and report the situation informally (Cortina & Magley, 2009:279). This is the least used strategy, similar to formal organisational support seeking as it involves some form of reporting to management (Cortina & Magley, 2009:282)

The strategy of formal organisational support seeking include behaviour such as making a formal complaint. Studies have found that this is the least utilized strategy accounting to few only 1% to 6% of targets or witnesses filing a formal complaint about the incivility (Cortina & Magley, 2009:285)

Confrontation

The strategy of confrontation includes behaviour such as confronting the person, asking the person to leave you alone, and letting the person know you didn't like what they did (Cortina & Magley, 2009:285). This coping strategy, also called confrontive coping is described as "aggressive efforts to alter a situation that involve using some degree of hostility and risk-taking behavior" (Lambert & Lambert, 2008: 40). This is not the most common strategy used by targets and it is not effective in preventing the continuation of the incivility and might lead to increased incivility. However, targets have a higher likelihood of "letting go" of the mistreatment as well as forgive the instigator because they were able to express themselves and try to resolve the problem (Hershcovis et al. 2018:165).

2.3.9 WORKPLACE CULTURE

Workplace culture refer to norms and values of the organization (Vilas-Boas, 2019:105) and it is vital to the experience and, ultimately, the output of its workers. When new staff enter the

workforce, they are socialised into workplace culture, either explicitly or indirectly, learning how things are done and what is expected (Catling & Rossiter, 2020:465).

Workplace culture can encourage incivility. In other words, rude interactions would be exchanged between co-workers in the workplace in an increasingly negative and spiralling way (Vilas-Boas, 2019:105). Organisational culture further contributes to workplace incivility when management tolerates uncivil behaviour and are reluctant to deal with it (Hodgins, MacCurtain and Mannix-McNamara, 2014:66). The culture of silence was also found to perpetuate the incivility (Pattani, Ginsburg, Johnson, Moore, Jassemi & Straus, 2018:1572)

It is important that an organisation has a clear set of values (Edmonson, Bolick and Lee, 2017:42) that will determine the culture of that organisation and could positively influence the staff performance. In order for a nurse to fulfil her role as a professional, she\he needs an environment that is created by the organisation to enable professionalism, one such a factor is strong, supportive and visible leadership.

Most organisations have written values or rules of engagement that outline how employees should behaviour in a professional setting, in many circumstances these values are only highlighted during new employee orientation and not reviewed since (Edmonson et al. 2017:42), although Al-Ghabeesh and Qattom (2019:6) argue that most employees have no knowledge of a clear institutional policy concerning incivility in the workplace and ways to report it.

Culture drives the formal and informal ways that work is done, how communication is conveyed, methods to share power. In contrast some aspects of organisational culture can only be in the unspoken agreement between employees about “how things are done” (Page, et al. 2019:29).

2.3.10 MANAGEMENT OF INCIVILITY

Studies show that as little as 1% to 6% of who employees experienced incivility in the workplace report it to management. This therefore means these incidences can perpetuate for a long time creating a toxic work environment. (Cortina & Magley, 2009:285). Hospital management must therefore not wait for incivility to be reported but must deal with what Crawford, Chu, Judson, Cuenca, Jadalla, Tze-Polo et al. (2019:140) refer to as “the uncivil elephant in the room”. While some organisations try to deal with incivility in the workplace, research by Pearson and Porath (2005:12) shows that only a quarter of victims of incivility were satisfied with how their organisation managed the experienced incivility.

The literature review study by Crawford et al. (2019:154) recommend that efforts by management that seek to establish a civil, safe, and just workplace culture must contain three characteristics, namely; it should be understandable by all the nurses, must address all forms of incivility across all levels of the organisation; and make every nurse responsible and accountable for a prevailing civil workplace.

Several studies propose solutions to managing workplace incivility including the following:

- Leaders should lead by example and continuously ask for feedback on their leadership style (Porath & Pearson, 2012:8; Khadjehturian, 2012:639; King et al. 2021:289).
- Resonant leadership that is empowering and creates a healthy work environment, that has been found to mitigate emotional burnout caused by incivility (Laschinger, Cummings, Grau & Wong, 2014:13).
- Zero tolerance to uncivil behaviour where it is sanctioned immediately when observed by management (Porath & Pearson, 2012:14; Johnson & Indvik, 2001:712; Khadjehturian, 2012:639).
- Recruit civil people who are emotionally intelligent (Porath & Pearson, 2012:9)
- Conduct on-the-job training and guidance on civility at the workplace such as “charm” school for temperamental employees, classes to help different generations to work together using role-playing in class, real-time guidance on conflict management, assertiveness, communication skills training and coping strategies (Porath & Pearson, 2012:11; Johnson & Indvik, 2001:711; Craft et al. 2020:42)
- Discuss appropriate and acceptable behaviour during the induction and orientation process, provide a safe and caring environment when new nurses enter the workplace and post-orientation e-learning on workplace incivility (Porath & Pearson, 2012:11; Craft et al. 2020:42; ANA, 2015:9).
- Video recording of uncivil behaviour for reflection during coaching (Porath & Pearson, 2012:11).
- Establish reporting mechanisms that are confidential, such as a 24-hour “neutral, unbiased corporate compliance hotline” where nurses can report acts of incivility, with information on the potential outcomes of the process and turnaround times (Craft et al. 2020:43; Pattani et al. 2018:1573).
- Create norms of civility within a group through dialogue for buy-in, including clear definition of what incivility is and examples of it (Porath & Pearson, 2012:12; Pattani et al. 2018:1573)
- Good behaviour should be rewarded to encourage it (Porath & Pearson, 2012:13)

- Conduct post-departure interviews six or more months after employee to get much more honest feedback about the organisation (Porath & Pearson, 2012:16)
- Conduct pre-shift team meetings to determine what concerns nurses' have and patients' needs to create a collaborative, ideas-sharing strong team that will lead to high morale and effective communication (Khadjehturian, 2012:63;9; King, Rossetti, Smith, Smyth, Moscatel, Raison et al. 2021:290).
- Instigator nurses should be made aware of their uncivil behaviour and how it negatively impacts on the unit; while being advised on how to deal with stress (Khadjehturian, 2012:639).
- Standing in solidarity with the victim, physically and symbolically and ensure that nursing managers are made aware and the witnesses come forward (Khadjehturian, 2012:639).
- Refer targets of incivility for counselling through employee assistance program to help them deal with the emotional impact of the incivility (Cortina & Magley, 2009:285)

In contrast to some of the strategies proposed above, Hodgins et al. (2014:65) argue that incivility management strategies that focus on incivility educational programmes, creation of awareness on uncivil behaviour and coaching efforts on how to respond to uncivil behaviour, are not effective. They propose a more integrated approach at the various levels of the job, organisation and society.

Other initiatives that have been found to manage incivility in the workplace include job rotation. Employees learn and get exposure to new tasks which make them experienced. Learning helps the employee to be flexible and makes them more productive. It enhances their knowledge. Job rotation helps in reducing conflicts which are major cause of stress. Managers can better assess their staff members through rotation and make better decision for their promotions and bonuses (Urooj et al. 2019:2).

A novel program that has been found to have a positive impact at a civil behaviour among group is the Civility, Respect, & Engagement in the Workplace (CREW) intervention (Abolfazi Vagharseyyedin, 2015:1230; Hodgins et al. 2014:65). This program is based on encouraging mutual respect, valuing differences between employees, promoting cooperation and team work, and finally determining and modifying problematic behaviours in the work environment (Leiter, Day, Gilin-Oore, & Mackinnon, 2012:316). The CREW approach involves trained facilitators who have regular engagements with group on a weekly or biweekly basis over a period of six months. The purpose of the interactions is to develop group goals of how to work together in a civil way. (Laschinger, Leiter, Day, Gilin-Oore, & Mackinnon, 2012:317). The

study further found that nurses' reports of supervisor incivility in the intervention group significantly declined after the intervention, as well as increased levels of trust in management (Laschinger et al. 2021: 323). It is argued that the effectiveness of the CREW intervention is due to its organisation-wide approach and the use of recommended workplace health promotion good practices that are based on principles of participation, responsiveness, contextual embeddedness and empowerment (Hodgins et al. 2014:65).

The American Nurses Association (2015:10) considers the following as civility best practices:

- Use clear communication verbally, nonverbally, and in writing (including social media).
- Treat others with respect, dignity, collegiality, and kindness.
- Consider how personal words and actions affect others.
- Avoid gossip and spreading rumours.
- Rely on facts and not conjecture.
- Collaborate and share information where appropriate.
- Provide assistance when needed, and, if refused, accept refusal gracefully.
- Take personal responsibility or accountability for one's own actions.
- Recognize that abuse of power or authority is never acceptable.
- Speak directly to the person with whom one has an issue.
- Demonstrate openness to other points of view, perspectives, experiences, and ideas.
- Be polite and respectful, and apologize when indicated.
- Encourage, support, and mentor others including new nurses and experienced nurses.
- Listen to others with interest and respect."

2.4 SUMMARY

The above literature has shown that most nurses find the workplace to be obnoxious with deviant behaviour that constitutes workplace incivility. This uncivil behaviour, although ambiguous in intent, has been found to have significantly negative impact on the nurses, the organisation and patients. These are primarily expressed in the form of stress-related symptoms and burnout, but also by negative effects on emotions and lower well-being. The cost associated with incivility has also been found to come to the millions, associated with lawsuits, time lost on addressing the incivility, absenteeism, lost productivity, and turnover. The causes and sources of workplace incivility has been shown to be associated with organisational context and culture factors such as work pressures, leadership styles, generational differences, prejudices power dynamics; and individual factors such as mental and personality disorders.

Literature also showed that there is limited reporting by victims of workplace incivility because nurses prefer to use coping strategies such as conflict avoidance, informal social support seeking and that as this incivility progresses, it spirals out of control to the level of aggression and violence because of the continuing cycle of retaliation. It is therefore imperative that nurse managers and healthcare organizations recognize incivility as a norm and that it be addressed swiftly where it is evidently rearing its ugly head.

Strategies and best practices in addressing workplace incivility were highlighted in literature such as prevention, improved reporting and zero-tolerance to incivility. Other effective strategies include the Civility, Respect, & Engagement in the Workplace (CREW) intervention that was found to significantly decrease workplace incivility and increase levels of trust in management. As there is ongoing change within the nursing profession as social groups, generations, technology, and cultures change, education about nursing incivility needs to be taken seriously by management to deal with the uncivil elephant in the room on a constant basis.

CHAPTER 3 - RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter will focus on the manner in which the research problem was investigated by referring to the study design, population and methods of sampling, data collection (an unstructured interview tool), data collection procedures, data analysis plan. The objectives for the study were to: 1) explore nurse-to-nurse incivility in the designated academic hospital, and 2) make recommendations to promote a respectful workplace culture to address nurse-to-nurse incivility in a designated academic hospital

3.2 RESEARCH DESIGN

The research design is the chosen strategy for gathering evidence to answer the research question (Crawford, Burkholder & Cox, 2020: 324). This study was conducted utilizing a descriptive qualitative design to describe the phenomenon as it occurred in its natural setting (Crawford et al. 2020:83). A research design is an overall plan for addressing a research question, and includes specifications for enhancing the integrity of the study (Polit & Beck 2008:765). Qualitative research is investigative in nature and it depicts an in-depth, holistic fashion of collection and narration of data (Polit & Beck 2017:743). With qualitative research the researcher strives to understand the meaning the participants socially constructed by interacting with their world. Furthermore, the researcher is the primary instrument for data collection and analysis (Merriam & Grenier, 2019:3, 4). Sandelowski (2000:336) explains that the goal of qualitative description is not a thick description as used by ethnographers, theory development as is the case with grounded theory or as with phenomenologists who provide an interpretative meaning of an experience but rather a rich description of the phenomenon. Due to its descriptive nature the researcher will provide descriptions of “the context, the participants involved, and the activities of interest” and the findings will be “supported by quotations from participant interviews” (Merriam & Grenier, 2019:6).

The researcher used an in-depth and holistic approach through the collection of rich narrative material using a flexible research design according to Polit and Beck (2017:741). The study was concerned with understanding human behaviours from the participants’ perspective. The design was suitable for the study as it explored current nurse-to-nurse incivility in the female medical ward and assisted with developing a respectful workplace culture by addressing the incivility. The design helped the researcher discover the nature of the events.

3.3 RESEARCH METHODS

The researcher viewed the research method as the steps to be followed throughout the research process. Polit and Beck (2017:735) describe research methodology as methods of obtaining, organizing, or analysing data. Following is a description of the research setting, population, sampling method and sample size, data collection and organisation, and data analysis.

3.3.1 Research setting

The designated academic hospital is located in Gauteng province. The hospital has 1113 beds that are shared in 28 wards. It operates 24 hours, including day and night shifts. It employs ± 800 nurses including professional nurses, enrolled nurses and enrolled nursing assistants. It has most disciplines at its disposal, including internal medicine (medical), surgical, orthopaedics, obstetrics and gynaecology, theatres, and emergency and trauma departments.

This study was conducted in the female medical ward in the designated academic hospital in Gauteng province. The ward has 40 beds, including two side wards. Female patients are admitted with medical conditions such as respiratory tract infections, cardiac conditions and Human Immuno-Deficiency Virus (HIV) related complications, and who are also admitted for palliative care. The bed occupancy in the ward is consistently 100%. The designated hospital is chosen for the study because the researcher is currently working at the hospital and she has observed and experienced nurse-to-nurse incivility as part of the workplace culture.

3.3.2 Population

The population encompassed different categories of nurses, namely registered, enrolled, and assistant nurses who worked in the female ward at the designated hospital. At the time of the study, 22 nurses inclusive of one operational manager, seven registered nurses, seven enrolled nurses, and seven assistant nurses were permanently employed.

3.3.3 Sampling method and sample size

Sampling is a process of selecting a small portion of participants from the accessible population (Crewell & Poth 2018:157). According to Holloway (2016:142), the qualitative researcher should gain access to “those who know about the phenomenon under study and who can talk about it, and/or contexts where the phenomenon is likely to be visible.”

Purposive and snowball sampling were used in selecting participants. With purposive sampling the researcher used her judgement (Holloway 2016:144) to select nurses who have been exposed and/or witnessed acts of incivility. The researcher was then assisted by these

participants to identify further participants they know who have been exposed and/or witnessed acts of incivility by means of snowball sampling. The reason the researcher included snowball sampling was because of the sensitive nature of the phenomenon under study and it is not so easy to identify participants (Holloway 2016:147). The sample size was determined when data saturation was reached, giving a total of eight participants, which consisted of four registered nurses, two enrolled nurses and two enrolled nursing assistants.

The inclusion criteria were: All categories of nurses who had worked a minimum of six months in the female medical ward, who were also permanently employed.

Exclusion criteria were nurses who had less than six months in the female medical ward, student nurses, and other healthcare professionals.

3.3.4 Data collection and organisation

The researcher conducted unstructured individual interviews to collect data from the participants about the current status of incivility in the female medical ward. The researcher chose individual interviews to obtain the feelings, perceptions and thoughts of the participants (Holloway, 2016:86). Data was collected once the study was approved by the Research Ethics Committee of the Faculty of Health Sciences, University of Pretoria and permission has been granted by the relevant hospital management.

Unstructured interviews were conducted at a date and time that was convenient to the participants. The researcher ensured that service delivery was not interrupted, the interviews were conducted based on the availability of the participants, which was during the participants' lunch time, off duty day, or after hours. Reminders were sent to participants 48 hours prior to the interview by means of a WhatsApp message.

An unstructured interview guide was used during the individual interview (Annexure A). The interviews were audio-recorded with the permission of the participants to ensure that what was said in the interviews was the actual responses of the study participants. With permission from the hospital management and ward operational manager, participants who met the inclusion criteria were provided with participant information leaflets (Annexure B) about the study. Contact details of nurses who were interested in the study were given by the operational manager of the ward. Those referred by other participants were given the researcher's contact details and if they were interested to participate, they then contacted the researcher to obtain more information. The researcher made appointments and provided information about the interview according to the availability of the participants.

On the day of the scheduled interview, arrangements were made with the nurse being interviewed, and the following steps where be adhered to: 1) an introduction of the study was given to the participants, 2) consent with explicit permission to audio-record the interview was obtained, 3) the interview was conducted, 4) the participants were thanked for their participation, and 5) a counsellor at the Employee Wellness Clinic was on standby should any of participants experience emotional discomfort. Interviews lasted between 25 and 30 minutes.

In addition, the researcher took written field notes during the interview that provided a written account of the things she heard, saw, experienced, and thought in the course of the interview. It included observational notes, personal notes and methodological notes. Field notes were necessary, since few people can remember all that went on without effective record keeping and, furthermore, if these notes are properly prepared it provides a framework and order to research (Polit & Beck, 2017:20).

The researcher found it difficult to obtain rich information from the participants. It could have been due to her being known to the participants and they found it daunting to open up to her. It was then decided in conjunction with her supervisors to seek assistance from a researcher who has extensive experience with interviewing participants. This researcher managed to make the participants feel safe and willing to share their experiences of uncivil behaviour they either witnessed or were exposed to themselves.

Covid-19 rules were adhered to during the interviews, body temperature monitoring was done for both the researcher and the participant, hand washing and sanitising were done before the interview, both the researcher and the participant wore masks during the interview and there was social distancing between the researcher and the participant.

3.3.5 Data analysis

The recorded data was transcribed verbatim and checked for correctness. Content analysis as described by Bengtsson (2016:12) was used to analyse the data. The four main stages of content analysis include: decontextualisation, recontextualisation, categorisation and compilation. Each stage was performed several times to maintain the quality and process assuring validity and reliability of the analysis (Bengtsson, 2016:12).

Decontextualisation

The researcher familiarised herself with the transcripts to obtain a sense of the whole data. Data was handed to the independent qualified qualitative researcher (co-coder) for co-coding. Data collected was broken into smaller meaning units. Each identified meaning unit was labelled with a code, which was related to the context. The codes facilitated concepts around

which data can be assembled into patterns. A coding list was used, which included explanations of the codes, to minimize a cognitive change during the process of analysis (Bengtsson, 2016:12).

Recontextualisation

The researcher checked if all aspects of the content have been covered in the meaning units in relation to the aim. The text was read along the meaning units. Coloured pencils were used to distinguish each meaning unit to the original transcript. After this process was done, any unmarked text that provided answers to the research question will be added to the analysis (Bengtsson, 2016:12).

Categorisation

The smallest units were grouped into sub-categories. The identified categories should be internally homogeneous and externally heterogeneous, which meant no data should fall between two groups. Categorisation was concluded when a reasonable explanation had been reached (Bengtsson, 2016:12).

Compilation

Once the categories were established, analysis and the writing process began according to what Bengtsson proposed (2016). Data collected was considered from a neutral perspective. The depth of the analysis depended on the data collected. In this case, the researcher used manifest analysis, working through identified categories. The researcher used participants' words, to stay closer to the original meaning and context. The researcher then summarised the subcategories in a table form. Themes and categories were identified during this process, see Figure 4.1 in chapter 4.

3.4 TRUSTWORTHINESS

Trustworthiness refers to the methodological soundness and adequacy of the research (Holloway, 2016:309). The researcher followed Lincoln and Guba's framework (in Polit and Beck, 2017:559) that includes the five criteria of credibility, dependability, confirmability, transferability and authenticity.

3.4.1 Credibility

The researcher ensured credibility by using reflexive notes and self-reflection to avoid subjectivity or personal bias (Polit and Beck, 2017:559). The researcher ensured the confidence in the truth of the data collected and that the data is interpreted correctly (Polit and Beck ,2017:559) by doing member checks (Holloway, 2016:311) during the interviews. She

paraphrased the participants' words and asked whether she understood them correctly to ensure true reflection.

3.4.2 Dependability

The researcher worked with her supervisors to ensure dependability; that is the findings are consistent and accurate (Holloway, 2016:309). Detailed descriptions on the research process/methods, were provided to ensure readers are able to follow the research process and she how she achieved her conclusions. Data was transcribed and analysed by the researcher, and a qualified qualitative researcher was requested to verify the coded data as part of adherence to trustworthiness. This researcher was requested as she has extensive experience in analysing data. She is a nurse educator who holds a PhD degree in nursing.

3.4.3 Confirmability

Confirmability is maintained if there is objectivity or congruency between two or more independent people's data in relation to accuracy, relevancy or meaning (Polit & Beck, 2017:747) The researcher strived to be as neutral as possible and not use her experience to be biased. Direct quotes obtained from participants reflected what participants had said during the individual interview and noted in the field notes.

The researcher tape-recorded the interviews with the permission of the participants. Data was thereafter transcribed, analysed and coded and was handed to the independent qualified qualitative researcher (co-coder) for co-coding. After the co-coding, the researcher and co-coder had a discussion to reach consensus on the identified themes and categories.

3.4.4 Transferability

Transferability is feasible if the findings of the research data obtained, can be transferred to other settings or groups, or be applicable in other groups (Polit & Beck 2017:560). A detailed, in-depth description of the research processes such as sampling, data collection and data analysis, was provided to allow other readers to evaluate its applicability in other similar contexts. The researcher reviewed literature to compare the findings with similar studies and findings as described in the literature.

3.4.5 Authenticity

A researcher's data is authentic if it fairly and faithfully shows a range of different realities (Polit & Beck 2017:559). The researcher ensured that multiple realities of the research participants are represented by presenting the true feelings of experiences voiced by those who participated in the study. The researcher used verbatim quotes and indicated which

participant's quote was used (See Chapter 4). Authenticity emerges in a report when it conveys the feeling or tone of participants' lives as they are lived.

3.5 ETHICAL CONSIDERATIONS

Ethical considerations were adhered to whilst conducting the study. Ethics includes what is right and good during the research. The Belmont Report (Polit & Beck 2017:139) articulates the three primary ethical principles as beneficence, respect for human dignity and justice.

3.5.1 Beneficence

The principle of beneficence is one of the most fundamental ethical principles in research. Any researcher has to minimise harm and maximise benefits (Polit & Beck, 2017:139). The researcher considered that participants may experience emotional trauma during the interviews; hence, a counsellor at the Employee Wellness Clinic in the designated hospital was on standby. Participants had the opportunity to verbalize and express their experiences. The researcher ensured the right to freedom from harm and discomfort for the participants by preparing a venue that was free from noise and any discomfort, by briefing the participants on what was expected of them during interviews, informing them of their voluntary participation and also of termination of the interview if they felt uncomfortable at any time, getting permission to use a tape-recorder, and not asking any questions that were personal in nature. The participant's right to protection from exploitation was ensured by making participants aware during the pre-interview phase that the information provided was not going to be used against them in any way. No coercion was used in any manner with participants as they consented voluntarily to participate in the research.

3.5.2 Respect

Respect for human dignity refers to the right to self-determination and full disclosure (Polit & Beck 2017:140). The researcher described the purpose of the study and provided her contact details to the participants. Respect for human dignity was adhered by obtaining informed consent from research participants based on the explained research processes, procedures, possible risks and benefits of the study (See Annexure B). Participants were ensured that they can withdraw from the study at any time without negative consequences. Data collected from the participants will be treated confidentially. Data will be stored safely in the Department of Nursing Science, University of Pretoria for 15 years.

3.5.3 Justice

Polit and Beck (2017:141) define justice as “participants’ right to fair treatment and their right to privacy”. Justice is fairness and equal distribution of benefits, harms and connotes fairness and equity of the research. The researcher ensured that all participants are treated fairly, equally and were not discriminated against on the grounds of race and or gender. The researcher ensured that she was not judgmental or biased in any way.

The right to privacy was adhered to as participants were informed that the information that they were going to give will be kept in the strictest confidential manner possible. No participant names are indicated in the research study or will be in any ensuing publications.

3.6 SUMMARY

The aspects that were addressed in this chapter included the research design, research method (individual interview), population, sampling technique, data collection, and analysis. Measures to ensure trustworthiness and ethical considerations which were adhered to in this research were also addressed. Chapter four will focus on presenting and discussing the findings.

CHAPTER 4 - DATA ANALYSIS AND FINDINGS

4.1 INTRODUCTION

This chapter presents the results from the collected data and provides the analysis and discussion of the data. The demographic information of participants together with the themes identified during the data analysis are presented. Direct quotes from participants are also presented in the discussion to provide substance and context of the presented findings.

4.2 PARTICIPANT DEMOGRAPHIC INFORMATION

In order to ensure confidentiality, the participants' real names were not used but represented with numbers according to the interview sequence. The biographical information of participants is presented in terms of category of nurses and years of experience.

Eight nurses participated in the study, with years of experience ranging from 3 to 12 years. Four of the participants are registered nurses, two are enrolled nurses, and the remaining two are enrolled nurse assistants. Table 4.1 below provides a summary of the participants demographic information.

PARTICIPANTS	CATEGORY OF NURSE	YEARS OF EXPERIENCE
Participant 1 - P1	Registered Nurse	7 years
Participant 2 - P2	Enrolled nurse	9 years
Participant 3 - P3	Enrolled Nurse assistant	3 years
Participant 4 - P4	Registered Nurse	6 years
Participant 5 - P5	Registered Nurse	10 years
Participant 6 - P6	Enrolled Nurse	12 years
Participant 7 - P7	Enrolled Nurse assistant	5 years
Participant 8 - P8	Registered Nurse	8 years

Table 4.1: Demographic information of participants

4.3 DATA ANALYSIS

The interviews with the eight participants were recorded and transcribed verbatim, and checked for correctness. The transcribed data was analysed using content analysis as described by Bengtsson (2016) and the following steps were undertaken: i) decontextualization – the researcher familiarised herself with the transcripts to obtain a sense of the whole data and codes were developed from meaning units; ii) recontextualization – the researcher checked if all aspects of the content was covered in the meaning units in relation

to the aim of the study; iii) categorisation – the researcher then grouped meaning units into categories and iv) compilation – once the categories were established, the analysis and the writing process began by working through identified categories, using participants' words to stay closer to the original meaning and context.

The outcome of the data analysis yielded five themes and nineteen categories associated with the identified themes as outlined in Figure 4.1.

4.4 FINDINGS AND DISCUSSION

This study sought to explore current nurse-to-nurse incivility in a designated academic hospital and to recommend how a respectful workplace culture can be developed to address nurse-to-nurse incivility. This section provides an interpretation of the findings based on the themes and categories identified during the data analysis together with verbatim statements. The participants' real names were not used but are represented with numbers according to the interview sequence. The themes and categories are listed and discussed below.

4.4.1 Theme 1: Conceptualisation of nurse-to-nurse incivility

The first theme identified from the study is how participants conceptualised nurse-to-nurse incivility. The following categories were identified from participants describing their understanding of the concept of nurse-to-nurse incivility; 1) unfair and unequal treatment; 2) disrespect, intolerance and gossiping; 3) humiliating, demeaning and degrading behaviour; and 4) threats, victimisation, retaliation and exploitation. These categories are discussed in detail below, including quotations from participants.

Category 1.1: Unfair and unequal treatment

The unfair and unequal treatment described by nurses involved favouritism on approval of time-off; different standards on what nurses' wear; inconsistent attendance to requests; unwillingness to help when needed and unfair allocation of workload. The following verbatim sentiments by participants reflect examples of their understanding of nurse-to-nurse incivility.

"Okay a simple example is the unit manager she has a favourite nurse or a nurses she gets along with better and a another nurse that she doesn't get along with for whatever reason whether it's that natural dislike of a person mmmh [interjection], nurses would request day off of duty for such and such a reason and when the drafting the off duties is done and the unit manager would overlook some requests because it's not someone she really appreciates even though she would not say it in many words, you can see the treatment of nurses is not the same you know…" ***Participant 8***

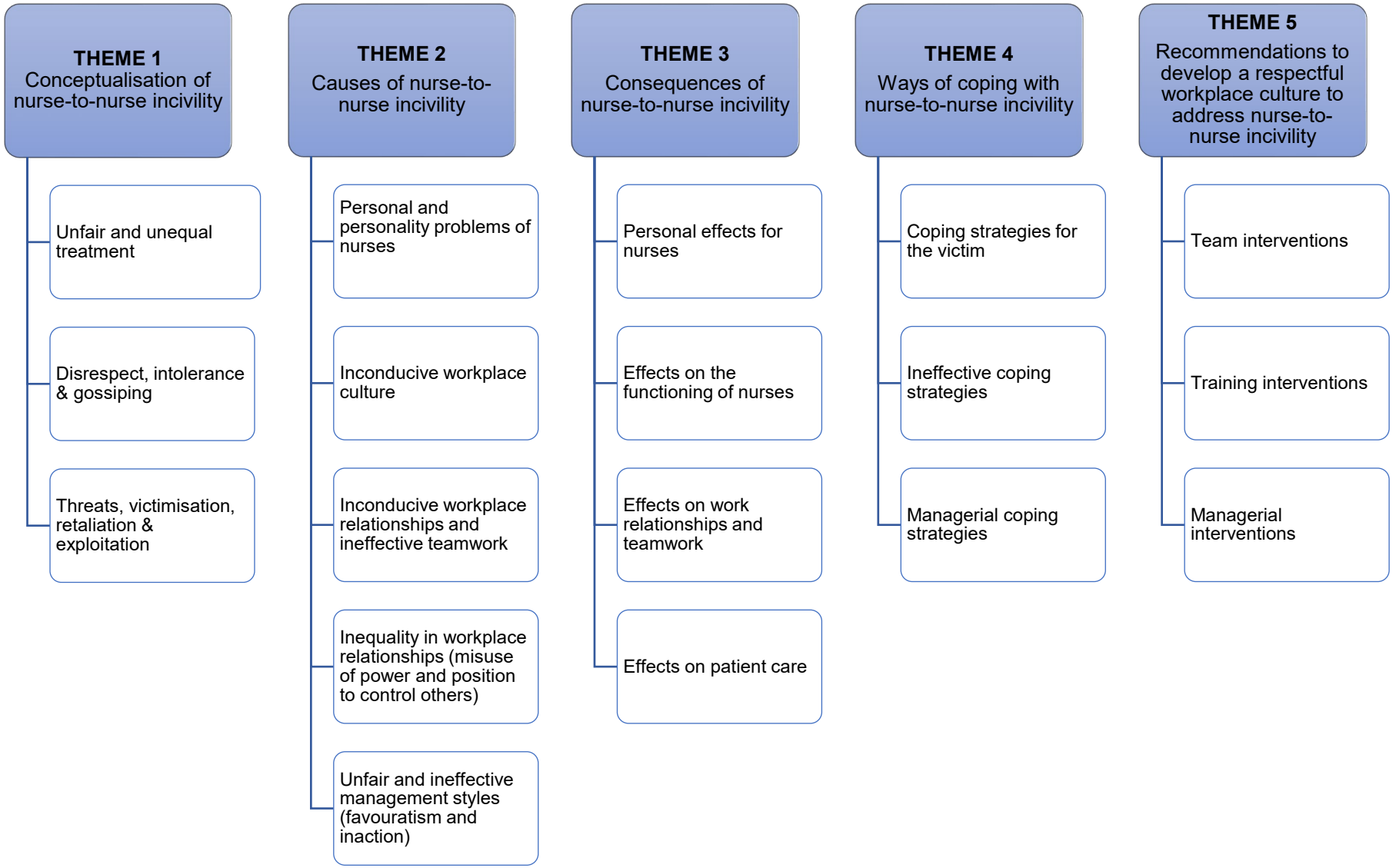

Figure 4.1 Themes and categories

"If somebody doesn't do their responsibility and I have to step in and do what the next person must do, I am threatened with disciplinary action. That's very unfair." ***Participant 7***

Category 1.2: Disrespect, intolerance and gossiping

Nurses in this study also believe that nurse-to-nurse incivility has to do with disrespect, intolerance and gossiping. Examples of disrespectful and intolerant behaviour expressed by the nurses include silent treatment, eye rolling, talking behind someone's back and being ignored, undermining one's work, being treated like an outcast, and gossiping about each other, as highlighted in the following quotes:

"Uncivil behaviour in the ward includes those colleagues that are rude, it includes disrespect, silent treatment, eye rolling, talking behind someone's back, being ignored. Undermining one's work, being treated like an outcast, yah I think that's it." ***Participant 1***

"My colleagues were gossiping about me all the time amongst themselves, not only that but with patients as well and only to find out that the things they were saying are not true, they are misinterpreted into something that is not true." ***Participant 2***

"You know, when working as a woman, when a woman in the same place there's a lot of jealousy, let me put it like that. What I've experienced people, especially people who love to live in groups. Yeah [interjection], they live in groups and they talk bad about each other." ***Participant 6***

Category 1.3: Humiliating, demeaning and degrading behaviour

The study found that some of the uncivil behaviour involved humiliating, demeaning and degrading behaviour. Examples provided by the participants included nurses saying demeaning things about hairstyles, style of uniform and body shaming. The use of positions to humiliate and demean lower staff was also found to be prevalent. These are reflected in the quoted expressions by the participants below:

"Uncivil behaviour is things like saying nasty comments about hairstyles and type of uniform worn by staff members." ***Participant 4***

"Some nurses will say why are you eating a packet of chips when you know you are so fat. Why are having these greasy chips and Vienna's or the take away foods while you so fat you, know." ***Participant 8.***

"So, don't talk to me the way you're talking to me. I'm your senior. You're a junior, just a mere staff nurse. It's just a humiliation." ***Participant 5***

Category 1.4: Threats, victimisation, retaliation and exploitation

The participants in the study also described uncivil behaviour as threats, victimisation, retaliation and exploitation. Examples given of such behaviour include fighting between senior and junior nurses, bullying, unfair threats of discipline for others' non-performance

"They were fighting because the sister told the staff nurse to do something and she didn't do it. Then this staff nurse just said, 'I will wait for you at the gate'." ***Participant 5***

"That is bullying because that is somebody's scope of work that you must do. If you didn't do, she doesn't reprimand the relevant person, she uses you as assistants to do somebody's work and even threaten you to answer to the review board. ***Participant 7***

The descriptions of uncivil behaviour by participants in this study support the description found in literature of rudeness, lack of courtesy and disregard for others (Andersson & Pearson, 1999:457); rude, discourteous, or disrespectful actions (The American Nurses Association, 2022); publicly criticizing a of co-worker, gossiping, or backstabbing, yelling or shouting, eye rolling (Clark, 2017:Kisner, 2018:26); and belittling people who think differently from you (Miner, Settles, Pratt-Hyatt & Brady, 2012 :345). The fact that in one description a senior and junior nurse were involved in a physical fight supports Andersson and Pearson (1999:456) concepts of "incivility spirals" and "tit for tat", confirmed by Bar-David (2018:2) where uncivil behaviour escalates from subtle incivility to more aggressive and violent behaviour as a result of retaliation.

4.4.2 Theme 2: Causes of nurse-to-nurse incivility

The second theme identified in the study relates to causes of nurse-to-nurse incivility which yielded the following categories of causes: 1) Personal and personality problems of nurses; 2) inconducive workplace culture; 3) inconducive workplace relationships and ineffective teamwork; 4) inequality in workplace relationships; and 5) unfair and ineffective management styles. These categories are discussed in detail below, including quotations from participants.

Category 2.1: Personal and personality problems of nurses

This study found that one category included in the theme on causes of nurse-to-nurse incivility, is personal and personality problems faced by nurses. Participants gave examples of these personal and personality problems such as job dissatisfaction, anger and stress from home, people who are naturally horrible to people, being new and afraid to speak up, incompetence masked with uncivil behaviour, poor communication skills, and jealousy over rank/qualifications.

"It also stems from people just being mean you know, people are just horrible, sometimes there isn't really an explanation." ***Participant 2***

"I think incivility is caused by not being happy in the workplace, incompetency which is hidden by rudeness." ***Participant 1***

"Mmmh [interjection], I think incivility comes from personal problems, people come to work carrying their own problems from home. Poor communication skills. Feelings of jealousy related to difference in job categories." ***Participant 4***

These findings support the findings by Estes and Wang (2008:7) and Jelavić., Aleksić and Braje, (2021:14) that identified mental and personality disorders as some of the causes of workplace incivility. The study by Urooj et al. (2019:6) which found family pressures and obligations to cause nurse-to-nurse incivility is further supported by the findings of this study. The finding of job dissatisfaction as a cause for nurse-to-nurse incivility in this study further supports literature in this regard that found lack of support from management and peers and little job autonomy (Craft, Schivinski & Wright, 2020:42; Al-Ghabeesh & Qattom, 2019:7). A further finding of poor communication from this study is also mentioned by Johnson and Indvik (2001:710) and Keller, Yule, Zagarese and Parker (2020:3) who found that poor communication contributes to incivility and advise that communication is vital for harmony in the workplace.

The reviewed literature does not support the finding of jealousy over rank/qualifications and incompetence that is masked as incivility, as the causes of nurse-to-nurse incivility. These are therefore new findings that will contribute to the new body of knowledge in this area of research.

Category 2.2: Inconducive workplace culture

The second category has been found to be an inconducive workplace culture that results in nurses feeling exhausted. Examples of inconducive workplace culture raised by the participants include not being acknowledged/rewarded for good work, being suppressed by seniors, work overload due to shortage of staff, resistance to change, lack of platforms to discuss problems. These are expressed by participants in the following quoted statements:

"I definitely think it's also caused by lack of rewards in nursing, because you know there won't be any rewards, you end up not working. It becomes a scare where other people do more and others do less and that actually causes incivility." ***Participant 2***

"They are many, for example resistance to change, some nurses are used to doing wrong things and when you tell them it's wrong, they bully you." ***Participant 4***

"Yes, that's true, because if you don't let people talk then they will just bottle it in. The day they will explode you think that they don't respect you but you didn't give them chance to express themselves." ***Participant 5***

The findings of this study support literature that also found that work pressures resulting from shortage of nursing staff caused nurse-to-nurse incivility (Al-Ghabeesh & Qattom, 2019:6; Holm, 2021:23; Johnson & Indvik, 2001:710; Mothibi, Rankoana & Nel, 2015:153). The use of power by senior nurses in this study further supports other studies that found power dynamics and use of rank, referred to as rankism by Lim and Bernstein (2014:127), to be contributing to nurse-to-nurse incivility (Cortina et al. 2001:75; Estes & Wang, 2008:13; Pearson & Porath, 2005:11). Other findings from studies that are supported by the causes of nurse-to-nurse incivility findings from this study involve not being acknowledged for good performance (Holm, Torkelson & Bäckström, 2016:76)

The reviewed literature does not support the findings regarding lack of platforms to discuss problems and resistance to change. These are therefore new findings that will contribute to the new body of knowledge in this area of research.

Category 2.3 Inconducive workplace relationships and ineffective teamwork

Inconducive workplace relationships and ineffective teamwork have been identified as the third category. The participants gave examples such as working in cliques, dysfunctional work environment, and being selective on who they want to work with. Participants expressed their sentiments in the following verbatim statements:

"I think a dysfunctional environment, where there's no order. You know there are staff members who are satisfied when they see others not getting along in the ward. Mmmh [interjection], how can I put it, they always think that they are right even if they are wrong." ***Participant 3***

"Yeah [interjection], and some people they are not talking to each other. They don't want to pair with the other nurses. And no team work, team work is not happening." ***Participant 6***

"People become brave and bold when they are in groups, it becomes like it is a group norm, some nurses gang on others, the groups became the in thing '' ***Participant 7***

The findings of this study support study findings on causes of nurse-to-nurse incivility such as lack of collaborative effort that decreases teamwork and organisational chaos (Abid, Khan, Rafiq & Ahmed, 2015:6308).

Category 2.4: Inequality in workplace relationships

The fourth category is inequality in workplace relationships. These include misuse of power and position to control others, abusive and demeaning behaviour by seniors towards their juniors and fear of victimization by seniors if they speak up.

"What I saw in nursing, especially when you are a junior nurse, assistant nurse some seniors they take advantage on junior nurses. Yes, you find sometimes they speak with junior nurses the way they want. They use words that can hurt." ***Participant 6***

"There are registered nurses who use their education, when you do the bed making and so on, they say they don't do the bed making, they are RN's [registered nurses], they don't change patients because they are RN's, they don't escort patients because they are RN's. Nursing needs working together, it doesn't mean because you are an RN you're not supposed to change the patient or escort the patient." ***Participant 7***

"Even though you see that the junior nurse does not really want to do it , she goes ahead , they are threatened by the fear of not getting the performance bonus, the PMDS [Performance Management Development System], the fear of, some of the contract nurses are afraid that maybe should they get the opportunity to be absorbed they would not be recommended because they refuse to go to the shop for the sister, they refused to do odd things, someone would just say get me a glass of water or make me a cup of tea which that's not why we are here for, if you want tea, make you own cup of tea, you know what I mean." ***Participant 8***

The use of power by senior nurses in this study further supports other studies that found the misuse of power/rank, referred to as rankism by Lim and Bernstein (2014:127), to be contributing to nurse-to-nurse incivility (Cortina et al. 2001:75; Estes & Wang, 2008:13; Pearson & Porath, 2005:11). According to a study done by Wikins (2014:284) instigators of incivility are more likely to be in higher positions of power, backed by a study done by Potal and Sonmez (2018:1) in which nurses indicated that they were to treated unfairly by their managers.

Category 2.5: Unfair and ineffective management styles

The fifth category has been found to be unfair and ineffective management styles. Participants gave examples of these issues such as favouritism, inaction, and lack of rotation of areas of work. Their sentiments are reflected in the following quotes.

"Okay, I will talk about managers, I'll talk about favouritism, we can see sometimes it's happening, sometimes it does happen. Because maybe the manager knows the other nurse more than the others or I don't know how to put it, but there is a favouritism, especially when

it comes to off duties. One will be given the off that she requested each and every month, she will just request and she will get that request. And then the others will not get a request each and every month or when they just apply for request." ***Participant 5***

"You know most of the time, in the hospital, if the nurses do not rotate to other wards. Because when a person works five years in the ward, they think they know better than other people. They start to bully. You already having the friendship with the boss, the manager. He knows the work. He knows the whole ward." ***Participant 6***

If a manager favours others, not giving equal tasks, not taking others nurses' problems serious, resulting in dissatisfaction." ***Participant 3***

"*And then our operational manager had to intervene by then she didn't know what to do."* ***Participant 1***

The findings from this study affirms other studies that found management style challenges such as favouritism (Kisner, 2018:28) and abusive supervision (Flink-Samnick, 2016:262; Logan, 2016:50) to be the cause of nurse-to-nurse incivility. According to Ahmad and Iqbal (2020:31) favouritism results in incivility as managers engage in favouritism due to colleague requests which results in lack of motivation and dissatisfaction among others.

4.4.3 Theme 3: Consequences of nurse-to-nurse incivility

The third theme identified in the study relates to the consequences of nurse-to-nurse incivility which yielded the following categories of consequences: 1) personal effects for nurses; 2) effects on the functioning of nurses; 3) effects on work relationships and teamwork; 4) effects on patient care. These categories are discussed in detail below, including verbatim statements from participants:

Category 3.1: Personal effects on nurses

The first category is the personal effects on nurses. Participants highlighted that these personal effects include low self-esteem, impact on family, performance anxiety, aggression, mental health issues such as depression, paranoia and suicidal thoughts.

"I started having lack of confidence in myself, I started doubting myself and my abilities which lead to self-blame. It started affecting me at home, my family saw that I was not happy, even during my rest days I thought about the work situation." ***Participant 1***

"When you are miserable at work and you find that you are miserable at home for whatever social problems you have at home and you get here at work and these this person that is making your life more miserable and you wonder, where do I turn to, don't you think that maybe

it will lead to suicide one day, when you are hopeless at home and you come to work, it's another hopeless case, then you feel, what am I living for? you know those are the small things that we over look, over time they build up and build up, then we are going to have suicide cases, you know." ***Participant 8***

"I had performance anxiety where I hoped that I don't do anything wrong. Whenever people laughed, I thought they were laughing about me and you find out that people were laughing at their own things. I couldn't sleep, I was thinking about the incivility all the time. When a person becomes mean to me, I also end up becoming mean, but after a while you become angrier." ***Participant 2***

"…and sometimes you know in the long run you find that nurses develop depression over work issues that you know it's so surprising that one shouldn't reach a level of depression while working you know, but I have seen once happened that a nurse over time just because depressed and depressed." ***Participant 8***

These findings support those found in the literature such as the effect of incivility on family found by Lim, Ilies, Koopman, Christoforou and Arvey (2016:2901) which found that there is a significant positive relationship between daily hostility at work and withdrawn and angry marital behaviours at home. Similar findings were made in the study by Holm (2021:31) where workplace incivility had a negative impact on the target's marital satisfaction. The proposed model by Lim, Cortina and Magley (2008:97) and the study by Holm (2021:31) that identify the effects of workplace incivility to include mental health issues such as depression, is supported by findings from this study.

The reviewed literature does not support the findings regarding suicidal thoughts as a result of workplace incivility. This new finding will contribute to the new body of knowledge in this area of research.

Category 3.2: Effects on the functioning of nurses

The second category identified in this theme is the effects on the functioning of nurses. These were found to include turnover intentions, low productivity, burnout, low morale, absenteeism, not going the extra-mile in performance.

"You just come to work to do what you need to do and she would not go the extra mile anymore because she would feel so degraded that it's not worth trying to do better at work you know. They feel you I'm here to work and that's it I'm going to do what I'm called here for, I'm not going to bother myself doing any better than what I'm doing in the moment." ***Participant 8***

(The nurse would only work their delegated duties and not go an extra mile)

"I almost resigned from work, I felt I didn't get support especially from my seniors. It became hard to work as people didn't want to work with me anymore." ***Participant 2***

"The morale is so low. And then you will just experience burnout. Because sometimes we just come to work because you have to come to work, but you're not happy. Any if you're not happy, I'm not saying we are here to get happy. You are here to work. But if you are not treated equally to others, then you won't be happy. And then the productivity is going to be low." ***Participant 5***

"It also frustrates the nurses to know that today I'm going to work and then so and so are not in good terms, one of them will not come to work. So, you also feel frustrated that today, how is my day going to be." ***Participant 7***

The findings from this study relating to performance challenges and intentions to quit, support findings from studies in the literature reviewed where workplace incivility affected the job performance of employees, decreased their creativity and fostered their intentions to leave the job (Ma, Meng, Shi, Xie., Wang, Dong et al. 2018:7; Porath & Pearson, 2012:5). The turnover intentions consequence further supports the other element of the proposed model by Lim, Cortina and Magley (2008:97).

The findings in this study relating to absenteeism support several studies that found increases in absenteeism and use of sick leave to avoid the instigator's uncivil behaviour (Al-Ghabeesh & Qattom, 2019:2; Craft et al. 2020:40; Holm, 2021:32; Porath & Pearson, 2012:3). Burnout and its negative effect of anxiety, depression and heart diseases has also been found to be a consequence of workplace incivility by Shi, Guo, Zhang, Xie, Wang, Sun et al. (2018:2), as supported by this study.

Category 3.3: Effects on work relationships and teamwork

The third category is the effects on work relationships and teamwork. Participants provided examples such as creation of cliques, hatred and resentment, no flow of information due to tensions in the team and work overload due to absenteeism.

"People are not going to work as a team, then now it's going to affect the work place and then we're going to have more complaints from our clients." ***Participant 5***

"Incivility leads to nurses hating each other in the workplace, gossiping and lack of information flow due to the tension between nurses." ***Participant 4***

"It affects the whole staff because when one is working with the person that they're not in good terms they will absent them self and then not only the patient will be suffering, even the staff who are working with those two staff members who are not in good terms." ***Participant 7***

The above findings on the effect of workplace incivility on teamwork and information flow supports the study by Bar-David (2018:2) that found incivility to reduce the amount of information sharing and help seeking behaviour by team members leading to poor team performance. Incivility interferes with teamwork, collaboration and communication (Admas & Maykut, 2015: 770)

Category 3.4: Effects on patient care

The fourth category identified in this theme is the effects on patient care. These have been found to include needs of patients not being met due to tensions, poor treatment of patients, and mistakes in giving medications to patients due to lack of communication.

"Small fights among colleagues, no peace in the ward, patients will suffer." ***Participant 3***

"And you are not going to treat patients very well. You're not going to give proper nursing care because you're angry. I'm not saying it's good, but it's the effect of burn out." ***Participant 5***

"…in the end the work becomes less effective on the patients because you have things that are done and others undone, you find that some patients didn't receive their medication on time because one nurse is not talking to the other nurse and the lack of communication, the other one was not able to know that she only gave up to number five and she was not able to give up to number 10 so in that you will find that certain things not done." ***Participant 8***

The findings in this study relating to the effect of workplace incivility on patient care supports several studies that found that incivility hampers professional nursing practice and decreases the quality of patient care (Alshehry, Alquwez, Almazan, Namis & Cruz, 2019:4583) and nurses make mistake critical errors that can cost a patient's life or prolong their recovery time (Al-Ghabeesh & Qattom, 2019:7; Porath & Pearson, 2012:2).

4.4.4 Theme 4: Ways of coping with nurse-to-nurse incivility

The fourth theme identified in the study relates to ways of coping with nurse-to-nurse incivility in a designated academic hospital, which yielded the following categories of coping strategies: 1) Coping strategies for the victim; 2) Ineffective coping strategies; and 3) Managerial coping strategies. These categories are discussed in detail below, with quotations from participants

Category 4.1: Coping strategies for the victim

The participants indicated that some of the coping strategies for victims include self-assertiveness such as confronting the instigator and escalating it to a higher level beyond the supervisor and professional support such as counselling. Self-assertiveness is however not used by most of the participants nurses.

"If it's me who is been disrespected, I call the person and talk to him or her, let them know that I do not like what they are doing." ***Participant 3***

"Providing individual support e.g. counselling as nurses we go through a lot and we have stress." ***Participant 1***

"But you do find those brave assistant nurses that feel like enough is enough and I want to stand up for what is right and they would if the unit manager doesn't help go straight to the matron [nursing service manager] to get help." ***Participant 8***

The study found that limited use of self-assertiveness strategy supports studies by Hershcovis, Cameron, Gervais and Bozeman (2018:165) and Cortina and Magley (2009:285) as it is considered as risk-taking behaviour (Lambert & Lambert, 2008: 40). The benefit of this coping strategy is that targets have a higher likelihood of "letting go" of the mistreatment as well as forgive the instigator because they were able to express themselves and try to resolve the problem (Hershcovis et al. 2018:165).

The escalation to higher authorities in this study was done by few participants. This supports literature that shows that this informal organisational support seeking is the least used strategy (Cortina & Magley, 2009:282)

Category 4.2: Ineffective coping strategies

Ineffective coping strategies have been found to include avoidance of the incivility, ignoring the incivility, absenting oneself from work and transferring to another department.

"I mind my own business. I keep quiet when I'm provoked because I don't want to be mean or end up fighting with someone. Its unprofessional and unethical. When I'm stressed, I absent myself from work." ***Participant 4***

"I tried to talk to other nurses about it and their advice would be, do mind it or ignore her, which didn't work so I resulted to just doing my work and avoid social interacts." ***Participant 1***

"You will feel like resigning or going to another place or maybe you change the department. Most of the people they go to Matron [nursing service manager] and want to change the department where they are working so that they can feel free again." ***Participant 6***

"Normally the junior nurse would not say anything, they would go ahead and do those things and most of the time what I have noticed elevates the absenteeism you know, when they know that registered particular nurse is going to come on duty, then she stays away from work ,you she will call in sick or call in you know I have a domestic problem or whatever just to avoid that particular registered nurse." ***Participant 8***

The findings of this study show that most commonly used coping strategies are avoidance and ignoring. These findings support literature that found that conflict avoidance is commonly used by targets of incivility as they believe it will neutralise the incivility and control their emotions (Cortina & Magley, 2009:280; Welbourne et al. 2016:732). This coping strategy has however, been found to have the opposite effect because it does not allow the target to "let go" because they have not made any effort to resolve the situation and this may lead to perpetuation of the uncivil behaviour, low levels of "psychological forgiveness" and increased emotional exhaustion (Hershcovis et al. 2018:165)

Ignoring the incivility as a coping strategy also support literature on minimization of incivility where the target minimizes the severity of the incivility and therefore does not attempt to confront the instigator (Cortina & Magley, 2009:283).

Category 4.3: Managerial coping strategies

The third category identified is managerial coping strategies. Participants in the study highlighted these to include mediation by the supervisor while other supervisors ignore the problem blaming it on the instigator's unchangeable personality; and moving the instigator to another department. The quotes below express participants' views.

"I tried to talk about the incivility with my supervisor which didn't help, she just said, you know she is like that referring to the person, she also just said ignore the person. I feel as a supervisor she could have done more." ***Participant 2***

"And then what we did as supervisors, we took them both to the duty room and try to sort it out then we left them together they try to apologize to each other and then it was a lesson to us to all of us that we must not take our personnel issues from home and come talk about it at work." ***Participant 5***

"Not at all because usually when maybe some issues that I don't like what the manager said to me or the other staff member, there's always a mediator, somebody that you speak to that, "I didn't like what you say to me," and then she'll call both of you and talk to both of you and then you apologize to each other and then life goes on and then it's a healthy working relationship." ***Participant 7***

(In some situations a nurse will act as a mediator in the ward, to calm the situation)

"With things like that what I have seen sometimes happen is that they would move that particular nurse away from that particular person just to see if maybe she is the trigger for this kind of behaviour for this particular senior nurse." ***Participant 8***

The above findings of supervisors blaming the instigator's unchangeable personality does not support findings from reviewed literature. The mediation by the supervisor and the transferring of the instigator to another department could be as a result of informal and formal organisational support seeking respectively, if reported by the target or witness. These strategies on their own are not supported by literature however supervisors ignoring the problem also support literature on the laissez-faire leader that avoid problems (Wachs, 2009:88)

4.4.5 Theme 5: Recommendations to develop a respectful workplace culture to address nurse-to-nurse incivility

The fifth and final theme identified in this study relates to recommendations on developing a respectful workplace culture to address nurse-to-nurse incivility at a designated academic hospital, which yielded the following categories of recommendations: 1) team interventions; 2) training interventions; and 3) managerial interventions. These categories are discussed in detail below, with quotations from participants.

Category 5.1: Team interventions

The first category identified under the theme of recommendations to develop a respectful workplace culture to address nurse-to-nurse incivility is team interventions. Examples of team interventions proposed by participants include team building, weekly/monthly meetings to discuss staff problem. Participants believe that the monthly meeting limit the perception that people are gossiping, and it will create a platform to express their concerns.

"My suggestion would be team building, whereby nurses have that one day where they don't focus on work but actually learn to build their people's skills." ***Participant 2***

"Not undermining each other, I think having meetings will help, just let people talk about things that are bothering them at work and then you must just allow everyone to express their feelings. Because if you're now going to allow one to stop another from talking about her feelings then it will seem as if you're favouring then you're going nowhere." ***Participant 5***

"I think meetings will be the best solution. If there's meetings once a month, or maybe every Monday in the morning, then they know the whole week, this is what happens. And then issues are solved, and then life goes on. And things will be better and the patients will get proper care that they need... because if you go by yourself to the manager to complain that this is what is happening, to another person it feels like you are gossiping. So, it's best to talk with everybody available." ***Participant 7***

The findings of this study relating to holding of meetings to discuss staff issues support several studies that recommended pre-shift team meetings to determine what concerns nurses' have and patients' needs to create a collaborative, ideas-sharing strong team that will lead to high morale and effective communication (Khadjehturian, 2012:639; King, Rossetti, Smith, Smyth, Moscatel, Raison et al. 2021:290).

Category 5.2: Training interventions

Training interventions suggested by participants in this study include orientation on appropriate behaviour at work, teaching staff on coping mechanisms, in-service training to teach nurses to understand their roles in their respective positions, and leadership skills for professional nurses so that they can be assertive to deal with the incivility.

"As staff members we need orientation of appropriate behaviour in the work place." ***Participant 1***

"…and addressing the issues related to incivility. In service training about scope of practice for staff members according to the categories." ***Participant 4***

"Encouraging staff to concentrate more on their duties than gossiping, and encourage them to respect each other, hold productive meetings and in-service training on things that other staff members do not know." ***Participant 3***

"I think leadership skills is essential for professional nurses because I think they are scared to step on people's toes." ***Participant 2***

There are several studies that are supported by the above findings such as discussing appropriate and acceptable behaviour during the induction and orientation process which will assist nurses to be familiar with the set standard of behaviour. (Porath & Pearson, 2012:11; Craft et al. 2020:42).

Job training and guidance on civility at the workplace can improve nurses 'assertiveness, communication skills and coping strategies (American Nurses Association, 2015:9; Porath & Pearson, 2012:11) .The study also revealed that leaders have a significant role in decreasing incivility which is supported by (Porath and Pearson, 2012:8; (Khadjehturian, 2012:639; King et al. 2021:289), leaders should receive training on how to lead, they should lead by example and continuously ask for feedback on their leadership style. Leadership that is empowering creates a healthy work environment (Laschinger, Cummings, Grau & Wong, 2014:13).

Category 5.3: Managerial interventions

The final category identified is managerial interventions. Participants suggested the following types of managerial interventions: managers dealing with incivility immediately, referring the instigators and victims of incivility to the Employee Wellness unit, making the instigator aware of his/her uncivil behaviour and that it is not acceptable, and resolving the incivility decisively by being fair, without any favouritism.

"If staff member displays uncivil towards another, correct it immediately, talk to them, it can be individually at first then have a meeting to address it." ***Participant 3***

"Because if you observe a bad behaviour on a staff member, you must intervene. There, EWP's [Employee Wellness Programme] where you can refer the staff members, if you see their behaviour, that bad behaviour is continuing. I think we must refer." ***Participant 5***

"As a manager, just try to resolve those problems without causing more problems. And then try to be firm and neutral. Don't, I'll just repeat the word, don't use favouritism." ***Participant 5***

"*What the unit manager can do to help with the situation either by talking to the person, letting them be aware that this kind of treatment is not allowed in the hospital, it's not allowed in the work setting."* ***Participant 8***

The finding of this study relating to managers dealing with incivility immediately supports several studies that recommend adopting a position of zero tolerance towards uncivil behaviour where it is sanctioned immediately when observed by management (Johnson & Indvik, 2001:712; Khadjehturian, 2012:639; Porath & Pearson, 2012:14). The study finding of making the instigator aware of his/her uncivil behaviour and its unacceptability supports the study by Khadjehturian (2012:639).

4.5 SUMMARY

The findings of this study have revealed that participants have a fair understanding of the concept of incivility as their descriptions are supported by existing literature. The prevalence of incivility at the designated academic hospital has been found to be caused by personal and personality problems of nurses, inconducive workplace culture, inconducive workplace relationships and ineffective teamwork, inequality in workplace relationships such as misuse of power and position to control others, and unfair and ineffective management styles such as favouritism and inaction.

The effects of the incivility on nurses at the designated hospital included personal effects for nurses, the effects on the functioning of nurses, work relationships and teamwork, and patient care. The nurses at the designated hospital use various coping strategies which include self-

assertiveness such as confronting the instigator and escalating it to higher level beyond the supervisor and professional support such as counselling. The nurses also used ineffective coping strategies such avoidance of the incivility, ignoring the incivility, absenting themselves from work and transferring to another department. Participants recommended interventions that management should consider such as team building, training and managerial interventions. Most of the findings of the study supports literature that has been reviewed. However, this study also provided new knowledge that was not found during literature review such as incivility can be caused by jealousy and qualification / rank among nurses.

CHAPTER 5: CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

The previous chapter presented the results from the collected data and provided an analysis and interpretation of the data in themes and categories. The findings were discussed and interpreted against the reviewed literature to determine patterns and trends, and summarized to conclude the chapter. This chapter will provide a summary of the main findings of the study in relation to the aim and limitation thereof. A conclusion, recommendations and opportunities for future research will also be presented

5.2 AIM OF THE STUDY

The aim of the study was to explore how a respectful workplace culture could be developed to address nurse-to-nurse incivility in a designated academic hospital.

5.3 SUMMARY OF MAIN FINDINGS

It is evident from the findings of the study that there is a disrespectful workplace culture that is caused by nurse-to-nurse incivility in the designated academic hospital. Firstly, the nurse-to nurse incivility has been found to be caused by personal and personality problems of nurses such as job dissatisfaction, anger and stress from home, people who are naturally horrible to people, being new and afraid to speak up, incompetence masked with uncivil behaviour, poor communication skills, and jealousy over rank/qualifications; inconducive workplace culture such as not being acknowledged/rewarded for good work, being suppressed by seniors, work overload due to shortage of staff, resistance to change, lack of platforms to discuss problems; inconducive workplace relationships and ineffective teamwork such as working in cliques, dysfunctional work environment, and being selective on who they want to work with; inequality in workplace relationships such misuse of power and position to control others, abusive and demeaning behaviour by seniors towards their juniors and fear of victimization by seniors if they speak up; and unfair and ineffective management styles such as favouritism, inaction and lack of rotation of areas of work.

Secondly, the consequences of the nurse-to-nurse incivility have been found to have a negative impact on the nurses and patient care. These consequences include personal effects for nurses such as low self-esteem, impact on family, performance anxiety, aggression, mental health issues such as depression, paranoia and suicidal thoughts; effects on the functioning of nurses such as turnover intentions, low productivity, burnout, low morale, absenteeism, and not going the extra-mile in performance; effects on work relationships and teamwork such as

creation of cliques, hatred and resentment, no flow of information due to tensions in the team and work overload due to absenteeism; and effects on patient care such as needs of patients not being met due to tensions, poor treatment of patients and mistakes in giving medications to patients due to lack of communication.

Thirdly, the study found that there are various ways nurses coped with the incivility that include victims using self-assertiveness such as confronting the instigator and escalating it to higher level beyond the supervisor and professional support such as counselling; ineffective coping strategies such as avoidance of the incivility, ignoring the incivility, absenting oneself from work and transferring to another department; and managerial coping strategies such as mediation by the supervisor while other supervisors ignore the problem blaming it on the instigator's unchangeable personality, and moving the instigator to another department.

The last and the most important findings related to the aim of the study are recommendations to develop a respectful workplace culture to address nurse-to-nurse incivility in an academic hospital. These recommendations include team interventions such as team building, weekly/monthly meetings to discuss staff problem; training interventions such as orientation on appropriate behaviour at work, teaching staff on coping mechanisms, in-service training to teach nurses to understand their roles in their respective positions and leadership skills for professional nurses so that they can be assertive to deal with the incivility; and managerial interventions such as managers dealing with incivility immediately, referring the instigators and victims of incivility to Employee Wellness unit, making the instigator aware of his/her uncivil behaviour and that it is not acceptable, and resolving the incivility decisively by being fair and without any favouritism.

5.4 RECOMMENDATIONS

The following recommendations are made to ensure that a respectful workplace culture is developed to address nurse-to-nurse incivility in the designated academic hospital. The recommendations are directed at victims of nurse-to-nurse incivility, nurse managers and hospital management.

5.4.1 Recommendations for nurses

It is recommended that nurses at the designated academic hospital should:

- Treat others with respect, dignity, collegiality, and kindness.
- Consider how personal words and actions affect others.
- Avoid gossip and spreading rumours.
- Speak directly to the person with whom one has an issue.

- Demonstrate openness to other points of view, perspectives, experiences, and ideas.
- Be polite and respectful, and apologize when indicated.
- Report experienced and witnessed incivility to avoid the spiralling of uncivil behaviour.
- Standing in solidarity with the victim, physically and symbolically and ensure that nursing managers are made aware and the witnesses come forward.

5.4.2 Recommendations for nurse managers

Nurse managers should:

- Lead by example and continuously ask for feedback on their management style.
- Deal with reported or observed incivility immediately, in a fair and objective manner to avoid the spiralling of such behaviour.
- Conduct pre-shift, weekly and/or monthly team meetings to determine what concerns nurses' have and patients' needs to create a collaborative, ideas-sharing strong team that will lead to high morale and effective communication.
- Create or institute team building activities/sessions to boost morale and team work.
- Make instigators aware of their uncivil behaviour and how it negatively impacts on the unit.
- Refer victims of incivility for counselling through the employee assistance program to help them deal with the emotional impact of the incivility.

5.4.3 Recommendations for hospital management

Hospital management should:

- Institute a zero-tolerance policy to uncivil behaviour where it is sanctioned immediately when observed by management.
- Establish hospital reporting mechanisms that are confidential, such as a 24-hour hotline where nurses can report acts of incivility, with information on the potential outcomes of the process and turnaround times.
- Include norms and standards of civility in the induction and orientation program and provide a safe and caring environment when new nurses enter the workplace and post-orientation e-learning on workplace incivility.
- Institute a job rotation policy to reduce conflict and expose employees to new tasks, as learning has been found to help employees to be flexible and more productive.
- Ensure that effective and innovative employee health and wellness programs are in place to help nurses deal with the demanding work and stress.

- Ensure that vacant nurse positions are budgeted for, and recruitment turnaround times are efficient to reduce the workload that such vacancies create.
- Consider a program similar to the Civility, Respect, and Engagement in the Workplace (CREW), a Veterans Affairs-wide culture change initiative launched by the VHA National Center for Organization Development in the United States of America (2022) in 2005 as it has been found to significantly decrease incivility, as well as increase levels of trust in management.

5.5 LIMITATIONS OF THE STUDY

The use of the qualitative research method and the study being conducted in one public hospital in Gauteng Province means that the findings cannot be generalized. The participants' first language is not English and therefore they may have not been able to express themselves efficiently to communicate their real feelings and thoughts. The researcher did not include student nurses or nurses from other wards, this implies that the research findings only applies to one ward.

5.6 IMPLICATIONS FOR NURSING MANAGEMENT

This study may help nursing managers in the designated hospital learn about the status quo of nurse-to-nurse incivility. Furthermore, it might help the nursing managers identify which specific negative behaviours have a high prevalence and require special attention. Moreover, this study recommends that nursing managers might mitigate the occurrence of nurse-to-nurse incivility through significantly improving their caring ability towards nurses and creating a respectful workplace culture in the designated hospital.

5.7 IMPLICATIONS FOR FUTURE RESEARCH

Future research conducted in a private hospital would provide new insights as to whether similar conditions are prevalent in the private sector. This would also help study the phenomenon of selective incivility based on racial discrimination as private sector hospitals are more diverse than the public sector hospitals that have predominantly black nurses. A study using a larger sample could shed more light on the topic.

5.8 FINAL CONCLUSION

Incivility continues to be prevalent in nursing, and the findings of this research support earlier findings that incivility adversely affects the workplace environment for nurses. This study makes several contributions to the current literature, i.e. nurses in the study indicated that jealousy over a colleague's rank/qualifications is masked as incivility; the issue of there being no formal platform to discuss problems and resistance to change exacerbates nurse-to-nurse uncivil

behaviour; and lastly, suicide ideation as a result of the workplace incivility. The recommendations following the study might help in changing the perceptions of nurses towards improving the quality of health.

Creating and sustaining civility in the workplace using evidence-based strategies to structure best practices and initiatives is an essential consideration for all healthcare settings. It is imperative that the nursing profession work collaboratively to prevent and address the negative consequences of incivility.

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ANNEXURES

ANNEXURE A

UNSTRUCTURED INDIVIDUAL INTERVIEW GUIDE

Two broad questions will be asked. Prompts will be based on the conversation and asked from participants for clarification or to provide more information.

How would you describe the nurse-to-nurse incivility occurring in the hospital?

How would you describe the effect of nurse-to-nurse incivility on the workplace culture?

Probing questions could include:

Tell me more about… What do you mean with…? Could you please describe …?

I am not sure I understand; could you explain further? How did you feel then?

ANNEXURE B

PARTICIPANT'S INFORMATION AND INFORMED CONSENT DOCUMENT FOR THE INDIVIDUAL INTERVIEW

Study title: Exploring nurse-to-nurse incivility in an academic hospital in Gauteng province

Principal Investigator: K.J Sengani
Supervisors: Prof R Leech and Prof T Heyns

Institution: [redacted]
DAYTIME AND AFTER HOURS TELEPHONE NUMBER(S):
Daytime number: 0785378741

Afterhours number:0785378741

Date and time of informed consent discussion:

Dear Prospective Participant

Dear Mr. / Mrs. .....

INTRODUCTION

You are invited to volunteer for a research study. I am doing this research for Master's degree purposes at the University of Pretoria. This document gives you information in this document is provided to help you decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this document, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about what we will be discussing during the individual interview.

THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to explore how nurse-to-nurse incivility in the hospital can be addressed to promote a respectful workplace culture. Part of the study will be an individual interview. The interview will be arranged at a time that is convenient to you and will take place in the ward's tea room or we could arrange to meet via an electronic platform such as Google Meet or Zoom

EXPLANATION OF PROCEDURES AND WHAT WILL BE EXPECTED FROM PARTICIPANTS

If you agree to participate, you will be asked to participate in an individual interview which will take about 60minutes. You and the other participants will be asked some questions about your opinion about nurse-to-nurse incivility in the hospital and the influence it has on the workplace culture. I will not ask any questions about your personal experience. With your permission, the discussions will be audio-recorded on a recording device to ensure that no information is missed.

RISKS AND DISCOMFORTS INVOLVED

I do not think that taking part in the study will cause any physical or emotional discomfort or risk. You do not have to share any knowledge you are not comfortable with. During the interview, if you find that some questions are sensitive; for instance, questions about uncivil nurse-to-nurse behaviour in the hospital, you do not have to answer them. If you feel overwhelmed or emotional during the interview I will immediately stop the interview, and if needed, will refer you for counselling at the Employee Wellness Clinic in the hospital.

POSSIBLE BENEFITS OF THIS STUDY

You may not benefit directly by being part of this study. Your participation is important for us to better understand nurse-to-nurse incivility in the hospital. The information you give may help the researcher to develop strategies to create a respectful workplace culture.

COMPENSATION

You will not be paid to take part in the study. However, should we need to conduct a virtual interview, data for one day will be provided to you.

VOLUNTARY PARTICIPATION

The decision to take part in the study is yours and yours alone. You do not have to take part if you do not want to. You can also stop at any time during the interview without giving a reason. If you refuse to take part in the study, this will not affect you in any way.

ETHICAL APPROVAL

This study was submitted to the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, Medical Campus, Tswelopele Building, Level 4-59, telephone numbers 012 356 3084 / 012 356 3085 and written approval has been given by that committee. The study will follow the Declaration of Helsinki (last update: October 2013), which guides doctors on how to do research in people. The researcher can give you a copy of the Declaration if you wish to read it.

INFORMATION ON WHO TO CONTACT

If you have any questions concerning this study, you should contact:

K.J Sengani
Cell No: 078 5378 741
Email: Kgaogelosengani@yahoo.com

CONFIDENTIALITY

We will not record your name anywhere and no one will be able to connect you to the answers you give. Your answers will be linked to a fictitious code number or a pseudonym (another name) and we will refer to you in this way in the data, any publication, report or other research output.

All records from this study will be regarded as confidential. Results will be published in medical journals or presented at conferences in such a way that it will not possible for people to know that you were part of the study.

The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Research Ethics Committee. All of these people are required to keep your identity confidential. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

All hard copy information will be kept in a locked facility in the Department of Nursing Sciences at the University of Pretoria, for a minimum of 15 years and only the research team will have access to this information.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person requesting my consent to take part in this study has told

me about the nature and process, any risks or discomforts, and the benefits of the study.

I have also received, read and understood the above written information about the study.

I have had adequate time to ask questions and I have no objections to participate in this study.

I am aware that the information obtained in the study, including personal details, will be anonymously processed and presented in the reporting of results.

I understand that I will not be penalised in any way should I wish to discontinue with the study and my withdrawal will not affect my treatment and care.

I am participating willingly.

I have received a signed copy of this informed consent agreement.

Participant's name (Please print)	**Date**
Participant's signature	**Date**
Researcher's name (Please print)	**Date**
Researcher's signature	**Date**

I understand that the interview will be audiotaped. I give consent that it may be audio recorded.

YES / NO

ANNEXURE C

: Initial Research Ethics approval 2021

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IORG #: IORG0001762 OMB No. 0990-0279 Approved for use through February 28, 2022 and Expires: 03/04/2023.

Faculty of Health Sciences **Research Ethics Committee**

29 April 2021

Approval Certificate
New Application

Ethics Reference No.: 183/2021
Title: Addressing nurse-to-nurse incivility in an academic hospital in the Gauteng Province by promoting a respectful workplace culture

Dear Miss KJ Sengani

The **New Application** as supported by documents received between 2021-03-29 and 2021-04-28 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on 2021-04-28 as resolved by its quorate meeting.

Please note the following about your ethics approval:

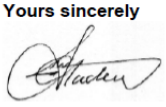
- Ethics Approval is valid for 1 year and needs to be renewed annually by 2022-04-29.
- Please remember to use your protocol number (183/2021) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely



Professor Werdie (CW) Van Staden
MBChB MMed(Psych) MD FCPsych(SA) FTCL UPLM
***Chairperson**: Faculty of Health Sciences Research Ethics Committee*

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

Research Ethics Committee
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Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

ANNEXURE D

RESEARCH ETHICS APPROVAL 2022

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 18 March 2022 and Expires 18 March 2027.
- IORG #: IORG0001762 OMB No. 0990-0278 Approved for use through August 31, 2023.

Faculty of Health Sciences **Research Ethics Committee**

14 July 2022

Approval Certificate
Amendment

Dear Miss KJ Sengani,

Ethics Reference No.: 183/2021 – Line 1
Title: Addressing nurse-to-nurse incivility in an academic hospital in the Gauteng Province by promoting a respectful workplace culture

The **Amendment** as supported by documents received between 2022-06-14 and 2022-07-13 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on 2022-07-13 as resolved by its quorate meeting.

Please note the following about your ethics approval:

- Please remember to use your protocol number (183/2021) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

On behalf of the FHS REC, Dr R Sommers
MBChB, MMed (Int), MPharmMed, PhD
Deputy Chairperson *of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria*

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).

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ANNEXURE E

PERMISSION TO CONDUCT RESEARCH

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

[redacted]
PRETORIA
0001

ENQUIRIES : MS PM MONYEPAO
TEL : 012 318 6995
EMAIL : Patricia.Monyepao@gauteng.gov.za
REF : KPTH 12/2021

TO: Ms K Sengani

RE: CONDITIONAL PERMISSION TO CONDUCT RESEARCH

TITLE: ADDRESSING NURSE-TO-NURSE INCIVILITY IN AN ACADEMIC HOSPITAL IN THE GAUTENG PROVINCE BY PROMOTING A RESPECTFUL WORKPLACE CULTURE.

Conditional permission is hereby granted for the research to be conducted at [redacted] Please note that full approval will be granted on receipt of Ethics approval.

This is done in accordance to the "Promotion of Access to Information Act. No 2 of 2000".

Please note that in addition to receiving approval from the hospital research committee, you are still required to seek permission from the relevant departments. You are obliged to inform this committee in writing of any amendments made to this protocol. Importantly, you require full approval (not conditional approval) before data collection can commence.

Furthermore, collecting of data and consent for participation remains the responsibility of the researcher.

You are also required to submit your final report or summary of your findings and recommendations to the office of the Chief Executive Officer.

Kind regards

[redacted]
MEDICAL MANAGER
DATE: 14/05/2021

Ethics approval submitted: YES NO

Approved.

[redacted]
MEDICAL MANAGER
DATE: 14/05/2021

GAUTENG PROVINCIAL GOVERNMENT
KA
14 MAY 2021

ANNEXURE F

COPY OF TRANSCRIBED INTERVIEW

TOPIC: ADDRESSING NURSE-TO-NURSE INCIVILITY IN AN ACADEMIC HOSPITAL IN THE GAUTENG PROVINCE BY PROMOTING A RESPECFUL WORKPLACE

Interview number: 8
Venue: Hospital X
Date :23 March 22

Time: 10:00

Duration: 25 minutes 55 seconds

Transcript of interview Interviewer: Good morning, how are you

Participant: Good day, how are you?

Interviewer: I'm okay thank you, I will be interviewing you on behalf of the researcher, did she explain everything?

Participant: Yes

Interviewer: Did you sign the consent form for the interview?

Participant: Yes, I did sign.

Interviewer: Okay, our interview will be recorded, do you give me consent?

Participant: Yes, I agree

Interviewer: Okay, now we can start. How would you describe nurse to nurse incivility in the hospital? That refers to when nurses treat each other in a way that is not very civil or civilised, when they may talk to each other in a degrading way or insulting way or if they treat each other in an insulting or degrading way. The are other examples that other examples we can discuss, you can tell me your experience I'm listening.

Participant : I have noticed incivility from the unit manager an example would she will ensure that her people are more favoured , she would discipline measures you will find out that she will treat nurses differently , and another thing would be when nurses report depending you

will find that if it's one of her nurses she will take quicker action attending the matter while the other one would be ignored or left for a later stage until the issue is escalated to a higher level.

Interviewer: Thank you for that so you are saying its more from the unit managers that you sometimes observe incivility that they give prefers to other nurses or discipline them differently. can you think of examples that you can describe to me?

Participant : Okay a simple example is the unit manager she has a favourite nurse or a nurse she gets along with better and a another nurse that she doesn't get along with for whatever reason weather it's that natural dislike of a person mmmh, they would request can I please have a certain day off of duty for such and such a reason when you are drafting the off duties and the unit manager would overlook that request because it's not someone she really appreciates even though she would not say it in many words , you can see the treatment of nurses is not the same you know so off duties it is what I noticed very much because as much as we have families and we have things to do , there a time that comes and you ask can I please be off duty on this particular day ,and she would grant it to someone who requested later than you did and you know that you requested that day on an earlier date than that particular person but because it's her favourite person she would overlook that request she would rather give it to someone she prefers

Interviewer: Okay thank you, that sound like favouritism as well but it is a form of you can almost say bullying

Participant: Yes, it is

Interviewer: So, any other examples that you can think of like behaviour or anything like that?

Participant : What I also noticed is that this is from my side mmmh I grew up I was raised that ladies wear dresses and long dresses so even at work I felt like cause some ladies wear pants wear why can't my long skirt , as much as the Indian nurses are allowed to wear something that covers their head , I can also wear my long skirt cause either way if its infection control those long pants that nurses wear touch the floor sometimes and it's going to spread infection so I would be discriminated as to why am I wearing such a long dress mmmh the dress is going to cause infection and whenever I ask y are u wearing such long pants and the pants are actually touching the ground the same concern that my long skirt is making is it not the same with the pants and no one really gets to understand what I am talking about . You know why is an Indian Muslim sister allowed a head covering while I'm not allowed to wear my long dress my long skirt even if it is not the skirt that touch the ground but cause it is longer than the usual almost just above my ankles its always an issue why am I wearing such a long skirt, maybe to her it looks untidy I'm not sure , she made it seems like I'm probably crazy .

Interviewer: So, in this case it's like lack a of understanding or a lack of mmh looking at the other person's point of view.

Participant: Yes

Interviewer: Anyway, in which this remark was made, the way in which people told you that they don't like it maybe in a rude or degrading way?

Participant: Yes, in a degrading way, the sister that I was taking about she said I dress like dis properly because I work in a mental health word, she made it seem like I'm crazy.

Interviewer: Okay I understand, what are the effects of these type of a thing on a person? the things you exampled to me now

Participant: To me it's very degrading and discouraging, sometimes it can go as far as when you have to come to work you first think should I go or should I not go, I'm always going to meet the same person that makes funny remarks about my skirt. I'm not willing to compromise what I want for myself but there is this person that is constantly reminding me that I look slightly different from all the other nurses wearing long pants, I'm the only one wearing long skirt or the community of nurses and you know think today I'm really not up to the person that is going to be on my case the long skirt or which is unnecessary because still able to do my job to the fullest function, it's not preventing me and she is aware that of that, she is just making these remarks just to remind me I'm just different from the other nurses, you dress a bit differently from other nurses from them

Interviewer: Yah so it's liked you are singled out

Participant: Yes, yes and they would make a remark like call that sister with a long dress I'm no longer sister glory you know or call that fat sister with a long dress you know

Interviewer: Yah a that is like labelling you in a negative way. What feelings would one experience when things like that happen?

Participant : You get feelings of resentment and you really get to a point whereby you are like I really do not like this person , I do not like the way they talk to me and I do not like the way they talk to me , its degrading most of the time you would feel I really don't want to come to work today because that person is going to be at work today and there's no way they are definitely going to make a rude comment towards me .

Interviewer: You have shared a lot of information already; can you about think of other examples not you personally experienced but share about what happens between other nurses in hospital that you observed

Participant: mmmh what I have noticed is that the senior nurses, maybe the registered nurses they would sort of undermine the junior nurses and expect them to do things that are not even on their not on the scope of practice for example a nurse would feel like because she doesn't want to walk to the cafeteria she would send the junior nurse, go and buy me some coffee and sandwich even though you see that the junior nurse does not really want to do it , she goes ahead , they are threatened by the fear of not getting the performance bonus, the PMDS , the fear of , some of the contract nurses are afraid that maybe should they get the opportunity to be absorbed they would not be recommended because they refuse to go to the shop for the sister , they refused to do odd things , someone would just say get me a glass of water or make me a cup of tea which that's not why we are here for , if you want tea make you own cup of tea , you know what I mean .

Interviewer: It sounds like a misuse of the situation to benefit yourself?

Participant: Most definitely.

Interviewer: What would be the consequences of this on the junior nurses if you put in a situation like that?

Participant : Normally the junior nurse would not say anything , they would go ahead and do those things and most of the time what I have noticed elevates the absenteeism you know, when they know that registered particular nurse is gonna come on duty , then she stays away from work ,you she will call in sick or call in you know I have a domestic problem or whatever just to avoid that particular registered nurse

Interviewer: Yah they try to cope with it using avoidance

Participant: Yes, by using avoidance yes

Interviewer: How would you think a person feel if things like this happen to you

Participant : I think they would feel degraded most definitely , discouraged and belittled actually , you are not here , you are not a tea lady , but you are expected to make tea for the registered nurse or sent to the café buy the unit manager you know, you will feel belittle because you are here to serve the patients , but it's not just about the patient, but you are also serving nurses as well .

Interviewer: Yah I can think myself into that situation mmmh I'll give you opportunity if you think of other examples later on but I'm just wondering if you can think of ways to address problems like that, what would you recommend one can do to or prevent or manage situations of incivility?

Participant: What I think works best cause normally if it's a registered nurse, the junior has the right to report the registered nurse to the unit manager, if the unit manager doesn't help much, then you have the right to escalate to the matrons and see what they can do to help you with the situation either by talking to the person, letting them be aware that this kind of treatment is not allowed in the hospital, it's not allowed in the work setting or with things like that what I have seen sometimes happen is that they would move that particular nurse away from that particular person just to see if if maybe she a trigger for this kind of behaviour for this particular senior nurse and sometimes just it's your unit manager that is giving you problems you defiantly the right to report to you matron , that I'm a problem and is there a way that this can be solved and let them find solutions . I don't believe that there should be single nurse that is not able to come to work because of another nurse

Interviewer: Yah that good suggestions, do you think that people that are exposed to this follow this root of reporting it to their manager

Participant: mmmh Its very scares, but do find those brave assistant nurses that feel like enough is enough and I want to stand up for what is right and they would if the unit manager doesn't help go straight to the matron to get help

Interviewer: Yah so some of them will and others would not, what do you think people be scared to report this.

Participant : The main thing that I think is that you know we use to have a system where the performance use to come , there would be a cash reimbursement if you had certain amount of points for you PMDS, so if I go tell on the sister she is not going to give enough points for me to receive that PMDS you know , so that is one of them , for the contract workers I noticed they afraid to speak out they have a hope that the government might give them an opportunity to get permanent posts and obviously the same unit manager is gonna probably going to be your reference point and you might have to get motivation from the unit manager as to why this particular nurse should be given a permanent post , so they sort of worry that if we tell on we might not get a permanent post which is not true .

Interviewer: Those are some of the things that make it difficult because it's happening and but on top of it, people are afraid to address it or report it?

Participant: Most definitely

Interviewer: You spoke about favouritism and discrimination and degrading, sort of remarks and also undermining of junior's nurses can you think of any other examples that you have observed ever that nurses presented with other type of behaviour similar to this

Participant: Mmmmh I can't think of anything right now, I'm trying to think, I can't think of anything in the past, mmmh sometimes what I think of now is that you would find even among junior nurses there would be some level of bullying, in a sense that they undermine each other, or the other one has been there for in the hospital longer and then whenever there's things to be done she would want the newer personnel to do anything, while they sit back and do nothing in a form they would say no I'm teaching you what to do in actual fact they are abusing that person, in actual factor they should be doing a shared job that one who has been in the hospital longer would make the newer personnel to do everything while they sit back and watch in the name of I'm trying to teach you how to learn the things that needs to be done in the ward

Interviewer: Yah that's also a good a example because it's not necessarily between that is between nurses that have different rank but it can also be on the same level that nurses behaviour like that to each other

Participant: Yes

Interviewer: anything like offensive language by nurses used against each other or hamulating each other or humiliating each other

Participant: Yes it happens from time to time where sometimes it's between the equal categories where you know once one nurse stands out for themselves to say enough is enough I cannot take that kind of behaviour we should be working together , not me doing everything , then the other one will start becoming offensive, oh now that I taught you what to do you have the mouth to speak up and tell me all of that, when you got here you didn't know how to do anything, I'm the one who taught you everything and now you want to speak up and now you have the mouth of your own, they say some nasty words to each other and the nurses themselves wouldn't want to work with each other anymore

Interviewer: It can escalate into conflict, is that something that often happens between nurses that there's conflict

Participant : Mmmh I think in my years as a nurse I have experienced it once or twice , it is not really a common thing, I think most of the nurses try to keep that professional level , they sort of keep it inside or try not have not to have an open conflict in public or in front of the patients, I think the one that broke up right in front of everyone, the patients and other nurses I have seen it maybe twice in my experience , but in the other cases you will find one nurse pulling the other nurse to a private side and telling them where to get off inside the office or something not in the presence of the other nurse and patients .

Interviewer: Oh, that is interesting that you mention that, maybe it's because of work that nurses do, they just keep it inside them. What can be the effect on them? if you receive the type of behaviour? and you also have to keep quiet about it, how would one start to feel inside?

Participant : I think most of the time it leads to that resentment, not ever wanting to work with that particular person , nurses withdrawing, absenting themselves from work just because they are on the same shift as with the particular person that they recent so much and don't want to work with, those vocal nurses are the one that would actual escalate it to the matron, saying I cannot go on like this I'm losing out on my leave days because I'm always absent because I don't want to see this person and sometimes you know in the long run you find that nurses develop depression over work issues that you know it's so surprising that one shouldn't reach a level of depression while working you know, but I have seen once happened that a nurse over time just because depressed and depressed eh because they couldn't speak up and say I'm unhappy because of this and this and they try keep everything inside and then sometimes it leads to that explosion in public in front of nurses, in front of patients where a nurse will explode , I no longer want to work with this person, this person makes me feel like this always saying this nasty things to me and always reacting in a nasty manner, I try to talk to them they don't even talk back all those sort of things

Interviewer: Yah so in the end it can actually lead to depression, in your experience how would the person look, when they start to develop depression, what would they present with?

Participant: That bullied nurse is always talking to other nurses and patients start withdrawing, she starts to become quite she start to be late to work you know, you see when it's time to eat, she would avoid eating within the other nurse, during tea she would have tea by herself, they become less interactive with over patients, she just come to work to do what she needs to do and she would not go the extra mile anymore because she would feel so degraded that it's not worth trying to do better at work you know. They feel you I'm here to work and that's it I'm gonna do what I'm called here for, I'm not going to bother myself doing any better than what I'm doing in the moment

Interviewer: Yah that is a very effective description of what the person would experience. Mmmm I see here there's another question, how would it affect the workplace culture? the way people work, the way people work, or work as a team, the culture in the ward?

Silence for 5 seconds

Interviewer: Looks as if…Can you still hear me?

Participant: Yes, I can hear you now

Interviewer: I think we had a small interruption, I just wanted to ask, how would it affect the culture at the work, the team work, the way people work amongst each other?

Participant: I think it will affect them negatively , you know if we were once a good team , working together, sharing the job , the job would be so heavy on one person, now one of the nurses are pulling away and avoiding to come to work and now its shorted, and when they do what they came for and they don't go for an extra mile, then the load becomes heavy on the nurses , once the load becomes heavy, then nurses start complaining and then they are not happy because the get too tired because there is this one nurse or two nurses, they are pulling in different directions and that time work and the team that was built sort of start breaking down and in the end the work becomes less effective on the patients because you have things that are done and others undone, you find that some patients didn't receive their medication on time because one nurse is not talking to the other nurse and the lack of communication , the other one was not able to know that she only gave up to number 5 and she was not able to give up to number 10 so in that you will find that certain things not done.

Interviewer: So, it's the work flow, the patient care and the team work and many other aspects of the team gets affected.

Any other thing that that you can think of that maybe we did not discuss or any other thing that you can mention? We spoke about the workplace culture, we spoke about the different types of incivility and the consequences on nurses and the team work. If the is any other thing that come to mind, you can just tell me?

Participant: Mmm I can't think of anything on top of my head at this moment but you know, this bullying thing is such a struggle because the factor that nurses don't speak up, you know nurses abuse each other nurse, nurses abuse their power, nurse abuse cleaners, nurse abuse the ladies that give patients food you know, and nothing is ever said about it because people are afraid to lose their jobs , people are afraid you that I'm a bread winner for my family and for children and now there is that is bugging me at work and not giving me peace of mind but I don't know what to about it because of this fear of not losing my job

Interviewer: So, it's something that happens not even between nurses, but to other workers and it has a negative effect on the workplace?

Participant : Most definitely and body shamming what I also noticed lately I think there's a lot of fat people in South Africa and we gotten use to that, you know we are different sizes you know fat and whatever and you still that make comments, why are you eating a packet of chips and you are so fat you know , why are having this gresery chips and Viennas or whatever these take away foods while you so fat you know, it's none of anyone's business what anyone

eats you know people making such lousy such comments not realising that they are affecting that person you know and they do not what is making that person eat that greasy food on that particular day but because of the careless of the things that we say but later we realised that the person was affected by those comments because some people being fat for them is a problem and they are struggling with their weight and some people when you make a fight comment just bounces off because you use to it while you are used to it from primary school and you really do not care but there are some people who care behind closed doors they are really trying so hard to lose that weight and sometimes it's just so hard that mmmh a person tries and some of them it's a medical condition and they just cannot keep the weight off and there's this nurse that keeps making comments about my lunch and tea hide their lunch and eat when people are not eating and we are a team, we should be sit in a group of 2/3 people, have our lunch together, take over everything and anything but when you cannot do that and we spend half of our lives here at the hospital you know it becomes so difficult when are miserable at work and you find that you are miserable at home for whatever social problems you have at home and you get here at work and these this person that is making your life more miserable and you wonder , where do I turn too , don't you think that maybe it will lead to suicide one day, when you are hopeless at home and you come to work, it's another hopeless case , then you feel , what am I living for? You know those are the small things that we over look , over time they build up and build up, then we are going to have suicide cases you know.

Interviewer: I think you have given a very good example and explanation now of that degrading you know and the type of remarks that people make, that will hurt another person.

Participant: Definitely

Interviewer: You gave a lot of information, you think its fine? You think we can end the interview or what do you think?

Participant: If you are happy, I'm also happy (laughs).

Interviewer: I really think you gave a lot, and I recorded everything, you name will not be mentioned on any reports, if I mentioned your name on the interview, it won't be transcribed, so it's totally private and confidential and thank you very much for your participation

Participant: Thank you for the opportunity.

Interviewer: Are you okay? you feel okay after talking you.

Participant: I'm definitely okay, I'm quite happy.

Interviewer: Okay, thank you very much, then I'm going to end the recording.

ANNEXURE G

COPY OF FIELD NOTES

Interview number: 1

Venue: Hospital: X

Date: 12 February 2022

Duration of interview: 26 minutes 10 seconds

Like with any interview I felt worried that I may not be able to gain the information desired during the interview, but I had tried to rephrase some of the questions so that the participant would understand as some words are academic English words.

The participant arrived on the time as scheduled, which I did not expect because knowing the type of ward she works in, it can be busy. So, after we went through the formalities, the interview began. The participants were able to was able to speak English but some questions she did not understand but I tried to rephrase them so that the participant can understand but also without losing the meaning to the question.

The participant was at ease and actively participating. She was loud and audible and the tap-recorded was able to recorded all the conversation. She had good eye contact. The venue had no interferences.

I used questions to prompt to try obtain the maximum amount of information that I could. The participants attempted most of the questions, some answers were brief answers, then I had to rephrase the question. In all, I think the interview went well. Both the participant and myself were relaxed.