



AMERICAN NURSES ASSOCIATION POSITION STATEMENT ON

# INCIVILITY, BULLYING, AND WORKPLACE VIOLENCE

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**Status:** New Position Statement  
**Written By:** Professional Issues Panel on Incivility, Bullying, and Workplace Violence  
**Adopted By:** ANA Board of Directors

## I. PURPOSE

This statement articulates the American Nurses Association (ANA) position with regard to individual and shared roles and responsibilities of registered nurses (RNs) and employers to create and sustain a culture of respect, which is free of incivility, bullying, and workplace violence. RNs and employers across the health care continuum, including academia, have an ethical, moral, and legal responsibility to create a healthy and safe work environment for RNs and all members of the health care team, health care consumers, families, and communities.

## II. STATEMENT OF ANA POSITION

ANA's *Code of Ethics for Nurses with Interpretive Statements* states that nurses are required to "create an ethical environment and culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect" (ANA, 2015a, p. 4). Similarly, nurses must be afforded the same level of respect and dignity as others. Thus, the nursing profession will no longer tolerate violence of any kind from any source.

All RNs and employers in all settings, including practice, academia, and research, must collaborate to create a culture of respect that is free of incivility, bullying, and workplace violence. Evidence-based best practices must be implemented to prevent and mitigate incivility, bullying, and workplace violence; to promote the health, safety, and wellness of RNs; and to ensure optimal outcomes across the health care continuum.

This position statement, although written specifically for RNs and employers, is also relevant to other health care professionals and stakeholders who collaborate to create and sustain a safe and healthy interprofessional work environment. Stakeholders who have a relationship with the worksite also have a responsibility to address incivility, bullying, and workplace violence.



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### III. BACKGROUND

Incivility, bullying, and workplace violence are part of a larger complex phenomenon, which includes a “constellation of harmful actions taken and those not taken” in the workplace (Saltzberg, 2011, p. 229). The phrase “actions taken and not taken” provides an overarching framework that includes using explicit displays of uncivil or threatening acts, as well as failing to take action when action is warranted or required to address incivility, bullying, or violence in the workplace.

Some harmful actions may be more overt, such as making demeaning comments or using intimidation to undermine a coworker. Other forms of incivility and bullying can be more covert, such as failing to intervene or withholding vital information when actions are clearly indicated and needed for work to be done in a safe manner. Actions taken and not taken occur along a continuum and range from the subtle and covert to the overt and from less to more harmful (Clark, 2013a; Einarsen, Hoel, Zapf, & Cooper, 2011; World Health Organization, 2015).

Unfortunately, the full range of actions related to this complex phenomenon has negatively impacted RNs globally and, in some cases, has been accepted and culturally condoned. For nearly a century, some form of incivility, bullying, or violence has touched far too many members of the nursing profession. They affect every nursing specialty, occur in virtually every practice and academic setting, and extend into every educational and organizational level of the profession (Hader, 2008; McKenna, Smith, Poole, & Cloverdale, 2003).

It is important to first acknowledge the existence of harmful actions taken and actions not taken in the workplace in order to eliminate them. Those who experience workplace incivility, bullying, or violence know firsthand their detrimental effects, especially when their experiences are not taken seriously by coworkers and supervisors. Those harmful effects have been described as additive in that they accumulate burden and can become synergistic. Moreover, their combined effects can go beyond what each can do alone. Bullying and other harmful actions can be “surrounded by a ‘culture of silence,’ fears of retaliation, and the perception that ‘nothing’ will change” (Vessey, DeMarco, & DiFazio, 2011, p. 142).

Any form of workplace violence puts the nursing profession and nursing’s contract with society in jeopardy (Saltzberg, 2011). Those who witness workplace violence and do not acknowledge it, who choose to ignore it, or who fail to report it (Hutchinson, 2009) are in fact perpetuating it. Thus, organizations that fail to address it through formal systems are indirectly promoting it (The Joint Commission, 2008). Refusal to engage in addressing what has become, in some workplaces, accepted norms surrounding workplace violence is no longer an option because “not all norms or values ... are moral norms or values” (Colby et al., 1987). Taking action is a moral stance consistent with the ANA *Code of Ethics for Nurses with Interpretive Statements* (2015a). The entire nursing profession must actively drive a cultural change to end incivility, bullying, and violence in the workplace.

#### INCIVILITY

RNs and their employers should acknowledge the various forms of workplace violence, as well as the extent to which each occurs in their work setting. By differentiating the various forms of harmful actions taken and of actions not taken, the nursing profession can focus its collective wisdom and experience on leading the campaign to create a culture of respect, safety, and effective interprofessional communication.

Incivility can take the form of rude and discourteous actions, of gossiping and spreading rumors, and of refusing to assist a coworker. All of those are an affront to the dignity of a coworker and violate professional standards of respect. Such actions may also include name-calling, using a condescending tone, and expressing public criticism (Andersson & Pearson, 1999; Read & Spence Laschinger, 2013). The negative impact of incivility can be significant and far-reaching and can affect not only the targets themselves, but also bystanders, peers, stakeholders, and organizations. If left unaddressed, it may progress in some cases to threatening situations or violence (Clark, 2013a).

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Oftentimes incivility is not directed at any specific person or persons. However, it may perpetuate or become a precursor to bullying and workplace violence; therefore, it cannot be characterized as innocuous or inconsequential (Pearson, Andersson, & Porath, 2005). Studies have shown that incivility experienced through email or other online forums affects targets in much the same way as face-to-face incivility does (Clark, 2013b; Clark, Ahten, & Werth, 2012; Clark, Werth, & Ahten, 2012; Giumetti et al., 2013).

## **BULLYING**

Bullying is repeated, unwanted harmful actions intended to humiliate, offend, and cause distress in the recipient. Bullying actions include those that harm, undermine, and degrade. Actions may include, but are not limited to, hostile remarks, verbal attacks, threats, taunts, intimidation, and withholding of support (McNamara, 2012). Such actions occur with greater frequency and intensity than do actions described as uncivil. Bullying actions present serious safety and health concerns, and they can cause lasting physical and psychological difficulties for targets (Washington State Department of Labor and Industries, Safety and Health Assessment and Research for Prevention Program, 2011).

Bullying often involves an abuse or misuse of power, creates feelings of defenselessness and injustice in the target, and undermines an individual's inherent right to dignity. Bullying may be directed from the top down (employers against employees), from the bottom up (employees against employers), or horizontally (employees against employees). Top-down bullying from organizational leaders allows bullying to become an accepted and condoned workplace norm (Deans, 2004a; Royal College of Nursing, 2002; Vessey, DeMarco, & DiFazio, 2011). Hutchinson, Wilkes, Jackson, and Vickers (2010) used structural equation modeling to test a model of bullying. Their survey data from 370 nurses revealed specific organizational characteristics, including misuse of authority, certain policies and procedures, organizational tolerance, and informal alliances, as the critical antecedents to bullying and its frequency.

RNs and employers must also be cognizant of workplace mobbing as a collective form of bullying and as an expression of aggression aimed at ostracizing, marginalizing, or expelling an individual from a group (Bowling & Beehr, 2006; Galen & Underwood, 1997; Harper, 2013). As Griffin and Clark (2014) state, workplace mobbing occurs when "more than one person commits egregious acts to control, harm, and eliminate a targeted individual" (p. 536). Mobbing is linked to physical, psychological, social, and emotional damage, and it can have devastating economic consequences as the targeted individuals fight to keep their jobs and careers (DiRosa et al., 2009; Hutchinson, Vickers, Jackson, & Wilkes, 2006; Monteleone et al., 2009; Vessey, DeMarco, Gaffney, & Budin, 2009).

When investigating experiences of workplace mobbing and comparing those experiences with indicators on various scales, Balducci, Alfano, and Fraccaroli (2009) found positive and significant correlations between the frequency of exposure to mobbing and the appearance of various indicators, including posttraumatic stress. The authors found that the frequency of exposure to mobbing predicted suicidal ideation and behavior.

In 1990, Leymann described workplace mobbing as the adult form of bullying. It is characterized by employees "ganging up" on a target employee and subjecting that individual to psychological harassment that may result in severe psychological and occupational consequences. In some cases, targets of workplace mobbing may be exceptional employees. For example, Westhues (2004) suggested that mobbing among faculty members in academic workplaces may be related to envy of excellence and to jealousy associated with the achievements of others. Mobbing may thus occur in such workplaces in an attempt to maintain group mediocrity and compliance with the status quo, so that the high performer is targeted to keep that person in line with prevailing workplace norms.

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## WORKPLACE VIOLENCE

Workplace violence consists of physically and psychologically damaging actions that occur in the workplace or while on duty (National Institute for Occupational Safety and Health [NIOSH], 2002). The Bureau of Labor Statistics releases an annual report about injuries and illnesses resulting in time away from work in the United States. In the health care and social assistance sectors, 13% of days away from work were the result of violence in 2013, and this rate has increased in recent years (U.S. Department of Labor [DOL], Bureau of Labor Statistics, 2014). According to a recent ANA survey of 3,765 registered nurses and nursing students, 43% of respondents have been verbally and/or physically threatened by a patient or family member of a patient. Additionally, 24% of respondents have been physically assaulted by a patient or family member of a patient while at work (ANA & LCWA Research Group, 2014).

Workplace violence is referred to by some as endemic, which, from a public health perspective, means it is commonly found in certain settings (Lipscomb & London, 2015). Such settings include emergency departments, psychiatric hospitals, nursing homes, long-term care facilities, and others. Hodgson et al. (2004) describe how employees who float from one unit to another experience assault three times more often than do permanent employees. Wolf, Delao, and Perhats (2014) provide evidence of the prevailing attitude that workplace violence is a culturally accepted and expected part of one's occupation. Oftentimes patient safety is given priority over employee safety, when in fact both are integral to quality and safe care (Lipscomb & London, 2015).

Workplace violence can lead to emotional distress, temporary or permanent injury, or even death (Tarkan, 2008). Examples of workplace violence include direct physical assaults (with or without weapons), written or verbal threats, physical or verbal harassment, and homicide (Occupational Safety and Health Administration, 2015).

NIOSH classifies workplace violence into four basic types. Types II and III are the most common in the health care industry. (Types I and IV are not addressed in this position statement.)

- Type I involves “criminal intent.” In this type of workplace violence, “individuals with criminal intent have no relationship to the business or its employees.”
- Type II involves a customer, client, or patient. In this type, an “individual has a relationship with the business and becomes violent while receiving services.”
- Type III violence involves a “worker-on-worker” relationship and includes “employees who attack or threaten another employee.”
- Type IV violence involves personal relationships. It includes “individuals who have interpersonal relationships with the intended target but no relationship to the business” (Iowa Prevention Research Center, 2001; NIOSH, 2006, 2013).

## DETRIMENTAL EFFECTS ON THE NURSING PROFESSION

An overview of relevant literature indicates that incivility, bullying, and workplace violence are concerns for the nursing profession, health care field, and beyond (Spector, Zhou, & Che, 2013). Kaplan, Mestel, and Feldman (2010) suggest that nurses ignore or tolerate incivility and bullying because of fear or lack of knowledge. However, incivility and bullying are also reasons nurses leave or plan to leave the profession (Johnson & Rea, 2009; Simons, 2008; Vessey, DeMarco, & DiFazio, 2010). Other negative effects include decreased job satisfaction, reduced organizational commitment, decreased personal health, and added direct and indirect costs to employers and RNs (Rodwell, Brunetto, Demir, Shacklock, & Farr-Wharton, 2014; Smith, Andrusyszyn, & Spence Laschinger, 2010).

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## FINANCIAL RAMIFICATIONS

Decreased productivity can occur following incidents of incivility, bullying, or workplace violence. Employee retention can also become more difficult. Yet the total financial cost of such actions is very difficult to calculate (Berry, Gillespie, Gates, & Schafer, 2012; Chapman, Styles, Perry, & Combs, 2010; D'Ambra & Andrews, 2014; Edward, Ousey, Warelow, & Lui, 2014; Gates, Gillespie, & Succop, 2011; Hegney, Tuckett, Parker, & Eley, 2010; Spence Laschinger, 2014). According to one study, lost productivity related to workplace incivility was calculated at \$11,581 per nurse annually (Lewis & Malecha, 2011).

Another study of a U.S. hospital employing 5,000 nurses estimated the cost of workplace violence treatment at \$94,156 annually: \$78,924 for treatment and \$15,232 for indemnity for the 2.1% of the hospital's nurses who reported injuries (Speroni, Fitch, Dawson, Dugan, & Atherton, 2014).

The costs of incivility increase when one takes into account the expenses associated with supervising the uncivil employee; managing the situation; consulting with attorneys; interviewing witnesses; and recruiting, hiring, and training new employees (Griffin & Clark, 2014; Lipscomb & London, 2015; Pearson & Porath, 2009, 2013).

## RN HEALTH, PATIENT SAFETY, AND CAREER CONSEQUENCES

Incivility, bullying, and workplace violence harm a person's intrinsic sense of self-worth and self-confidence, which may result in physical symptoms such as headaches, interrupted sleep, and intestinal problems. Those actions may also be associated with psychological conditions, including heightened levels of psychological stress, anxiety, irritability, and depressive symptoms (Clark, 2013a; Demir & Rodwell, 2012; Gates et al., 2011; Gillespie, Gates, & Berry, 2013; Magnavita, 2014; Nicholson & Griffin, 2014; Stecker & Stecker, 2014; Wing, Regan, & Spence Laschinger, 2015). Some report that this heightened stress may progress to posttraumatic stress disorder (Gillespie, Bresler, Gates, & Succop, 2013) or depression (Gullander et al., 2014).

Such effects may impair clinical judgment to the extent that nurse performance is affected. For example, the Institute for Safe Medication Practices (2009) examined the impact that intimidation of nurses had on medication errors. In the subsample, 7% of RNs stated that intimidation had led to a medication error. Other studies report an increase in errors related to patient safety (Sofield & Salmond, 2003) and to an increased incidence of patient falls, delayed medication administration, and medication errors (Roche, Diers, Duffield, & Catling-Paull, 2010). If confidence and competence decrease as a result of incivility, bullying, and workplace violence, this result can adversely affect the quality of patient care and care outcomes (Deans, 2004b; Leivers, 2004).

Incivility, bullying, and workplace violence also occur in academic settings, thus affecting students, faculty members, and all people in the campus community. Numerous studies have documented the existence of harmful actions taken and not taken in academic settings, as well as their consequences (Clark, 2013b; Davis, 2014; Saltzberg, 2011). One such consequence that has major implications for (a) the future of the nursing profession, (b) the ability to honor nursing's contract with society, and (c) the ability to attract new nurses to the profession is, faculty's intent to leave academia at a time when the United States is facing unprecedented projected increases in demand for nurses (DOL, Bureau of Labor Statistics, 2012).

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Documents describing a shortage of faculty refer to academic institutions' claims of financial and salary issues, a shortage of doctoral-level faculty, a shortage of faculty members who are willing and able to teach in clinical settings, an increase in faculty age and retirement, and an inadequate pool of qualified faculty (American Association of Colleges of Nursing, 2015).

Further study is needed on (a) how faculty, including those who are new or are perceived by faculty peers as highly accomplished, are treated within the halls of academe by administrators, peers, and students, and (b) how such treatment contributes to the loss of qualified faculty members and to the detrimental effects that this loss has on nurses' lives and careers (Clark, 2013b; Davis, 2014).

## **A CULTURE OF RESPECT**

Relationships marred by incivility and bullying can contribute to unhealthy work environments that ultimately have a negative impact on the quality and safety of care delivered (American Association of Critical-Care Nurses, 2005). The establishment of positive, respectful relationships is crucial to preventing incivility, bullying, and workplace violence.

Several foundational documents support the need for civility and a culture of respect that must be continuously demonstrated by nurses in all areas of nursing education and practice. For example, "Essential VIII: Professionalism and Professional Values," described by the American Association of Colleges of Nursing (AACN, 2008), underscores the importance of nurses being accountable and responsible for their individual actions and of ensuring that civility underlies professionalism.

Similarly, Provision 1.5 of the ANA Code of Ethics (2015a) requires nurses to treat colleagues, students, and health care consumers with dignity and respect. It also states that any form of harassment, disrespect, or threatening action will not be tolerated. In addition, an Institute of Medicine report (2010) recommends empowering nurses to participate in collaborative efforts to improve work environments and health care systems.

Respectful relationships in which each person is recognized and valued need to be fostered in every workplace. Drawing on a study of registered nurses, Antoniazzi (2011) defines respect as "an open-minded willingness to accept, acknowledge, and value the uniqueness of an individual and her or his knowledge, experiences, and perceptions" (p. 752). Respect is promoted through communication, collaboration, support, and fairness, each of which is foundational for nurses to establish healthy relationships with others.

## **IV. RESPONSIBILITIES OF REGISTERED NURSES AND EMPLOYERS**

A safe work environment promotes physical and psychological well-being. If members of the health care team do not feel safe, the work environment is left vulnerable, and everyone's safety is compromised (National Patient Safety Foundation, 2013). When incivility, bullying, or workplace violence exists, serious problems in the workplace can occur. Rebuilding trust within the workplace community is critical. RNs and employers must come together to identify specific issues and to create a plan of action.

Effective interventions require an ongoing commitment on behalf of RNs and employers to create a safe and trustworthy environment. A shared and sustained commitment to promote dignity and respect is necessary to prevent incivility from escalating to bullying or violence. The goal is to promote and create a culture of health and safety that translates into a safe environment for nurses and other members of the health care team, health care consumers, families, and communities.

Employers also have a legal responsibility to provide a safe and healthy workplace. Under the Occupational Safety and Health Act's General Duty Clause, employers "shall furnish ... a place of employment ... free from recognized hazards that are causing or are likely to cause death or serious physical harm." Employers that do not take steps to prevent or abate a recognized workplace hazard can be cited under the General Duty Clause (DOL, 1970).

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The following two sections detail for RNs and employers recommendations that are related to preventing and mitigating incivility, bullying, and workplace violence. Those recommendations are organized according to the three-level prevention framework commonly used when addressing public health concerns (Wallace, 2008). Primary, secondary, and tertiary prevention strategies are included at each level.

Primary prevention involves education and other measures to identify and reduce vulnerabilities in order to prevent workplace violence from occurring. Primary prevention initiatives are also aimed at improving interpersonal and interprofessional relationships (International Labour Office, International Council of Nurses, World Health Organization, & Public Services International, 2005). Secondary intervention strategies are designed to reduce harm once an incident of workplace violence has begun, and tertiary strategies aim to reduce the consequences associated with such an event.

Within these two sections, *employer* refers to the health care organization, agency, system, corporation, academic setting, business, or persons that employ or contract with the RN across the continuum of care. Nurse leaders responsible for education and the application of policies and procedures are also included in this definition.

Although specified for RNs and employers, the following recommendations may also be relevant to other health care professionals and stakeholders who collaborate to create and sustain a safe and healthy interprofessional work environment.

## V. INCIVILITY AND BULLYING: RECOMMENDED INTERVENTIONS

### A. PRIMARY PREVENTION

Intervention intended to address vulnerabilities and to improve interpersonal and interprofessional relationships

#### RECOMMENDATIONS FOR REGISTERED NURSES

1. RNs must make a commitment to—and accept responsibility for—establishing and promoting healthy interpersonal relationships with one another and with all members of the health care team.
2. RNs must be cognizant of their own interactions, including actions taken and not taken and communication with others. To do so, nurses should insist on and participate in effective communication, diversity and inclusiveness, and conflict negotiation and resolution training offered by their employer, by an academic program, or through continuing education courses.
  - a. **Recommended resource:** The ANA Leadership Institute’s™ “Diversity Matters: Create an Inclusive Nursing Culture that Leads to Better Outcomes” webinar (ANA, 2015b).
  - b. **Recommended resource:** Standards for Establishing and Sustaining Healthy Work Environments (American Association of Critical-Care Nurses, 2005).
  - c. **Recommended resource:** “Civility Tool-kit: Resources to Empower Healthcare Leaders to Identify, Intervene, and Prevent Workplace Bullying” (Adeniran et al., 2015).
  - d. **Recommended resource:** *Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young and Each Other* (2nd ed.) (Bartholomew, 2014).
3. RNs should consider cocreating norms for a civil workplace.

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4. RNs are responsible to themselves and to others for becoming familiar with their employer's incivility and bullying prevention policies and procedures, along with professional and institutional codes of conduct. If no policies exist, RNs are obligated to participate in the development of relevant policies.
  5. RNs should establish an agreed-upon code word or signal to seek support when feeling threatened.
  6. RNs should practice using suggested predetermined phrases or cognitive rehearsal of responses so they can be prepared to deflect incivility and bullying (Griffin, 2004; Griffin & Clark, 2014; Stagg, Sheridan, Jones, & Speroni, 2011, 2013).
  7. RNs, both individually and through their professional associations, are obligated to advocate for incivility and bullying identification and prevention education to be taught in schools of nursing.
  8. RNs should demonstrate respect and a professional demeanor to help reinforce civility and positive norms. Civility best practices include the following:
    - a. Use clear communication verbally, nonverbally, and in writing (including social media).
    - b. Treat others with respect, dignity, collegiality, and kindness.
    - c. Consider how personal words and actions affect others.
    - d. Avoid gossip and spreading rumors.
    - e. Rely on facts and not conjecture.
    - f. Collaborate and share information where appropriate.
    - g. Offer assistance when needed, and, if refused, accept refusal gracefully.
    - h. Take responsibility or be accountable for one's own actions.
    - i. Recognize that abuse of power or authority is never acceptable.
    - j. Speak directly to the person with whom one has an issue.
    - k. Demonstrate openness to other points of view, perspectives, experiences, and ideas.
    - l. Be polite and respectful, and apologize when indicated.
    - m. Encourage, support, and mentor others, including new nurses and experienced nurses.
    - n. Listen to others with interest and respect.
  9. Above all, RNs must aspire to uphold the professional Code of Ethics (ANA, 2015a).

### RECOMMENDATIONS FOR EMPLOYERS

1. Employers must ensure that the organizational vision, mission, philosophy, and shared values are closely aligned with a culture of respect and safety.
  - a. Employees should be given the opportunity to participate in developing those organizational statements.
  - b. Employers should share organizational statements with employees throughout the organization.
2. Employers must orient new employees to existing organizational policies and procedures.
  - a. Employees should be given the opportunity to participate in developing policies and procedures.
  - b. Established policies must be included in employees' initial orientation, documented, and repeated as needed.



3. Employers must establish a zero-tolerance policy regarding incivility and bullying wherein all cases of incivility and bullying are treated in the same manner, regardless of who is involved. The policy must allow for corrective action and must mitigate unacceptable actions in a timely and effective manner.
  - a. The policy must outline reporting mechanisms.
  - b. The policy must include a statement emphasizing that employees must not be retaliated against for reporting.
  - c. The policy must outline investigation protocol and allow for neutral third-party involvement.
  - d. Employers must inform employees of the policy at orientation and repeatedly as needed.
  - e. The policy must specify which entities will be involved in zero-tolerance enforcement (e.g., human resources).
4. Employers must provide a mechanism for RNs to seek support when feeling threatened.
5. Employers must orient employees to strategies available for conflict resolution and respectful communication.
  - a. **Recommended resource:** Agency for Healthcare Research and Quality’s “Team Strategies and Tools to Enhance Performance and Patient Safety” (TeamSTEPPS) program (2013). TeamSTEPPS is an evidence-based program developed to advance teamwork and communication among health care professionals.
6. Employers must make available education sessions that define incivility and bullying, introduce prevention strategies, discuss the organization’s zero-tolerance policy, and detail the consequences of not following the policy.
  - a. Clinical educators, administrators, and nursing faculty should be integral parts of any training offered, because those individuals understand the specific health care organization or the academic setting, and they are familiar with navigating their particular system (Longo, Dean, Norris, Wexner, & Kent, 2011).
7. Academic nursing leaders and nursing faculty members play key roles in preparing nursing students to foster both a culture of civility and a healthy workplace. Nursing leaders and faculty members prepare the students by providing initial civility education, integrating civility content throughout the curriculum and in policy development, and modeling the desired actions. Faculty members can also share with their students the importance of peer coaching and mentoring, plus recommendations for stress-reducing activities.
8. Nursing curricula should include interprofessional communication; crisis theory, identification, and intervention; and conflict negotiation and resolution.
  - a. Strategies for learning may include role-play, clinical simulation, and problem-based scenarios designed to prepare nursing students to prevent and address incivility in academic and practice settings (Clark, Ahten, & Macy, 2012, 2014).

## **B. SECONDARY PREVENTION**

Intervention intended to reduce the negative impacts of incivility and bullying

### **RECOMMENDATIONS FOR REGISTERED NURSES**

1. When RNs experience incivility and bullying, either they can respond directly to the perpetrator, or they can seek out guidance and support through the appropriate channels. When possible, perpetrators of incivility and bullying should be addressed privately.

2. RNs are encouraged to use preestablished code words or other mechanisms to seek support when they feel threatened. This outreach may involve the targeted individual or a bystander using a predetermined phrase that signals all available nurses to move toward the target both to provide nonverbal support and to witness the harmful actions taking place.
3. RNs who observe what they believe to be incivility or bullying should consider letting the perpetrators know that their actions are not consistent with established policies.
  - a. RNs who observe an incident of incivility or bullying should offer support to the target and encourage him or her to report the incident to the employer.
  - b. **Recommended resource:** Workplace Bullying Institute’s “3-Step Target Action Plan” (n.d.).

### RECOMMENDATIONS FOR EMPLOYERS

1. Leaders at all levels need to support efforts to prevent further instances and any repercussions of incivility and bullying. RN leaders must recognize their own vulnerabilities to incivility and bullying and must act in accordance with established policies.
2. Organizations should use empirical measures to (a) assess the type and level of incivility or bullying occurring and (b) develop and implement an action plan that addresses the problem.
3. Employers should offer stress-management and stress-reduction strategies to employees who experience incivility or bullying.
4. Employers should implement measures to reduce both fatigue among employees and incivility associated with fatigue.
  - a. **Recommended resource:** ANA’s Position Statement: “Addressing Nurse Fatigue to Promote Safety and Health: Joint Responsibilities of Registered Nurses and Employers to Reduce Risks” (ANA, 2014).
5. Employers should offer training that enhances employees’ psychological hardiness and resilience (Lambert, Lambert, & Yamase, 2003), self-care measures, and self-reflection practices (Clark, 2014).

### C. TERTIARY PREVENTION

Intervention intended to reduce the consequences of incivility and bullying

### RECOMMENDATIONS FOR REGISTERED NURSES—FOLLOWING INCIDENTS

1. Following an incident of incivility or bullying, report the event as soon as possible through the appropriate channels and in accordance with established policies and procedures.
2. Keep a detailed written account of the incident and, if the incident occurs more than once, its frequency, to help in determining whether a pattern is developing. Include specific information about the incident, including details of what happened, relevant names, dates, and any witnesses to the incident. Ask witnesses to document their observations and to provide you with a signed copy of the written document.
3. Obtain support through peers or another type of support system, engage the employee assistance program, seek counseling, obtain legal counsel, activate the security system, and—if one’s health is affected—consider filing a workers’ compensation claim.
4. Provide support to colleagues who have experienced incivility or bullying. Support can include acknowledging that incivility and bullying are inappropriate and unprofessional. It can also include helping the targeted individual document and report the incident.
5. Recognize one’s own actions taken and not taken as they relate to incivility and bullying. Apologize or make amends. RNs can reflect on, assess, and take actions to initiate change and to transform the ways they interact with and engage others.

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## RECOMMENDATIONS FOR EMPLOYERS—FOLLOWING INCIDENTS

1. Following an incident or report of incivility or bullying, activate reporting mechanisms in accordance with established policies and procedures.
2. Ensure that detailed written accounts of the incident and of its frequency are maintained and monitored to help in determining whether a pattern is developing. Relevant information should be documented and maintained according to established policy.
3. Designate a neutral representative to meet with the involved parties.
4. Consider establishing evidence-based practice committees to identify other solutions for intervening in incidents of incivility and bullying.
5. Establish a performance improvement plan to address employees' actions taken and not taken as they relate to incivility and bullying. Include specific actions the employees must take to demonstrate change as well as a timeline for demonstrating it. Consider including the performance improvement plan in employees' annual or regularly scheduled performance evaluations.
6. Remember that transparency is key; all employees involved in an incident of incivility or bullying should know how it will be handled and how long the process is expected to take.
7. Inform employees that retaliation will not be tolerated.
8. Check in with the person who reported the incident to ensure that instances of incivility and bullying have stopped and that no retaliation has occurred.

## VI. WORKPLACE VIOLENCE: RECOMMENDED INTERVENTIONS

### A. PRIMARY PREVENTION

Education and other strategies to identify and reduce vulnerabilities in order to prevent workplace violence

### RECOMMENDATIONS FOR REGISTERED NURSES

1. Actively participate in the development of the workplace violence prevention program.
2. Understand organizational policies and procedures related to workplace violence prevention and response. If no policies exist, actively participate in the development of relevant policies.
3. Actively participate in education associated with workplace violence prevention. Seek continuing education opportunities to learn more about violence prevention.
  - a. **Recommended resource:** NIOSH's online training titled "Workplace Violence Prevention for Nurses" (NIOSH, 2013).
4. Understand the importance of using situational awareness to identify the potential for violence before it occurs.
  - a. For example, question the presence and purpose of all unknown individuals in the academic or work environment.
  - b. Learn the importance of paying attention to one's surroundings and of being vigilant in unfamiliar surroundings. Learn how to assess the work environment and individuals within it for potential threat or danger. Learn to recognize cues that suggest a potential threat, a danger, or an impending crisis situation.

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5. Learn how to anticipate, prevent, and respond in crisis situations.
  6. Be aware of and know how to use environmental controls to both prevent and reduce violent incidents.
  7. Continually incorporate personal health and wellness strategies that will minimize workplace stressors.
  8. Provide and be open to receiving constructive, timely, and respectful feedback from colleagues, health care consumers, family members, and other relevant stakeholders.

## RECOMMENDATIONS FOR EMPLOYERS

1. Ongoing leadership commitment is essential for creating and supporting a culture of safety and zero tolerance for all types of workplace violence.
2. Employers must foster a supportive work environment in which respectful communication is the norm, organizational policies are understood and followed, and professional codes are honored.
3. Employers must foster a nonpunitive work environment by encouraging reporting, never blaming employees for incidents, and recognizing that employees are not responsible for system failings over which they have no control.
  - a. **Recommended resource:** ANA's Position Statement: "Just Culture" (ANA, 2010b).
  - b. **Recommended resource:** American Psychiatric Nurses Association's "Workplace Violence: APNA 2008 Position Statement" (APNA, 2008).
4. Employers should develop a comprehensive violence prevention program that aligns with the Occupational Safety and Health Administration's "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers" (OSHA, 2015; Lipscomb & London, 2015). Program elements should include the following:
  - a. Management commitment and employee involvement. Employer commitment is the foundation of an effective workplace violence prevention program. Genuine involvement by a health care worker is critical. Health care workers are skilled at (a) recognizing health care consumers who are at risk for violence and (b) identifying prevention strategies.
    - (1) Convene an interprofessional safety committee or workplace violence prevention committee that comprises both employers and frontline health care workers as they plan and implement each phase of the prevention program.
    - (2) Involve health care workers in each element of the violence prevention program.
  - b. Worksite analysis. A thorough analysis is necessary to identify trends and risk factors for violence.
    - (1) Plan to use all available data sources, which may include OSHA logs, injury reports, workers' compensation data, safety or security incident information, and employee surveys.
    - (2) Conduct an analysis of each unit or department within an organization; pay special attention to those areas where incidents have occurred. Develop a mechanism or plan to review and track incidents of violence by organizational-, environmental-, patient-, unit-, and employee-level factors.
    - (3) Schedule regular walk-throughs of all areas of the organization, and enlist clinical employees who will identify potential vulnerabilities and develop a plan to address them.
    - (4) Repeat the analysis at least annually or as needed.

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- c. Hazard prevention and control. Prevention and control measures should be designed in accordance with the result of the worksite analysis.
    - (1) Follow the hierarchy of controls: elimination, substitution, engineering controls, administrative controls, and personal protective equipment (Centers for Disease Control and Prevention, 2015).
    - (2) Engineering controls may include modifying the layout of admissions areas, nurses' stations, and rooms; ensuring adequate lighting; limiting access to certain areas; and securing or eliminating furniture or equipment that may be used as weapons.
    - (3) Engineering controls may also include personal alarm devices, panic buttons, and cellular phones. Those items must be made available to at-risk employees as appropriate.
    - (4) Administrative controls may include developing policies and procedures, establishing codes (such as active shooter or disruptive patient codes), and conducting training and education sessions.
  - d. Training and education. Provide training and education for all employees and relevant stakeholders as needed to ensure familiarity with elements of the workplace violence prevention program.
    - (1) Training should be conducted at the time of hire, repeated annually, and then conducted as needed.
    - (2) Information should be included about the prevalence of violence in health care settings and about risk factors that may increase vulnerability.
    - (3) Training should be specialized to the type of setting. For instance, areas with a documented incidence of violent acts, or those at high risk of violence such as emergency departments and psychiatric units, may require more training on de-escalation techniques and the use of restraints.
    - (4) Training should help employees recognize when others may be experiencing workplace stressors.
    - (5) Mock drills of emergency or crisis scenarios, such as active shooter codes, should be included.
    - (6) De-escalation techniques, self-defense, and situational awareness should be incorporated into trainings.
    - (7) Training and education should encompass a variety of methods, including, but not limited to, hands-on practice, simulation, and follow-up debriefing.
  - e. Development of a plan for reporting, tracking, and evaluating incidents and near-misses.
- 5. Employers must ensure that human resources personnel thoroughly prescreen job applicants and follow procedures for conducting background checks of prospective employees.
  - 6. Employers must confirm that human resources personnel follow procedures to minimize the chance of provoking retaliation by former employees.
  - 7. Optimal levels of staffing are essential to safe patient care and a healthy work environment.
    - a. **Recommended resource:** ANA's Principles for Nurse Staffing, 2nd ed. (2012).

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## **B. SECONDARY PREVENTION**

Intervention intended to reduce the negative impact of workplace violence

### **RECOMMENDATIONS FOR REGISTERED NURSES**

1. Participate in the implementation of the comprehensive workplace violence program.
2. Use crisis intervention and management strategies to assess, plan, and intervene in order to reduce the potential for workplace violence.
3. Use existing administrative controls.
4. Use existing environmental controls (visitor access, panic buttons, etc.).
5. Use the approved reporting system.
6. Report concerns about weaknesses in the system in order to improve processes and communication.

### **RECOMMENDATIONS FOR EMPLOYERS**

1. Continually identify strengths and weaknesses, and make improvements to the workplace violence prevention program.
  - a. Maintain and update engineering controls as necessary.
2. Treat all reports of suspicious actions or threats seriously, and investigate them thoroughly.
3. Review each reported episode of violence with the interprofessional team to identify ways to improve the system and to mitigate future episodes of violence.

## **C. TERTIARY PREVENTION**

Intervention intended to reduce the consequences of workplace violence

### **RECOMMENDATIONS FOR REGISTERED NURSES**

1. Engage in evaluation and continued improvement of the workplace violence prevention program.
2. Participate, as appropriate, in post-incident meetings.
3. Use counseling programs after an incident of workplace violence.
4. Refer bystanders, surviving colleagues, and family members to grief and bereavement counseling or other appropriate health services following the injury, death, murder, or suicide of an employee or patient.
5. Express sympathy and provide support to bystanders and survivors after a colleague or patient is injured or dies during a violent workplace incident.

### **RECOMMENDATIONS FOR EMPLOYERS**

1. Evaluate and improve the workplace violence prevention program and procedures for responding to incidents.
2. Acknowledge the injury or loss of an employee, colleague, or patient after a violent incident occurs in the workplace.
3. Arrange for immediate coverage if an RN needs to leave work following a violent incident (i.e., to seek health care services, report the incident, or work with law enforcement).
4. Provide ongoing support and facilitate return to work for employees who have experienced workplace violence, as appropriate.
5. Provide bystanders, survivors, and employees access to or referral to grief and bereavement counseling or other health services following a violent workplace incident.
6. Conduct a root cause analysis to understand all factors contributing to workplace violence.

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## VII. SUMMARY OF RELEVANT ANA PUBLICATIONS AND INITIATIVES

### 2015 PUBLICATION: CODE OF ETHICS FOR NURSES WITH INTERPRETIVE STATEMENTS (THE CODE)

The Code makes explicit the primary goals, values, and obligations of the nursing profession. ANA believes that The Code is nonnegotiable and that each nurse has an obligation and is expected to uphold and adhere to its ethical precepts.

Four provisions within The Code speak to the obligation of registered nurses to act in a manner that is consistent with maintaining patient, coworker, and personal safety, civility, and respect:

- **Provision 1:** The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person. Specifically, this provision reminds nurses that all individuals with whom the nurse interacts are to be respected, including coworkers. Fair and kind treatment, best resolution of conflicts, and promotion of a culture of civility are stressed. Bullying, harassment, violence, and other unacceptable behaviors are not to be tolerated.
- **Provision 3:** The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
- **Provision 5:** The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.
- **Provision 6:** The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care. The nurse achieves this participation through both individual and collective action. Specifically, this provision addresses creation of a safe health care environment in which nurses are supported in attaining and maintaining a higher moral code. This environment may be accomplished through a variety of practices, including health and safety initiatives, policies addressing discrimination, and incivility position statements (ANA, 2015a).

### 2015 PUBLICATION: NOT PART OF THE JOB: HOW TO TAKE A STAND AGAINST VIOLENCE IN THE WORK SETTING

This book serves as a resource to identify actions and best practices that nurses and their employers can enact to reduce workplace violence. It examines risk factors, worker rights, legal issues, worksite analysis, hazard prevention and control, training and education, and program evaluations. It also emphasizes the establishment of beneficial collaborations and provides case studies for further assistance (Lipscomb & London, 2015).

### 2015 PUBLICATION: NURSING: SCOPE AND STANDARDS OF PRACTICE, 3RD ED.

ANA's *Nursing: Scope and Standards of Practice* is the consummate resource for professional nursing practice. It examines the who, what, where, when, why, and how of nursing practice in measurable, specific competencies that serve as evidence of compliance. Six standards in this publication address the obligation of RNs to act in a manner that is consistent with maintaining the personal safety, civility, and respect of patients, coworkers, and other individuals:

- **Standard 7 (Ethics):** The RN practices ethically. This standard includes integrating social justice, practicing self-reflection, advocating for the rights of others, and respecting the dignity of all people.
- **Standard 8 (Culturally Congruent Practice):** The RN practices in a manner that is congruent with cultural diversity and inclusion principles.

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- **Standard 9 (Communication):** The RN communicates effectively in all areas of practice. This standard asks that RNs assess their own communication skills with patients, families, and coworkers while improving their personal communication and conflict resolution skills.
  - **Standard 10 (Collaboration):** The RN collaborates with the health care consumer and other key stakeholders in the conduct of nursing practice. This standard asks the RN to practice effective (a) conflict management and resolution, (b) engagement, (c) consensus building, and (d) group dynamics and strategies.
  - **Standard 11 (Leadership):** The RN leads within the professional practice setting and the profession. This standard requires the RN to treat coworkers with respect, trust, and dignity.
  - **Standard 12 (Education):** The RN seeks knowledge and competence that reflects current nursing practice and promotes futuristic thinking. This standard requires the RN to mentor and acclimate nurses who are new to their roles, to practice lifelong learning through self-reflection, and to share educational experiences with peers (ANA, 2015c).

### ONGOING INITIATIVE: HEALTHYNURSE™

ANA's HealthyNurse™ initiative provides RNs with resources to guide them toward improved health, safety, and wellness. ANA defines a healthy nurse as one who actively focuses on creating and maintaining a balance and synergy of physical, intellectual, emotional, social, spiritual, personal, and professional well-being. Healthy nurses live life to the fullest capacity, across the wellness–illness continuum, as they become stronger role models, advocates, and educators—personally and professionally—for themselves, their families, their communities, their work environments, and ultimately for their patients (ANA, n.d.).

### 2012 PUBLICATION: BULLYING IN THE WORKPLACE: REVERSING A CULTURE

This booklet guides nurses in recognizing bullying and in identifying its causes and consequences. It discusses the responsibilities of nurses, nurse managers, and employers in regard to bullying identification and mitigation. It also provides recommended actions for responding to and decreasing bullying (Longo, 2012).

### 2011 PUBLICATION: ANA HEALTH & SAFETY SURVEY: HAZARDS OF THE RN WORK ENVIRONMENT

This ANA survey of more than 4,600 RNs examined the unique health and safety risks that RNs face in the workplace. Demographics and ANA membership were also surveyed. Of the survey participants, 34% reported that “an on-the-job assault” was among their top four most serious health and safety concerns (ANA, 2011, p. 3).

### POSITION STATEMENTS AND RESOLUTIONS

A full list of ANA position statements and resolutions can be found on [nursingworld.org](http://nursingworld.org) under the “Policy & Advocacy” tab.



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## VIII. REFERENCES

Adeniran, R., Bolick, B., Cuming, R., Edmonson, C., Khan, B., Lawson, L., & Wilson, D. (2015). "Civility toolkit: Resources to empower healthcare leaders to identify, intervene, and prevent workplace bullying." Retrieved from <http://www.stopbullyingtoolkit.org>.

Agency for Healthcare Research and Quality. (2013). TeamSTEPPS™ Pocket Guide-2.0. Team strategies & tools to enhance performance and patient safety. Publication #14-0001-2. Retrieved from <http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/essentials/pocketguide.html>.

American Association of Colleges of Nursing. (2015). 2014–2015 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing. Retrieved from <http://www.aacn.nche.edu/research-data>.

American Association of Colleges of Nursing. (2008). The essentials of baccalaureate education for professional nursing practice. Retrieved from [www.aacn.nche.edu/education-resources/baccessentials08.pdf](http://www.aacn.nche.edu/education-resources/baccessentials08.pdf).

American Association of Critical-Care Nurses. (2005). *AACN standards for establishing and sustaining healthy work environments: A journey to excellence*. Aliso Viejo, CA: American Association of Critical-Care Nurses.

American Nurses Association. (2010). Position statement: "Just culture." Retrieved from <http://nursingworld.org/psjustculture>.

American Nurses Association. (2011). 2011 ANA health & safety survey: Hazards of the RN work environment. *American Nurses Association Backgrounder*. Retrieved from <http://nursingworld.org/FunctionalMenuCategories/MediaResources/MediaBackgrounders/The-Nurse-Work-Environment-2011-Health-Safety-Survey.pdf>.

American Nurses Association. (2012). *ANA's Principles for Nurse Staffing* (2nd ed.). Silver Spring, MD: Nursesbooks.org.

American Nurses Association. (2014). Position Statement: "Addressing nurse fatigue to promote safety and health: Joint responsibilities of registered nurses and employers to reduce risks." Retrieved from <http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Work-Environment/Work-Environment/NurseFatigue/Addressing-Nurse-Fatigue-to-Promote-Safety-and-Health.html>.

American Nurses Association. (2015a). *Code of Ethics for Nurses with Interpretive Statements*. Silver Spring, MD: Nursesbooks.org.

American Nurses Association. (2015b). "Diversity matters: Create an inclusive nursing culture that leads to better outcomes" [webinar]. Retrieved from <http://www.ana-leadershipinstitute.org/DiversityMatters>.

American Nurses Association. (2015c). *Nursing: Scope and Standards of Practice*. Silver Spring, MD: Nursesbooks.org.

American Nurses Association. (n.d.). HealthyNurse™. Retrieved from <http://www.nursingworld.org/healthynurse>.

American Nurses Association & LCWA Research Group. (2014). ANA HRA: Results and analysis, October 2013–2014 (PowerPoint slides).

American Psychiatric Nurses Association. (2008). "Workplace violence: APNA 2008 position statement." Retrieved from [http://www.apna.org/files/public/APNA\\_Workplace\\_Violence\\_Position\\_Paper.pdf](http://www.apna.org/files/public/APNA_Workplace_Violence_Position_Paper.pdf).

- 
- Andersson, L. M., & Pearson, C. M. (1999). Tit for tat? The spiraling effect of incivility in the workplace. *Academy of Management Review*, 24(3), 452–471. doi: 10.5465/AMR.1999.2202131.
- Antoniazzi, C. D. (2011). Respect as experienced by registered nurses. *Western Journal of Nursing Research*, 33(6), 745–766. doi: 10.1177/0193945910376516.
- Balducci, C., Alfano, V., & Fraccaroli, F. (2009). Relationship between mobbing at work and MMPI-2 personality profile, posttraumatic stress symptoms, and suicidal ideation and behavior. *Violence & Victims*, 24(1), 52–67.
- Bartholomew, K. (2014). *Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young and Each Other* (2nd ed.). Danvers, MA: HCPPro, Inc.
- Berry, P. A., Gillespie, G. L., Gates, D., & Schafer, J. (2012). Novice nurse productivity following workplace bullying. *Journal of Nursing Scholarship*, 44(1), 80–87. doi: 10.1111/j.1547-5069.2011.01436.x.
- Bowling, N. A., & Beehr, T. A. (2006.) Workplace harassment from the victim's perspective: A theoretical model and meta-analysis. *Journal of Applied Psychology*, 91(5), 998–1012.
- Centers for Disease Control and Prevention. (2015). Hierarchy of controls. Retrieved from <http://www.cdc.gov/niosh/topics/hierarchy/>.
- Chapman, R., Styles, I., Perry, L., & Combs, S. (2010). Examining the characteristics of workplace violence in one non-tertiary hospital. *Journal of Clinical Nursing*, 19(3–4), 479–488. doi: 10.1111/j.1365-2702.2009.02952.x.
- Clark, C. M. (2013a). *Creating and Sustaining Civility in Nursing Education*. Indianapolis, IN: Sigma Theta Tau International Publishing.
- Clark, C. M. (2013b). National study on faculty-to-faculty incivility: Strategies to promote collegiality and civility. *Nurse Educator*, 38(3), 98–102.
- Clark, C. M. (2014). Seeking civility: The author offers strategies to create and sustain healthy workplaces. *American Nurse Today*, 9(7), 18–21, 46.
- Clark, C. M., Ahten, S. M., & Macy, R. (2012). Using Problem Based Learning (PBL) scenarios to prepare nursing students to address incivility. *Clinical Simulation in Nursing*, 9(3), e75–e83.
- Clark, C. M., Ahten, S. M., & Macy, R. (2014). Nursing graduates' ability to address incivility: Kirkpatrick's level-3 evaluation. *Clinical Simulation in Nursing*, 10(8), 425–431.
- Clark, C. M., Werth, L., & Ahten, S. M. (2012). Cyber-bullying and incivility in the online learning environment: Part One—Addressing faculty and student perceptions. *Nurse Educator*, 37(4), 150–156.
- Clark, C. M., Ahten, S. M., & Werth, L. (2012). Cyber-bullying and incivility in the online learning environment: Part Two—Promoting student success in the virtual classroom. *Nurse Educator*, 37(5), 192–197.
- Colby, A., Kohlberg, L., Speicher, B., Hewer, A., Candee, D., Gibbs, J. & Power, C. (1987). *The Measurement of Moral Judgment: Theoretical Foundations and Research Validation (Vol. 1)*. New York, NY: Cambridge Press.
- Davis, N. P. (2014). *Nursing Faculty Descriptions of Horizontal Violence in Academe*. (Unpublished doctoral dissertation). University of Kansas, Lawrence, KS.

- 
- D'Ambra, A. M., & Andrews, D. R. (2014). Incivility, retention, and new graduate nurses: An integrated review of the literature. *Journal of Nursing Management*, 22(6), 735–742. doi: 10.1111/jonm.12060.
- Deans, C. (2004a). Nurses and occupational violence: The role of organizational support in moderating professional competence. *Australian Journal of Advanced Nursing*, 22(2), 15–18.
- Deans, C. (2004b). Who cares for nurses? The lived experience of workplace aggression. *Collegian*, 11(2), 32–36.
- Demir, D., & Rodwell, J. (2012). Psychosocial antecedents and consequences of workplace aggression for hospital nurses. *Journal of Nursing Scholarship*, 44(4), 376–384.
- DiRosa, A. E., Gangemi, S., Cristani, M., Fenga, C., Saitta, S., Abenavoli, E., Imbesi, S., Speciale, A., Minciullo, P. L., Spatari, G., Abbate, S., Saija, A., & Cimino, F. (2009). Serum levels of carbonylated and nitrosylated proteins in mobbing victims with workplace adjustment disorders. *Biological Psychology*, 82(3), 308–311.
- Edward, K. L., Ousey, K., Warelow, P., & Lui, S. (2014). Nursing and aggression in the workplace: A systematic review. *British Journal of Nursing* (Mark Allen Publishing), 23(12), 653–654, 656–659. doi: 10.12968/bjon.2014.23.12.653.
- Einarsen, S., Hoel, H., Zapf, D., & Cooper, C. L. (2011). *Bullying and Harassment in the Workplace* (2nd ed.). New York, NY: CRC Press.
- Galen, B. R., & Underwood, M. K. (1997). A developmental investigation of social aggression among children. *Developmental Psychology*, 33(4), 589–600.
- Gates, D. M., Gillespie, G. L., & Succop, P. (2011). Violence against nurses and its impact on stress and productivity. *Nursing Economics*, 29(2), 59–67.
- Gillespie, G. L., Bresler, S., Gates, D. M., & Succop, P. (2013). Posttraumatic stress symptomatology among emergency department workers following workplace aggression. *Workplace Health & Safety*, 61(6), 247–254. doi: 10.3928/21650799-20130516-07.
- Gillespie, G. L., Gates, D. M., & Berry, P. (2013). Stressful incidents of physical violence against emergency nurses. *Online Journal of Issues in Nursing*, 18(1).
- Giumetti, G. W., Hatfield, A. L., Scisco, J. L., Schroeder, A. N., Muth, E. R., & Kowalski, R. M. (2013). What a rude e-mail! Examining the differential effects of incivility versus support on mood, energy, engagement, and performance in an online context. *Journal of Occupational Health Psychology*, 18(3), 297–309. doi: 10.1037/a0032851.
- Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *The Journal of Continuing Education in Nursing*, 35(6), 257–263.
- Griffin, M., & Clark, C. M. (2014). Revisiting cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later. *Journal of Continuing Education in Nursing*, 45(12), 535–542.
- Gullander, M., Hogh, A., Hansen, A. M., Persson, R., Rugulies, R., Kolstad, H. A., & Bonde, J. P. (2014). Exposure to workplace bullying and risk of depression. *Journal of Occupational and Environmental Medicine*, 56(12), 1258–1265. doi: 10.1097/JOM.0000000000000339.
- Hader, R. (2008). Unsettling findings: Employees' safety isn't the norm in our healthcare settings. *Nursing Management*, 39(7), 13–19.

---

Harper, J. (2013, April 8). Surviving workplace mobbing: Seeking support. Psychology Today's Beyond Bullying blog. Retrieved from <http://www.psychologytoday.com/blog/beyond-bullying/201304/surving-workplace-mobbing-seeking-support>.

Hegney, D., Tuckett, A., Parker, D., & Eley, R. M. (2010). Workplace violence: Differences in perceptions of nursing work between those exposed and those not exposed: A cross-sector analysis. *International Journal of Nursing Practice*, 16(2), 188–202. doi: 10.1111/j.1440-172X.2010.01829.x.

Hodgson, M. J., Reed, R., Craig, T., Murphy, F., Lehmann, L., Belton, L., & Warren, N. (2004). Violence in healthcare facilities: Lessons from the Veterans Health Administration. *Journal of Occupational and Environmental Medicine*, 46(11), 1158–1165.

Hutchinson, M. (2009). Restorative approaches to workplace bullying: Educating nurses toward shared responsibility. *Contemporary Nurse*, 32(1–2), 147–155.

Hutchinson, M., Vickers, M. H., Jackson, D., & Wilkes, L. (2006). “They stand you in a corner; you are not to speak”: Nurses tell of abusive indoctrination in work teams dominated by bullies. *Contemporary Nurse*, 21(2), 228–238.

Hutchinson, M., Wilkes, L., Jackson, D., & Vickers, M. H. (2010). Integrating individual, work group and organizational factors: Testing a multidimensional model of bullying in the nursing workplace. *Journal of Nursing Management*, 18(2), 173–181. doi: 10.1111/j.1365-2834.2009.01035.x.

Institute for Safe Medication Practices. (2009). Results from ISMP Survey on Workplace Intimidation. Retrieved from <https://www.ismp.org/Survey/surveyResults/Survey0311.asp>.

Institute of Medicine. (2011). *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: National Academies Press. Retrieved from <http://www.nap.edu/catalog/12956/the-future-of-nursing-leading-change-advancing-health>.

International Labour Office, International Council of Nurses, World Health Organization, and Public Services International. (2005). Framework guidelines for addressing workplace violence in the health sector. Retrieved from [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---safework/documents/instructionalmaterial/wcms\\_108542.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/instructionalmaterial/wcms_108542.pdf).

Iowa Prevention Research Center. (2001). *Workplace Violence: A Report to the Nation*. Iowa City, IA: University of Iowa, Injury Prevention Research Center.

Johnson, S. L., & Rea, R. E. (2009). Workplace bullying concerns for nurse leaders. *Journal of Nursing Administration*, 39(2), 84–90.

The Joint Commission. (2008). Behaviors that undermine a culture of safety. Sentinel Event Alert, 40 (July 29). Retrieved 3/3/15 from [http://www.jointcommission.org/assets/1/18/SEA\\_40.pdf](http://www.jointcommission.org/assets/1/18/SEA_40.pdf).

Kaplan, K., Mestel, P., & Feldman, D. L. (2010). Creating a culture of mutual respect. *AORN Journal*, 91(4), 495–510.

King-Jones, M. (2011). Horizontal violence and the socialization of new nurses. *Creative Nursing*, 17(2), 80–86.

Lambert, V. A., Lambert, C. E., & Yamase, H. (2003). Psychological hardiness, workplace and related stress reduction strategies. *Nursing and Health Sciences*, 5(2), 181–184. doi: 10.1046/j.1442-2018.2003.00150.x Retrieved from <http://onlinelibrary.wiley.com/doi/10.1046/j.1442-2018.2003.00150.x/pdf>.

- 
- Leivers, G. (2004). Harassment by staff in the workplace: The experience of midwives. *MIDRS Midwifery Digest*, 14, 19–24.
- Lewis, P. S., & Malecha, A. (2011). The impact of workplace incivility on the work environment, manager skill, and productivity. *The Journal of Nursing Administration*, 41(1), 41–47. doi: 10.1097/NNA.0b013e3182002a4c.
- Leymann, H. (1990). Mobbing and psychological terror at workplaces. *Violence and Victims*, 5(2), 119–126.
- Lipscomb, J., & London, M. (2015). *Not Part of the Job: How to Take a Stand Against Violence in the Work Setting*. Silver Spring, MD: Nursesbooks.org.
- Longo, J. (2012). *Bullying in the Workplace: Reversing a Culture*. Silver Spring, MD: Nursesbooks.org.
- Longo, J., Dean, A., Norris, S. D., Wexner, S. W., & Kent, L. N. (2011). It starts with a conversation: A community approach to creating healthy work environments. *Journal of Continuing Education in Nursing*, 42(1), 27–35. Retrieved 3/5/15 from [http://cdn.trustedpartner.com/docs/library/PalmHealthcareFoundation2010/Community%20Conversation\\_JCEN\\_01\\_11.pdf](http://cdn.trustedpartner.com/docs/library/PalmHealthcareFoundation2010/Community%20Conversation_JCEN_01_11.pdf).
- Magnavita, N. (2014). Workplace violence and occupational stress in healthcare workers: A chicken-and-egg situation—Results of a 6-year follow-up study. *Journal of Nursing Scholarship*, 46(5), 366–376.
- McKenna, B. G., Smith, N. S., Poole, S. J., & Cloverdale, J. (2003). Horizontal violence experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing*, 42(1), 90–96.
- McNamara, S. (2012). Incivility in nursing: Unsafe nurse, unsafe patients. *Association of Operating Room Nurses Journal*, 95(4), 535–540. doi: <http://dx.doi.org/10.1016/j.aorn.2012.01.020>.
- Monteleone, P., Nolfé, G., Serritella, C., Milano, V., Di Cerbo, A., Blasi, F., & Maj, M. (2009). Hypoactivity of the hypothalamo-pituitary-adrenal axis in victims of mobbing: Role of the subjects' temperament and chronicity of the work-related psychological distress. *Psychotherapy and Psychosomatics*, 78(6), 381–383.
- National Institute for Occupational Safety and Health. (2002). "Violence: Occupational hazards in hospitals." Retrieved from <http://www.cdc.gov/niosh/docs/2002-101/pdfs/2002-101.pdf>.
- National Institute for Occupational Safety and Health. (2006). "Workplace violence prevention strategies and research needs." NIOSH Publication No. 2006-144. Cincinnati, OH: NIOSH Publication Dissemination.
- National Institute for Occupational Safety and Health. (2013). Workplace violence prevention for nurses. CDC Course No. WB1865–NIOSH Pub. No. 2013-155. Retrieved from [http://www.cdc.gov/niosh/topics/violence/training\\_nurses.html](http://www.cdc.gov/niosh/topics/violence/training_nurses.html).
- National Patient Safety Foundation. (2013). *Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care*. Boston, MA: Lucian Leape Institute.
- Nicholson, T., & Griffin, B. (2014). Here today but not gone tomorrow: Incivility affects after-work and next-day recovery. Epub: *Journal of Occupational Health Psychology*, 20(2), 218–225. doi: 2014-48745-001.
- Occupational Safety and Health Administration. (2015). "Guidelines for preventing workplace violence for healthcare and social service workers" (Publication No. OSHA 3148-04R 2015). Retrieved from <https://www.osha.gov/Publications/osha3148.pdf>.

---

Pearson, C. M., Andersson, L. M., & Porath, C. L. (2005). Workplace incivility. In S. Fox & P. E. Spector (Eds.), *Counterproductive Work Behavior Investigations of Actors and Targets* (pp. 177–200). Washington, DC: American Psychological Association.

Pearson, C., & Porath, C. (2009). *The Cost of Bad Behavior: How Incivility Is Damaging Your Business and What to Do About It*. New York, NY: Portfolio.

Pearson, C., & Porath, C. (2013, January/February). The price of incivility. *Harvard Business Review*. Retrieved from <https://hbr.org/2013/01/the-price-of-incivility/>.

Read, E., & Spence Laschinger, H. K. (2013). Correlates of new graduate nurses' experiences of workplace mistreatment. *Journal of Nursing Administration*, 43(4), 221–228. doi: 10.1097/NNA.0b013e3182895a90.

Roche, M., Diers, D., Duffield, C., & Catling-Paull, C. (2010). Violence toward nurses, the work environment, and patient outcomes. *Journal of Nursing Scholarship*, 42(1), 13–22.

Rodwell, J., Brunetto, Y., Demir, D., Shacklock, K., & Farr-Wharton, R. (2014). Abusive supervision and links to nurse intentions to quit. *Journal of Nursing Scholarship*, 46(5), 357–365. doi: 10.1111/jnu.12089.

Royal College of Nursing. (2002). *Dealing With Bullying and Harassment: A Guide for Nursing Students*. London, U.K.: Royal College of Nursing.

Saltzberg, C. W. (2011.) Balancing in moments of vulnerability while dancing the dialectic. *Advances in Nursing Science*, 34(3), 229–242.

Simons, S. (2008). Workplace bullying experienced by Massachusetts registered nurses and the relationship to intention to leave the organization. *Advances in Nursing Science*, 31(2), E48–E59.

Smith, L. M., Andrusyszyn, M. A., & Spence Laschinger, H. K. (2010). Effects of workplace incivility and empowerment on newly graduated nurses' organizational commitment. *Journal of Nursing Management*, 18(8), 1004–1015. doi: 10.1111/j.1365-2834.2010.01165.x.

Sofield, L. & Salmond, S. W. (2003). Workplace violence: A focus on verbal abuse and intent to leave the organization. *Orthopaedic Nursing/National Association of Orthopaedic Nurses*, 22(4), 274–283.

Spector, P. E., Zhou, Z. E., & Che, X. X. (2013). Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review. *International Journal of Nursing Studies*, 51(1), 72–84. doi: 10.1016/j.ijnurstu.2013.01.010.

Spence Laschinger, H. K. (2014). Impact of workplace mistreatment on patient safety risk and nurse-assessed patient outcomes. *Journal of Nursing Administration*, 44(5), 284–290. doi: 10.1097/NNA.0000000000000068.

Speroni, K. G., Fitch, T., Dawson, E., Dugan, L., & Atherton, M. (2014). Incidence and cost of nurse workplace violence perpetrated by hospital patients or patient visitors. *Journal of Emergency Nursing*, 40(3), 218–228; quiz 295. doi: 10.1016/j.jen.2013.05.014.

Stagg, S. J., Sheridan, D. J., Jones, R. A., & Speroni, K. G. (2011). Evaluation of a workplace bullying cognitive rehearsal program in a hospital setting. *The Journal of Continuing Education in Nursing*, 42(9), 395–401.

Stagg, S. J., Sheridan, D. J., Jones, R. A., & Speroni, K. G. (2013). Workplace bullying: The effectiveness of a workplace program. *Workplace Health & Safety*, 61(8), 333–338. doi: 10.3928/21650799-20130716-03.

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Stecker, M., & Stecker, M. M. (2014). Disruptive staff interactions: A serious source of inter-provider conflict and stress in health care settings. *Issues in Mental Health Nursing*, 35(7), 533–541. doi: 10.3109/01612840.2014.891678.

Tarkan, L. (2008, December 1). Arrogant, abusive, and disruptive—and a doctor. *The New York Times*. Retrieved from <http://www.nytimes.com/2008/12/02/health/02rage.html>.

U.S. Department of Labor. Occupational Safety and Health Act of 1970. (1970). Retrieved from <https://www.osha.gov/law-regs.html>.

U.S. Department of Labor, Bureau of Labor Statistics. (2012, January). Employment outlook: 2010–2020. *Monthly Labor Review*. Retrieved from <http://www.bls.gov/pub/mlr/2012/01/mlr201201.pdf>.

U.S. Department of Labor, Bureau of Labor Statistics. (2014). Nonfatal occupational injuries and illnesses requiring days away from work, 2013. (No. USDL-14-2246). Retrieved from <http://www.bls.gov/news.release/pdf/osh2.pdf>.

Vessey, J. A., DeMarco, R., & DiFazio, R. (2010). Bullying, harassment, and horizontal violence in the nursing workforce: The state of the science. *Annual Review of Nursing Research*, 28, 133–157.

Vessey, J. A., DeMarco, R. F., Gaffney, D. A., & Budin, W. C. (2009). Bullying of staff registered nurses in the workplace: A preliminary study for developing personal and organizational strategies for the transformation of hostile to healthy workplace environments. *Journal of Professional Nursing*, 25(5), 299–306.

Wallace, R. B. (Ed.). (2008). Wallace/Maxcy-Rosenau-Last *Public Health & Preventive Medicine* (15th ed.). Philadelphia, PA: McGraw-Hill.

Washington State Department of Labor and Industries, Safety and Health Assessment and Research for Prevention Program. (2011). Workplace bullying and disruptive behavior: What everyone needs to know. Retrieved 3/3/15 from <http://www.lni.wa.gov/safety/research/files/bullying.pdf>.

Westhues, K. (2004). *The Envy of Excellence: Administrative Mobbing of High-Achieving Professors*. Lewiston, NY: Edwin Mellen Press.

Wing, T., Regan, S., & Spence Laschinger, H. K. (2015). The influence of empowerment and incivility on the mental health of new graduate nurses. *Journal of Nursing Management*, 23(5), 632–643.

Wolf, L. A., Delao, A., & Perhats, C. (2014). Nothing changes, nobody cares: Understanding the experience of emergency nurses physically or verbally assaulted while providing care. *Journal of Emergency Nursing*, 40(4), 305–310, doi: 10.1016/j.jen.2013.11.006.

Workplace Bullying Institute. (n.d.). The WBI 3-step target action plan. Retrieved from <http://www.workplacebullying.org/individuals/solutions/wbi-action-plan/>.

World Health Organization. (2015). Violence. Retrieved from <http://www.who.int/topics/violence/en/>.

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