Strategies Combating Workplace Incivility: An Integrative Review of Literature

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Abstract. Workplace incivility can be likened to an insidious disease that has infiltrated healthcare settings worldwide, leaving a trail of destructive consequences. This is a spotlight of concern as there are many unfavourable consequences of workplace incivility, including increased medical errors, reduced patient satisfaction, increased turnover rates, job dissatisfaction, and decreased productivity. It is unrealistic to assume that workplace incivility can be completely eradicated, aiming to reduce its impact by effective identification, manipulation and control is a priority. This integrative review aimed to explore the interventions used to minimize and control workplace incivility in the healthcare setting. Specific objectives identified were to identify interventions to minimize incivility and its impact; and to explore the impact of these interventions on reducing incivility. The search strategy commenced with a search of numerous electronic databases, namely PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline and Google Scholar search engine and was conducted in December 2022. The keywords and terms used were: "Impact & Management of Incivility" and "nursing". Twelve articles identified met the inclusion criteria. The results identified various considerations and mechanisms employed to successfully minimize workplace incivility and its impact on healthcare employees. Common strategies were identified, the most prominent of these being psychological capital, education/cognitive rehearsal, and leadership. The study highlights that workplace incivility is a multifactorial issue that requires multidimensional solutions. A 'triple whammy' approach - enhancing psychological capital, leadership empowerment, and education with cognitive rehearsal will have a positive impact in combating workplace incivility.

Keywords: Workplace Incivility · nursing · psychological capital · cognitive rehearsal · Themes: Nursing Management and Administration Nursing Education

1 Introduction

Workplace incivility (WPI) is a universal problem that has increased in notoriety in recent years [1–4]. Workplace incivility can be likened to an insidious disease that has infiltrated healthcare settings worldwide, leaving a trail of destructive consequences, and

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as such, has become a spotlight of concern. Workplace incivility can be described as any negative behaviour with low-intensity and unclear ambiguous intentions that violates the required norms for mutual respect in the workplace [5, 6]. Example behaviours include rude comments, using a condescending tone, hostility, sarcastic gestures such as eye-rolling, and addressing someone unprofessionally [5, 7, 8].

A plethora of research on the subject has elucidated many of the unfavourable aspects of WPI in nursing, including increased turnover rates, job dissatisfaction, decreased productivity and absenteeism [1, 6, 9]. Victims of incivility, be it the affected individual or the witness, are prone to negative behavioural, psychological, and somatic effects such depressed mood, anxiety, fear, irritability, headaches, fatigue, and loss of concentration [7, 10, 11]. The culmination of the effects of this disruptive behaviour ultimately has the propensity to lead to increased medical errors, reduced patient satisfaction and negative patient outcomes [10, 12].

In order to effectively address any pressing issue such as WPI, it is prudent to approach it in a strategic and systematic manner, ultimately culminating in quality improvement. Identifying a goal, or aim, in this case to combat incivility in the workplace, initiates a streamlined and systematic process whereby clear objectives are ascertained [13]. These objectives or drivers can be primary or secondary in nature. Primary drivers in WPI include the need to eliminate uncivil behaviour in the workplace as well as finding preventive and protective measures for victims of WPI. Secondary objectives may include focusing on offender behaviour change, focusing on victim coping mechanisms, corrective measures, and education and awareness. The identification of these clear objectives, or drivers lends itself to the establishment of change ideas such as developing rehabilitation-based programs, as well as programs to equip victims with protective mechanisms, and to maximize self-efficacy and psychological capital. As it is unrealistic to assume that WPI can be completely eradicated, aiming to reduce its impact by effective identification, manipulation and control is a dutiful priority [2]. However, the traditional means of addressing incivility in the workplace practiced in healthcare organizations focuses on minimizing the frequency of its occurrence by identifying causal and contributory factors, and by establishing systems for reporting and addressing it after the fact [5, 14]. Equally important for healthcare organizations and nurse leaders to consider and implement are strategies that can be applied to protect nurses from the devastating consequences of incivility in the workplace [15–17].

Based on review of the available literature, it can be concluded that workplace incivility has negative consequences. It has been shown to cause widespread emotional distress and can be regarded as a negative behaviour that leads to increased absences, lower productivity or impeded ability to work [18]. Retention and attrition are also negatively impacted by workplace incivility [19]. The prevention and management of WPI is a crucial factor in maintaining a healthy workforce and in promoting recruitment and retention.

2 Objectives

This integrative review aims to explore the interventions used to minimize and control workplace incivility. Specific objectives of this study are two-fold:

1) Identify interventions to minimize incivility and its impact;
2) Explore the impact of these interventions on reducing incivility;

This study helps to enrich the body of scientific knowledge of workplace incivility in respect of the exploration of preventive, management and control interventions that can be utilized by all stakeholders. It also contributes to the literature regarding turnover, recruitment, and retention in nursing by adding a different perspective in the integration with these in the current study.

3 Methods

The search strategy commenced with a search of numerous electronic databases, namely PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), as well as Google Scholar search engine and was conducted in December 2022. The keywords and terms used were: "Impact & Management of Incivility" and "nursing." All studies related to management of incivility in nursing were included, regardless of the type of management strategy discussed. Inclusion criteria encompassed all scientific qualitative and quantitative empirical research study designs, that were published between 2013 to 2022. The studies were to be written in English and pertaining to nurses only. All the studies were to be presented in peer-reviewed journals and were to study management of incivility in nursing and/or management of the impact of incivility in nursing, specifically related to preventive &/or protective measures. Studies conducted before 2013 were excluded as well as those not specifically related to nurses. Studies that did not include the topic 'incivility' were excluded, as well as those not written in English. The data collection process involved utilizing the PRISMA method (Fig. 1).

To identify potentially eligible studies, at least two reviewers (author and independent reviewer) screened all titles and abstracts. The two reviewers independently read the abstracts and titles selected for possible inclusion. The references were screened against the inclusion criteria. The author and independent reviewer conferred once they had individually decided which papers should be included in the review. In total, 153 articles were identified, and of those, 12 were applicable and met the inclusion criteria and were therefore included in the integrative review. The findings of the literature were then organized on a table of evidence.

With regards to data extraction and management, two data extraction tables were designed. The first table consisted of details of demographic data, study design/s, strategies identified, and interventions. The second table was comprised of information regarding the various studies results in terms of participation rates, components measured, and consequences *(See appendix 1 & 2).* The two reviewers extracted data using the agreed tables thereby identifying common themes such as psychological capital, leadership, as well as education and cognitive rehearsal as having an impact on WPI. Similarities and differences with regards to age/level of experience, geographical/cultural aspects, and

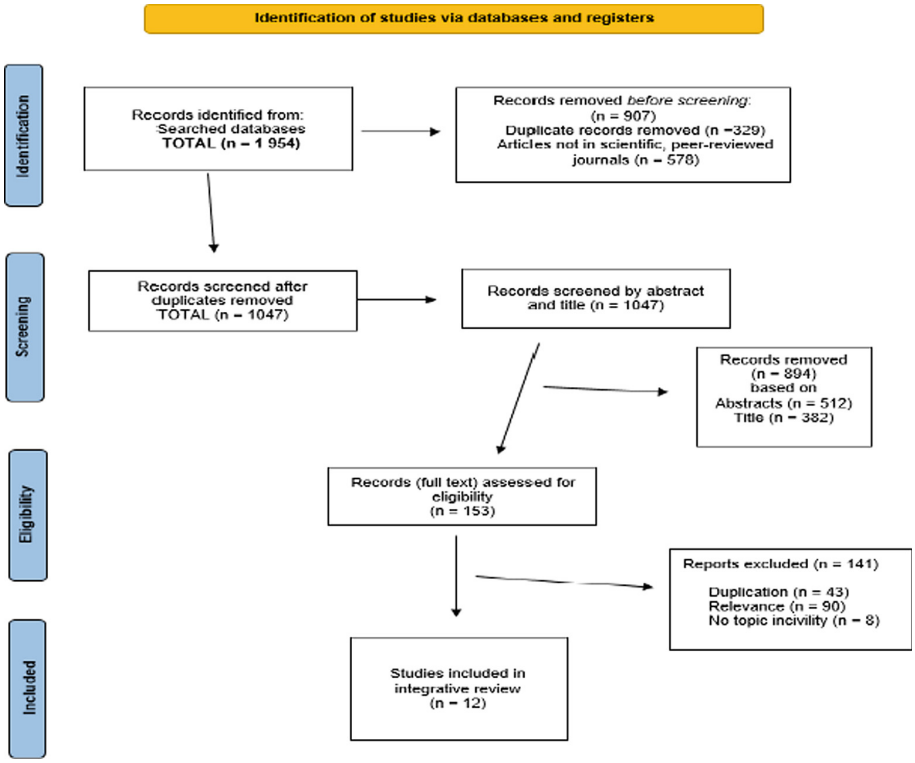

Fig. 1. PRISMA flow diagram (2020) of study literature search and selection process.

specific topics addressed within the studies were also highlighted within the accumulated data.

4 Results

Twelve studies were reviewed to ascertain incivility in daily nursing life, nurses' awareness of incivility, factors impacting incivility, as well as the types of preventive and protective interventions implemented to address incivility in the workplace. Participants in eight of the twelve studies were solely nurses and the remaining four studies consisted of a combination of physicians, nurses and administrative staff. Specific nurse roles were not determined although there were a variety of nurse educators, front-line nurses, nurse managers and novice nurses. Student nurses and newly licenced nurses were the target participants in three studies. The average ages of participants ranged from 23 to 56 years across all the studies and sample sizes varied from 9 to 1241participants. Two studies were conducted in Europe, [20, 21] two in the Middle East [8, 10], two in the US and Canada [22, 23] two in China [24, 25] and the rest were unspecified. The participants of all of the studies worked in the hospital environment except two studies that combined hospital and healthcare education institution locations, and one study that didn't specify work environment [25, 26].

Four studies evaluated the impact of the protective mechanism of psychological capital on incivility, [10, 20, 24, 25] four studies assessed the role and/or type of leadership style moderating incivility in the workplace [21–23, 26] and four studies incorporated participant education and/or cognitive rehearsal related to identifying and managing incivility [8, 11, 15, 27].

Although some studies didn't record participants' response rate, [10, 11, 25] there were more than (>50%) response rates in four studies, [20, 24, 26, 27] and two studies had 100% response rate [8, 15]. Participants from seven studies acknowledged experiencing incivility in the workplace, either personally or as a witness. [15, 20–23, 26, 27] Results revealed that there was an increased awareness among participants of what constitutes as incivility after a specified intervention in four of the studies [8, 11, 15, 27] and two studies reported a decrease in the incidence of incivility [8, 10]. Three main strategies for combating workplace incivility were identified in the review, namely psychological capital, education and cognitive rehearsal, and leadership.

4.1 Psychological Capital

Psychological capital was discussed in four of the studies and is defined as an individual's positive psychological state of development, is characterized by having high levels of HERO; the four elements of Hope, (Self) Efficacy, Resilience, and Optimism [28]. Psychological capital as a protective buffer against the negative consequences of incivility was strongly evidenced in the four included studies. The consensus throughout the four studies deduced that psychological capital was an effective protective and preventive mechanism against the occurrence of WPI. One of these studies was undertaken across seven healthcare institutions and involved > 320 nurses, doctors and administrative staff in Jordan found that co-worker incivility had a significant positive impact on psychological distress, and that "PsyCap", or psychological capital, buffered the effects of co-worker incivility in that employees with high PsyCap experienced lower levels of distress even when co-worker incivility was high [10]. Two studies focused on the impact of bullying and workplace violence (both forms of incivility) on mental health [20, 24]. Chatzioannidis et al., (2017) in their study of bullying in the workplace, utilized a General Health Questionnaire to examine psychological distress of 398 doctors and nurses in NICU's in 20 hospitals in Greece. The results showed that bullying exposure, witnessed bullying of others and self-labelling as a victim were associated with lower levels of psychological health status and that psychological support had a moderating effect on the GHQ-12 scale for those employees being bullied [20]. Moreover, they correlated that a supportive work environment and factors such as job control and personal self-regulation could play a protective role against bullying acts. Li et al.,'s study in 2021 further corroborated the protective function of psychological capital by finding that PsyCap could mediate the effect of workplace violence on depressive symptoms among doctors and nurses and that those with high levels of psychological capital were adaptable to changing demands and demonstrated emotional stability when faced with workplace violence [24]. The effectiveness of empathy interventions for both victims and perpetrators, like enhanced communication skills, and improved ability to understand the emotional status of others was considered in one of the studies which focused

on young nurses coping strategies against lateral violence from their senior colleagues [25].

4.2 Education and Cognitive Rehearsal

Various structured and focused educational interventions were evaluated in four of the studies reviewed. Educational activities ranged from a cognitive rehearsal program and written instructional material, [8, 27] didactic instruction and practicing cognitive rehearsal, [11] a Civility, Respect, and Engagement in the Workplace (CREW) program of facilitated discussions, team building exercises and experiential learning activities, otherwise known as cognitive rehearsal [15]. Three of the studies incorporated cognitive rehearsal as one of the modes of incivility education delivery, [11, 15, 27] and one was a single-blinded parallel randomized clinical trial with an intervention and a control group [8]. All four studies reported an increase in incivility awareness and a decrease in WPI overall after intervention. Interestingly, one of the studies indicated a paradoxical response. This single-blinded randomized clinical trial by Kousha et al. (2013) involved an intervention group and a control group of emergency nurses where the intervention group received a cognitive rehearsal program involving role-playing ten common incivility behaviours and how to deal with them, whereas the control group only received written information on incivility. After the intervention, overall incivility increased in the intervention group, while it decreased in the control group. This phenomenon was explained by the authors of the study as being due to an increase in awareness of uncivil behaviours and therefore increased reporting of such. This was further supported by Ramacciati et al. (2016), who assumed that after an intervention, by increasing participants' awareness of workplace violence characteristics, a higher prevalence of workplace violence was recorded [8, 29].

4.3 Leadership

A positive work environment was closely correlated to leadership as evidenced in the four studies reviewed. One study concluded that nurse manager ability, leadership, and support of nurses were potential avenues to address co-worker incivility. Resonant leadership, in particular, was noted to have a strong positive direct effect on workplace empowerment which in turn had a significant negative effect on co-worker incivility [23]. Resonant supervisory behaviours were also seen to be inversely correlated with nurse peer incivility [26]. Additionally, resonant leadership was found to have both a direct influence on job satisfaction as well as an indirect effect through creating a greater sense of empowerment and lower incivility [23]. Attaining happiness through self-actualization and having a purpose in life by means of servant leadership was also addressed in one study, [21] which provided insights into workplace factors, in the form of servant leadership and workplace civility, which shape the good functioning of employees.

5 Discussion

The results of the twelve studies that were reviewed identified various considerations and mechanisms employed to successfully minimize WPI and its impact on healthcare employees. Although the studies did not include the same strategies, similarities and common techniques were identified, the most prominent of these being psychological capital, education and cognitive rehearsal, and leadership. The equal distribution of these themes across the twelve studies can be interpreted as being representative of uniformity in importance in terms of outcomes and suggests justified consideration by stakeholders. None of the studies considered possible root causes of workplace incivility, which may be detrimental to the overall aim of identifying effective eradication and management options. Identifying the root cause of a problem is a standard principle in any quality improvement initiative, and is a necessary precursor in the development of an effective course of action [30]. By identifying the root causes of incivility, one is then able to eradicate, minimize, or mitigate them, resulting in proactive management of incivility.

Several studies in the review linked the participants level of experience and job category to their experience of incivility. A quarter of the studies specifically studied incivility among nursing students and newly licenced nurses, both in hospital and tertiary educational environments [11, 22, 25]. Studies included novice nurses reporting of high workplace incivility. This is justified by the student and or new nurse's level of competency as well as vulnerability in the newly allocated role, as new nurses are assumed to be inexperienced and ill-equipped psychologically to deal with WPI [31]. This premise is supported by other studies such as that by Laschinger et al. (2017) who noted that newly licenced nurses with an average age of twenty-seven who experienced co-worker incivility reported poorer mental health; and that workplace incivility was found to be a significant predictor of low job satisfaction in graduate nurses transitioning into practice [32]. Relating to the aforementioned notion, one should consider all employees level of experience and competency when developing and incorporating civility awareness education programs., but perhaps most especially, due to their vulnerability, to take due care with regards to student and novice nurses who have not yet been exposed to life experiences nor been afforded sufficient time to develop their life coping skills, and gain the required knowledge for confidence and empowered practice, as stated by Benner in her theory, knowledge embedded in practice [33].

An interesting finding of this review was that although the geographical location of the various studies was diverse and far-reaching from East to West, none highlighted the aspect of cultural diversity as a potential influencing factor in incivility experience or in combating WPI. Groups with cultural differences are prone to misinterpretations and misunderstandings that can culminate in perceived or actual incivility. The impact of staff diversity and multicultural background on incivility incidence or prevalence is a valid and reasonable construct that is underappreciated, especially in light of the phenomenon of global migration of nurses [34]. Global nursing shortages have resulted in widespread nurse migration that has led to the experience of cultural diversity within multidisciplinary and patient interactions [35]. To provide quality patient care, the implementation of nursing care that is transcultural is unchallengeable in our diverse world and is a subject that requires further addressing and priority attention. Furthermore, it is well regarded to cross-examine individual cultural traits so as to create tailor-made awareness

programs of the cultural norms in order to determine what is acceptable or unacceptable behaviours to the particular cultures, subsequently minimizing the possibility of incivility.

Psychological Capital, as a protective mechanism against WPI and the negative effects of incivility, was evaluated in four studies in the review and all determined that having psychological capital was an effective protective quality against the negative impact of WPI [10, 20, 24, 25]. It is important to find ways to invest in nurses' psychological capital in the workplace environment as it will empower them to act against WPI. This notion is supported by positive psychology paradigms that promote the importance to focus not only on employee performance, but also individual psychological well-being and happiness. Positive Organizational Behaviour, based on positive psychology, examines positive resource capacities such as emotional intelligence, confidence, resilience, and self-esteem, and underlines the importance of acquiring and applying these psychological and human resource skills on an individual level [36]. One could argue that eradicating workplace incivility totally is an impossible dream. This could be attributed to the nature of construct under study (incivility) as it deals with more abstract human qualities, beliefs, and expectations, in addition to other personnel characteristics and experiences. It is therefore an effective strategy to equip employees with the psychological means to minimize the negative impact of incivility once they have been subjected to it. Although psychological capital is an inherent human quality, the level of PsyCap differs from one individual to another, and is arguably not a prerogative of older, more experienced nurses, as noted in one of the review studies where new nurses displayed high levels of "PsyCap" that minimized the negative impact of incivility experienced or witnessed by them [25]. This implies that psychological capital is not determined by age, but rather other factors influence one's psychological capital. Identification of these factors was not addressed and represents a shortcoming in this literature review.

Four of the studies directly assessed the results of interventions involving education and cognitive rehearsal programs as a strategy to combat WPI [8, 11, 15, 27]. Cognitive rehearsal was a central element in all four educational programs reviewed and involved interactive practice sessions including role-play and mentally rehearsing responses to scenarios involving behaviours commonly associated with workplace incivility. Providing tools and equipment to facilitate patient care delivery is one of the structure-related health care dimensions, according to Donabedian's structure-process-outcome quality of care model [37]. A legitimate suggestion would be to provide standardized, evidence-based tools in the form of "cognitive rehearsal and education" regarding WPI. This can be seen as a structure-related necessity in such a diverse and ever-changing health care environment. Building staff confidence and resilience coupled with cognitive rehearsal to face incivility can augment the favourable outcome of minimizing the impact of incivility on staff. Cognitive rehearsal allows nurses to translate the training they received on dealing with WPI into acquired behaviours they can use in the workplace. The value of applying cognitive rehearsal in WPI education and training programs appears to be justified in terms of not only does it decrease incivility in the workplace but at the very least, increases awareness of and consequently, the reporting of WPI.

Leadership and managerial involvement were also addressed as valuable strategies to combat WPI. Leadership is directly correlated to work environment and staff empowerment, and in turn influences staff ability to deal with WPI and minimizing its occurrences [22, 23, 26]. It is important to assess leaders' qualities and abilities as nurse manager qualities are a principal factor of the nurse work environment associated with incivility and that supportive nurse managers reduce co-worker incivility [22]. One can conclude that leader development is an important consideration that can be successfully initiated and implemented within an organization to support development and empowerment of both leaders and workers. Deciding what leadership style/s to adopt remains a contentious issue among scholars, such as resonant leadership or servant leadership as good examples of arguably more suitable ones. However, regardless of the style, those leaders who support the attainment of organizational objectives through facilitating the growth and potential of employees, are usually more successful [21].

6 Conclusion

This integrative review advances the current knowledge base in that it identifies reliable interventions that can be implemented to reduce workplace incivility and its impact, especially in the nursing context. It is clearly evident that workplace incivility is a multifactorial issue that requires a multidimensional management approach [38–40].

7 Implications for Practice

- Taking into consideration all the factors influencing WPI, a 'triple whammy' approach of incorporating the enhancement of psychological capital, leadership empowerment, and education with the implementation of cognitive rehearsal might have a positive impact in combating WPI.
- A thorough assessment and root cause analysis of workplace incivility can be incorporated to develop an effective management program for any healthcare organization.
- Strategic structures and processes can assist in creating civil organizations, with improved nursing, environment, and patient outcomes.
- The creation of a supportive and civil organizational culture whereby organizational policies contains clear terminology that promotes civil behaviour. Assess organizational infrastructure, nurse perceptions, workplace design, and policies on a regular basis.

Appendix 1:

Table 1. DEMOGRAPHIC DATA, DESIGN, STUDY DESCRIPTIONS, INTERVENTIONS

Author, year	Sample size	Design	Location of study	Nurse experience	Strategy used to combat incivility			Type of intervention
					PsyCap	CR & Education	Leadership	
Kousha et al., 2013	80 – 40 in Intervention Group and 40 in Control Group	Single-blinded, parallel randomized clinical trial	2 Emergency Rooms – Iran	Mean age: 31.6 (Intervention Group) 29.9 (Control Group)	-	X (Cognitive Rehearsal & Education in Intervention Group. Education. in Control Group)	-	Intervention Group: Cognitive rehearsal program (include of definitions of incivility, 10 common incivilities, appropriate practice methods & role-plays). Control Group: participants completed the Incivility Scale at the beginning of the study and after 1 month without intervention (they were only given written information about what incivility is and how to deal with it).
Al-Zyoud et al., 2019	326 Drs, Nurses, interns, & admin	Survey, random sampling	7 Health Care institutions in Jordan	50% 23-33years. 32.5% 34 –	X	-	-	No intervention

(*continued*)

Table 1. (*continued*)

Author, year	Sample size	Design	Location of study	Nurse experience	Strategy used to combat incivility			Type of intervention
					PsyCap	CR & Education	Leadership	
Griffin et al., 2014	26 nurses	Exploratory descriptive study	Hospital	Newly licenced	-	X	-	General orientation - lateral violence and its impact on patient care and nursing practice. Interactive instruction on cognitive rehearsal and practice on appropriate responses to frequent forms of lateral violence. Laminated cards that summarized accepted behavioural expectations for professionals and appropriate responses to the 10 most frequent forms of lateral violence
Li et al., 2021	1062 participants -644 doctors and 418 nurses	Cross-sectional survey	China – 6 general hospitals	Mean age: 33.48 for nurses,.	X	-	-	No Intervention
Mao et al., 2021	58 nursing students	Qualitative research study. Purposive sampling. Semi structured interviews	China – 2 private nursing school, 3 general hospitals	Student nurses and young newly qualified nurses	X	-	-	Two themes emerged from the data, indicating the strategies used by young nurses in dealing with LV: making extra efforts and soothing emotional distress

(*continued*)

Table 1. (*continued*)

Author, year	Sample size	Design	Location of study	Nurse experience	Strategy used to combat incivility			Type of intervention
					PsyCap	CR & Education	Leadership	
Smith et al., 2018	233 nurses	Quantitative, correlational, and cross-sectional. Convenience sample. Online survey	5 acute care hospitals in US.	The most frequent age was 26	-	-	X	No intervention
Chatziioannidis et al., 2017	398 Doctors & nurses. 163 (41%) were physicians and 235 (59%) nurses.	Self-administered questionnaire survey.	20 NICUs in 17 hospitals in Greece	Mean age was 43.3 years	X	-	-	No intervention
Armstrong, N., 2018.	9 evening shift nurses on Med/surg ward	Quality Improvement Project. Pre and post intervention: questionnaire containing Workplace Incivility Scale and the Confidence Scale	Public hospital	24 to 56 years of age, with a mean age of 38.	-	X	-	CREW training program, involves facilitated, small group training sessions with active learning exercises. The foci of the program are to teach about workplace incivility and its effects, to train nurses how to respond to incivility when it occurs, and to improve group cohesion thorough teambuilding exercises aimed at improvements in respect and communication. Cognitive rehearsal
Casale et al., 2017	139 nurse educators faculty – convenience sample	Quantitative, descriptive correlational study. Cross sectional design	17 universities	25 – 65 years	-	-	X	No intervention

(*continued*)

Table 1. (*continued*)

Author, year	Sample size	Design	Location of study	Nurse experience	Strategy used to combat incivility			Type of intervention
					PsyCap	CR & Education	Leadership	
Spence-Laschinger et al., 2014	1241 nurses	Survey	Canada	41.52 years of age	-	-	X	No intervention
Stagg et al., 2013	Ten (67%) of	non-experimental pilot research study used a survey design.	?	?	-	X	-	cognitive rehearsal training program. Included theoretical concepts of bullying, common bullying behaviours, the consequences of bullying, responses to bullying, and the cognitive rehearsal response (Table 1). Cue cards, identifying the expected behaviours of professionals and providing responses to common bullying behaviours, were distributed during the program
Der Kinderen et al., 2020	312 subjects – nurses, managers and administrative staff.	self-reports and a correlational cross-sectional survey design	Netherlands	Mean age of 46.76 years	-	-	X	No intervention

Appendix 2:

RESULTS TABLE								
Author, year	Response Rate	Outcome Variables	Reported Incivility experience	Reported Increased Awareness of Incivility	Decreased impact of incivility due to education	Decreased Impact of Incivility due to PsyCap	Decreased incivility impact due to leadership	Reported Decreased incivility
Kousha et al.,2022	-			Yes	Yes			Yes
Al-Zyoud et al., 2019	-	Co-worker incivility, psychological distress, PsyCap		-	-	Yes		
Griffin et al., 2014	-			Yes	Yes			Yes
Li et al., 2021	(86.6%) doctors and (88.2%) nurses	Depression, WPV, PsyCap		-	-	Yes		-
Mao et al., 2021	-	Making extra efforts & soothing emotional distress		-	-	Yes		

(*continued*)

(*continued*)

RESULTS TABLE

Author, year	Response Rate	Outcome Variables	Reported Incivility experience	Reported Increased Awareness of Incivility	Decreased impact of incivility due to education	Decreased Impact of Incivility due to PsyCap	Decreased incivility impact due to leadership	Reported Decreased incivility
Smith et al., 2018	8.1%	three models: (1) nurse manager ability, leadership, and support of nurses as an independent variable to predict co-worker incivility, (2) staffing and resource adequacy as an independent variable to predict co-worker incivility, and (3) nurse manager ability, leadership, and support of nurses and staffing and resource adequacy, in the same model, predict co-worker incivility.	Yes	-	-	-	Yes	
Chatziioannidis et al., 2017,	62.8%	Workplace bullying Psychological Distress Psychological support	Yes	-	-	Yes	-	-

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(*continued*)

RESULTS TABLE								
Author, year	Response Rate	Outcome Variables	Reported Incivility experience	Reported Increased Awareness of Incivility	Decreased impact of incivility due to education	Decreased Impact of Incivility due to PsyCap	Decreased incivility impact due to leadership	Reported Decreased incivility
Armstrong, 2018	100%	modified version of the CREW program. Included facilitated educational discussions about workplace, teambuilding exercises, and experiential learning activities	Yes ↑after CREW	Yes	Yes	-	-	No
Casale et al., 2017	53.46%	Resonant Leadership	Yes	-	-	-	Yes	-
Spence-Laschinger et al., 2014	35%	Workplace environment Resonant leadership	Yes (minimal)	-	-	-	Yes	-
Stagg et al., 2013	67%		Yes	Yes	Yes	-	-	-
Der Kinderen et al., 2020	-	Employee Wellbeing (EWB) Workplace Civility Culture Servant leadership	Yes	-	-	-	Yes	-

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