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THE CASCADING EFFECT OF CIVILITY ON OUTCOMES OF CLARITY, JOB SATISFACTION, AND CARING FOR PATIENTS

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Abstract

Implementation of a model of care requires partnering among members of the health care team and patients and their families. Each participant must have clarity about each person's role and how the system is used to implement and/or utilize a model of care delivery. A community hospital in the Midwest implemented Relationship-Based Care (RBC), a model based on concepts of partnering with self and others to build inclusive systems of care. Implementation included education about the culture of caring and discussions centered on the concept of civility as a prerequisite to role clarity within the concept of partnering in caring for self and others. The discussions demonstrated to hospital leaders that incivility, involving negative cultural norms, fundamentalism, oppression, hierarchical leadership, and conformity to old ways, was a barrier to creating a caring environment. This study examined the impact of civility on professional clarity, social and technical dimensions of work, and caring for patients and families.

Civility was measured by a 24-item instrument using Bartholomew's theory of civility (2006). The instrument includes two dimensions of civility: education in civility during academic and clinical training, and the experience of civility in the work setting. Results revealed that staff who had received and observed civil behaviors from academic faculty and clinical preceptors were more likely to report working within a civil environment. This in turn predicted greater levels of clarity, which then predicted greater satisfaction with both the technical and social dimensions of the job. The final outcome, caring for patients, was predicted by job satisfaction.

Keywords: Civility, Relationship-Based Care, Lateral Violence, Partnering, Caring, Watson's Theory of Caring, Job Satisfaction, Clarity

BACKGROUND

The Relationship-Based Care (RBC) model proposes that clarity of self, role, and system are critical for effective care delivery (Felgen, 2007; Koloroutis, 2004). Specifically, clarity of self, role, and system is the first of a series of six interdependent "C's" proposed to make the care process more efficient and effective and to subsequently improve outcomes both for employees and for patients (Felgen, 2007; Koloroutis, 2004). The "C's" are clarity, competence, confidence, collaboration, commitment, and the courage to change. In unison, these elements empower employee growth. Clarity plus competence leads to confidence. When confident individuals are able to collaborate with others who are equally committed, it creates ideal conditions for individual and collective empowerment to challenge the status quo and to make changes (Felgen, 2007). Ultimately, clarity is foundational to the implementation of RBC because clarity is necessary for establishing competence and the other four subsequent "C's."

In order for health care workers to have clarity, they must partner with others. Partnerships across departments and disciplines helps employees understand how their individual roles fit into the larger picture of the health care environment. Essentially, partnering supports employees' understanding of clarity. As such, partnering between departments and disciplines is also critical to the success of implementing RBC.

Yet, partnering can be obstructed by incivility. In fact, the detrimental effects of incivility among health care workers are well documented. New graduate nurses who experienced incivility perceived greater levels of disrespect from physicians, co-workers, and managers (Kerber, Woith, Junkins, Shafer, & Astroth, 2015). New graduate nurses who reported experiencing incivility also reported lower career satisfaction and greater intent to leave (Laschinger & Read, 2016). When bullying, a more severe form of incivility, occurs, it creates a risk to the health and safety of employees (State of Washington, Department of Labor and Industry, 2006). Bullying is regrettably common in health care; in a survey by the Joint Commission for the Accreditation of Healthcare Organizations (2002), 90% of nurse respondents had witnessed some form of bullying

behavior. Bullying behavior increased workload, prevented meeting patients' needs, and inhibited meeting the faith needs of patients (Kerber et al., 2015).

Fortunately, several studies have shown how effective leadership and organizational cultures that support civility can significantly reduce co-worker incivility (D'Ambra & Andrews, 2014; Laschinger, Finegan, & Wilk, 2009; Laschinger, Wong, Cummings, & Grau, 2014). Civility has been shown to mitigate hostile work environments, with concurrent improvement in productivity (Hutton & Gates, 2008). Laschinger and Read (2016) found that nurse managers who demonstrate authentic leadership, including maintaining civility norms, enhanced perceived job fit for their employees. Moreover, civility has been shown to serve as a strategy for creating a safe environment for patients (Laschinger, 2014), and organizations have used civility as an intervention for patient safety (McGonagle, Walsh, Kath, & Morrow, 2014; Osatuke, Moor, Ward, Dyrenforth, & Belton, 2009).

Bartholomew (2006) holds that civility must begin within the setting of formal education. Education in and demonstration of civility enhance the likelihood that civility will become enacted within a community. Dimensions of formal education in academia and less formal education during job training that serve as predictors of civility include learners being taught the importance of managers showing respect to their staff, mentoring, and teaching civility by living as an example.

In 2012, a mid-size acute care hospital in the Midwestern United States implemented Relationship-Based Care (RBC) as the philosophy and framework of care delivery. The existing philosophy of care, which predated RBC, was task-driven and was characterized by blame, hierarchical domination, and apathy. The detriments of this philosophy were best exhibited in the Emergency Department (ED), which had high turnover in all staff classifications, reports of incivility and bullying, transient leadership, and poor patient satisfaction and efficiency metrics. The staff struggled with the implementation of RBC, pointing out incivility within the ED and between inpatient units. The authors hypothesized that educating staff about civility would have a cascading effect that

would not only increase civil behaviors but would also improve employees' clarity and facilitate the implementation of RBC. This would ultimately improve job satisfaction and employees' perception of caring.

DEFINITIONS OF CONCEPTS

Relationship-Based Care

RBC is a model of care delivery that emphasizes clarity of one's role and one's place in the system as central to establishing professional authority and accountability within professional practice (Koloroutis, 2004). Establishment of professional authority and accountability facilitates the navigation of barriers to partnering (e.g. bullying). The primary methods used for the implementation of RBC and facilitation of partnerships included:

- Education in crucial conversations to deal with incivility and bullying behaviors (Patterson, Grenny, McMillian, & Switzler, 2002; Koloroutis, 2004).
- The treatment of Unit Governance Councils as the foundational organizational element to operationalize RBC. Orientation to Unit Councils included learning methodologies for building consensus. Unit Council members learned to listen respectfully and to talk through differences.
- The use of hospital-wide Results Councils to share outcomes of partnerships within shared governance. Results Councils included department heads, senior leadership team members, and chairs of all the shared governance councils. Staff and leadership "owned the patient experience" and worked together to find solutions in a form in which civility and respect were modeled by all.
- The use of town hall meetings to ensure that staff could voice concerns, including concerns about leadership. Town hall meetings helped staff address and manage the experience of both lateral incivility from and between coworkers, and vertical incivility from and between leaders. Failure to deal with superiors, regardless of title (e.g. charge nurse, manager, director, senior executive or physician), allows

incivility to escalate, spread, and fester in the culture, creating an uncivil, unhealthy and/or even violent work environment.

Civility

Bartholomew (2006) describes civility in health care as a 14-dimensional construct that includes these attributes: 1) autonomy, 2) immediate supervisor support, 3) peer support, 4) voicing concern, 5) profession is valued, 6) physicians share credit for patient care, 7) conflict management, 8) preceptor efficiency, 9) ideas from new staff welcome, 10) clinical learning environment, 11) relationships with physicians, 12) relationships with nurses, 13) relationships with co-workers, and 14) managerial support. When all 14 dimensions are enacted, civility is perceived and embraced by every member in the community.

Clarity

Campbell and colleagues define clarity of self as "a structural aspect of the self-concept: the extent to which self-beliefs are clearly and confidently defined, internally consistent and stable" (Campbell, et al., 1996, p. 141). Such clarity of self is important in order to interact healthfully within a team as the organization's mission is executed (Besser & Priel, 2011).

Clarity of role guides behavior and use of knowledge as the job is enacted within the organization (Rizzo, House, & Lirtzman, 1970). Role clarity has been identified as important to job satisfaction (Cowin, Johnson, Craven, & Marsh, 2008; Gulliver, Towell, & Peck, 2003; Jones, Smith, & Johnston, 2005; Nelson & Felgen, 2015; Wickramasinghe, 2010).

Clarity of system is defined as the employees' understanding of how systems within the organization work, including committees, technology, policies, and roles (Nelson, 2013). Knowledge about systems has been shown to predict job satisfaction (Korunka, Scharitzer, Carayons, & Sainfort, 2003).

Job Satisfaction

Job satisfaction for nurses has been defined from several theoretical viewpoints (Nelson, Hozak, Albu, & Thiel, 2015). Nelson, Hozak et al. (2015) identified 26 different theories cited to measure nurse job satisfaction. Socio-technical systems theory asserts that both technical and social dimensions of work are essential to nurse job satisfaction (Maxwell, Ziegenfuss, & Chisholm, 1993). This theory was tested using the Healthcare Environment Survey (HES) in 10 different studies (n = 9,220 nurses) across hospital settings; survey results revealed that 52.5% of the variance of job satisfaction was explained by the social (relational) dimensions of the HES while 21.4% of the variance of job satisfaction was explained by the technical dimensions of the HES. Combined, the social and technical dimensions explained 73.9% of the variance of job satisfaction (Nelson, Persky, Hozak, Albu, Hinds, & Savik, 2015). Social dimensions included relationships with other nurses, physicians, patients and one's unit manager. Technical variables included distributive justice, professional growth, executive leadership, autonomy, and staffing and scheduling (Nelson, Persky, et al., 2015). Job satisfaction of staff, as measured using the HES, has been shown to relate to several patient outcomes, including increased patient satisfaction with hour of sleep cares by nurses, caring of the staff, and a positive patient experience as measured by five Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) questions (Nelson & Felgen, 2015).

Caring

According to Watson's Theory of Caritas (2008), if the 10 Caritas Processes toward self or others are present, the recipient of the behaviors will feel cared for (i.e. loved) and thus will initiate an internal cascade of healing at the physical, mental, and spiritual levels. The 10 Caritas Processes are listed below.

1. Cultivating the practice of loving kindness and equanimity toward self and others. Loving kindness includes listening to, respecting, and identifying vulnerabilities in self and others.

2. Being authentically present: Enabling, sustaining, and honoring faith and hope which is future-oriented and includes self-discovery.

3. Cultivating one's own spiritual practices and transpersonal self and going beyond one's ego-self.

4. Developing and sustaining a helping-trusting caring relationship.

5. Being present to and supportive of the expression of positive and negative feelings.

6. Creative use of self and all ways of knowing as part of the caring process: engaging in the artistry of caritas. This can best be described as creative problem solving.

7. Engaging in a genuine teaching-learning experience that attends to the unity of being and subjective meaning: attempting to stay within others' frame.

8. Creating a healing environment at all levels.

9. Administering sacred acts of caring-healing by tending to basic needs.

10. Opening and attending to spiritual/mysterious and existential unknowns of life-death. This is belief in the impossible (miracles), even when others may assert doubt. (Nelson, DiNapoli, Turkel, & Watson, 2012, in section titled The Future of Nursing Knowledge)

Previous research has shown a relationship between the work environment as reported by nurses and patients' perception of feeling cared for (Persky, Nelson, Watson, & Bent, 2007).

THEORETICAL MODEL

The proposed model of research for this study is noted in Figure 1. The hypothesis was that there would be a cascading effect of civility, beginning with instruction and observation of civility in school and early clinical training. Specifically, individuals who were taught about and observed civility would be better equipped to establish clarity of self, role, and system. Once clarity of self, role, and system were established, consensus building could be used within the unit councils to develop and refine the

social and technical systems that are essential for care. Establishment and refinement of supportive social and technical systems were hypothesized to result in improved job satisfaction and to facilitate a stronger caring connection with the patient as perceived by the staff member.
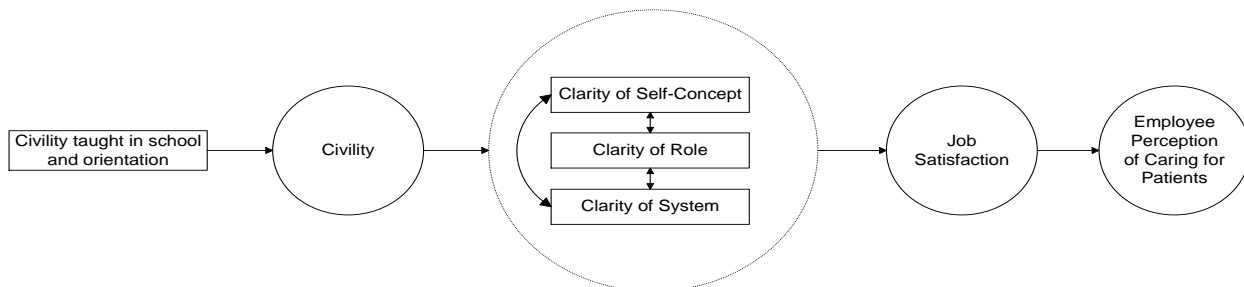

Figure 1. Proposed Model of Cascading Effect of Civility

METHODS

This descriptive study used a convenience sample to test a model of research during the implementation of RBC. Regression equations were used to test the relationships of interest. The study took place in a suburban hospital of a large city in the Midwestern United States. Nine patient care units with a total of 414 clinical care staff members were invited to participate in the study. The researchers wished to have at least 40% of the invited staff participate, as this has been identified as an adequate response rate to be representative of the entire sample (Kramer, Schmalenberg, Brewer, Varran, & Keller-Unger, 2009).

All instruments had been tested for validity and reliability in a study conducted in 2015 in the same organization to ensure adequate psychometric properties. Instruments were tested in this current study using Cronbach's alpha for reliability and factor analysis for construct validity testing. Oblique methods were applied in factor analysis and Eigen values greater than 1.0 were used.

Instruments

The Civility Assessment was developed by Kathleen Bartholomew and author Nelson using the book, *Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young*

(Bartholomew, 2006). A pilot test of the assessment tool was conducted among nurses (n=154) at a different urban hospital in the Northeastern US. The pilot test used an 87-item survey with good model fit, and explained 74% of civility. The construct-validated 87-item form was deemed too long; considering the good model fit and high percentage of explained variance, Nelson and Bartholomew developed a shorter 24-item version using the highest-loading items that were consistent with the 14 dimensions of civility. There were 10 items related to education and demonstration of civility by educators and preceptors. The 2-factor short form of the civility assessment tool was tested in January 2015 in a sample of 240 staff from the same Midwestern hospital as this study.

Principle axis factoring extraction and Promax rotation (analytic procedures used for non-orthogonal data) were used. A minimum of value of .2 was used for factor loadings, and Eigen values greater than 1.0 were selected. Cronbach's alpha was used for reliability testing, seeking an alpha greater than .80. Results revealed that all items loaded into a single factor of civility and a single factor of education in civility. Both factors had good model fit. Cronbach's alpha was .84 and .80, respectively, for these two factors.

The other three tools have had extensive psychometric testing. The 30-item clarity scale has been shown to have good factor structure and reliability (Felgen & Nelson, 2016). Nurse job satisfaction was measured using the 52-item Healthcare Environment Survey (HES; Nelson, Persky, et al., 2015). Caring for patients as reported by staff was measured using the 10-item Caring Factor Survey – Care Provider Version (Nelson, Thiel, Hozak, & Thomas, 2016). Combined, all four instruments included 115 items. Each item was scored using a 7-point Likert scale from strongly disagree (1) to strongly agree (7). For example, in the measure regarding job satisfaction, specifically the dimension of coworker relationships, the statement reads, "I am satisfied with how easy it is for new employees to feel welcome in my unit or department." The higher the score, the more satisfied the worker is with this single item that comprised the subscale for satisfaction with coworkers.

In addition to the Likert scale items, there were 12 demographic questions, including gender, age, role, marital status, hours worked, shift, number of years in same unit/hospital/profession, unit worked, education level, and number of continuing education hours per year. Combining the Likert questions and demographics, there were 127 items to respond to.

Procedures

After Ethics Board approval, clinical staff were sent an electronic secure link to access the survey. Respondents could save their answers and return as often as needed. Respondents were assured of the confidentiality of responses and that they could withdraw from the study at any time; submission of responses was considered consent to participate in the study.

RESULTS

A total of 177 staff members of a possible 414 submitted a survey, representing a 43% initial response rate. Eighteen responded to only one of the four surveys and were not included in this analysis. A total of 159 respondents were included in this study, a final response rate of 38.4%. There were 1,024 data points missing among 18,285 possible from the 159 respondents across all surveys, a rate of 5.6% of data missing. This level of missing data is slightly higher than the targeted goal of no more than 5% missing data. Based on a post hoc power analysis using 150 responders, an alpha of .05 was applied to this study. This included power of .96 and effect size of .15 for a linear regression.

All scales, both subscales and the total score of all subscales combined, were valid and reliable. The Kaiser-Meyer-Olkin measure (KMO) for model fit was above .80. Only the Civility Scale had an item with a factor loading less than .4. This is described further in descriptive statistics of Civility, later in this work. Cronbach's alpha for all subscales and total scores was greater than .80. Data for validity and reliability testing for all scales are noted in Figure 2.

Scales and Subscales	Cronbach's alpha	KMO	Lead Item	Wording of item with highest factor loading:
Total HES	.98	.91	33	I am satisfied with my daily work how I am able to build trust with the patient and family by using clinical skills and knowledge.
Clarity of Self	.93	.90	57	I spend very little time wondering what kind of person I really am
Clarity of Role	.86	.84	71	I know exactly what is expected of me.
Clarity of System	.89	.88	77	I understand how the schedule is made in consideration of … scheduling requirements for staff.
Total Clarity (self/role/system)	.93	.88	57	I spend very little time wondering what kind of person I really am
Caring for Patients (CFS-CPV)	.97	.96	8	I respond to each patient as a whole person, helping to take care of all their needs and concerns.
Civility	.88	.83	4	I feel accepted as a person on this unit.
Education Civility	.92	.83	22	The school I attended that trained me for my current job taught me how important it was to have managers treat new employees with compassion.
Total Civility (civility and education in civility combined)	.90	.85	6	I am able to voice my concerns to the manager of my unit/department without feeling I will be criticized by the manager of my unit/department.

Figure 2. Psychometrics of Measures

Parceling was used to interpret the rank order of the dimensions of job satisfaction in this study. Results revealed that autonomy (using knowledge and experience to do the job as the employee deems fit) was most important, followed by workload, professional growth, and so on, as listed in rank order in Figure 3. The higher the factor loading, the more important the item was for job satisfaction.

Dimension of Work Environment	Factor Loading
Autonomy	.811
Workload	.769
Professional Growth	.754
Relationship with Coworkers	.753
Professional Patient Care	.751
Relationship with Nurses	.728
Distributive Justice	.721
Executive Leadership	.701
Participative Management	.653
Relationship with Physicians	.489

Figure 3. Rank Order of Dimensions of the Work Environment, in Order of Importance. Note: blue highlights indicate social dimensions

Examination of the descriptive statistics reveals that the highest mean score as reported by responders was for caring for the patient. However, the range was from 1 to 7 and standard deviation was .93, which indicates there is variance in the perceived experience of caring for the patient. The lowest mean score was for report of civility, with a mean score of 5.41. The minimum score was 2.57 and standard deviation was .87, which indicates there is less variance in the experience of civility. Descriptive statistics for all scales and subscales from the research model are noted in Figure 4.

Scales / Subscales	N	Min.	Max.	Mean	SD
HES Total Score	141	1.00	7.00	5.54	.88
Clarity of Self	150	1.73	7.00	5.78	1.11
Clarity of Role	149	3.33	7.00	5.88	.79
Clarity of System	146	3.64	7.00	5.95	.76
Clarity, Total Score	142	3.89	7.00	5.88	.72
Caring Factor Survey - Care Provider Version (CFS-CPV)	153	1.00	7.00	6.44	.93
Civility	132	2.57	7.00	5.41	.87
Civility Education (school and preceptor)	130	2.20	7.00	5.89	1.03
Civility, Total Score	129	2.54	7.00	5.62	.82

Figure 4. Descriptive Statistics all Scales and Subscales from Research Model

Regression analysis revealed that education in and observation of civility in school and orientation predicted 26.9% of the variance of civility (β = -.46, t(127) = 6.85, p < .001). Civility predicted 25.9% of clarity (β = -.45, t(121) = 6.50, p < .001). A hierarchical regression equation with self, role, and system entered as the first, second, and third step explained 44.9% of the variance of caring for the patient with clarity of role explaining 36.3% (β = .45, t(135) = 4.69, p < .001) and clarity of system explaining 8.7% (β = .46, t(134) = 5.59, p < .001). Finally, job satisfaction predicted 32.9% of the variance of caring for patients (β = .60, t(136) = 8.17, p < .001). These findings are noted graphically in Figure 5.
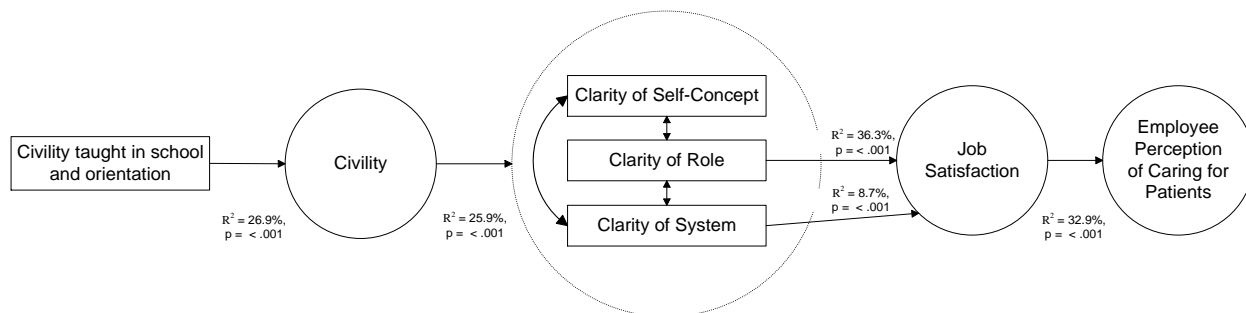
Figure 5. Cascading Effect of Civility in the Context of Relationship-Based Care (RBC)

DISCUSSION

The statistically significant relationship between educated and observed civility in school and orientation, and perception of civility supports the assertion made by Laschinger and Read (2016) that concepts of civility can be influenced by leadership and education. Laschinger and Read (2016) reported that authentic leadership, which facilitates civility, can be developed through both formal and informal learning and practice. Stimulating authentic leadership requires programs that have both leadership theory and action learning (i.e. self-reflection, experimentation, opportunities for practice and application, and coaching) to be effective (Laschinger & Read, 2016). Authentic leaders promote awareness and understanding, helping people behave collaboratively instead of confrontationally (Laschinger & Read, 2016). Development of civility norms is an actionable strategy that leadership can use to create healthy work environments that foster positive outcomes including job satisfaction and retention of new staff (Laschinger & Read, 2016).

The importance of leadership within the construct of civility is further supported by the factor analysis of this study. It is noteworthy that the highest loading factors in the construct of civility are related to management (refer to Figure 1). In the subscale that contained the 14 dimensions of civility, the highest loading item was being able to voice concerns to the unit manager without feeling criticized. Factor analysis of these two subscales suggests that civility begins with leadership. The civility survey asked about

preceptors, educators, and coworkers, but it was the manager who surfaced as the most significant element in both the scale regarding education and the construct of civility.

It is not clear why responders who reported high levels of civility also were satisfied with the social and technical dimensions of their job. It may be that, as asserted by Laschinger and Read (2016), those trained in civility were able to apply concepts of civility to partner and create healthy teams because they understood the underlying concepts of relationships. It may be that the internal knowledge employees possess about civility assists them with navigating the work environment, which makes for a more satisfying job.

Previous research has shown that staff who engage in the framework of RBC and learn concepts like civility and clarity of role are able to act more autonomously within their role (Persky, Felgen, & Nelson, 2012). Staff enrolled in RBC training evolved from being dependent on the physician for autonomy at Year One of the RBC program to depending on their own professional knowledge by Year Three (Persky, et al., 2012). It can be very frustrating for employees when expectations are presented (such as when a new framework of care is introduced) but the social and technical requirements for implementation are not available. Providing internal resources such as knowledge can assist with successful partnering and implementation of concepts of care. It can be equally frustrating when efforts to implement necessary social or technical requirements are thwarted by incivility or bullying. Understanding how to confront bullies, negotiate for civility, and/or even navigate around incivility are important when creating requirements to make the new framework of care operate in one's own professional practice and clinical care team.

This study provides additional support to previous research demonstrating that civility predicts job satisfaction as measured by the HES and that job satisfaction predicts positive patient experience (Nelson & Felgen, 2015). Both the study described in this article and the one published by Nelson and Felgen (2015) revealed that civility predicted over 30% of the variance in job satisfaction as measured by the HES. The

current study revealed that job satisfaction, as an outcome of civility, predicted 33% of employees' perceptions of caring for the patient. In contrast, the previous study by Nelson and Felgen (2015) found that job satisfaction as measured by the HES predicted only 9% of the variance in staff caring for patients. While both studies showed a statistically significant relationship between job satisfaction and caring as reported by staff, it is not clear why the percentages were so different. Both studies support the theoretical model proposed by this study, and support the cascade of positive outcomes that civility has on job satisfaction and caring. It could be that staff who are able to negotiate within the work environment to secure the needed resources to implement a new model of care such as RBC are not only more satisfied with their jobs, but feel more effective at caring for patients because they have successfully negotiated for needed resources. Successful negotiation is much more likely if one understands how to partner in civility.

Implications

This study reveals how important civility is to the implementation of a framework of care (in this case, RBC). Understanding what civility is and what it looks like is important in establishing partnerships to develop and refine systems of care. It appears that civility education accompanied by demonstration of civility predicts the establishment of civility. Nurses in this study who learned and observed civility reported more civil environments, likely due to successful promotion of civility and management of incivility. Some incivility, such as physical abuse, is obvious, but detection and management of less obvious incivility may require training. Undetected and ongoing incivility are likely to impede consensus building and partnering.

Strategies of civility and partnering used in this study illustrate how these tools can be used to implement and sustain the concepts of RBC. The class on the foundational concepts of RBC and Nursing Culture of Caring was especially helpful in collaboratively envisioning the structure of care. In the class, data from an organizational assessment helped with a contextual discussion of civility norms prior to implementing a model of care grounded in caring for self and others. Contextual discussion related to civility

helped identify potential barriers to successful implementation of RBC. During the series of classes, participants learned the importance of partnering with each other and with other disciplines.

Initially, staff in this study were resistant to utilizing components of the RBC model. Staff complained that coming to consensus took too long. It was a chairperson of a Unit Council who, despite being challenged through intimidation at a meeting, pronounced a clear understanding of the importance of consensus building and helped to introduce concepts of RBC across departments. Processes of achieving consensus required practice, including working through feelings of coercion. Leaders were instructed to make clearly obvious their zero tolerance for intimidation, to allow staff to develop partnering skills, and to support implementation of positive civility norms. Through discussion and practice of partnering, members of practice councils developed skills to help unit staff fully engage in the processes of RBC. All decisions were made through full partnerships among various roles, using professional authority and accountability to enact caring moments, for every patient, every time.

Consensus can be used to adjust policies to have greater buy-in due to engagement in the process. This methodology has implications for consistency across disciplines. In addition, such refinement of policy based on consensus will assist with aligning all the major elements of leadership, including the framework of care delivery, mission, vision, and organizational strategic plan. The more aligned these major elements are with the process of care and the consensus of the staff, the easier it will be to articulate and achieve organizational gains.

This study revealed the importance of civility to several outcomes, including job satisfaction of staff and care of patients. This research also adds validity to the assertions made within the RBC framework, a model based on relationships. Results revealed that those who engage with social dimensions of their job (relationship with the patient, coworkers, and manager) reported more connection with the patient. Use of the tools of RBC provided a strategy of implementation that included all employees

and leadership across departments. Unit Councils, Results Councils, and town hall meetings all provided venues for communication and consensus building. Identification and use of tools to implement a model of care are vital for successful development of partnerships that are healthy and enjoyable.

The organization described in this article continues to expand and improve its use of the RBC model, including tools to refine and adapt to new environments and health care challenges. Results Councils continue to delineate successes and improvements in all clinical areas as well as in some ancillary departments. The organization's systems and outcomes, as well as reports of employees' continuing personal and professional improvement through deeper learning about civility, partnerships, and consensus building, continue to improve. Senior leaders continue to report that through RBC they are learning how to be caring leaders who demonstrate the caring that is expected in others, while staying true to the goal of a safe and caring experience for patients. The CNO reports learning that implementation of any care delivery model is difficult, but that when the foundation of the model is caring and partnering, leadership style must change first. The CNO also reports that believing and living the vision must be present in each interaction and decision, and that leading and living the tenets of the model are necessary for leaders' effective persuasion of acceptance of the new culture, especially within the senior leadership team and with physicians. Finally, the CNO learned that civility and acceptance among the team members who deliver the care are essential ingredients in providing exceptional care for every patient and family.

Limitations of Study and Suggestions for Future Research
The sample size was adequate for the power parameters of this study, but a larger sample would allow for more extensive study of additional variables while maintaining adequate power parameters. This study was missing 5.6% of its data, which was above the threshold for no concern for bias in results. This also was the first study to examine this series of variables within the context of Relationship-Based Care. It would be important to retest in other contexts of RBC as well as in other frameworks of care besides RBC.

SUMMARY

Based on the results of this study, the literature and the experience of the authors, civility is a critical dimension in introducing and implementing a new model of care such as RBC. Initial and ongoing identification of, and strategic planning to deal with, barriers such as incivility can facilitate successful implementation of frameworks of care such as RBC. The literature supports the assertion that creating positive civility norms can improve return on staff investment (e.g. by decreasing intent to leave), staff satisfaction, and patient safety. The hypothesized and the tested models (Figures 1 and 5, respectively) reveal how employees who embrace the concepts of civility can create not only a satisfying environment for themselves, but more opportunities for connecting and partnering with the patients their care.

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