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The Relationship between Workplace Incivility Behaviors and Nurses' Intention to Share Knowledge

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Abstract: **Workplace incivility behaviors poisoning the organizational climate disrupts the working harmony of health care team and impairs interprofessional communication and collaboration. Aim: To examine the relationship between workplace place incivility behaviors and nurses' intention to share knowledge at Itay El-Baroud General Hospital. Methods: A descriptive, correlational research design was utilized in all inpatient medical, surgical and critical care units at Itay El-Baroud General hospital, El-Beheira, Egypt, for all head nurses and their assistants and staff nurses. Tools: two tools were used: Tool I: Nursing Incivility Scale (NIS) and a demographic characteristics data sheet; Tool II: Intention to Share Knowledge Questionnaire. Results: staff nurses got moderate mean percent score for both workplace incivility and intention to share knowledge. Moreover, the first source of incivility was general environment; and the last one was patient/visitor. Whereas; the first dimension for nurses' intention to share knowledge was attitude toward knowledge sharing, and the last dimension was anticipated extrinsic rewards. Conclusion: There are negative highly significant correlations between total workplace incivility behaviors and all its dimensions and total nurses' intention to share knowledge and all its dimensions. Recommendations: Develop and disseminate workplace incivility policy; develop positive workplace culture; and provide incentives and rewards.**

Keywords: **Workplace incivility behaviors, Intention to share knowledge, Head nurses, Staff nurses.**

1. INTRODUCTION

Nurses are the backbone of the health care industry and one of the largest groups in health care workforce and constantly interact with patients, their visitors, colleagues as well as other members of the multi-disciplinary health care providers inside and outside the health care organization (Nursing Community, 2011). They can often engender aggressive and incivility behaviors against them; so, nurses are known to be more vulnerable to workplace incivility, due to factors such as: occupational stress, difficult working conditions, increased health care complexity, lack of rules and policies, and decreased social isolation that can provoke the emergence of workplace incivility behavior (Jelavić, 2022).

Workplace incivility is defined by Andersson and Pearson (1999) as: "low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect". There are three important characteristics of workplace incivility, namely: frequency, density, and uncertainty (Torkelson et al., 2016). It always occurs in stressful work environments, where lack of clear anti-incivility policies, poor communication, unfair treatment between peers, lack

of friendly and supportive atmosphere, hierarchical nature of workplace, organizational changes and leadership style (authoritative-laissez faire) (Magee et al., 2014).

Nurses may be exposed to different perpetrators, as: supervisors, physicians, patient/visitors and their co-workers (Alquwez, 2023). Workplace incivility affects organizational performance by causing a decrease in the efforts of nurses in terms of their roles and obligations; and can cause further psychological consequences such as stress, depression, and suicide (Cortina et al., 2013; Söyük et al., 2019). Managers, who do not pay attention to workplace incivility behaviors, spend time to solve conflicts within the organization due to such behaviors. Hospitals offer nurses the chance to interact and communicate with other health care providers and patients (Jahanzeb et al., 2020) Presence of hostile work environment and uncivil behaviors reduce nurses interaction and communication which eventually decrease nurses' knowledge sharing (Serenko & Abubakar, 2022).

Knowledge sharing is viewed as: "the process of transferring organizational expertise and knowledge to business operations through channels of communication between individuals" (Olan et al., 2016). Sharing knowledge with health care team support organizations to perfect their work experiences and ultimately gain more success (Davison et al., 2013). Knowledge sharing is a set of specific behaviors that involve sharing data or related knowledge to collaborate with others to develop new ideas and implement policies (Zhang, 2017).

Knowledge sharing involves two stages. The first stage consists of having tacit and explicit knowledge, and the second stage is participation in knowledge sharing (Sheng et al., 2015). Tacit knowledge is complex, spontaneous, subjective, and difficult to explain to others and it accumulates through collaborative practices, experiences, and observations (Maravilhas & Martins, 2019). Explicit knowledge consists of information and know-how that are teachable objective, and verbalizable (Rogers et al., 2015). Knowledge sharing is the factor that encourages innovation among nurses (Kremer et al., 2019).

Nurses managers are supposed to effectively use strategies to confront incivility behaviors that include improving communication, social skills and teaching conflict management; in order to foster positive behaviors to achieve nurse's satisfaction and commitment and to decrease turnover rate. The prevalence of workplace incivility behaviors increased among nurses in Egypt and represent 50% of nurses, who experienced high incivility behaviors, leading to negative effect on nurses' work and may lead to increase errors and decrease quality of nursing care, decrease job satisfaction, engagement, increase turnover, and psychological disorders such as moral distress (El-Guindy et al., 2022; Mabrouk). Hence, the present study is needed in order to increase nurses' job satisfaction and commitment to the organization, interprofessional communication and collaboration, and improve patient quality of care.

Aim of the study

To examine the relationship between workplace incivility behaviors and nurses' intention to share knowledge.

Research Question:

What is the relationship between workplace incivility behaviors and nurses' intention to share knowledge?

2. MATERIALS AND METHODS

Research design:

Descriptive, correlational research design was used.

Setting:

This study was conducted in all inpatient (medical and surgical) units and critical and Intensive Care Units (ICUs) at Itay El-Baroud General hospital (n=8). This hospital is the third largest hospital at El-Beheira Governorate, with bed capacity (n=281), affiliated to the Ministry of Health and Population (MOHP). It is classified as: ***(1) medical units*** (n=2), as: general medical units (male and female); ***(2) surgical units*** (n=2), namely: general surgical units (male and female); and lastly,***(3) ICUs*** (n=4), as: general ICUs (A and B), coronary care unit, neonatal ICUs (A, B and C) and pediatrics ICU. The hospital, is one of the largest hospital, and has other departments, such as: paramedics, laundry, maintenance, radiology, laboratory, pharmacy, dietary department …etc.

Subjects:

The subjects of the study were composed of two groups, as follows (n=273):

1. All head nurses and their assistants, who were working in the previously mentioned settings and who were available at the time of data collection (N=13).

2. All staff nurses, who were working at the previously mentioned settings, and who were available at the time of data collection with at least one of year of experience, were included in the study. (N=260).

Tools:

Two tools were used in this study:

Tool (I): The Nursing Incivility Scale (NIS):

This tool was developed by Guidroz et al. (2010), to measure workplace incivility among nurses. It consists of 43-item, divided into five dimensions that are divided into eight sub-dimensions, namely: firstly, incivility from general environment (9-item), which is divided into three sub-dimensions: a) hostile climate (3-item), b) inappropriate joke (3-item) and c) inappropriate behavior (3-item); secondly, incivility from nurses (10-item), that is divided into three sub-dimensions: a) hostile climate (3-item), b) gossip/rumors (4-item) and c) free-riding (3-item); thirdly, incivility from direct supervisor (7-item), which is divided into two sub-dimensions: a) abusive supervision (4-item) and b) lack of respect (3-item); fourthly, incivility from physicians (7-item), which is divided into two sub-dimensions: a) abusive physician (4-item) and b) lack of respect (3-item); and finally, incivility from patient/visitor (10-item), which is divided in to two sub-dimensions: a) lack of respect (6-item) and b) displaced frustration (4-item). Responses were measured on 5-point Likert rating scale ranging from (1) strongly disagree to (5) strongly agree. The overall score level ranged from (43-215), where score (43-128) indicates low level of nursing workplace incivility, score (129-171) indicates moderate level and score (172-215) indicates high level.

Tool (II): Intention to Share Knowledge Questionnaire

This tool was developed by Bock and Kim (2002), to measure intentions to knowledge sharing behaviors. It consists of 38 items that are divided into nine dimensions, namely: (1) anticipated extrinsic rewards(2-item); (2) anticipated reciprocal relationships (5-item); (3) sense of self- worth (5-item); (4) affiliation (4-item); (5) innovativeness (3-item); (6) fairness (3-item); (7) attitude toward knowledge sharing (5-item); (8) subjective norms (6-item), which is divided into two sub-dimensions: a) normative beliefs on knowledge sharing (3-item) and b) motivation to comply (3-item); and finally, (9) intention to share knowledge (5-item), which is divided into two sub-dimensions: a) intention to share explicit knowledge (2-item) and b) intention to share implicit knowledge (3-item). Responses were measured on 5-point Likert scale ranging from (1) extremely unlikely to (5) extremely likely. The overall score level ranged from (38-190), where score (38-113) indicates low level of intention to share knowledge; score (114-151) indicates moderate level and lastly, score (152-190) indicates high level. In addition to that, a demographic characteristics data sheet was developed by the researcher. It included demographic characteristics of study participants, namely: age, working unit, gender, educational qualifications, years of nursing experience, years of unit experience and marital status.

II- Methods

1. An official permission was obtained from the Dean of Faculty of Nursing, Damanhour University and the responsible authorities of the study settings at Itay El-Baroud General Hospital, after explanation of the purpose of the study.

2. The two tools were translated into Arabic language, and were tested for its content validity and translation by five experts in the field of the study. Accordingly, some modifications were done.

3. The two tools were tested for its reliability, using Cronbach's Alpha coefficient test, where tool I: Nursing Incivility Scale (α=0.837); and tool II: Intention to Share Knowledge Questionnaire (α=0.934); indicating good and excellent reliability, respectively.

4. A pilot study was carried out on (10%) of total sample size; head nurses (n=1) and nurses (n=26), who were not included in the study sample, to ascertain the relevance of the tool, to test the wording of the questions, clarity and applicability of

the tools; to estimate the average time needed to collect the necessary data and to identify the different obstacles and problems that might be encountered during data collection. Based on the findings of the pilot study, no modifications were done.

5. Data collection was conducted by the researcher through hand-delivered questionnaire to study subjects, after individualized interview with each one for about (5) minutes to explain the aim of the study and the needed instructions were given before the distribution of the questionnaire in their settings. Every subject took from (15) to (20) minutes to fill out the two tools. Data collection took a period of three months from the beginning of January 2021 to the end of March 2021.

Ethical Considerations

- The research approval was obtained from the ethical committee at the Faculty of Nursing - Damanhour University, prior to the start of the study.
- An informed written consent was obtained from the study subjects after explanation of the aim of the study.
- Privacy and right to refuse to participate or withdraw from the study we reassured during the study.
- Confidentiality and anonymity regarding data collected were maintained.

Statistical analysis

The collected data was revised, categorized, coded, computerized, tabulated and analyzed using Statistical Package for Social Sciences (SPSS) version 25.0. Reliability of the tools was determined by Cronbach's alpha and presented in descriptive and association forms. The necessary tables were then developed. P value ≤ 0.05 was considered statistically significant, and P value ≤ 0.01 was considered highly statistically significant.

3. RESULTS

Table (1) shows that mean±SD of head nurses was 37.84±7.057; compared to 30.08±7.465 for nurses. In relation to working unit, more than half of head nurses and nurses were working in ICU (61.5%, 56.5%), respectively. Regarding gender, the majority of head nurses and nurses were female (92.3%, 89.6%), consecutively. As for educational qualification, all head nurses had Bachelor degree of Sciences in Nursing (100%); compared to (51.5%) of nurses. Pertaining to years of nursing experience, mean±SD of head nurses was 15.92±7.319; compared to 8.96±7.446 for nurses. According to years of unit experience, mean±SD of head nurses was 11.46±5.994; whereas, for nurses 7.05±5.527. In relation to marital status, the majority of head nurses and nurses were married (92.3%, 81.5%), respectively.

Table 2 shows that total and all workplace incivility behaviors dimensions got moderate mean percent scores, namely: general environment, nurses, direct supervisor, physicians, and patient/visitor (58.68%, 64.47%, 58.92%, 57.06%, 56.2%, 42.72%), respectively.

Table 3 shows that total intention to share knowledge and all its dimensions got moderate mean percent scores, namely: anticipated extrinsic rewards, anticipated reciprocal relationships, sense of self-worth, affiliation, innovativeness, fairness, attitude toward knowledge sharing, subjective norms, and intention to share knowledge (53.15%, 33.99%, 47.22%, 55.09%, 61.03%, 50.94%, 44.59%, 61.63%, 53.19%, 56.47%), consecutively.

Table 4 states that there are positive highly significant correlations between total workplace incivility behaviors and its dimensions and there are positive highly significant correlations between total nurses' intention to share knowledge and its dimensions, where (P=0.000). However, there are negative highly significant correlations between total workplace incivility behaviors and all its dimensions and total nurses' intention to share knowledge and all its dimensions, where (P=0.000).

Table 5 presents the result of multiple regression analysis between workplace incivility behaviors as independent variables and nurses' intention to share knowledge as a dependent variable, where adjusted R^2=0.824. This means that 82.4% of the explained variance of nurses' intention to share knowledge is related to workplace incivility behaviors, where the model is highly significant (F = 80.227, P = 0.000).

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Table (1): Demographic characteristics of the study subjects, working at Itay El-Baroud General Hospital. (N=273)

Demographic characteristics	Head nurses (N=13)		Nurses (N=260)		Total (N= 273)	
	No.	%	No.	%	No.	%
Age (years)						
20 -	0	0	137	52.7	137	50.2
30 -	9	69.2	83	31.9	92	33.7
40 -	2	15.4	25	9.6	27	9.9
50+	2	15.4	15	5.8	17	6.2
Min-Max	**30 - 50**		**21– 53**		**21 – 53**	
Mean ±SD	**37.84±7.057**		**30.08±7.465**		**30.45±7.616**	
Working Unit						
Medical	3	23.1	46	17.7	49	17.9
Surgical	2	15.4	67	25.8	69	25.5
ICU	8	61.5	147	56.5	155	56.6
Gender						
Male	1	7.7	27	10.4	28	10.3
Female	12	92.3	233	89.6	245	89.7
Educational qualification						
Diploma of Secondary Technical Nursing School	0	0	55	21.2	55	20.2
Diploma of Technical Health Institute	0	0	71	27.3	71	26.0
Bachelor of Sciences in Nursing	13	100	134	51.5	147	53.8
Years of nursing experience						
1-	0	0	77	29.7	77	28.2
5-	2	15.4	114	43.8	116	42.5
10 +	11	84.6	69	26.5	80	29.3
Min-Max	**7 – 30**		**1 – 32**		**1 – 32**	
Mean ±SD	**15.92±7.319**		**8.96±7.446**		**9.29± 7.573**	
Years of unit experience						
1-	2	15.4	93	35.8	95	34.8
5-	2	15.4	109	41.9	111	40.7
10 +	9	69.2	58	22.3	67	24.5
Min-Max	**2 – 19**		**1–26**		**1 – 26**	
Mean ±SD	**11.46±5.994**		**7.05±5.527**		**7.26± 5.617**	
Marital status						
Single	1	7.7	48	18.5	49	17.9
Married	12	92.3	212	81.5	224	82.1

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Table (2): Mean percent scores of study subjects' workplace incivility behaviors, working at Itay El-Baroud General Hospital. (N=273)

Workplace incivility behaviors sources/dimensions	Min.	Max.	Mean ± SD	Mean % Score
General environment	**9**	**45**	**29.01± 7.241**	**64.47**
• Hostile climate	3	15	9.02 ± 3.981	60.13
• Inappropriate joke	3	15	8.99± 2.881	59.93
• Inappropriate behavior	3	15	10.99± 2.387	73.27
Nurses	**10**	**50**	**29.46 ±10.193**	**58.92**
• Hostile climate	3	15	9.39 ±2.904	62.60
• Gossip/Rumors	4	20	11.65 ±4.481	58.25
• Free-riding	3	15	8.41 ±3.487	56.07
Direct supervisor	**7**	**35**	**19.97±7.282**	**57.06**
• Abusive supervision	4	20	10.65±3.863	53.25
• Lack of respect	3	15	9.33±3.603	62.20
Direct physicians	**7**	**35**	**19.67±7.132**	**56.20**
• Abusive physician	4	20	12.23±4.125	61.15
• Lack of respect	3	15	7.43±3.249	49.53
patient / visitor	**10**	**50**	**28.04±9.608**	**42.72**
• Lack of respect	6	30	14.23±5.962	26.70
• Displaced frustration	4	20	13.81±4.123	41.32
Total workplace incivility	**43**	**215**	**126.16 ± 39.787**	**58.68**

Low score: 0 - < 33.3%; Moderate score: ≥33.3% - < 66.6%; High score ≥ 66.6% -100%

Table (3): Mean percent scores of study subjects' intention to share knowledge, working at Itay El-Baroud General Hospital. (N= 273)

Nurses' intention to share knowledge dimensions	Min.	Max.	Mean ± SD	Mean % Score
Anticipated extrinsic rewards	2	8	3.40±1.184	33.99
Anticipated reciprocal relationships	5	25	11.81±4.703	47.22
Sense of self- worth	5	25	13.77±5.323	55.09
Affiliation	7	20	12.21±2.683	61.03
Innovativeness	3	15	7.64±2.841	50.94
Fairness	3	15	6.69±2.920	44.59
Attitude toward knowledge sharing	5	25	15.41±5.076	61.63
Subjective norms	6	30	15.96±5.397	53.19
1. Normative beliefs on knowledge sharing.	3	15	7.02±3.360	46.80
2. Motivation to comply.	3	15	8.92±3.201	59.47
Intention to share knowledge.	7	25	14.12±4.483	56.47
1. Intention to share explicit knowledge.	3	10	6.06±1.953	60.60
2. Intention to share implicit knowledge.	3	15	8.04±3.749	53.60
Total nurses' intention to share knowledge	**43**	**178**	**100.99±32.435**	**53.15**

Low score: 0 - < 33.3%; Moderate score: ≥33.3% - < 66.6%; High score ≥ 66.6% -100%

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Table (4): Correlation matrix between study subjects' workplace incivility behaviors and nurses' intention to share knowledge, working at Itay EL-Baroud General Hospital. (N= 273)

Workplace incivility behaviors dimensions/Nurses' intention to share knowledge dimensions		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
General environment (1)	r	1	0.818	0.764	0.762	0.81	0.864	-0.522	-0.57	-0.619	-0.717	-0.655	-0.595	-0.728	-0.62	-0.627	-0.677
	P(2-tailed)		0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**
Nurses (2)	r		1	0.964	0.961	0.958	0.985	-0.715	-0.427	-0.52	-0.609	-0.499	-0.31	-0.706	-0.499	-0.468	-0.554
	P(2-tailed)			0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**
Direct supervisor (3)	r			1	0.986	0.958	0.977	-0.684	-0.379	-0.471	-0.542	-0.442	-0.256	-0.66	-0.457	-0.412	-0.5
	P(2-tailed)				0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**
Physicians (4)	r				1	0.954	0.975	-0.685	-0.347	-0.44	-0.53	-0.423	-0.23	-0.645	-0.437	-0.385	-0.476
	P(2-tailed)					0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**
Patient/visitor (5)	r					1	0.981	-0.683	-0.396	-0.481	-0.548	-0.459	-0.298	-0.662	-0.468	-0.423	-0.514
	P(2-tailed)						0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**
Total workplace incivility (6)	r						1	-0.691	-0.44	-0.527	-0.613	-0.514	-0.348	-0.71	-0.516	-0.481	-0.566
	P(2-tailed)							0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**
Anticipated extrinsic rewards (7)	r							1	0.398	0.472	0.514	0.422	0.227	0.64	0.499	0.339	0.502
	P(2-tailed)								0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**
Anticipated reciprocal relationships (8)	r								1	0.934	0.785	0.889	0.876	0.82	0.898	0.913	0.938
	P(2-tailed)									0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**
Sense of self- worth (9)	r									1	0.861	0.922	0.863	0.905	0.959	0.938	0.977
	P(2-tailed)										0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**
Affiliation (10)	r										1	0.919	0.81	0.89	0.889	0.869	0.917
	P(2-tailed)											0.000**	0.000**	0.000**	0.000**	0.000**	0.000**
Innovativeness (11)	r											1	0.923	0.887	0.938	0.929	0.966
	P(2-tailed)												0.000**	0.000**	0.000**	0.000**	0.000**
Fairness (12)	r												1	0.756	0.869	0.908	0.903
	P (2-tailed)													0.000**	0.000**	0.000**	0.000**
Attitude toward knowledge sharing (13)	r													1	0.929	0.868	0.941
	P(2-tailed)														0.000**	0.000**	0.000**
♀♀Subjective norms (14)	r														1	0.931	0.98
	P(2-tailed)															0.000**	0.000**
Intention to share knowledge (15)	r															1	0.963
	P(2-tailed)																0.000**
Total Nurses' intention to share knowledge (16)	r																1
	P(2-tnided)																

* Significant P ≤ 0.05 ** Highly significant P ≤ 0. 01 Interpretation of r: Weak(0.1-0.24) Intermediate (0.25-0.7) Strong (0.75-0.99) Perfect (1)

Table (5): Multivariate regression analysis of nurses' intention to share knowledge among the study subjects, working at Itay El-Baroud General Hospital. (N=273)

	Unstandardized Coefficients	Standardized Coefficients	T	`P
	B	β		
(Constant)	142.038		8.523	0.000**
Age (years)	0.626	0.147	0.821	0.412
Years of nursing experience	0.607	0.142	0.760	0.448
Years of unit experience	0.539	0.093	1.719	0.087
Hostile climate (general environment)	-2.907	-0.357	-3.739	0.000**
Inappropriate joke	-0.569	-0.051	-0.912	0.363
Inappropriate behavior	-2.333	-0.172	-3.879	0.000**
Hostile climate (nurses)	-0.967	-0.087	-0.801	0.424
Gossip/Rumors	-2.355	-0.325	-1.913	0.057
Free riding	-2.673	-0.287	-3.422	0.001**
Abusive supervision	-0.389	-0.046	-0.317	0.752
Lack of respect (direct supervisor)	-3.224	-0.358	-2.363	0.019*
Abusive physician	-0.643	-0.082	-0.534	0.594
Lack of respect (physician)	-7.067	-0.708	-7.266	0.000**
Lack of respect (patient/ visitor)	-3.346	-0.615	-5.329	0.000**
Displaced frustration	-5.633	-0.716	-7.350	0.000**
ANOVA[a]				
Model	**R^2**	**Df**	**F**	**P**
Regression	0.824	15	80.227	0.000**[(b)]

a: Dependent Variable: Nurses' intention to share knowledge.
b: Predictors: (Constant), Displaced frustration, Age (years), Inappropriate behavior, Inappropriate joke, Free riding, Years of unit experience, Hostile climate, Abusive supervision, Hostile climate, Lack of respect (physician), Lack of respect (patient/ visitor), Lack of respect (Direct supervisor), Abusive physician, Gossip/Rumors, Years of nursing experience. *P (significant) ≤ 0.05 **P (highly significant) ≤ 0.01 df = degree of freedom. F = One Way Anova.
T = Independent samples t-test. R^2 = Coefficient of multiple determination.

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4. DISCUSSION

Workplace incivility behaviors is a phenomena that numerous health care professionals have experienced in their careers (Neubert et al., 2022). Various negative health and organizational outcomes were found to be associated with workplace incivility (Fida et al., 2018). The total workplace incivility and all its dimensions, namely; general environment, nurses, direct supervisor, physicians and patient/visitor got moderate mean percent scores. This may be related to lack of rules and policies that support ethical guidelines among nurses, frustrated and unfair work environment, lack of accountability among nurses, ineffective patient hand-offs, nature of nursing work, which is characterized by increase workloads, stress, multiple care demands for a variety of patients, lack of resources, irregular schedules, shortage of staff, leading to their inabilities to take their rights such as holiday for entitlement, night and evening shifts especially in holidays that interrupt their personal life.

This is supported by Alshehry et al. (2019) and Oyeleye et al. (2013), who reported that staff nurses had moderate level of exposure to workplace incivility behaviors and found that urgency for patient care, long working hours and uncertainty over treatment lead to uncivil interactions during working hours. Additionally, Alqahtani (2019) indicated that about (75%) of Saudi nurses experienced moderate workplace incivility. Moreover, Garma et al. (2018) and Sharma and Singh (2016) claimed that nurses experienced a moderate level of workplace incivility and reported that occupational stress, difficult working conditions, unresolved conflict, lack of leadership, increased health care complexity, nurses' isolation, and decreased social engagement, can provoke the emergence of disruptive and uncivil behaviors and consequently evolve into workplace incivility.

In addition to that, Kanitha and Naik (2021) reported that nurses experience incivility in their workplace almost from all sources and that the highest percentage of staff nurses (64%) had moderate level of incivility. Furthermore, Alquwez (2020) and Bambi et al. (2018) found that staff nurses experienced moderate incivility behaviors and revealed that despite the moderate experiences among nurses workplace incivility still requires vital attention because its negative impact on the well-being and work outcomes of nurses.

On the other hand, this result is contradicted to Dirgar et al. (2021) , who reported that (43.6%) of Turkish nurses perceived high level of incivility behaviors, and that those nurses were working only night shifts, had higher scores than those working only during daytime hours. Woo and Kim (2020) also found that Korean nurses experienced higher score of workplace incivility. Moreover, Klingberg et al. (2018) showed that 38% of health care professionals reported a high degree of incivility in the workplace. Additionally, Zhang et al. (2018) revealed that (60.7%) of nurses experienced high level of incivility in China. Furthermore (Mabrouk, n.d), , who reported that half of the nurses experienced high level of workplace incivility. In addition to that, Porath and Pearson (2013) found that 98% of American nurses reported incivility behaviors with half of them encounter incivility once/week. Wilson et al. (2011) reported also that 85% of them had experienced or witnessed some form of incivility.

Furthermore, the majority of nurses got moderate mean percent score of total sources of workplace incivility behaviors. The first source of incivility among them was general environment; while the last one was patient/visitor. This could be related to that the feminine nature of the nursing profession leading to spreading of gossips and rumors can affect them. Moreover, excessive monitoring of nursing work; nurses may feel undervalued, unrespected, are criticized, have displaced frustration and unclear job design in the nursing profession. These factors contribute to the development of role conflict, lack of cooperation, and increase hostile climate at work environment.

This is agreement with, Hutton and Gates (2008), who determined that the most frequent source of incivility was general environment and therefore, cultivating a positive and supportive environment among collegial work relationships by allowing even small, nonthreatening interactions that reduce workplace incivility. Additionally, (Mabrouk, n.d) found that the first source of incivility behaviors was general environment; and the last one was patient/visitors. Moreover, Guidroz et al. (2010), who found that the lowest reported incivility was from the direct supervisor and the greatest incivility was from the general environment.

On the other hand, this result is contradicted with Luttik et al. (2017), who showed that patients/visitors in hospitals in Norway and Denmark tend to be the most common offenders of nurses. Furthermore, the majority of workplace incivility experienced was from patients/visitors as increasing numbers of relatives and lack of visiting policy; while the lowest was

from supervisors (Alyaemni & Alhudaithi, 2016; Alshehry et al., 2019; Layne et al., 2019; Alquwez, 2020). Additionally, nurses experience incivility from co-workers who feel excluded, dismissed, insignificant, anxious, nervous and depressed (Zhou et al., 2015; Viotti et al., 2018). Nurses also experienced the highest incivility from interactions with physicians (Kalantari et al., 2012; Hosseinpour-Dalenjan et al., 2017).

The present study illustrated that total nurses' intention to share knowledge and all its dimensions, namely: anticipated extrinsic rewards, anticipated reciprocal relationships, sense of self-worth, affiliation, innovativeness, fairness, attitude toward knowledge sharing, subjective norms and intention to share knowledge got moderate mean percent scores. This may be related to the nature of work that create life-threatening situations for patients, enforces nurses to work in teams, so they have to share knowledge with each other. In addition, by applying quality standards, nurses ought to sharing knowledge with health care team members. Moreover, nurses want to gain co-workers' attention, trust and love, feel valuable member and find better ways to perform any tasks, that cannot happen without sharing knowledge. Nurses know also that knowledge sharing is essential for organizations to achieve their goals and the urgent need for communication and collaboration, improve organizational productivity and efficiency and manage future risks.

These results are in agreement with that of Diab and Eldeeb (2020), who found that more than half of nurses (55.33%) had a moderate level of knowledge sharing behavior and reported that knowledge sharing help nurses develop their experience and self-confidence at work, make better vital decisions faster, stimulate innovation and growth, update and enrich resources with additional updates and information, and learn new techniques to improve patients care. Nurses also perceived their level of knowledge sharing to be above average and clarified that knowledge sharing improve organizational productivity and efficiency and manage future risks. It facilitates dissemination of overall awareness among them, creates a better work environment, lowering the training costs, medical errors, and promoting the patient care quality (Yoo et al., 2019). On the other hand, the highest percentage of nurses had a high mean percent score of knowledge sharing (Castaneda & Durán, 2018; Elasid et al., 2020).

Furthermore, the attitude toward sharing was the first dimension and got high mean percent score among staff nurses and the lowest dimension was anticipated intrinsic rewards. This could be related to most of nurses were female hold bachelor degree, thus they consider sharing knowledge their duty toward patients and confess that sharing knowledge and helping co-workers is enjoyable experience, wise move and valuable to them.

The finding is partially in line with Tohidinia and Mosakhani (2010), who found that attitude toward knowledge sharing, affiliation and perceived behavioral control are the highest predictor of knowledge sharing behavior. While, both intrinsic and extrinsic motivations placed a positive effect on the intention to knowledge sharing among nurses (Mohsen Allameh et al., 2014; Hajian & Sardar, 2017; Rafieian-Isfahani et al., 2020).

The findings of the present study illustrated that there were positive highly statistical significant correlations between total workplace incivility behaviors, and all its dimensions. This could be related to the exposure of nurses to workplace incivility from different sources as: general environment, nurses, supervisors, physician and patient/visitors. These findings are in the same line with El-Guindy et al. (2022), Alshehry et al. (2019) and Mabrouk (n.d), who identified that all five dimensions of workplace incivility behaviors have positive and significant correlations with each other and with workplace incivility behaviors. Moreover, there were positive highly statistical significant correlations between total nurses' intention to share knowledge and all its dimensions. This may be due to nurses, who are treated with respect and trust from other co-workers, feeling loyalty about their hospital and mercy on their patient. Moreover, nurses attend training programs, which raise awareness about the importance of knowledge sharing.

The findings of this study revealed that there were negative highly significant correlations between total workplace incivility behaviors and total nurses' intention to share knowledge**.** This may be related to nurses, who experienced incivility behaviors retaliated by impairing knowledge sharing or conserve their resources by indulging in overt deviant behavior, they are more likely prone to engage in behaviors that is less visible, but may be harmful for organizations. Lack of ethical conduct, and stressful work environment also contribute to resist to share ideas, experiences and skills among nurses, as they think to be criticized and judged. The finding is supported by Holm et al. (2021), who demonstrated that workplace incivility behaviors have effects beyond target perpetrator relationship. Furthermore, workplace incivility behaviors lead to reduce job performance, nurses collaboration and increase organizational retaliatory behaviors (Armstrong, 2018).

Moreover, workplace incivility and abusive supervision impair knowledge sharing (Zhao et al., 2016; Liu et al., 2017; Khalid et al., 2018). The presence of a negative significant influence between abusive supervision on knowledge sharing and the healthier working environment and workplace incivility behaviors disturbs the harmony of the organizations, nurses do not engage in deviant behavior directly; their anxiety, stress, depression and anger may eventually lead towards display of deviant behavior and provoke a hostile work environment that impair sharing knowledge (Wulandari & Muafi, 2021). Participants tend to hide their knowledge due to this negative behaviors and the higher the level of workplace incivility experienced by team members, the higher the tendency for them to hide knowledge. Nurses also when disrespected or mistreated from co-workers, lose their confidence and trust that reduce their contribution and motivation because of negative reciprocity and negatively aroused emotions (Sharifirad, 2016; Arshad & Ismail, 2018).

5. CONCLUSION

The result of the present study concluded that there was highly significant negative relationship between workplace incivility behaviors and nurses' intention to share knowledge at Itay El-Baroud General hospital. In addition, the majority of nurses got moderate mean percent scores for both workplace work place incivility and all its dimensions and nurses' intention to share knowledge and all its dimensions.

6. RECOMMENDATIONS

In the light of the study findings, it is recommended that:

Hospital administrators should:

- Develop workplace incivility behaviors policy that protect victims and disseminate the policy through different channels of communications (e.g: publications, posters, websites, and newly hired nurses orientations…etc) to nursing department members.
- Implement zero tolerance policy that prevent incivility behaviors and provide adequate safeguards to nurses and others, who accused of incivility.
- Identify early any unreasonable behaviors and situations that increase the risk of workplace incivility behaviors and implement control measures to manage the risk.
- Allow opportunities for nurses to participate in decision making and problem solving in order to promote healthy working environment through encouraging nurses to express their opinions and share in different organizational activities.

Head nurses should:

- Provide staff nurses with accepted behaviors and written rules within the group and continuous feedback about nurses performance.
- Encourage sharing knowledge and become a role model for their staff.
- Communicate openly with the nurse managers through regular meetings to discuss ways of improvement of quality of work life and expressing fears from any deviant behaviors.

Staff nurses should:

- Attend awareness workshops about signs and symptoms of workplace incivility behaviors, impact of incivility on personal health as well as actions that will prevent and stop any abuse.
- Follow workplace incivility behaviors policy and zero tolerance policy.

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