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Impact of an Educational Intervention on Faculty to Faculty Incivility

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Title: Impact of an Educational Intervention on Faculty-to-Faculty Incivility

Abstract: Faculty –to- faculty incivility within schools of nursing is a growing problem. Incivility amongst nursing faculty has the potential to effect other nursing faculty, nursing students, the school of nursing, and increase the risk of harm to patients in the clinical setting. A common recommendation for addressing faculty-to-faculty incivility is an educational offering about civility, incivility, and methods to address incivility. Ideally, an educational intervention about incivility can decrease levels of incivility in nursing education thereby increasing the amount of civility within the organization. The purpose of the research was to measure the impact of an educational intervention on nursing faculty's perception of faculty-to faculty incivility within a school of nursing utilizing the Faculty-to-Faculty Incivility Survey (F-FI). The research design was a quasi-experimental, one group, pretest – post-test design using a convenience sample. The research hypothesized an educational offering would have an impact on the faculty's perception of faculty-to-faculty incivility in a school of nursing. The data analysis using the Wilcoxon Rank Sums test supported the null hypothesis. The null hypothesis stated there would be no statistical significant difference between the pre-educational and post-educational scores on the F-FI. The results of the research supports the need for multiple interventions to address faculty-to-faculty incivility in nursing education.

Keywords: incivility, academia, Faculty-to-Faculty Incivility Scale, faculty-to-faculty incivility, nursing

Introduction

Incivility between nursing faculty members is a problem in the academy. Research indicates up to 68% of nursing faculty experience some form of incivility (Clark, Olender,

Kenski & Cardoni, 2013; Clark & Springer, 2007a, Lashley & deMeneses, 2001; Luparell, 2004). This level of incivility is a problem for nursing faculty, nursing programs, and nursing students because incivility does not just affect the individual perceiving the incivil act (Anderson & Pearson, 1999). Incivility has the potential to spread from person to person throughout an organization (Anderson & Pearson, 1999). Faculty members engaged in incivil behaviors with one another can experience mental fatigue, which can lower their ability to monitor their behavior. These same faculty members, when exposed to stress or incivility from a student or administrators, could respond with incivility. This is how incivility spreads from just a faculty issue to a nursing program issue (Anderson & Pearson, 1999; Morin, 2016). Furthermore, nursing faculty incivility has been linked to increased student attrition rates and decreased student satisfaction with the nursing program (Marchiondo, Marchiondo, & Lasiter, 2010; Clark, 2008b). Unfortunately, more and more nursing faculty characterize behaviors as incivil, bully, and rude when describing how faculty behave towards each other (Clark & Springer 2007a, 2007b). Additionally, complaints of workplace incivility are one of the major reason nurse educators are choosing to leave university settings (Clark & Springer 2007a, 2007b).

Incivility among nurses has become so prevalent the American Nurses Association (ANA) developed an official position statement to address the issue (American Nurses Association, 2015b). The ANA's position statement recommends nurses use the Code of Ethics for Nurses as a guideline in creating an ethical environment and culture of civility in the workplace (2015b). The ANA believes it is the registered nurse and employer's ethical, moral, and legal responsibility to create work environments that promote civility, respect, and dignity for others (ANA, 2015b).

The Joint Commission identified an increasing trend of disruptive and intimidating nursing behaviors interfering with the culture of safety in the work environment and issued a sentinel alert (Joint Commission, 2008). The Joint Commission (2013) defines a sentinel event as an "unexpected occurrence involving death, serious physical or psychological injury or the risk thereof" (SE-1). Intimidating behaviors, verbal and physical threats and passive aggressive behaviors increase the risk for medical errors, contribute to poor patient satisfaction and cause healthcare workers (nurses, administrators, and managers) to leave their jobs (Joint Commission, 2008). The Joint Commission's Sentinel Event Alert (2008) recommends skills- based training and coaching, ongoing surveillance, and assessment of staff perceptions of the extent and seriousness of unprofessional behaviors as one way to decrease incivil behaviors in the work environment (Joint Commission,2008).

Considering the recommendations by the ANA and the Joint Commission, registered nurses working in academia should establish a workplace environment that does not include acts of incivility or bullying. The purpose of this study was to determine the effect of an educational intervention on nursing faculty's perception of faculty-to faculty incivility based on the pretest and post-test scores of the F-FI survey.

Background

Work Environment

The American Association of Critical-Care Nurses (AACN) (2016) began promoting the need for nurses to have a healthy work environment in 2001with the development of the Standards for Establishing and Sustaining Healthy Work Environments. The AACN believes a healthy work environment is "safe, healing, humane, and respectful of the rights, responsibilities, needs, and contributions of all people" (AACN, 2016, p.1). The American Nurses Association

(ANA)(2015b) states a healthy work environment is one that is safe, empowering, and satisfying and not merely the absence of real and perceived threats to health, but a place of physical, mental, and social well-being.

Unhealthy work environments contribute to medical errors, ineffective delivery of care, conflict, and stress (AACN, 2016; Joint Commission, 2008). These safety risks also apply to nurse educators. Nurse educators are responsible for supervising students in the clinical setting, overseeing the administration of medication, and being an important safety check for the student to prevent potential patient harm. The effects of an unhealthy work environment may cause the instructor a lack of focus on the task and consequently increase the risk of harm to the patient. Furthermore, the work environment directly effects the retention of faculty, team effectiveness, and burnout among health care professionals (AACN, 2016).

A healthy work environment is essential to faculty retention. Heinrich's (2006) research revealed faculty who experienced incivility at work experienced decreased joy in performing their job, had reduced productivity, and had trouble focusing while at work. Acts of incivility between faculty members can cause the victim to have feelings of humiliation, isolation, and become alienated from colleagues and the nursing program (Goldberg, Beitz, Wieland, & Levine, 2013).

The importance of a healthy work environment cannot be over stated. Sigma Theta Tau International Honor Society (STTI) in Nursing developed and hosted the Creating Healthy Work Environments conference in attempt to increase awareness of the issue of incivility and the negative effects incivility has on the nurse's work environment (Sigma Theta Tau International, 2017). Part of creating a healthy work environment is having a shared vision, values, and team norms, creating organizational civility, and the development and maintenance of civility

conversations in all organizational levels (AACN, 2016; Clark, 2015). Clark recommends including faculty in the design process for developing new norms such as identifying faculty behaviors are incivil and the consequences for incivil acts (Clark, 2013a; 2013b).

In 2012, the Robert Wood Johnson Foundation Executive Nursing Fellows program developed a team of nurses, PACERS: Passionate About Creating Environment of Respect and civilitieS,- whose goal is to eliminate bullying and incivility in the work place and create work environments of respect and civility (Passionate About Creating Environment of Respect and civilitieS (PACERS), 2015). The PACERS (2015) recommend actively engaging frontline nurses to development a culture of civility by providing education, which includes a prevention and intervention focus. PACERS recommended integrating incivility prevention and minimization into the orientation process and ongoing staff training (PACERS, 2015).

Incivility within the organization can lead to work relations becoming frayed, employees being miserable on the job, increase in aggressive behaviors, higher employee turnover, lower productivity, and lost customers (i.e. students) (Anderson & Pearson, 1999; Longo & Sherman, 2007; Pearson, Anderson, & Wegner, 2001). Incivility can destroy a teacher's passion for education, cause low morale, diminish the quality of work, and result in nurses leaving academia. The more stressed a faculty member is, the more likely he/she will look for employment elsewhere, leave nursing education, or abandon the profession of nursing altogether (Clark, 2013a). Continuous acts of incivility spread incivility throughout an organization until the incivility is normal and alters the culture and climate for the worse (Anderson & Pearson, 1999).

Faculty Health

Incivility can lead to serious physical and mental harm to faculty (Dalpezzo & Jett, 2010). Acts of incivility increase stress levels and can lead to weight loss or gain, headaches,

high blood pressure, and sleep disturbances. The stress associated with being a victim of incivility causes loss of concentration and lack of creativity (Clark, 2013a; Pearson & Porath, 2009). In addition, increased levels of stress causes short-term and long-term physical and mental symptoms. Short-term symptoms include headaches, muscular tension, chest pain, indigestion, palpitations, and disturbed sleep. Long-term work- related stress could lead to serious health issues such as heart disease, hypertension, ulcers, irritable bowel syndrome, high cholesterol and diabetes (Blaug, Kenyon, & Lekhi, 2007).

Figure 1. Impact of Incivility

Role Modeling, Professionalism, and Ethics

Role Modeling

All nurses have a responsibility to foster civility; however, nurse educators must be acutely aware of their role as a guide and mentor to nursing students and new faculty members. Nursing faculty members should teach and role model professional communication, crisis management, and efficient conflict resolution for nursing students. Nursing faculty have the

additional responsibility to role model civil behaviors for students, so that civility can be re-established as normal within the health care setting and nursing in general. The nurse educator is responsible for demonstrating civil actions to the future generation of nurses and giving the students the tools to address incivil behaviors (AACN, 2008; ANA, 2015a, 2015b; Becher & Visovsky, 2012; Clark & Ahten, 2012; Joint Commission, 2008).

Interactions that occur during the nursing students' education will shape their professional image. Nursing students observe how other nurses behave and begin developing a concept for how professionals act towards others including patients, colleagues, and students (Baltimore, 2006; Randle, 2003). It is the role of the nursing instructor to demonstrate civil, professional behaviors for students to adopt and carry into their practice.

Professionalism

Professionalism in nursing includes more than just extensive education and training regarding the skills nurses use in their day-to-day work. Being a professional requires attention to work ethics, following the nursing code of conduct, and using an effective and therapeutic communication style. Faculty instructing students to act like a professional, yet personally engaging in activities considered incivil (e.g. gossip, sarcastic remarks, eye rolling and using foul language), set a poor example for students to follow (Clark, 2009, 2013a, 2015; Barr-David 2015).

Ethics

The American Nurses Association's (2015a) Code of Ethics for Nurses with Interpretive Statements declares nurses to treat colleagues and patients with respect, dignity and in a civilized manner free from bullying and harassment. Nurses are to "create an ethical environment and a culture of civility and kindness." (ANA, 2015a, p.4). The American Nurses Association's

position regarding incivility reinforces the concept that nursing is a caring and compassionate profession, free from acts of incivility (ANA, 2015b). One of the duties of the nurse educator is to pass down the ANA Code of Ethics of Nursing to future generations. Nursing faculty displaying acts of incivility are in exact opposition to the ideas discussed in the ANA's Code of Ethics for Nursing. Nurse faculty are held accountable to the standards outlined in the Code of Ethics for Nurses and have a responsibility to conduct themselves in an ethical, professional manner (ANA, 2015b).

Faculty face many external pressures in their role: institutional pressures to retain and graduate students; potential litigation from disgruntled students or parents; and lack of administrative support for faculty decisions. "We stand little chance of breaking the chain of workplace incivility if we communicate to the next generation of nurses that this type of behavior is accepted as part of our professional culture." (Luparell, 2011, p.95). Incivility begets incivility, and faculty-to-faculty incivility can promote student incivility by role modeling a behavior that does not reflect the Nursing Code of Ethics or the philosophy of nursing. Finally, faculty-to-faculty incivility does not coincide with the basic ideas of the medical profession: first, do no harm.

A common recommendation from research and experts in the field is to provide appropriate education to raise awareness of the problem of incivility. Development of an educational offering for faculty along with activities to provide faculty with the tools to recognize incivility and respond appropriately is one solution to incivility in nursing education (Clancy, 2014; Bar-David, 2015; Clark, 2013a, Porath, 2016).

Theoretical Framework

Clark's theory of effective communication and active engagement to create a culture of civility was the framework for the design of this research (Clark, 2008b; Clark, Olender, Cardoni, & Kenski, 2011). Educational offerings to raise awareness of incivility and the havoc incivil actions can have on others is the first step to take in addressing incivility within academia. According to Clark's theory, missed, avoided, or poorly managed remedies, encounters, and opportunities for engagement are the basis for increasing the culture of incivility within nursing education (Clark, 2008b; Clark, Olender, Cardoni, & Kenski, 2011). Clark's theory of incivility in nursing education was the guide to the development of this research by illustrating where interventions could reduce the culture of incivility and promote a culture of civility within nursing education. Sharing the importance of recognizing incivility and learning to become mindful of one's own incivil acts via an educational offering is necessary to raise the faculty's awareness of the issue (Clark, 2013a, 2013b; Clark, Olender, Cardoni, & Kenski, 2011; Clark & Springer, 2010; Nazir & Ahmed, 2016; Williams, & Lauerer, 2013). According to Clark's theory, educating faculty to recognize incivility and respond to incivil acts without escalating the situation will increase the potential number of opportunities to address incivility and consequently move the academic culture away from one of incivility towards one of civility. The opportunities for faculty to work together to resolve conflict increase and a more civil workplace environment is created (Clark, 2008b; Clark, Olender, Cardoni, & Kenski, 2011).

Figure 1. Clark's Conceptual Model for Fostering Civility in Nursing Education

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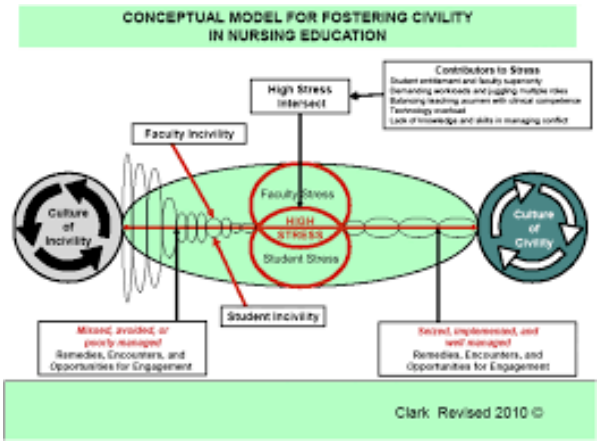

Clark, C.M. (2017). Creating and sustaining civility in nursing education, 2 nd ed, Indianapolis, IN, Sigma Theta Tau International Publishers.
Clark, C. M., & Davis-Kenaley, B. L. (2011). Faculty empowerment of students to foster civility in nursing education: A merging of two conceptual models. Nursing Outlook, 59(3), 158-165.
Clark, C. M., & Springer, P. J. (2010). Academic nurse leaders' role in fostering a culture of civility in nursing education. Journal of Nursing Education, 49(6), 319–325.
Clark, C.M. (2008). The dance of incivility in nursing education as described by nursing faculty and students, Advances in Nursing Science, 31(4), E37-E54.

Methods

Design

A single group pretest-post-test research design answered the following question: Is there a significant change in the perception of faculty-to-faculty incivility as measured by the pretest and post-test scores on the Faculty-to-Faculty Incivility Survey after an educational intervention? The participants acted as their own control in completing the Faculty-to-Faculty Incivility Survey before and after an educational offering. The educational offering (independent variable) was predicted to influence the faculty's perception of faculty-to-faculty incivility. The Faculty-to-Faculty Incivility Survey (F-FI) measured the variable of interest of the study. The survey for the research was designed by Dr. C. Clark (2013b) to specifically measure faculty perceptions of faculty-to-faculty incivility. The F-FI has a Cronbach's coefficient of 0.965.

Participants

This study included a convenience sample of nursing faculty from the Baccalaureate (BSN) and Masters (MSN) program at a four-year university school of nursing located in the Southeastern United States. Inclusion criteria consisted of all adjunct, part-time, and full-time school of nursing faculty teaching in the BSN and MSN programs along with administrative faculty for both programs. There were no exclusion criteria for this study.

Implementation

Nursing faculty received an email containing the pretest Faculty-to-Faculty Incivility Survey (F-FI) link and a separate link to the demographic data survey. The pretest FF-I and demographic data were separated to provide anonymity to the participants of the study. The faculty were also instructed to make an individual identification number consisting of their mother's first and last initials and father's year of birth to further protect their anonymity. Seven days later faculty received a reminder to complete the pretest F-FI survey and the demographic survey. The pretest F-FI survey remained open for fourteen days. The educational offering, *Incivility in Nursing Education: Let's Do Something About It*, was held in a face-to-face session at the school of nursing. There were fourteen days between the educational offering and the post-test F-FI survey. After the educational offering, nursing faculty received the post-test F-FI survey and a separate email with the demographic survey. The investigator sent a reminder to complete the post-test survey to the faculty seven days after the original post-test survey. The post-test survey remained open for fourteen days. The investigator turned off the Internet Protocol (IP) feature within the online survey program. IP addresses can link the computer to a given participant. This helped to protect the confidentiality of the participants.

The nursing faculty response rate for the F-FI pretest survey was 64% (n=25), with no missing data. The nursing faculty response rate for the F-FI post-test survey was 43.5% (n=17)

with no missing data. The nursing faculty response rate for the demographic survey was 10% (n=4). There were four faculty demographic responses, which was inadequate to give a picture of the group; therefore, the data was omitted from the survey analysis.

Results

The original plan for data analysis included the use of the Wilcoxon Signed Rank Test that analyzes matched sets of data. The data analysis method was changed because the personal identification numbers on the pretests did not match the personal identification numbers on the post-test. There were multiple reasons this could have happened. The participants may not have remembered their individual identification number and/or the participants from the pretest were not the same as the participants for the post-test. Another potential reason is the participants may have worried the investigator could still identify them and purposely changed their identification number on the post test. Therefore, data analysis was performed using the Wilcoxon Rank Sums test that does not require matched sets of data (Burns & Grove, 2009).

Questions on the F-FI are divided into three sections. The first section of questions determines the participant's perception of the level of incivility of a specific behavior. The second section of questions determines the frequency the faculty member encounters the specific behaviors. The third section asks the participant to identify factors that contribute to faculty-to-incivility and what keeps faculty from addressing incivility. The survey answers are scored using a Likert scale ranking the behaviors from one to four as follows: always (1), usually (2), sometimes (3), and never (4). The lower the score, the more incivil the behavior is to the participant.

The faculty who took the pretest F-FI considered all the behaviors listed in the survey as incivil (n < 2.2). There were several behaviors that tied for first and second, so the behaviors were clumped together in groups. The group of behaviors scoring the lowest on the Likert scale (M=1.12) included personal attacks/threatening comments, physical threats, and circulating private emails. The second lowest ranked group of incivil behaviors (M=1.16) included gossip/rumors, racial ethnic, sexual, gender or religious slurs, rude remarks/name calling, and setting another faculty member up to fail. Table A displays the top incivil nursing faculty behaviors as perceived by the nursing faculty on the pretest.

Table A. ***Top Incivil Nursing Faculty Behaviors as Perceived by Nursing Faculty – Pretest***

Rank	Behavior	Mean	SD
1	Personal attacks/threatening comments	1.12	0.6
1	Physical threats	1.12	0.6
1	Circulate private emails	1.12	0.43
2	Gossip or rumor	1.16	0.48
2	Racial, ethnic, sexual, gender, religious slurs	1.16	0.62
2	Rude remarks, name calling	1.16	0.62
2	Setting someone up to fail	1.16	0.47
3	Abuse position/authority	1.2	0.64
3	Entitled or narcissistic attitude	1.2	0.64
3	Rude nonverbal behaviors/gestures	1.2	0.64
3	Breech a confidence	1.2	0.5
4	Take credit for others work	1.32	0.627

5	Inattentive or distractions during meeting	1.36	0.63
6	Fail to perform share of work	1.4	0.70
7	Personal technology use interrupts interactions	1.48	0.71
8	Refuse to listen or communicate about work	1.52	0.71
9	Resist or create friction r/t change	1.56	0.65
10	Consistently interrupt	1.64	0.75
10	Circumvent normal grievance process	1.64	0.63
11	Challenge knowledge or credibility	1.84	0.74
12	Intentionally exclude from activity	1.88	0.92
13	Invoke personal/religious/political values	2.16	1.06
14	Engage in secretive meetings	2.2	0.86

SD = Standard deviation. Note. Likert scale used 1=always, 2=usually, 3=rarely, 4=never. Mean degree and SD calculated from Likert scale of nursing faculty responses to incivil nursing faculty behaviors.

The faculty were given the opportunity to participate in an education offering 14 days after the pretest F-FI was administered. Fourteen days after the educational offering, the faculty were sent the post-test F-FI and demographic survey via email. These are the results for the post-test F-FI.

The faculty choices for the most incivil behaviors changed between the pretest and post-test survey. There were multiple behaviors that had the same score, so the behaviors were again grouped together by rank. The group of behaviors that scored the lowest (M=1) included: setting someone up to fail, abuse of position/authority, physical threats,(racial/ethnic/sexual/gender/religious) slurs, gossip/rumors, entitled and having a narcissistic attitude. The second group of behaviors (M=1.05) included rude nonverbal

behaviors/gestures, circulate private emails, breech a confidence, and rude remarks/name calling. Table B displays the top incivil nursing faculty behaviors as perceived by nursing faculty on the post-test.

Table B. ***Top Incivil Nursing Faculty Behaviors as Perceived by Nursing Faculty – Post-test***

Rank	Behavior	Mean	SD
1	Setting someone up to fail	1	0
1	Abuse position/authority	1	0
1	Physical threats	1	0
1	Racial, ethnic, sexual, gender, religious slurs	1	0
1	Gossip or rumor	1	0
1	Entitled or narcissistic attitude	1	0
2	Rude nonverbal behaviors/gestures	1.05	0.24
2	Circulate private emails	1.05	0.24
2	Breech a confidence	1.05	0.24
2	Rude remarks, name calling	1.05	0.24
3	Personal attacks/threatening comments	1.11	0.33
4	Take credit for others work	1.17	0.39
4	Personal technology use interrupts interactions	1.17	0.39
5	Inattentive or distractions during meeting	1.23	0.43
5	Fail to perform share of work	1.23	0.43
6	Refuse to listen or communicate	1.29	0.46

7	Resist or create friction r/t change	1.35	0.49
8	Circumvent normal grievance process	1.41	0.50
8	Intentionally exclude	1.41	0.50
8	Consistently interrupt	1.41	0.50
9	Challenge knowledge or credibility	1.43	0.51
10	Invoke personal/religious/political values	1.47	0.79
11	Engage in secretive meetings	1.58	0.50

SD = Standard deviation. Note. Likert scale used 1=always, 2=usually, 3=sometimes, 4=never. Mean degree and SD calculated from Likert scale of nursing faculty perception of nursing faculty incivil behaviors.

The second section of questions on the pretest F-FI asks the participant to document how often they experienced incivil faculty behaviors. The most common incivil behavior the nursing faculty experienced was having a coworker fail to perform their share of the work (M= 2.12). The second most common incivil behaviors experienced by nursing faculty were having their coworker refuse to listen or openly communicate on work related issues and resist/create friction to prevent changes from occurring in the workplace (M=2.32). The third most common incivil behavior faculty experienced was having a coworker make rude remarks, put downs, or name calling (M=2.36). Table C displays the frequency of occurrence of incivil faculty behaviors as reported by nursing faculty according to the pretest data.

Table C. ***Frequency of Incivil Faculty Behaviors in Past 12 Months-Pretest***

Most frequent behavior

Rank	Behavior	Mean	SD
1	Fail to perform share of work	2.12	1.01
2	Refuse to listen or communicate	2.32	1.06
2	Resist or create friction r/t change	2.32	0.85
3	Rude remarks, name calling	2.36	1.03
4	Setting someone up to fail	2.40	0.91
4	Entitled or narcissistic attitude	2.40	1.19
5	Abuse position/authority	2.44	1.12
5	Inattentive or distractions during meeting	2.44	1.00
6	Consistently interrupt	2.48	0.77
7	Engage in secretive meetings	2.52	0.91
8	Personal technology use interrupts interactions	2.60	1.08
8	Intentionally exclude	2.60	1.11
9	Circumvent normal grievance process	2.72	0.93
10	Gossip or rumor	2.80	1.08
11	Personal attacks/threatening comments	2.84	1.14
11	Challenge knowledge or credibility	2.84	0.94
12	Breech a confidence	2.88	0.97
13	Take credit for others work	3.04	0.93
14	Rude nonverbal behaviors/gestures	3.12	0.97

15	Invoke personal/religious/political values	3.36	0.81
16	Circulate private emails	3.44	0.96
17	Racial, ethnic, sexual, gender, religious slurs	3.48	0.82
18	Physical threats	3.80	0.64

SD = standard deviation. Note: Likert scale used 1=often, 2=sometimes, 3=rarely, 4=never. Mean degree and SD calculated from Likert scale of nursing faculty responses for frequency of occurrence in last 12 months.

The post-test F-FI data indicates a change in the most frequently occurring incivil behaviors experienced by faculty. There were multiple behaviors tied for first and third place so the behaviors for those two ranks were grouped together. The first group of incivil behaviors included the following: resist or create friction to prevent changes from occurring in the workplace, personal technology use interrupts interactions, and inattentive or cause distractions during a meeting (M=2.23). The second most common incivil behavior experienced by nursing faculty was having a coworker consistently fail to perform his/her share of workload (M-2.29). The third group of most frequent incivil behaviors included: abuse of position or authority (make unreasonable or unfair demands, assign inequitable workload), consistently interrupting, and intentionally excluding others from activities (M=2.35). Table D displays the frequency of occurrence of incivil faculty behaviors as reported by nursing faculty according to the post-test data.

Table D. ***Frequency of Incivil Faculty Behaviors in Past 12 Months- Post-test***

Most frequent behavior

Rank	Behavior	Mean	SD
1	Resist or create friction r/t change	2.23	0.97
1	personal technology use interrupts interactions	2.23	0.90
1	Inattentive or distractions during meeting	2.23	0.66

2	Fail to perform share of work	2.29	0.91
3	Abuse position/authority	2.35	1.11
3	Consistently interrupt	2.35	0.70
3	Intentionally exclude	2.35	0.60
4	Entitled or narcissistic attitude	2.47	1.06
4	Setting someone up to fail	2.47	0.71
4	Rude remarks, name calling	2.47	1
4	Engage in secretive meetings	2.47	0.94
5	Refuse to listen or communicate	2.52	0.94
6	Challenge knowledge or credibility	2.70	0.58
6	Gossip or rumor	2.70	1.10
7	Breech a confidence	2.82	0.95
8	Circumvent normal grievance process	2.88	0.99
9	Take credit for others work	2.94	0.89
10	Personal attacks/threatening comments	3.00	1
11	Rude nonverbal behaviors/gestures	3.05	1.08
12	Racial, ethnic, sexual, gender, religious slurs	3.47	0.94
13	Invoke personal/religious/political values	3.52	0.62
14	Circulate private emails	3.64	0.70
15	Physical threats	3.88	0.33

SD = standard deviation; Note: Likert scale used 1=often, 2=sometimes, 3=rarely, 4=never. Mean degree and SD were calculated from Likert scale of nursing faculty responses for frequency of occurrence in last 12 months.

The major shifts in rank from the pretest F-FI results to post-test F-FI results was the movement of personal technology use interrupting interactions (M=2.60 pretest to M=2.23 post-test), inattentive or distractions during meeting (M=2.44 pretest to M=2.23 post-test), refusing to listen or openly communicate on work related issues (M=2.32 pretest to M=2.52 post-test) and failure to perform share of work (M=2.12 pretest to M=2.29 post-test) (Table 5). Table E displays the difference in ranking between the pretest score and post-test score.

Table E. ***Comparison of Top Ranked Frequency of Incivil Faculty Behaviors Pretest vs Post-test***

Incivil Faculty Behaviors	Pretest score	Post-test score	Difference
Fail to perform share of work	2.12	2.29	0.17
Refuse to listen or communicate	2.32	2.52	0.20
Resist or create friction r/t change	2.32	2.23	0.09
Rude remarks, name calling	2.36	2.47	0.11
Setting someone up to fail	2.40	2.47	0.07
Entitled or narcissistic attitude	2.40	2.47	0.07
Abuse position/authority	2.44	2.35	0.09
Inattentive or distractions during meeting	2.44	2.23	0.21
Consistently interrupt	2.48	2.35	0.13
Personal technology use interrupts interactions	2.60	2.23	0.37

Discussion

In comparing Clark, Olender, Kenski and Cardoni (2013) findings to these findings, the results are similar regarding the ranking of perception of behaviors considered incivil by nursing faculty. The top behaviors for Clark,Olender, Kenski and Cardoni's (2013) study were setting a co-worker up to fail, making rude remarks or putdowns, personal attacks/threatening comments, abuse of position of authority, and racial ethical, sexual, gender or religious slurs.

In comparing the pretest ranking of perceived behaviors to post-test ranking of perceived behaviors there are changes in the ranking of the behaviors. Setting someone up to fail, abuse of position/authority, and entitled or narcissistic attitude move to the number one ranked position of behaviors perceived as being incivil. This could indicate nursing faculty were not previously aware these behaviors are considered incivil and not a normal part of the nursing education culture.

In comparing Clark, Olender, Kenski, and Cardoni's (2013) findings to this research finding, the results are similar regarding the ranking of the most frequent incivil behaviors experienced by nursing faculty. The top behaviors for Clark, Olender, Kenski, and Cardoni (2013) are 1) resisted change or were unwilling to negotiate, 2) consistently failed to perform his or her share of the workload, 3) distracted others by using media during meetings, 4a) refused to listen or openly communicate on work-related issues, and 4b) made rude remarks or put-downs toward you or others.

In comparing the pretest ranking of frequency of incivil behaviors experienced by nursing faculty to the post-test ranking, there are changes in the top three incivil behaviors experienced by nursing faculty. The difference could be related to different personal perspective of the participants i.e. what one person considers incivil another person is indifferent to. Another

potential reason for the difference in scores could be the age of the participant. Unfortunately, there is no demographical data available to compare age and frequency of incivil nursing faculty behaviors.

The purpose of the research was to measure the impact of an educational intervention on nursing faculty's perception of faculty-to-faculty incivility within a school of nursing utilizing the F-FI. The research question for this research was as follows:

1). Is there a significant change in the perception of faculty-to-faculty incivility as measured by the pretest and post-test scores on the Faculty-to-Faculty Incivility Survey after an educational intervention?

The hypothesis for the research was nursing faculty who participated in an educational offering about incivility/civility would have a decreased perception of faculty-to-faculty incivility within the nursing academic environment as evidence by changes in the scores on the F-FI. The null hypothesis for the study was there would be no significant difference between pre-educational and post-educational scores on the F-FI Survey after an educational intervention. The results of the data analysis supported the null hypothesis. There was no significance in the perception of incivility or how often the incivility was experienced. The findings did suggest a single intervention was not effective in addressing faculty-to-faculty incivility.

The findings of this research supported Clark (2008a) conceptual model for Fostering Civility in Nursing Education. The conceptual model indicates there are multiple opportunities, remedies, and encounters needed to affect the culture in either a positive or a negative way. The inability of one intervention to cause significant change in nursing faculty perception and experience with faculty-to-faculty incivility supports the concept that multiple interventions are

necessary to address incivility to see a significant change (Clark, Olender, Cardoni, & Kenski, 2013).

Limitations

A limitation of the research was the time between the completion of the educational offering and the recollection of the F-FI. The participants may have not had much interaction with other faculty in the two weeks post educational offering. A second limitation may have been the participant's reluctance to participate in the survey for fear of being identified by the investigator. Other limitations to the study design included the threats to validity: history, maturation, and testing. Outside events could have occurred during the times between surveys that altered the responses to the post-test instead of the educational intervention. A change could have occurred between pretest and post-test due to the personal growth and change of the participant unrelated to the educational offering. Frequent exposure to the test may have caused the participants to think about the content and change behaviors to reflect expected social norms prior to the educational offering (Robson, 2011; Burns & Grove, 2009).

Conclusions and Contributions to the Profession of Nursing

The research findings have important implications for nursing faculty and nursing administration. The results indicated that a single intervention was not sufficient to make a significant change in faculty's perception of faculty-to-faculty incivility, or frequency of faculty-to-faculty incivility. Clark (2013a) suggests multiple interventions are necessary to transform an incivil environment to one of civility. However, Clark (2013a) refrains from making a prescriptive list of interventions based on the idea that what works for one environment may not work in another. Now the question to answer is what combination of interventions will make an impact?

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References

American Association of Colleges of Nursing [AACN]. (2008). *The essentials of baccalaureate education for professional nursing practice education.* Retrieved from www.aacn.nche.edu

American Association of Critical Care Nurses [AACN]. (2016). *AACN standards for establishing and sustaining healthy work environments: A journey to excellence, 2nd Ed*. Retrieved from: www.aacn.org

American Nurses Association [ANA]. (2015a). *Code of ethics for nurses with interpretive statements*. Washington, DC: American Nurses Association.

American Nurses Association [ANA]. (2015b). *Incivility, bulling, and workplace violence position statement*. Washington, DC: American Nurses Association. Retrieved from: www.nursingworld.org.

Anderson, L. & Pearson, C. (1999). Tit for tat? The spiraling effect of incivility in the workplace. *Academy of Management Review*, *24*(3), 452-471.

Baltimore, J. (2006). Nurse collegiality: Fact or fiction? *Nursing Management, 37*(5), 28-36.

Barr-David, S. (2015). *Trust your canary: Every leader's guide to taming workplace incivility*. Toronto, Canada: Fairleigh Press.

Becher, J. & Visovsky, C. (2012). Horizontal violence in nursing. *MEDSURG Nursing, 21*(4), 210-213.

Blaug, R., Kenyon, A. & Lekhi, R. (2007). *Stress at work: A report prepared for The Work Foundation's principal partners.* Project Report. The Work Foundation, London.

Burns, N. & Grove, S. (2009). *The practice of nursing research: Appraisal, synthesis, and generation of evidence*. St. Louis, MO: Saunders/Elsevier.

Clancy, C. (2014). *Critical conversations in healthcare: Scripts and techniques for effective interprofessional & patient communication*. Indianapolis, IN: Sigma Theta Tau International.

Clark, C. (2008a). The dance of incivility in nursing education as described by nursing faculty and students. *Advances in Nursing Science ,31*, E37-E54.

Clark, C. (2008b). Student voices on faculty incivility in nursing education: A conceptual model. *Nursing Education Perspectives, 29* (5), 284-289.

Clark, C. (2009). Faculty field guide for promoting student civility. *Nurse Educator, 34*(5), 194-197.

Clark, C. (2013a). *Creating & sustaining civility in nursing education*. Indianapolis: IN. Sigma Theta Tau International.

Clark, C. (2013b). National study on faculty-to- faculty incivility: Strategies to foster collegiality and civility. *Nurse Educator, 38*(3), 98-102.

Clark, C. (2015). Conversations to inspire and promote a more civil workplace. *American Nurse Today, 10* (11), 18-23.

Clark, C. & Ahten, S. (2012). Beginning the conversation: The nurse educator's role in preventing incivility in the workplace. Georgia Nursing, 16-17.

Clark, C. & Springer, P. (2007a). Incivility in nursing education: A descriptive study of definitions and prevalence. Journal of Nursing Education, 46(1), 7-14.

Clark, C. & Springer, P. (2007b). Thoughts on incivility: Student and faculty perceptions of incivil behavior in nursing education. Nursing Education Perspectives, 28 (2), 93-97.

Clark, C. & Springer, P. (2010). Academic nurse leader's role in fostering a culture of civility in nursing education. Journal of Nursing Education, 49(6), 319-325.doi:10.3928/01484834-20100224-01

Clark, C., Olender, L., Cardoni, C. & Kenski, D. (2011). Fostering civility in nursing education and practice. The Journal of Nursing Administration, 41(7/8), 324-330

Clark, C., Olender, L., Kenski, D., & Cardoni, C. (2013). Exploring and addressing faculty-to-faculty incivility: A national perspective and literature review. Journal of Nursing Education, 52(4), 211-218.

DalPezzo, N. K. & Jett, K. (2010). Nursing faculty: A vulnerable population. Journal of Nursing Education, 49(3), 132-136.

Goldberg, E., Beitz, J., Wieland, D., & Levine, C. (2013). Social bullying in nursing academia. Nurse Educator, 38,191-197.

Heinrich, K. (2006). Joy-stealing games. Reflections on Nursing Leadership, 32(2).

Joint Commission. (2008, July 9). Sentinel event alert: Issue 40. Retrieved from: https://www.jointcommission.org/assets/1/18/SEA_40.PDF

Joint Commission. (2013). Sentinel events (SE). Retrieved from https://www.jointcommission.org/assets/1/6/CAMH_2012_Update2_24_SE.pdf

Lashley, F. R. & deMeneses, M. (2001). Student civility in nursing programs: A national survey. Journal of Professional Nursing, 17, 81-86.

Longo, J., & Sherman, R. O. (2007). Leveling horizontal violence. Nursing Management, 38(3), 34-37.

Luparell, S. (2004). Faculty encounters with incivil nursing students: an overview. Journal of Professional Nursing, 20 (1), 59-67.

Luparell, S. (2011). Incivility in nursing: The connection between academia and clinical settings. Critical Care Nurse, 31(2), 92-95.

Marchiondo, K., Marchiondo, L. & Lasiter, S. (2010). Faculty incivility: Effects on program satisfaction of BSN students. Journal of Nursing Education, 49(11), 608-614.

Morin, A. (2016). Why you can't afford to ignore rude behavior—Workplace incivility cost you more than you think. Forbes. Retrieved from: www.forbes.com

Nazir, T. & Ahmed, U. (2016). Interrelationship of incivility, cynicism and turnover intention. International Review of Management and Marketing, 6(1), 146-154.

Passionate About Creating Environment of Respect and civilitieS [PACERS]. (2015). Civility tool-kit: Resources to empower healthcare leaders to identify, intervene, and prevent workplace bullying. Retrieved from: http://stopbullyingtoolkit.org/

Pearson, C., Anderson, L., & Wegner, J. (2001). When workers flout convention: A study of workplace incivility. Human Relations, 54(11), 1387-1419.

Pearson, C. & Porath, C. (2009). The cost of bad behavior: How incivility is damaging your business and what to do about it. New York, NY: Portfolio.

Porath, C. (2016). Mastering civility: A manifesto for the workplace. New York, NY: Hachette Book Group.

Randle, J. (2003). Bullying in the nursing profession. Journal of Advanced Nursing 43(4), 395-401.

Robson, C. (2011). Real world research. West Sussex, United Kingdom: John Wiley & Sons Ltd.

Sigma Theta Tau International. (2017). Proceedings from: Creating a Healthy Work Environment conference. Indianapolis, IN: Sigma Theta Tau International.

Williams, S. & Lauerer, J. (2013). Implementing a nursing civility code: Implications for education. Journal of Nursing Education, 52(3), 165-170.