Summer 8-7-2021

The Impact of a Structured Civility Educational Module and Cognitive Rehearsal Training (CRT) on Job Satisfaction and Turnover in Rural Healthcare Employees: A Quality Improvement Pilot Project

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Abstract

Incivility is a top-cited stressor resulting in decreased job satisfaction and turnover. Uncivil behaviors jeopardize patient safety through poor communication and team ineffectiveness. This project aimed to determine if a structured civility educational module with CRT positively impacted job satisfaction and turnover of healthcare employees.

A pretest using the Workplace Civility Index (WCI) and investigator generated questions determined current civility behaviors, notable civility issues, and attitudes surrounding job satisfaction and turnover. The interactive, virtual modules highlighted dilemmas regarding incivility and their consequences to patient care. During CRT, the participants responded to filmed, uncivil conflicts using provided frameworks to curate civil responses. After implementing the provided education, a post-test assessed changes in the frequency of civil behaviors, job satisfaction, and the module's effectiveness. Turnover rates and reasons for resignation were collected before the intervention and six months after the intervention.

Results of this pilot project revealed that few participants had previous knowledge of civility, and none had exposure to CRT. Analysis of the WCI demonstrated a positive increase in overall civility scores. Responses from the CRT scenarios revealed the themes of acknowledging feelings and expectations, appropriate setting, and addressing civility directly. Job satisfaction remained unchanged; however, turnover was reduced. Civility education and CRT can be a cost-effective way to improve employee morale while decreasing safety concerns. Implications of this project show that civility education with CRT can have a positive effect on employee behaviors and turnover.

Keywords: civility, structured education module, cognitive rehearsal, turnover, job satisfaction, rural, nurse

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Every element of the workplace is affected by an organization's culture. Each employee can influence change in the workplace and contribute to the desired environment. Workplace civility is a powerful predictor of job satisfaction (Yanchus et al., 2017). Improving employee satisfaction retains health care's most critical resource, staffing. Thus, decreasing the tension associated with a shortage of manpower (Huang et al., 2018). Roberts et al. (2018) discussed that civility in the workplace creates a healthy environment that contributes to increased employee productivity, reduced absenteeism, and minimized turnover.

Workplace violence and bullying are terms that have been used to describe incivility within an organization. Historically, new graduates have been at an increased risk of becoming targets for workplace bullying (Razzi & Bianchi, 2019). It is viewed as a rite of passage in the health care profession (Roberts et al., 2018). While there is increased prevalence in new graduates, up to 77% of nurses report witnessing or experiencing incivility in their work environments (Houck & Colbert, 2017). This long-accepted practice is being brought into the spotlight and is associated with accelerated turnover (Johnson, 2019). Haddad and Toney-Butler (2020) reported that nursing turnover could be as high as 37% among nurses depending on geographic location and area of work. Up to 17% are leaving within their first year of practice (Blegen et al., 2017).

Evidence points to health care being, on average, more stressful than other career choices (Cheung & Yip, 2015). Workplace stress directly connects to these physical and psychological ailments that reduce resiliency and cause burnout, resulting in decreased job satisfaction and

turnover (Cheung & Yip, 2015). As the facility is located in a rural environment, assessing these effects on rural employees is critical. Rural health employees are particularly vulnerable, as compared to their urban counterparts, and report more significant psychosomatic responses, burnout, and decreased job satisfaction rates (Huang et al., 2018).

In the health care field, the work environment's effects surpass the impacts on just the employees. Patient safety is also affected by incivility. The Joint Commission (2016) released its report *Sentinel Event Alert: Behaviors that undermine a culture of safety,* which spoke directly to the safety concerns impacted by an uncivil culture in the workplace. It is imperative to create a culture of civility within the workplace and establish measures to minimize incivility. This minimization is critical to improving job satisfaction, increasing retention, and promoting quality patient care (Quality and Safety Education for Nurses, 2020).

Thus, a quality improvement pilot project designed to address incivility in the workplace was proposed. A structured civility educational module with CRT was used with the expectation to improve employee job satisfaction and decrease turnover in rural health care employees. The project focused on increasing healthcare employees' knowledge of civil conduct and navigating discourse (Kile et al., 2019).

Available Knowledge

Literature Review

An extensive literature search was undertaken, and several databases were queried for literature significant to the issue of civility including, CINAHL, Embase, Scopus, PubMed, and Cochrane. The terms turnover, incivility, workplace bullying, cognitive rehearsal, rural, and nurs* (nurse, nurses, and nursing) were used. Literature searches were limited to articles in English from 2014 to 2021. Articles that discussed incivility or workplace bullying in the health

care practice setting, regardless of the profession, and those using CRT to combat incivility were included. Governing bodies, including Quality and Safety Education for Nurses (QSEN), American Nurses Association (ANA), Texas Board of Nursing (TXBON), and The Joint Commission (TJC), were reviewed for their official stances regarding incivility in the health care setting. Articles on incivility in the education setting or those that did not specify the setting were excluded. A total of 16 articles, ranging from Level I to Level V evidence, with good to high-quality ratings and notable practice implications were selected for inclusion. The Johns Hopkins Evidence Level and Quality Guide was used to facilitate the literature's critical appraisal (Dang & Dearholt, 2018).

After concluding the literature review, substantial evidence supporting the proposed project was discovered. Several notable concepts emerged from the literature, including evidence that incivility can have determinantal effects on the work environment, particularly in rural locations, power imbalances exist along the employment hierarchy and are at the root of incivility, and CRT can have positive effects on the health of the work environment.

Effects of Incivility

According to Kang and Jeong (2019), workplace bullying is 3.7% - 9% among general workers. However, workplace bullying incidence is 22% among nurses (Kang & Jeong, 2019). The stress associated with colleague conflicts, such as those seen in uncivil work environments, directly correlates with declining job satisfaction and incidence of depression (Cheung & Yip, 2015). With up to 77% of nurses experiencing incivility and bullying in the workplace, nurses prioritize their health care and leave practice early as a result (Cheung & Yip, 2015; Houck & Colbert, 2017). Nurses have noted increases in the prevalence of health-related distress, which ultimately leads to stress-related burnout (Huang et al., 2018). Cheung and Yip (2015) noted that

newly graduated nurses are particularly vulnerable to these effects due to lack of clinical inexperience, putting them at increased risk of being targets of incivility.

High levels of occupational stress lead to a deterioration in the employees' psychological and behavioral health (Huang et al., 2018). Manifestations of this decline in health include insomnia, anxiety, depression, and an increased risk of substance abuse (Huang et al., 2018; Kang & Jeong, 2019). Physical symptoms, like palpitations, headaches, and fatigue, can also occur due to workplace bullying (Kang & Jeong, 2019). Hajek and König (2019) noted a clear association between uncivil working conditions and a rise in primary care visits from employees. These physical and psychological symptoms often result in emotional exhaustion, which is a significant indicator of increased turnover among health care workers.

The personal health effects resulting from an uncivil atmosphere influence the employee's environmental health, as well. Incivility leads to decreased work effort and a decline in productivity and job performance (Yanchus et al., 2017). The decline in performance results is often secondary to deteriorating job satisfaction and organization commitment (Yanchus et al., 2017). All of which increases the employee's intent to leave the organization.

Lack of resources, including staff, exacerbates the health effects workplace bullying has on employees. Smith et al. (2019) discussed that staff would often report exhaustion and feelings of insufficient rest. The researchers noted that a lack of restorative downtime from working extra shifts and increased over time, resulting from insufficient staffing, is more likely to lead to burnout. After reaching burnout, there is an increased risk of errors and a decline in the quality of care provided to patients, directly impacting patient safety (Smith et al., 2019). Additionally, facilities begin to see more absenteeism, and eventually, turnover rates begin to rise, perpetuating the cycle of insufficient resources (Smith et al., 2019).

Deterioration in the provider's health can inadvertently lead to a decline in the quality of care they can provide to their patients (Huang et al., 2018). Houck and Colbert (2017) found that a consistent message exists in the literature that workplace bullying affects patient outcomes. TJC (2016) noted that uncivil behaviors directly "undermine a culture of safety" (p. 1). Moreover, the organization found that the association of workplace bullying and its effects on patient care were not unseen by health care employees. Houck and Colbert (2017) noted that nurses have clear perceptions of the potential risk posed to patients due to workplace bullying. The authors also noted that nurses often felt powerless to protect their patients when their work environment was hostile. Nurses were also more likely to leave their jobs as a result (Houck & Colbert, 2017). As turnover continues to rise, there will eventually be a destabilization of the nursing workforce (Kang & Jeong, 2019). In turn, the quality of patient care declines, and patient safety is jeopardized (Kang & Jeong, 2019).

When there is a lack of access to resources, the cycle of incivility worsens, and the effects multiply. Rural nurses are at a disproportionate risk for incivility and therefore at an increased risk for burnout, decreased job satisfaction, and increased turnover. Huang et al. (2018) found that as facility size decreased, the risk of health effects resulting from workplace bullying increased. These rural nurses and local facilities experienced higher nurse burnout rates and lower work satisfaction rates due to a lack of resources and staffing shortage (Huang et al., 2018). Smith et al. (2019) noted that rural nurses often reported feelings of professional isolation, citing less access to professional development and the inability to participate in offsite educational offerings. Expenses, a lack of time, and long travel distances were reported as factors prohibiting participation (Smith et al., 2019). However, it was also noted that by supporting

tactics like continuing education positively correlated with improved job satisfaction and decreased turnover; thus, stopping the cycle of a staffing shortage.

Power Imbalances

Incivility and workplace bullying can occur at any level along the hierarchy of employment. These power imbalances can occur laterally from peer to peer or vertically from supervisor to subordinate and mentor to mentee. Inequities and biases towards employees can generate new workplace bullying instances or further exacerbate existing power imbalances (Johnson, 2019). At all levels of employment, biases exist, whether implicit or explicit (Johnson, 2019). People in certain ethnic or racial groups, as well as older adults and those with a perceived disability, are at an increased risk of becoming targets of workplace bullying (Johnson, 2019). The power imbalance established between instigators and targets commonly leads to workplace bullying and is associated with its cause (Blackstock et al., 2015). It should be noted that the instigator and the target can be one or more individuals.

One of the most common arenas of power imbalance occurs between established nurses and new graduates (Johnson, 2019). The effects of targeted incivility negatively impact newly graduated nurse retention (Roberts et al., 2018). With novice nurses being at higher risk for becoming victims of workplace bullying, incivility education should be provided as part of the nursing education curriculum or early on in the nurse's practice to mitigate the harmful effects reaped by workplace bullying (Razzi & Bianchi, 2019). Amongst nurses, there has been an accepted adage that "nurses eat their young" (Johnson, 2019, p. 1533). The saying developed as older nurses bullied incoming nurses in a manner similar to hazing. It has become a rite of passage into the nursing profession that bullying is a way for novice nurses to earn their place within the profession (Johnson, 2019).

Workplace incivility is not limited to lateral transgressions. Incivility can occur on a vertical spectrum, as well. An existing power imbalance occurs between supervisors to employees (Johnson, 2019). Supervisors can very well be the instigators, with their subordinates as targets. Through excessive work evaluations and performance appraisals, supervisors encourage subordinates to self-terminate (Johnson, 2019). Additionally, unequal work duties and responsibilities are assigned to employees to encourage voluntary turnover (Johnson, 2019). Physicians can also assert covert and overt signs of incivility in the health care workforce. A reluctance to answer questions or return calls, and the use of condescending language reinforces incivility and directly impacts the quality of care and safety provided to the client (TJC, 2016) .

Those in supervisory roles often have duties that extend beyond performance evaluation. Nurse perceptions of organizational alliances and misuse of organizational processes predicted workplace bullying experiences, which in turn predicted the intent to leave (Blackstock et al., 2015). Interventions, such as prioritizing civility education and the ability to identify uncivil behaviors, are needed to reduce informal alliances that promote bullying and allow it to exert influence over others (Blackstock et al., 2015). Nursing managers should receive formal decision-making authority to implement policies and fair process principles in the organization to reduce workplace bullying and support a civil culture (Blackstock et al., 2018).

Incivility in the workplace is engrained deeply into everyday facility practices (Blackstock et al., 2018). These behaviors remain seemingly protected and often go unpunished when perpetrated by management (Blackstock et al., 2018). To eliminate power imbalances, organizations must dismantle hierarchies that propagate oppressive, uncivil conditions by instituting zero-tolerance policies that directly address intimidating and disruptive behaviors (Blackstock et al., 2018; TJC, 2016) .

Cognitive Rehearsal Empowers Health Care Workers

General Effects of Cognitive Rehearsal Training. CRT has historically been used as a counseling approach in which the therapist and the patient collaborate to find solutions to a specific issue. Individuals who "rehearse" ways of coping with a specific situation become more prepared for when those scenarios occur. This same technique can be applied to incivility to improve communication and resilience. With improved resilience, nurses are empowered to adapt to stressful situations, including bullying, positively (Yu et al., 2019). Additionally, improving resiliency helps nurses proactively addresses bullying, therefore stopping potential problems before they occur (Yu et al., 2019).

To apply CRT strategies, providers must first be able to identify behaviors that are associated with workplace violence. Civility education provides fundamental training on identifying bullying behaviors that propagate workplace violence (Blackstock et al., 2018). According to Kile et al. (2019), CRT improved participants' recognition, perception, and ability to confront incivility. Kile et al. (2019) also noted that provider sensitivity and ability to confront uncivil actions are increased by civility education and cognitive-behavioral interventions, resulting in a reduction in this occurrence.

In health care, coping skills, self-efficacy, and social support are essential components to building resiliency and adapting to patient care (Yu et al., 2019). Educational programs on incivility can provide the tools needed to develop effective coping skills and emotional regulation, as well as identify uncivil behavior (Razzi & Bianchi, 2019; Yu et al., 2019). These supportive programs help providers address workplace adversity as it occurs (Yu et al., 2019). By preventing unprofessional and uncivil behaviors, negative impacts on the personnel are lessened, and the workforce is retained (Yu et al., 2019). Kang et al. (2017) noted that even in

instances where CRT did not reduce the occurrence of bullying, health care providers felt they could more confidently navigate discourse and remained in their positions.

A defining characteristic of civility is a willingness to seek common ground through open communication (Clark & Carnosso, 2008). CRT can improve communication by teaching providers to react to incivility proactively and competently (Razzi & Bianchi, 2019). Improved communication, in turn, positively impacts relationships by creating a two-way channel of information exchange (Yanchus et al., 2017). When civil relationships are fostered, particularly between staff and supervisors, job satisfaction is enhanced, and turnover intent decreases (Yanchus et al., 2017). Moreover, enhanced communication positively affects patient care quality and safety (Razzi & Bianchi, 2019; Yanchus et al., 2017).

Digital Delivery of Cognitive Rehearsal Training. While CRT is commonly conducted through live roleplaying, evidence supports using virtual or mobile device platforms to relay CRT techniques. Kang and Jeong (2019) found that indirect CRT, through smartphone delivery, could be a practical and effective alternative. Using a smartphone application to deliver the training increased its accessibility and convenience (Kang & Jeong, 2019). Additionally, using a digital delivery method improves the intervention's cost-effectiveness (Kang & Jeong, 2019).

Rationale

Categorization and Monetization of Costs and Benefits

As healthcare costs continue to rise, institutions must make strategic decisions on investing their available resources. The proposed CRT intervention was implemented in a rural, county-funded facility. As Royse et al. (2016) discuss, these agencies have restricted budgets and cannot entertain new programs without cost considerations. This pilot project's expenditures include paid nurse training time, educational materials, advertisement, follow-up materials, and

space for implementation. These expenses total approximately $405. Monetary benefits from the structured civility education module with CRT total approximately $298,140 and include savings from reduced nursing turnover, health plan expenditures for mental health treatment, improved productivity from employees, and potential savings from malpractice lawsuits related to declining safety practices.

The project offered numerous benefits that cannot be assigned a monetary cost yet bring value to the institution, such as reduced stress, increased job satisfaction, improved quality of care, and enhanced safety. Oppel et al. (2019) discussed how a civil climate improves employee perceptions of care performance and creates an environment focused on patient safety. The authors noted that a civil climate could indirectly enhance patient safety and hospital care performance through prompt reporting of medical errors. A willingness to reveal, discuss, and learn from mistakes continues to cultivate and reinforce the civil climate (Oppel et al., 2019). As a result, facilities can reduce costs associated with errors and their consequences (Oppel et al., 2019). CRT has demonstrated that it can offer a low-cost intervention option to address incivility and result in significant dollar savings for the institution. This rationale makes CRT a highly effective and less expensive means to reduce incivility in the workplace.

Framework

The Clinical Scholar Model (Appendix A) is a helpful structure for direct care practitioners to investigate and incorporate evidence-based practice (EBP) at the bedside (White et al., 2015). The model helps recognize concerns and challenges, as well as critical stakeholders and the need for practice improvements. Additionally, the model offers a structure for analyzing and synthesizing external and internal data. Observation, analysis, synthesis,

application/evaluation, and distribution are the five main stages proposed in the model for using evidence in practice.

The Clinical Scholar Model was chosen because it emphasizes skilled mentors who promote improved patient outcomes through EBP and quality improvement (White et al., 2015). To achieve optimal patient outcomes, these point-of-care mentors develop bedside health providers to guide and critique their colleagues in integrating EBP. This grassroots style of leadership, through peer accountability, leads to the sustainable implementation of EBP. This quality improvement pilot project focuses on civility, maintained through a willingness to engage in meaningful discourse and hold others accountable for a civil culture. These strategies ultimately increase patient safety. Part of the sustainability plan involves training point-of-care mentors to maintain the instruction after the project's conclusion.

Purpose and PICOT

The purpose of this project is to determine if a structured civility educational module with CRT has a positive impact on job satisfaction and turnover of healthcare employees in a rural facility. The institution has cited turnover related to incivility as a common reason for exiting the organization. It is expected to reduce turnover and improve job satisfaction through the implementation of a structured civility educational module and CRT.

P: Healthcare employees to include clinicians and support staff members in a rural hospital setting;

I: Structured civility educational module and Cognitive Rehearsal training;

C: Employees with no past training;

O: Improved job satisfaction, civility knowledge, civil behaviors, and reduced turnover

T: Pretest prior to intervention and post-test one week after the intervention.

Specific Aims and Objectives

Project Aims

- **Aim #1**. Identify the health care employee's knowledge base of civility in the workplace.
    - **Objective #1**. Determine the participants' prior understanding of civility.
    - **Objective #2**. Determine the participants' prior understanding of CRT.
- **Aim #2.** Implement a structured civility educational module with CRT to reduce the frequency of incivility behaviors and improve the navigation of uncivil situations in the workplace.
    - **Objective #1.** Implement a structured civility educational module with CRT in a rural health system for 7 days.
    - **Objective #2.** Analyze changes in the frequency of civility behaviors using Workplace Civility Index scores before intervention and one week following the intervention.
    - **Objective #3.** Analyze responses to CRT scenarios for the use of civil discourse techniques.
- **Aim #3.** Measure the effectiveness of a structured civility module with CRT on turnover and job satisfaction declaration among participants
    - **Objective #1.** Evaluate participant job satisfaction declaration before intervention and one week following the intervention using a five-point Likert scale.
    - **Objective #2**. Analyze the rate of employee turnover before intervention and six months after the intervention.

Measures

The first aim of this project was to determine the knowledge base of civility in the

workplace. The pretest assessed prior exposure to civility education and CRT. The questionnaire permitted open-ended elaboration on how the education or training had been received if the participant indicated prior knowledge. Before the structured educational module began, participants were asked to define their understanding of civility. This assessment allowed for the project champion to ascertain the knowledge base of the participants.

The second aim of the project was to implement a structured civility educational module with CRT to reduce the frequency of incivility behaviors using the WCI and improve the navigation of uncivil situations in the workplace. Pretesting occurred immediately before intervention to determine the frequency of behaviors before education. Pretesting assessed the frequency of civil behaviors and issues surrounding civility the participant felt they faced in their workplace. Throughout the educational module, participants were asked to apply the material they had learned and respond in a question-and-answer format through an interactive survey using the Slido platform. Interactive scenarios measured the participant's ability to use civility knowledge and CRT techniques to resolve discourse. Post-testing, using the WCI, and investigator-designed questions occurred one week after the intervention. The post-test evaluated for improvement in the frequency of civility behaviors and issues the participants still faced concerning civility. Thematic analysis was used to determine significant themes and compare them to pre-intervention themes.

The project's third aim was to measure the effectiveness of a structured civility module with CRT's effectiveness on turnover and job satisfaction declaration among participants. Existing data regarding employee-cited reasons for leaving were collected from the institution's human resources division to determine the prevalence of the problem and current turnover prior to the pilot project. An investigator-curated question during the pretest asked participants to self-

disclose reasons they felt led to turnover within their organization. The participants were also asked to rank their perceived job satisfaction using a five-point Likert scale. One week post-intervention, participants completed the post-test and were again asked to disclose what they felt still led to turnover and their current perceived job satisfaction. Turnover was assessed six months after intervention in conjunction with the facility's human resource division and again analyzed for turnover rates and themes related to exiting the organization.

Methods

Project Site and Participants

The organization is a small, rural health care system in Southeast Texas. It is comprised of one hospital and several satellite clinics. The organization employs healthcare professionals at all levels, including physicians, advanced practice registered nurses (APRN), registered nurses (RN), licensed vocational nurses (LVN), unlicensed assistive medical personnel, and office staff. The facilities offer a variety of services, from primary to specialty care. A needs assessment consultation with the clinic's administration and leadership led to choosing two clinics to pilot the project. Anyone who desired to participate in the educational session was invited.

The rural, East Texas facility was selected due to its known affiliation with the primary investigator. The primary investigator met with the clinic administration team to ascertain the facility's needs related to incivility. Through discussion, the site revealed that its clinics had seen substantial turnover within the past year. A needs assessment was conducted with the assistance of the facility's human resource department to isolate clinic sites in the greatest need of the pilot intervention and collect a baseline understanding of the reasons associated with turnover. Thematic analysis identified personnel-cited reasons for turnover, including "low job satisfaction" and "workplace stressors." These causes can be directly related to uncivil behaviors

and can lead to low job satisfaction and turnover. By ascertaining if a particular unit and clinic are experiencing more incivility than another, interventions can be tailored to meet that department's needs and increase their buy-in. The frequency of turnover and number of people citing these reasons and facility stakeholder input determined that two separate but specific clinics would receive the pilot project intervention. The implementation timeline of this pilot project was shared with facility stakeholders (see Appendix B).

Intervention

The project was comprised of two distinct elements delivered in a synchronous virtual format using Zoom. The primary investigator provided the Zoom link to the institution and the information technology department established socially-distant meeting areas where the presentation could be viewed. The first element was the structured civility educational module, and the second was the CRT. Both elements were delivered concurrently during a one-hour session. After consent was obtained, pretesting began. Participants were assessed for their prior exposure to civility education and CRT through closed-ended, self-disclosure questions that permitted open-ended elaboration on how any education or training was received. The 20-item WCI standardized tool (Appendix C) was incorporated into the questionnaire to assess the frequency of civil behaviors and establish a baseline of the participant's current civil performance. Additional questions ascertained the participant's current job satisfaction, as well as factors they felt led to turnover and any current civility issues present prior to intervention.

After the structured educational module concluded, CRT followed immediately thereafter. Participants were asked to implement what they had learned from the session over the following week. At the end of one week, participants completed the post-test survey (Appendix D). The post-test used the WCI tool to determine the difference in frequency of civil behaviors

and any noted changes in job satisfaction, turnover factors, and existing civility issues. The post-test also measured the effectiveness of the training provided.

Measurement Tools

Participants were consented to join in a virtual quality improvement pilot project that was hosted over Zoom. A virtual delivery was chosen to accommodate social distancing guidelines during the COVID-19 pandemic. Before starting the structured civility education module with CRT, a pretest was given using the online survey platform Qualtrics. Participants were assured that only the project champion had access to the database. Participants were asked to create a unique pin number for completing both the pretest and post-test survey to deidentify any collected data, preserve confidentiality, and provide paired analysis. A mobile device was the only tool required for the participant to access the surveys and engage in the structured educational module and CRT. Alternatively, the participant could also engage in the activities using a computer of their choice. No participants chose to access the activities through a personal computer, and all engaged through mobile devices. The consent form, surveys, and interactive elements were all accessed using Quick Response (QR) codes, scannable by the participant's mobile device. All participants were instructed on using their camera application as a QR code scanner from their mobile device.

The Workplace Civility Index. The Workplace Civility Index (see Appendix C and Appendix D), was chosen to assess the frequency of participant's current civility-related behaviors using a five-point Likert scale and included the frequency choices never, rarely, sometimes, usually, and always (Clark et al., 2018) . Each Likert scale frequency was given a point value assignment: never (1 point), rarely (2 points), sometimes (3 points), usually (4 points), and always (5 points). These points were totaled at the end of the WCI tool during both

the pretest and the post-test. Higher total scores indicated more frequent civil behavior; whereas, lower scores represented less frequent civil actions. The WCI is a proven valid and reliable standardized tool (Cronbach's alpha 0.82) that other authors have used to study incivility in the workplace (Clark et al., 2018; Howard & Embree, 2020). Permission to use the WCI was sought and provided by the author, Dr. Cynthia Clark (see Appendix E).

Three investigator-designed, open-ended questions accompanied the WCI tool (see Appendix C). They assessed what civility issues the participant currently faced and what factors they feel led to turnover. Participants rated their current job satisfaction using a five-point Likert scale including no satisfaction (1 point), a little satisfied (2 points), somewhat satisfied (3 points), moderately satisfied (4 points), and very satisfied (5 points). Questions to assess the participant's demographics, including profession; age; race/ethnicity; and gender were also included at the end of the survey.

The Structure Civility Educational Module

The structured civility educational module was presented in a virtual format, leveraging Zoom video conferencing software. During the presentation, participants engaged with material by answering any presented question using an online polling platform, Slido, from their mobile device by scanning a QR code. The educational module ascertained preconceived perceptions of civility in health care practice and presented the rationale for exploring the topic. The primary investigator presented examples of general overt and covert uncivil behaviors, as well as behaviors and actions that can be seen from perceived superiors. An assessment of how many participants had experienced or witnessed these behaviors was collected. Additionally, information was presented that addressed the effects of incivility on health care employees and

how these behaviors impacted patient care. Participants were asked to weigh in on the perceived safety concerns incivility could cause.

Part of the structured educational module focused on the legal and ethical standards set forth by governing health care bodies regarding civility. Before presenting these organizations' stances, participants were asked if they felt legally obligated to provide a civil environment. Notable publications and positions of the ANA, QSEN, TXBON, and TJC regarding civility were presented to the participants.

Cognitive Rehearsal Training

Before engaging in CRT, participants were educated on the components required to build a civil culture. A definition of CRT and an exploration of the technique's use in health care was provided to the participants. The phases of engaging in discourse were discussed with the participants. TeamSTEPPS' prompts and discussion support frameworks, including the D.E.S.C. and C.U.S models, were given to the participants to deliver the tools required to determine if civil discourse is necessary and to formulate a civil response (Agency for Healthcare Research and Quality, 2013).

Participants were then asked to review three recorded conflicts and curate civil responses based on the structured educational module's information and the provided frameworks. These responses were obtained using the online polling plaform, Slido. The Slido platform was chosen to engage each participant and provide them an anonymous voice to interact with the content. The collected responses were reviewed after each scenario to highlight the participant's knowledge.

Post-test

After the structured educational module and CRT, the participants were asked to implement the knowledge they had gained from the presentation into practice over the next week. The participants were instructed on the next steps regarding post-testing. It was presented that at the end of their implementation week, a post-test survey would be sent via their workplace email. Though the email would be facilitated by workplace administration, participants were reassured that all answers obtained could only be accessed by the primary investigator. The participants received thank you for participating flyers with a scannable QR code embedded in the email.

The WCI was assessed in the post-testing phase (see Appendix D). Participants were asked to discuss civility issues that they still face in their work roles and rate their job satisfaction using the same five-point Likert scale as in pretesting. To assess the effectiveness of the presentation, the participants were asked to reflect on the value of the structured civility educational module with CRT and qualitative data were collected. The participants were asked to rate the presentation's effectiveness on a five-point Likert scale and describe aspects they found most helpful. Effectiveness ratings included not effective at all (1 point), slightly effective (2 points), moderately effective (3 points), very effective (4 points), and extremely effective (5 points). Additionally, the participants were asked to provide suggestions for the civility program at their organization in the future.

Potential Barriers

It was anticipated the project would encounter barriers. These barriers included:

- Resistance to change – Rogers (2003) notes that people adopt change differently and some are likely to resist and lag behind in change initiatives. Rapport development will be critical in overcoming change resistance.

- COVID-19 precautions – This project was implemented virtually due to the ongoing COVID-19 pandemic. Distance learning makes rapport building and engagement more difficult in this given, rural environment, where personal interaction is highly-valued. Developing interactive elements to engage individual voices without being face-to-face will be a key component to minimizing this barrier.
- Project implementation time frame – Implementation of this project was scheduled to occur near Christmas, which limited staff availability. Additionally, given the ongoing COVID-19 pandemic, these staff members had to divide their time between clinic duties and COVID-19 screening and vaccination efforts. Offering multiple sessions as suggested by the facility was necessary to increase participation.

Data Analysis

To analyze the proposed aims and objectives, quantitative and qualitative data were collected. Pretesting data were collected before the intervention, and the post-test was administered one week after the intervention. Turnover from the past year was assessed prior to the intervention and then again six months after the intervention. Quantitative data focused on the rate of turnover; number of participants; prior exposure to civility and CRT; frequency of civility behaviors; job satisfaction; and intervention effectiveness.

Quantitative data were collected using the Qualtrics system and the online polling platform, Slido. These results were exported and input into an excel spreadsheet. Due to the small sample size and having data that is potentially not normally distributed, a Wilcoxon signed-rank test was used to compare the pre-, and post-testing overall score means from the WCI. Using the five-point Likert scale values as points, the overall civility score was totaled. The mean score and standard deviation were calculated based on the overall scores of all

participants. Data analysis tools in excel generated Wilcoxon signed-rank values. A Wilcoxon signed-rank table was used to assign a critical value to compare the generated test statistic to determine significance. Effect size using the differences in standard deviations from post-testing to pre-testing divided by the mean, the standard deviation was used to calculate the overall impact of the intervention. Descriptive statistics were used to relay turnover rates among employees, perceived participant job satisfaction, and intervention effectiveness.

Qualitative data from the intervention focused on the participants' baseline understanding of the concept of civility and responses to CRT scenarios. Statements regarding the employees' current experiences with incivility and perceived reasons leading to turnover were reviewed for anecdotal evidence. A thematic analysis was used to analyze emerging themes related to the participants' baseline understanding of civility and perceived reasons for turnover. In contrast, an inductive approach was used to analyze themes from the CRT scenarios. The inductive approach was chosen as the thematic analysis method because participants were previously given a framework to form responses. Therefore, this was an expectation for this to be reflected in the response.

Results

The demographics of the participants are shown in Appendix F. A total of 15 participants completed the pretest and participated in the structured civility education module with CRT. During post-testing, a total of 14 participants returned the post-testing. Participants were instructed to create a numerical pin to allow for pair matching and provide anonymity; however, only 11 participants entered the same numerical pin during post-testing. For this reason, only 11 participants were used to conduct statistical analysis related to the pretest and post-test.

The participants (*n*=11) included APRNs, RNs, an LVN, unlicensed auxiliary medical personnel, office staff, and an undeclared participant. Most participants were female, except for one male participant. Participants declared their racial/ethnic background, with 72.7% identifying as white, 18.2% identifying as Hispanic or Latino, and 9.1% declined to report. The ages of the participants ranged from 20-59 years.

Baseline Knowledge of Civility

Participants declared previous exposure to civility education and CRT (see Figure G1 and Figure G2). Before the structured civility education modules, baseline knowledge of civility was assessed. Of the sample, 27.3% stated they had received prior education on civility, with 18.2% receiving it while in college and 9.1% having received it through in-service training. The remaining 72.7% had never received civility education. None of the participants had ever received CRT.

Participants were asked to define their interpretation of what it means to be civil before implementing the structured civility education module. Analysis of participant responses revealed two prevalent themes, mutual respect and acts of kindness (Appendix H). An interactive poll asked participants to respond to their experience with overt, covert, and vertical incivility. All participants reported having experienced or witnessed these acts of incivility. Additionally, participants were asked to disclose issues related to civility they experience in their current role. Declaration of gossip, departmental discourse, and patient-to-staff incivility were reported. While these were not part of the clinical aims, it is essential to understand current civility issues to apply targeted interventions.

Changes in Civility Behaviors

Pretest and post-testing overall scores of the WCI were analyzed for statistical significance. A Wilcoxon rank test was chosen, due to the small size of the sample, to analyze the results of the WCI statistically. Overall civility index scores ranged from 78 points to 100 points in the pretest and 70 points to 98 points in the post-test. However, the overall mean of the civility index scores increased from 88.09 in pretesting to 89.45 in post-testing (see Appendix I). These results demonstrated an increase in overall civility. The calculated test statistic was 24, and the critical value for a sample size of n=11 with an a=0.05 is 10, demonstrating positive change. Standard deviations were 8.03 for pretesting and 8.30 for post-testing. The effect size was calculated to determine the overall impact between the pre-test and post-test overall scores. The mean standard deviation was 8.16, and the calculated effect size was 0.17. This demonstrates that the structured civility education modules and CRT may cause a shift in civility behaviors and may be useful in mitigating incivility in workplace. (See Appendix I)

Responses for the CRT scenarios were collected using the polling platform, Slido. These responses were not matched for pairs. A thematic analysis was used to extract emerging themes from the CRT scenarios. From the initial participant responses, sub-themes emerged, giving way to the three emerging primary themes. As noted in Appendix J, three key themes were derived from the responses, including acknowledging feelings and expectations, appropriate setting, and addressing incivility directly.

Job Satisfaction and Turnover

To quantify job satisfaction, a score of one to five was given to each level of job satisfaction including no satisfaction (1), a little satisfied (2), somewhat satisfied (3), moderately satisfied (4), and very satisfied (5). Using the points assigned to the rating of job satisfaction, in pretesting, five participants rated their job satisfaction as moderately satisfied (4 points), and six

participants rated their job satisfaction very satisfied (5 points). The points totaled to an overall mean job satisfaction of 4.5 (standard deviation = 0.52) (see Appendix K). Post-testing results were the same, demonstrating no change in job satisfaction scores.

Turnover was assessed with the help of the human resources department at the institution. In 2020, the facility experienced a total of 86 employee turnovers, with 9.3%, or eight resignations, involving the clinic system (see Appendix L). Human resources within the organization conduct exit interviews to determine the nature of terminations. Reasons for resignation included personal reasons, pursuing education, health reasons, retirement, job elimination, and unsatisfied with the position.

As part of the aims and objectives of this pilot project, turnover was measured six months post-intervention. The facility experienced a total of 53 employee turnovers, with the clinic system experiencing 1.9%, or one employee resignation. The employee cited personal reasons for resignation (See Appendix L).

Intervention Effectiveness

During post-testing, participants were asked to rate the effectiveness one week after implementing the structured civility education modules and CRT, using a five-point Likert scale. The Likert scale was used to assign points (1-5) for the effectiveness including no satisfaction (1), a little satisfied (2), somewhat satisfied (3), moderately satisfied (4), and very satisfied (5). Of the participants, one participant reported the intervention as moderately effective, six participants reported it as very effective, and four participants reported it as extremely effective. The mean score for this measure was 4.27, standard deviation = 0.65, demonstrating the intervention was better than very effective overall (Appendix M).

Feedback was solicited on how they would like civility education addressed in their institution. Participants noted that they would like to see the structured civility education modules used in new employee orientation and annual competencies. These suggestions can be used to form suggestions for sustainability.

Ethical Considerations

The project was formally submitted to the University's Internal Review Board (IRB) on 11/06/2020 for review. The IRB committee verified that the project fits the definition of a quality improvement project and was exempt from IRB review. The organization selected for implementation did not require any additional review and accepted the decision of the University's IRB. No ethical conflicts of interest or considerations were present in implementing this quality improvement pilot project. Participants were compensated at the agreed-upon contractual employment rates provided by the organization as part of paid training. All participant data were de-identified.

Discussion

Summary

The first aim of this quality improvement pilot project was to identify the employee's knowledge base of civility in the workplace. In partnership with the institution's human resource division, baseline data collection of reasons cited for turnover included themes rooted in incivility. Dissatisfaction with the work environment was cited and is similar to reasons found by Huang et al. (2018) and Yu et al. (2019). Each group of authors found similar causes for turnover in health care staff, supporting the need for civility education.

This pilot project determined that only 27.3% participants had prior exposure to civility education; however, no participants had any previous exposure to CRT. These results

demonstrated and supported the need for the intervention, as few participants had knowledge on using CRT techniques and little understanding of the impact of civility on workplace satisfaction, job turnover, and patient safety.

The second aim of this project was to implement a structured civility education module with CRT to reduce the frequency of incivility behaviors and improve the navigation of uncivil situations. The WCI is a standardized and reliable tool that measures the frequency of civil behaviors. Data analysis from pretesting and post-testing demonstrated a slight positive increase in overall civility scores, indicating a possibly more civil environment. The calculated effect size demonstrates a small but positive impact.

Analyzed responses from the CRT scenarios revealed the themes of acknowledging feelings and expectations, appropriate setting, and addressing civility directly. The purpose of CRT is to provide actionable responses to given situations. In the case of this pilot project, it is in response to uncivil behavior in the healthcare workplace. The themes generated from peer responses demonstrate the participants' ability to use the frameworks provided in the structured civility educational modules to form civil responses. Participants recognized that civil often occurs because of poor communication related to expectations and acknowledges the emotional response when expectations are unmet. Responses also indicated that the participants' understanding of the need for a private setting is most appropriate to resolve discourse. Additionally, participants recognized the need to address civility directly through seeking further details while confronting and correcting the behavior. Moreover, participants recognized that it might be necessary to bring in supervisors to mediate and correct behavior.

The final aim of this project was to measure the effectiveness of a structured civility module with CRT on turnover and job satisfaction declaration among participants. Job

satisfaction was shown to remain the same from pretesting and post-testing. This information demonstrates there was no decline in overall job satisfaction and that the small sample size could be a contributing factor. Turnover was significantly less during the six month time period following the intervention. The single employee resignation that occurred during this time period came from a clinic that did not receive the intervention. While causality on job satisfaction and turnover cannot be assumed from this pilot project, these results provide a positive prognosis for continuation of this project with a larger scale.

Limitations

Though appropriate for a pilot project, the most notable limitation of this project is the small sample size. Results demonstrate a small but positive impact. It could be expected that results would be more significant if the sample size had been larger. The sample size was impacted due to the clinic's role during the COVID-19 pandemic. The clinic's administration and its employees were heavily involved in the COVID-19 triaging call center, testing center, and vaccination efforts within the county. This limited the availability of employees to participate in the intervention and made scheduling complicated for the clinics.

Furthermore, the COVID-19 pandemic caused an additional limitation because of its impact on the ability to host training sessions. The culture of the region and institution prefer a face-to-face approach for training. However, the presence of the pandemic forced the presentation to become virtual. While effectiveness was noted to better than very effective, a virtual presentation in addition to COVID-19 duties reduced attendance.

Conclusion

This pilot project's purpose was to investigate the impact of a structured civility education module with CRT on job satisfaction and turnover in a rural health clinic. The clinic system had

been experiencing an increase in turnover with reports of civility concerns. This pilot project demonstrated a small but positive impact on civil behaviors. Job satisfaction was unchanged, and turnover was notably reduced. However, the limitations posed by the small sample size could be a significant barrier, with larger sample sizes rendering a more notable impact.

Literature supports the results found by this project and suggests an even more significant impact may be possible. The minimal costs associated with this intervention are vastly offset by the potential return on investment garnered by implementing civility education. Future recommendations would be to grow and expand the implementation of this project to determine the effects of larger sample sizes. The framework of the project, the Clinical Scholar Model, emphasizes sustainability through training and accountability.

It is recommended that the scope and scale of this project expand. The two key areas that would enhance sustainability include new hire orientation and incorporation into annual competencies. New hire orientation establishes the foundation for cultural change and sets the standard of civility in all new employees. Providing civility education as part of annual competencies targets seasoned clinicians and promotes the values of civility throughout the organization. Additionally, it would be necessary to include civility training for those who are not routinely required to participate in annual competency training, such as custodial, unlicensed staff, and administration.

Establishing a culture of civility affects the facility's internal success and the institution's outcomes in patient care. Civility is a noted requirement among several healthcare governing boards, highlighting its critical role and focus in practice. Moreover, TJC, which provides the gold standard in hospital accreditation, emphasized the role of civility in respect to patient safety.

As each of these bodies recognizes the impact of an uncivil environment, it is the institution's responsibility to address incivility before it occurs.

Structured civility education modules and CRT can be an effective way to highlight the role incivility plays in the legal and ethical realm of practice and its impact on the institution's employees and its patients. These modules showcase uncivil behaviors and provide practice response scenarios to better understanding how to cope and address incivility when it occurs in practice. The effect is a reduction in uncivil instances and hopefully an increase in civil responses and behaviors.

This project demonstrated that even in a small population, there could be an overall increase in the frequency of civil behaviors. Moreover, it noted that participants can use the frameworks provided in CRT and put them to use when they see incivility occurring in practice. These results demonstrate the usefulness of the structured civility educational modules with CRT executed in the pilot project.

The impact of mitigating incivility in practice can be most notable in dollars saved from clinical mistakes and lack of communication. An uncivil institution undermines a culture of safety and can result in reduced patient outcomes. Turnover also represents a costly expense to the institution. As clinicians leave the bedside, many within their first year, the costs of their training investment are wasted. However, when they are retained, the employee only becomes more valuable. Civility appears to be a vital component of organizational work culture.

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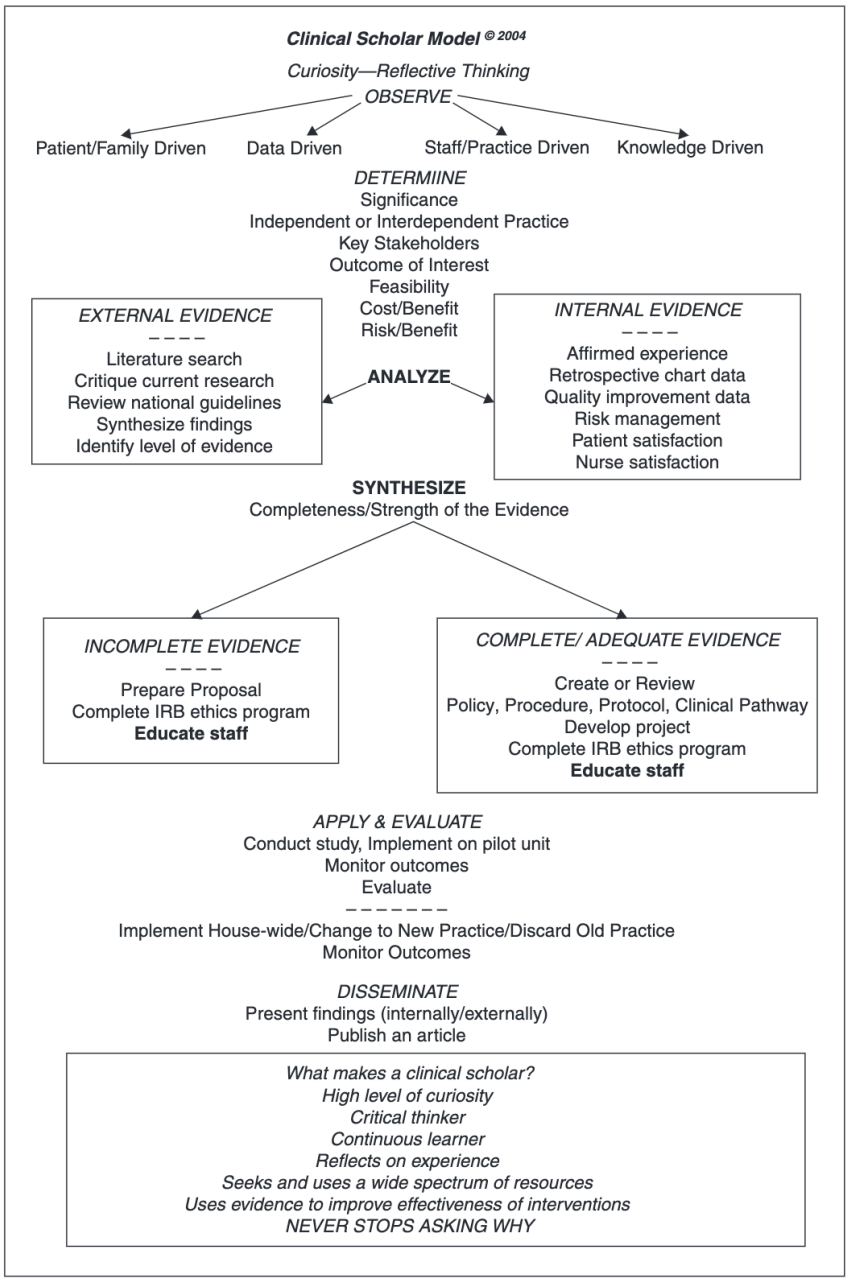
Appendix A

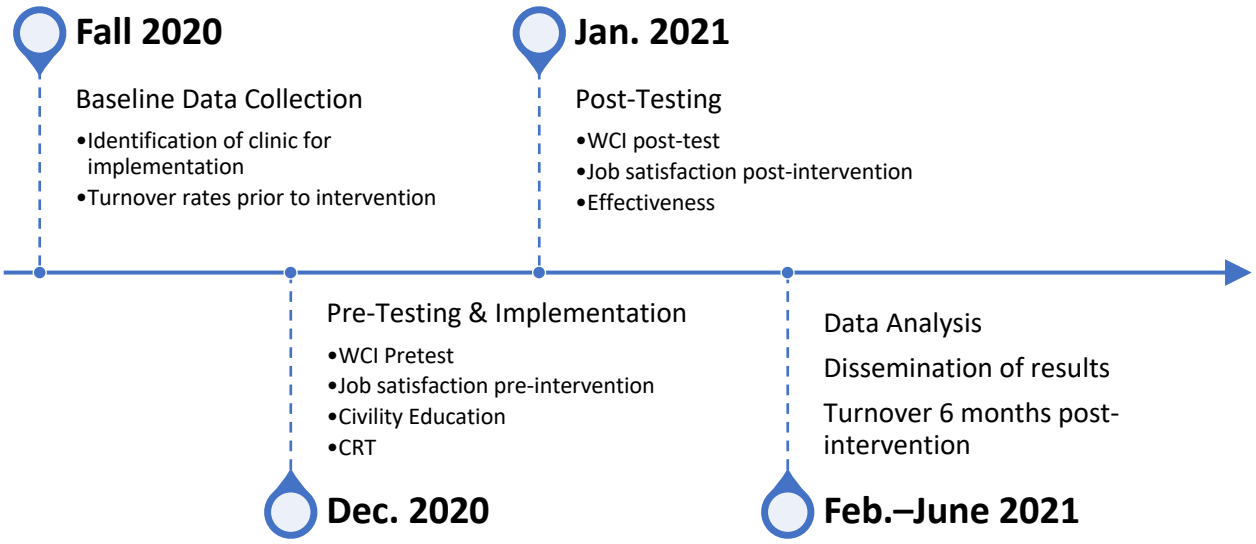
The Clinical Scholar Model



Note. In White et al. (2015)

Appendix B

Implementation Timeline



Appendix C

Workplace Civility Index Pre-Test

Workplace Civility Index - PreTest

Q19 I have read the above statements and understand what is being requested of me. I also understand that I will be provided a copy of this informed consent statement. I further understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason without penalty or consequence. On these terms, I certify that I am willing to participate in this quality improvement project.

I understand that should I have any further questions about my participation in this project, I may call the investigators Laurel Matthews at (936) 468-7727 office or matthewsl1@duq.edu, Manjulata Evatt at (412) 396-4509 office or evattm@duq.edu.

- ○ I consent (1)
- ○ I do not consent (2)

Skip To: End of Survey If I have read the above statements and understand what is being requested of me. I also understand... = I do not consent

Pin Create a 4-digit pin number that you will remember.

_____

Q16 Have you received education on civility before?

- ○ Yes (1)
- ○ No (2)

Skip To: End of Block If Have you received education on civility before? = No

Q17 How did you receive the civility education?

_____

Q20 Have you received education on Cognitive Rehearsal training before?

- ○ Yes (1)
- ○ No (2)

Skip To: End of Block If Have you received education on Cognitive Rehearsal training before? = No

Q19 How did you receive Cognitive Rehearsal training?

_____

Description
Workplace Civility Index

This index is not an empirical instrument; instead it is an evidence-based questionnaire designed to assess civility, increase awareness, generate discussion, and identify ways to enhance civility acumen.
It may be completed as a self-assessment tool using the following stem, "How often do I ……", or it may be used to assess a work group using the stem, "How often do my co-workers [including myself]..."

Carefully consider the behaviors below. Respond as truthfully and as candidly as possible by answering 1) never, 2) rarely, 3) sometimes, 4) usually, or 5) always regarding the frequency of each behavior. Select a response for each behavior, and then add up the number of 1-5 responses to determine the overall civility score. Scores range from 20-100.

Q1 Ask yourself, "how do often do I"...OR "how often do my co-workers [including myself]"…

	Never (1)	Rarely (2)	Sometimes (3)	Usually (4)	Always (5)
Assume goodwill and think the best of others (1)	○	○	○	○	○
Include and welcome new and current colleagues (2)	○	○	○	○	○
Communicate respectfully (by e-mail, telephone, face-to-face) and really listen— (3)	○	○	○	○	○

Avoid gossip and spreading rumors (4)	○	○	○	○	○
Keep confidences and respect others' privacy (5)	○	○	○	○	○
Encourage, support, and mentor others (6)	○	○	○	○	○
Avoid abusing my position or authority (7)	○	○	○	○	○
Use respectful language (avoid racial, ethnic, sexual, gender, religiously biased terms) (8)	○	○	○	○	○
Attend meetings, arrive on time, participate, volunteer, and do my share (9)	○	○	○	○	○
Avoid distracting others (misusing media, side conversations) during meetings (10)	○	○	○	○	○
Avoid taking credit for another individual's or team's contributions (11)	○	○	○	○	○
Acknowledge others and praise their work/contributions (12)	○	○	○	○	○

Take personal responsibility and stand accountable for my actions (13)	○	○	○	○	○
Speak directly to the person with whom I have an issue (14)	○	○	○	○	○
Share pertinent or important information with others (15)	○	○	○	○	○
Uphold the vision, mission, and values of my organization (16)	○	○	○	○	○
Seek and encourage constructive feedback from others (17)	○	○	○	○	○
Demonstrate approachability, flexibility, and openness to other points of view (18)	○	○	○	○	○
Bring my 'A' Game and a strong work ethic to my workplace (19)	○	○	○	○	○
Apologize and mean it when the situation calls for it (20)	○	○	○	○	○

End of Block: Workplace Civility Index

Start of Block: Block 2

Q2 From the previous statements. How did you score?

- ○ 90-100 - Very Civil (6)
- ○ 80-89 - Moderately Civil (5)
- ○ 70-79 - Mildly Civil (4)
- ○ 60-69 - Barely Civil (3)
- ○ 50-59 - Uncivil (2)
- ○ Less than 50 - Very Uncivil (1)

Q3 What issues related to civility do you face most frequently in your current role?

_____

_____

_____

_____

_____

Q4 What factors do you feel lead to turnover in your workplace?

_____

_____

_____

_____

_____

Q5 How do you currently rate your job satisfaction?

- ○ Very Satisfied (5)
- ○ Moderately Satisfied (4)
- ○ Somewhat Satisfied (3)
- ○ A Little Satisfied (2)
- ○ No Satisfaction (1)

Q17 About You

Q6 Gender

- ○ Identify as male (1)
- ○ Identify as female (2)
- ○ Other (3)
- ○ Prefer not to specify (4)

Skip To: Q8 If Gender != Other

Q7 Define other gender.

_____

Q8 With which race/ethnic background do you identify with?

- ☐ American Indian or Alaska Native (1)
- ☐ Black or African American (2)
- ☐ Asian (3)
- ☐ Native Hawaiian or Other Pacific Islander (4)
- ☐ Hispanic or Latino (5)
- ☐ White (6)
- ☐ Other (7)

Skip To: Q10 If With which race/ethnic background do you identify with? != Other

Q9 Define other race or ethnicity.

_____

Q10 Age

- ○ Less than 20 years old (1)
- ○ 20-29 years old (2)
- ○ 30-39 years old (3)
- ○ 40-49 years old (4)
- ○ 50-59 years old (5)
- ○ 60-69 years old (6)
- ○ 70+ years old (7)

Q11 Profession

- ○ Physician (1)
- ○ APRN (FNP, GNP, PNP, etc.) (2)
- ○ RN (3)
- ○ LVN (4)
- ○ Auxiliary medical staff (CNA, Med Assistant, etc.) (5)
- ○ Staff (Office manager, office staff, etc. (6)

End of Block: Block 3

Appendix D

Workplace Civility Index Post-Test

Workplace Civility Index - PostTest

Pin Enter your 4 digit pin number.

_____

Description
Workplace Civility Index

This index is not an empirical instrument; instead it is an evidence-based questionnaire designed to assess civility, increase awareness, generate discussion, and identify ways to enhance civility acumen.
It may be completed as a self-assessment tool using the following stem, “How often do I ……”, or it may be used to assess a work group using the stem, “How often do my co-workers [including myself]...”

Carefully consider the behaviors below. Respond as truthfully and as candidly as possible by answering 1) never, 2) rarely, 3) sometimes, 4) usually, or 5) always regarding the perceived frequency of each behavior. Select a response for each behavior, and then add up the number of 1-5 responses to determine the overall civility score. Scores range from 20-100.

Q1 Ask yourself, "how do often do I"...OR "how often do my co-workers [including myself]"…

	Never (1) (1)	Rarely (2) (2)	Sometimes (3) (3)	Usually (4) (4)	Always (5) (5)
Assume goodwill and think the best of others (1)	○	○	○	○	○
Include and welcome new and current colleagues (2)	○	○	○	○	○
Communicate respectfully (by e-mail, telephone, face-to-face) and really listen— (3)	○	○	○	○	○

Avoid gossip and spreading rumors (4)	○	○	○	○	○
Keep confidences and respect others' privacy (5)	○	○	○	○	○
Encourage, support, and mentor others (6)	○	○	○	○	○
Avoid abusing my position or authority (7)	○	○	○	○	○
Use respectful language (avoid racial, ethnic, sexual, gender, religiously biased terms) (8)	○	○	○	○	○
Attend meetings, arrive on time, participate, volunteer, and do my share (9)	○	○	○	○	○
Avoid distracting others (misusing media, side conversations) during meetings (10)	○	○	○	○	○
Avoid taking credit for another individual's or team's contributions (11)	○	○	○	○	○
Acknowledge others and praise their work/contributions (12)	○	○	○	○	○

Take personal responsibility and stand accountable for my actions (13)	○	○	○	○	○
Speak directly to the person with whom I have an issue (14)	○	○	○	○	○
Share pertinent or important information with others (15)	○	○	○	○	○
Uphold the vision, mission, and values of my organization (16)	○	○	○	○	○
Seek and encourage constructive feedback from others (17)	○	○	○	○	○
Demonstrate approachability, flexibility, and openness to other points of view (18)	○	○	○	○	○
Bring my 'A' Game and a strong work ethic to my workplace (19)	○	○	○	○	○
Apologize and mean it when the situation calls for it (20)	○	○	○	○	○

End of Block: Workplace Civility Index

Start of Block: Block 2

Q2 From the previous statements. How did you score?

- ○ 90-100 - Very Civil (6)
- ○ 80-89 - Moderately Civil (5)
- ○ 70-79 - Mildly Civil (4)
- ○ 60-69 - Barely Civil (3)
- ○ 50-59 - Uncivil (2)
- ○ Less than 50 - Very Uncivil (1)

Q3 What issues related to civility do you still face most frequently in your current role?

_____

_____

_____

_____

_____

Q5 How do you currently rate your job satisfaction?

- ○ Very Satisfied (5)
- ○ Moderately Satisfied (4)
- ○ Somewhat satisfied (3)
- ○ A Little Satisfied (2)
- ○ No Satisfaction (1)

End of Block: Block 2

Start of Block: About the modules

Q18 How effective was this structured module and Cognitive Rehearsal training?

- Not effective at all (1)
- Slightly effective (2)
- Moderately effective (3)
- Very effective (4)
- Extremely effective (5)

Q19 Which aspect of the structured module and Cognitive Rehearsal training was most effective?

_____

Q20 What suggestions do you have for civility programs at your organization in the future?

_____

End of Block: About the modules

Appendix E

Copyright Permission for the Workplace Civility Index

RE: Workplace Civility Index

Cindy Clark <Cindy.Clark@atitesting.com>

Fri 5/22/2020 9:25 AM

To:Laurel Matthews <matthewsle2@sfasu.edu>;

2 attachments

Development and Psychometric Testing of WCI Clark. Sattler. Barbosa-Leiker 2018.pdf; Clark Workplace Civility Index©.pdf;

Dear Laurel, it's great to hear from you. I hope you are safe and well. As requested, I have attached the Workplace Civility Index© along with an article describing its development and psychometric properties. Because it is a copyrighted instrument, it can only be used with my express written permission (provided by this email) and with full citation/referencing (contained on the attached). If it is distributed in hard copy, all copies must be collected to protect the copyright. You may administer the index using a secure, web-based system; however, the index must be removed once your study is completed.

I wish you well with your project,

Cynthia Clark, PhD, RN, ANEF, FAAN
Strategic Nursing Advisor
ATI Nursing Education
Author of "Creating and Sustaining Civility in Nursing Education"
Mobile 208-866-8336
cindy.clark@atitesting.com

From: Laurel Matthews <matthewsle2@sfasu.edu>
Sent: Thursday, May 21, 2020 8:22 PM
To: Cindy Clark <Cindy.Clark@atitesting.com>
Subject: [EXTERNAL] Workplace Civility Index

Hello Dr. Clark,

You and I met at the Sigma Conference in Washington D.C. and discussed your Workplace Civility Index. I'm currently working on my DNP through Duquesne and would like to use your tool in my investigation. You said there was copyright procedures I would need to follow. How do I begin that process to use your tool? Forgive me if I'm going about this in the wrong way. This is my first experience seeking copyright permission. I'm happy to take whatever steps needed.

Appendix F

Demographics

Characteristic	Sample	
	n=11	%
Gender		
Male	1	9.1
Female	10	90.9
Age (years)		
less than 20	0	0.0
20-29	2	18.2
30-39	3	27.3
40-49	3	27.3
50-59	2	18.2
60-69	0	0.0
70+	0	0.0
Declined to report	1	9.1
Race/Ethnicity		
American Indian or Alaskan Native	0	0.0
Black or African American	0	0.0
Asian	0	0.0
Native Hawaiian or Other Pacific Islander	0	0.0
Hispanic or Latino	2	18.2
White	8	72.7
Other	0	0.0
Declined to report	1	9.1
Profession		
Physician	0	0.0
APRN (FNP, GNP, PNP, etc.)	2	18.2
RN	1	9.1
LVN	1	9.1
Auxiliary Medical Staff (CNA, Med Assistant, etc.)	1	9.1
Staff (Office manager, office staff, etc.)	5	45.5
Declined to report	1	9.1

Appendix G

Prior Participant Knowledge of Civility and CRT

Figure F1

Prior Knowledge of Civility

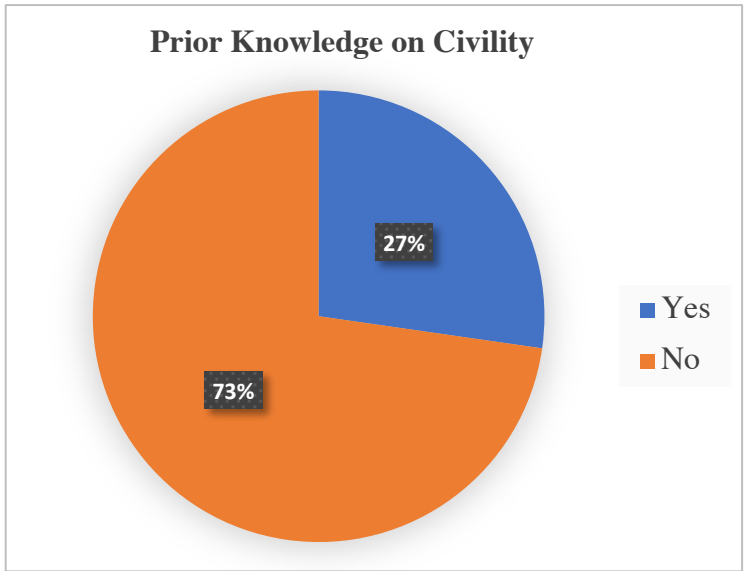
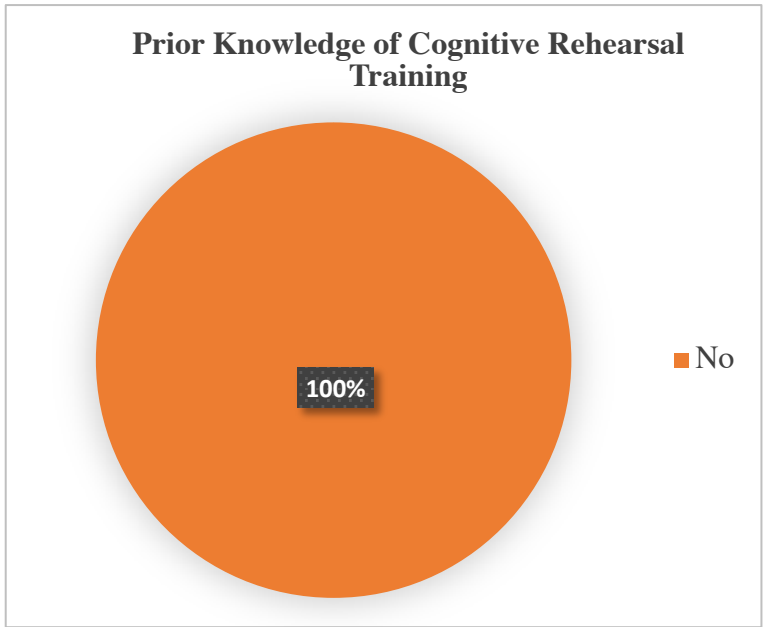


Figure F2

Participant Knowledge of CRT



Appendix H

Baseline Knowledge of Civility

Main Theme	Sub-Theme	Detailed Description
Acts of Kindness	Gestures towards others Kindness	Patient ; Kind ; Understanding; Politeness, Manners, Courteous, Helpful, Empathy
	Self-Control	Peaceful; Patient
Mutual Respect	Respect for others	Helpful ; Respect; Professional

Appendix I

Changes in Civility Behaviors

n	Pre-Test Score (Max=100)	Post-Test Score (Max=100)	Pre-Test Mean/SD	Post-Test Mean /SD	Mean SD	Effect Size
1	93	98	88.09/8.03	89.45/8.30	8.16	0.17
2	96	91				
3	90	98				
4	83	95				
5	81	89				
6	78	91				
7	91	96				
8	90	84				
9	74	82				
10	100	90				
11	93	70				

Appendix J

Cognitive Rehearsal Response Themes

Main Theme	Sub Theme	Detailed Description
Acknowledging Feelings and Expectations	Calming down Giving space	"Let her cool down a bit"; "Take a breath"; "I would take time to calm down"
	Apologizing Disconnected expectations	"I'm sorry, you know I really want to do what's needed and the right thing"; "I'm sorry I'm not meeting your expectations"; "It sounds like we are not on the same page"; "I wish you had told me."; "Ask what have I done"
	Collaboration	"Let's work through this"
	Acknowledging self-response	"That hurt my feelings"; "This makes me uncomfortable"
Appropriate Setting	Privacy	"Would prefer to discuss in private one on one"; "Ask to talk in a private setting"; "Can we go somewhere private to discuss it further"; "Let's take this conversation to your office"; "I would ask that we take it to somewhere private"; "We need to take this to the office"; "Could we talk about this in your office?"; "Talk about it away from patients"
	Setting	"I'm uncomfortable discussing this in public"; "This isn't a good place to be having this conversation"; "State that this is not the time or place for the discussion"; "Remind them we are at work"; "Let's talk on break"
Addressing Incivility Directly	Detail seeking	"Ask for specifics"; "Discuss more in depth how I can improve"; "Ask what about me is driving her crazy"; "Ask what specific issues have been a problem."
	Confrontation	"I should confront them"; "Politely interject"; "I'd want to say something right away."; "Respectfully address the situation"
	Correction	"Remind them they wouldn't want someone to be talking about them like that"; "Let them know its unprofessional"; "We shouldn't gossip and it possibly may not be true"; "I don't appreciate them starting gossip"
	Upward reporting	"Go to the boss"; "Report it to your supervisor"

Appendix K

Job Satisfaction

Job Satisfaction	Pre-Test Sample			Post-Test Sample		
	n	%	Scoring: Pre	*n*	%	Scoring: Post
No Satisfaction (1)	0	0.0	0	0	0.0	0
A Little Satisfied (2)	0	0.0	0	0	0.0	0
Somewhat Satisfied (3)	0	0.0	0	0	0.0	0
Moderately Satisfied (4)	5	45.5	20	5	45.5	20
Very Satisfied (5)	6	54.5	30	6	54.5	30
Mean			4.5			4.5
Std Dev			0.52			0.52

Appendix L

Staff Turnover

Appendix M

Perceived Effectiveness of Structured Civility Educational Module with CRT by Participants

Effectiveness	Sample		
	n	%	Scoring
Not Effective At All (1)	0	0.0	0
Slightly Effective (2)	0	0.0	0
Moderately Effective (3)	1	9.1	3
Very Effective (4)	6	54.5	24
Extremely Effective (5)	4	36.4	20
Mean			4.27
Std. Dev.			0.65