Spring 2021

Promoting Civility in the Workplace: Addressing Bullying in New Graduate Nurses Using Simulation and Cognitive Rehearsal

Sandy Phan
California State University, Northern California Consortium Doctor of Nursing Practice

Promoting Civility in the Workplace: Addressing Bullying in New Graduate Nurses Using Simulation and Cognitive Rehearsal

Sandy Phan

San Jose State University

Author Note

I want to acknowledge everyone that provided their unwavering support throughout the DNP program. First, I want to express my deepest gratitude to my incredible DNP chair, Dr. Michelle DeCoux Hampton and mentors for their guidance, patience, and compassion during this challenging time. I also want to recognize SJSU's outstanding DNP faculty and student support team. A special thank you to my project site's leadership team for approving and supporting my evidence-based practice project. Lastly, I am grateful to my family, friends, colleagues, and fellow cohort peers for the love and encouragement; this would not have been possible without your support.

Abstract

Bullying continues to be a widespread, devastating problem in nursing. Research indicates that bullying has a negative, rippling impact on nurses, organizations, and patient care. This evidence-based practice project aimed to enhance new graduate nurses' abilities to identify and respond to bullying behaviors. The intervention used a mixed educational methodology of didactic, simulation role-play, and cognitive rehearsal. The project was implemented at a large academic healthcare system in Northern California. Outcomes were evaluated using Kirkpatrick levels 1-4 and the Clark Workplace Civility Index (CWCI). Participants reported that the educational intervention met intended learning objectives, enabled them to apply learned behaviors to address bullying behaviors in the practice setting, and that it was favorable, engaging, and relevant. Self-reported civility using the CWCI ranged between 91 and 93% from baseline to post-intervention with a non-significant increase from immediately-post to 2.5, and 5-month post-intervention scores. Factors that may influence civility ratings are survey timeframes, nursing experience, and exposure to job stress. Implementing mixed educational methodologies can improve communication, peer relationships, teamwork, patient safety, and care. Future exploration of effective strategies to eliminate bullying in all settings is warranted.

Keywords: Bullying, nurse bullying, workplace bullying; civility; incivility; simulation; role-play; cognitive rehearsal; Kirkpatrick levels; Clark Workplace Civility Index; CWCI

Promoting Civility in the Workplace: Addressing Bullying in New Graduate Nurses Using Simulation and Cognitive Rehearsal

Nurse Bullying

For the past forty years, bullying remains a prevalent phenomenon in the nursing profession (Purpora et al., 2019). Sixty-four to 97% of nurses report witnessing or encountering Nurse Bullying (NB) behaviors in their practice (Rainford et al., 2015; Gilbert et al., 2016; Workplace Bullying Institute, 2018). NB is defined as unwanted, repeated, physical, or verbal disruptive behaviors intended to harm another person in the workplace (American Nurses Association [ANA], 2015). NB is also referred to as nurses eating their young, workplace mobbing, incivility, lateral and horizontal violence, and horizontal hostility (Ayasreh et al., 2015).

Nurse bullying behaviors can be covert or overt. Examples of covert behaviors are indirect harmful behaviors, such as spreading rumors, gossiping, withholding information, giving unfair assignments, and sabotage (ANA, 2015; Edmonson & Zelonka, 2019). Overt behaviors are direct threats, such as yelling, insulting, name-calling, refusing to help, and misplacing blame (ANA, 2015; Edmonson & Zelonka, 2019). Covert behaviors are reported to be more common than overt behaviors, including being ignored or excluded, avoided, isolated, intimidated, and experiencing non-verbal bullying behaviors (Gilbert et al., 2016; Etienne, 2014; Smith et al., 2016).

Contributing factors of NB are organizational structures and culture, unit environment, nursing workload, leadership and management, and personal factors (Rainford et al., 2015; Crawford et al., 2019). Strict hierarchical organizational structures promote oppressed group behaviors and feelings of disempowerment perpetuating intragroup abuse (Matheson & Bobay,

2007). Unit environments with a lack of supervision or mentorship, poor teamwork, overtime, and perceived unequal workload can trigger NB (Crawford et al., 2019). Nursing workloads of heavy patient care assignments that involve multi-tasking and time-sensitive duties can increase stress (Croft & Cash, 2012; ANA, 2015). Stressful atmospheres can lead to interpersonal conflict and frustration. Overbearing, controlling, and dictatorial leadership and management styles can leave victims unable to report issues and create unsafe work environments (Johnson & Rea, 2009; Embree & White, 2010). Personal factors such as poor communication and coping skills, negative interpersonal factors, low self-esteem, and lack of respect and dignity for others foster an environment for NB (Croft & Cash, 2012; Crawford et al., 2019).

Prevalence and Consequences of NB

NB threatens the safety of patients, nurses, and organizations (Vessey et al., 2010). NB has been linked to nurses' physical and psychosocial health problems, burnout, absenteeism, and turnover resulting in inadequate staffing, financial costs, and patient errors (ANA, 2015; Lasater et al., 2015; Vessey, et al., 2010; Griffin & Clark, 2014). According to the Bureau of Labor Statistics (2020), the estimated number of new nurse jobs between 2018-2028 is a 12% increase of 371,500 openings. Furthermore, multiple studies revealed that 34% of nurses leave or consider leaving the profession due to bullying (King-Jones, 2011).

New graduate nurses (NGN) are at risk for NB victimization. As the brand-new employee on a unit, NGNs are at the lowest level of the traditional power-related hierarchy (D'Ambra & Andrews, 2014). NGNs are vulnerable as they naturally possess less professional and practice competence than experienced nurses and rely on peer support to provide safe, effective care (Rush et al., 2014). Lee et al.'s (2013) study found that negative workplace behavior perpetrated by more experienced nurses was often justified to improve NGN's capabilities. Berry et al.

(2012) states that NB experiences negatively affected NGN's work productivity, cognitive demand, and ability to manage workload. Approaches to strengthen NGNs abilities in managing NB can assist with novice and advanced beginner nurse practice transitions. Interventions supported by the literature are needed to address the NB problem to meet healthcare demands.

Approaches to NB response

Nurses as Wounded Healers (NWH) Framework

The NWH Theory developed by Dr. Marion Conti-O'Hare (2002) is a framework that can help nurses care for others by healing from NB incidents. The NWH theory consists of the three phases of recognition, transformation, and transcendence to become a wounded healer (See Figure 1) (Conti-O'Hare, 2002; Christie & Jones, 2013). The recognition and transformation phases consist of examining the situation, engaging in deep reflection, and managing the pain by learning from the experience. Lastly, the transcendence phase empowers the nurse to become a wounded healer by tapping into personal insights learned from previous painful or traumatic experiences to be more empathetic to others.

The NWH theory is the selected theory for framing reactive and proactive approaches to managing NB (Sanner-Stiehr, 2015; Przychodzen, 2018). The NWH phases encourage healing through self-reflection and growth by moving past pain and trauma, such as NB incidents, to heal others (Conti-O'Hare, 2002). If healing phases do not occur, a nurse may become a "walking wounded" or future NB perpetrator (Conti-O'Hare, 2002). Christie & Jones (2013) stress that nurse leaders need to be aware of the NWH theory and become catalysts to help nurses begin the NWH pathway to promote healers instead of walking wounded. The transcendence into a wounded healer fosters therapeutic and caring relationships for optimal healing environments.

The NWH theory will be integrated into the DNP project to guide learning outcomes and activities for NGNs to reflect on NB simulation and scenarios in a safe environment. The simulation role-play focuses on the affective and cognitive domains to promote skill mastery and experiential learning by practicing scripted responses to NB scenarios (Sanner-Stiehr, 2017). The simulation uses a structured process to facilitate meaningful learning experiences by engaging in the scenario and debriefing to support outcomes achievement (See Table 1). Promoting the transcendence of wounded nurses from NB incidences into NWH is vital to promoting and sustaining healing environments.

Professional Organizations and NB

Professional nursing associations, accreditation and regulatory agencies, and healthcare improvement organizations support the elimination of NB. The ANA released a positional statement on incivility, bullying, and workplace violence, and end nurse abuse campaigns (ANA 2015; n.d.). The Tri-Council for Nursing states that NB must be identified and eradicated in academic and practice settings (National League for Nursing, 2017). The Joint Commission (2016) developed recommendations for organizations to address workplace violence and recognizes that bullying has no place in healthcare. The Institute for Healthcare Improvement's quadruple aim in healthcare supports the elevation of health equity and joy in the workplace (Feeley, 2017). Further research and quality improvement initiatives are needed to implement evidence-based practice interventions to eliminate NB.

Rationale

Despite the evidence to support implementing an educational program using simulation role-play and cognitive rehearsal to address NB, it has not been widely disseminated in practice settings. The project is aimed at implementing an evidence-based practice educational NB

intervention at a large academic health system in Northern California. The intervention uses simulation role-play and cognitive rehearsal to improve NGNs' abilities to identify and manage NB behaviors.

Methods

Design

This evidence-based practice project was a mixed methods, quasi-experimental design. Data collection was completed at baseline, immediately after the intervention, and at 2.5 and 5 months after the intervention.

Setting

The project was implemented at a level-one trauma center in a large academic health system in the western region of the United States. The hospital's areas of expertise ranges from primary care to more than 100 of the most advanced medical and surgical specialty and subspecialty service areas. Specialty care units include surgical, trauma, and cardiovascular intensive care units, adaptable acuity units with intermediate intensive care, medical-surgical care, and specialized nursing care such as cardiac, transplants, neuro-trauma, orthopedics, medicine, oncology, and more.

The facility has over 1,910 medical staff and 1,500 Registered Nurses. The health system has magnet designation and practice transition accreditation from the American Nurses Credentialing Center. The approximate number of NGNs hired each year is 120 with spring, summer, and fall cohorts. The NGN retention rate after one year of the nurse residency program is 100% and 90% after two years. The average RN turnover rate for 2018 and 2019 was 12%. In 2017, nearly 30% of the organization's nursing units scored below the national benchmark for

nurse-to-nurse interaction scale, indicating a low perception of teamwork and support (Press Ganey Associates, 2018).

Participants

All nurses enrolled in the facility's 12-month Vizient American Association of Colleges of Nursing (AACN) New Nurse Residency Program had the option to participate in the project. Nurse Residency Program participants must be graduates from a Bachelor of Science Nursing program or Master of Science in Nursing practice program accredited by the National League for Nursing Accrediting Commission or Commission on Collegiate Nursing Education. Applicants' must submit an official graduation transcript dated no more than 18-months from the cohort start date and have a current state Registered Nursing license. Nurses must have proof of basic life support and advanced cardiac life support certification from the American Heart Association and commit to the one-year program with no foreseeable break in service. The duration of this project was 5-months, with one cohort of 34 NGN participants. The facility designated the project as a quality improvement, and therefore it was not under the purview of an institutional review board.

Data Collection

Demographic Data. Demographic data were collected at baseline. It included the participant's age, gender, and the highest level of education completed (nursing associate, baccalaureate, masters, or doctoral program).

Clark Workplace Civility Index. Participants completed the Clark Workplace Civility Index (CWCI) created by Dr. Cynthia Clark (2017). The CWCI is a self-reflective tool that measures individual and group perceptions of workplace civility (Clark, 2017). The CWCI uses a Likert scale survey with 20-items assessing the frequency of elements associated with civil

interactions. The Likert scale ranges from 1 (never) to 5 (always), and total scores for the full instrument range from 20-100 (See Appendix B). The lower ratings indicate uncivil workplace perceptions, and higher ratings indicate civil workplace perceptions (Clark, Sattler, & Barbosa-Leiker, 2018).

The CWCI was deemed a valid and reliable tool for measuring workplace civility through Bartlett's test of sphericity and Kaiser-Meyer-Olkin test in a study of 393 nurses (Clark et al., 2018). The CWCI's internal validity had factor loadings higher than 0.30 in all items except one (avoid taking credit for another individual's or team's contribution). It was internally consistent with a Cronbach's alpha .82 (Clark et al., 2018). Studies by Howard & Embree (2020); El-Aal & Shousha (2019); Abd-Elrhaman & Ghoneimy (2019), and Hudson (2019) utilized the CWCI to measure civility perceptions in academic and practice settings effectively.

Kirkpatrick Levels. The training program was evaluated using Kirkpatrick's four training levels. In 1954, Kirkpatrick's evaluation was first used to evaluate industrial supervisor training and evolved as the industry standard for training evaluation (Kirkpatrick Partners, 2009). Kirkpatrick's four training evaluation levels measure the learner's reaction, learning, behavior, and results (J. Kirkpatrick & W. Kirkpatrick, 2016). Kirkpatrick levels measure training favorability, relevance, and engagement; acquisition of intended knowledge, skills, attitudes, confidence, and commitment based on participation; application of learned behaviors and required drivers; and targeted outcomes from applying behaviors on the job. Kirkpatrick's level 1 and 2 questions used a Likert scale, and levels 3 and 4 had open-ended responses. Refer to Appendix C and D for questions. There were no studies located that establish reliability and validity of Kirkpatrick levels, but research by Roberts et al. (2017); Clark and Gorton (2019); Clark et al. (2013, 2014); and Sanner-Stiehr (2018) implemented Kirkpatrick's model to evaluate

the learner's reaction, learning, behavior, or results in NB or incivility educational programs in academic and workplace settings.

Kirkpatrick Levels 1 & 2: Reaction and Learning. Kirkpatrick's levels 1 and 2 measure reaction and learning after a training program using a Likert-scale rating 1 (strongly disagree) to 5 (strongly agree) (J. Kirkpatrick & W. Kirkpatrick, 2016). Kirkpatrick's level 1 reaction is "the degree in which participants find the training favorable, engaging, and relevant to their jobs" (J. Kirkpatrick & W. Kirkpatrick, 2016, p. 39). Kirkpatrick level 2 learning measures "the degree in which the participants acquired the intended knowledge, skills, and attitudes, confidence, and commitment based on their training participation" (J. Kirkpatrick & W. Kirkpatrick, 2016, p. 42). See Appendix C for Kirkpatrick level 1 and 2 evaluation questions.

Kirkpatrick Levels 3 & 4: Behavior and Results. Kirkpatrick level 3 assesses the processes and systems that reinforce, encourage, and reward performances of critical behaviors on the job (J. Kirkpatrick & W. Kirkpatrick, 2016). Kirkpatrick level 4 is an evaluation of the results, leading indicators, short-term observations, and measurements of critical behaviors, such as speaking up when NB occurs (J. Kirkpatrick & W. Kirkpatrick, 2016). Kirkpatrick levels 3 and 4 evaluation questions use open-ended questions for responses (Refer to Appendix D).

Procedures

Planning

The Workplace Violence and the Code of Conduct policies at the facility identify NB as an act of workplace violence and violation of the Code of Conduct. The Workplace Violence policy outlines the requirements and procedures to ensure that the facility maintains a free workplace following local, state, and federal requirements applicable to all employees and

departments. The policy states zero-tolerance for threats or acts of workplace violence and outlines steps to take if perceived intimidation or threatening behavior.

Furthermore, the policy defines guidelines for managers, supervisors, safety officers, the environment of care committee, human resources, risk management, and security if such incidents occur. Designated topics in the policy include workplace violence events, assessment, prevention, reporting, recording and documenting, training and education requirements, evaluation and continuous quality improvement, and compliance. The Code of Conduct Policy defines integrity in the workplace, workplace harassment, violence, health, and safety.

In 2019, the facility's Medicine Task Force released the report on Healthcare Professionals and Staff Mistreatment. The facility's Health Alliance created an interprofessional task force to conduct a report and lead enterprise-wide initiatives to prevent and manage workplace violence. The DNP project supports the report recommendations of providing education, consistent messaging, and processes to healthcare professionals and increasing awareness of the resources available to assist health care professionals who have experienced mistreatment. Nurse leaders, including directors, managers, nursing professional development specialists, Clinical Nurse Specialists, and unit educators, were invited to attend the NB educational program, and senior leadership emphasized adhering to policies and investigating any reports.

Implementation

The 2.75 hours of NB training were completed in October 2020. Refer to Appendix A for evidence-based training content and cognitive rehearsal cue card. Training included a brief didactic session covering the prevalence and definition of NB, ANA Code of Ethics, risk for NGNs, theories, contributing factors, consequences, organizational data, strategies for

preventing, responding, and resources to manage NB. Learning activities included simulation role-play, cognitive rehearsal, debriefing, and polling. To reinforce concepts, a booster was provided to the participants 2.5 months post-training. (See Appendix A for training agenda).

Demographic data were collected at baseline only. Participants completed the CWCI four times: at baseline, immediately after the intervention, and at 2.5 and 5 months after the intervention. Kirkpatrick levels 1 and 2 were collected only immediately after the intervention and Kirkpatrick levels 3 and 4 were measured at 2.5 and 5 months after the intervention.

Analysis

Descriptive analysis for categorical variables included frequencies and percentages. Means and standard deviations were calculated for continuous variables. Frequencies were calculated for Kirkpatrick level Likert scale ratings for training favorability, relevance, and engagement; acquisition of intended knowledge, skills, attitudes, confidence, and commitment. Qualitative responses for Kirkpatrick levels 3 and 4 regarding application of learned behaviors were coded by two reviewers independently and consolidated into broad themes. CWCI mean scores were compared at four time points (baseline, immediately after the intervention, and at 2.5 and 5 months after the intervention) using repeated measure analysis of variance (ANOVA). IBM SPSS Statistics, Version 25.0, was used for the quantitative analyses.

Results

The sample included 36 participants. The survey response rate was 100% (N = 36) at baseline, 86% (n = 31) immediate after the intervention, 88% (n = 32) at 2.5 months, and 94% (n = 34) at 5 months. The majority of the participants identified as female (83%, n = 30), reported age between 21-39 years old (92%, n = 33), and completed a baccalaureate degree in nursing (64%, n = 23) (See Table 2).

CWCI

CWCI scores were grouped into moderately civil (70-79), civil (80-89), and very civil (90-100) categories. Over the four time periods, CWCI very civil scores increased from 67% at baseline to 87% at five months (with a decrease to 60% at the 2.5-month follow-up). Civil scores increased from 23% to 37% from immediately after the intervention to the 2.5-month follow-up. Total CWCI mean scores increased from baseline (M = 91.89) to immediately after the intervention (M = 92.96), 2.5 months (M = 92.77), and 5 months after the intervention (M = 93.81) (See Table 4). There were no statistically significant differences in CWCI scores ($F(3,24) = .938$, $p = .668$).

Kirkpatrick Levels 1-2: Reaction and Learning

The majority (94%-97%) of the participants "agreed or strongly agreed" that the training was favorable, relevant to their jobs, engaging, helped them to achieve the course's learning objectives, fostered confidence in addressing bullying, and they planned to apply what was learned on the job (See Table 3).

Kirkpatrick levels 3-4: Behavior and Results

Regarding implementing skills, participants stated that they learned how to communicate effectively (n = 5) with statements such as, “My communication is stronger;” “Communicating more openly with co-workers;” and “Using better communication techniques.” They also reported they would not tolerate gossiping or rumor spreading, and would speak up when bullying occurred (n = 8). A sampling of participant quotes included: “I speak more openly with co-workers about what is acceptable behavior;” “Combat workplace violence and promote a safe work environment;” and “Helped [defuse] situations by standing up for co-workers when they’re being gossiped about.”

The participants identified the processes and systems that reinforce and reward critical behaviors on the job such as building awareness, knowledge, and confidence (n = 5), reflecting on concepts learned in training and personal actions (n = 3), and practicing bullying scenarios and response communication skills (n = 9). Illustrative quotes included: “Being empowered by peers, having confidence to speak up about what is right and just;” “Being aware and conscious about the power of our words and actions and how to approach certain situations;” and “The examples of incivility helped me identify situations that have occurred, and the examples of responses helped me prepare for handling these situations better in the future”.

Participants’ identified challenges in applying learned skills including the current culture, being new (n = 4), fear of retaliation (n = 2), and working with difficult personalities and attitudes (n = 3). Quotes included, “People are set in their own ways;” and “do not recognize their habits and personality is toxic”.

Participants’ identified possible solutions to overcome the challenges. They suggested providing universal education on NB (n = 2), having more experience, time, and confidence to speak up (n = 3), building team rapport and having common goals (n = 7). Quotes included: “Offer the workshop to a broader audience so everyone has learned the same techniques and baseline knowledge;” “More confidence and realization that counteracting incivility provides a safer and better work environment;” and “Finding common grounds and goals, re-establishing the purpose of conversations that I feel are going down a road to gossip”.

Finally, participants reported the that they applied skills learned from the training in terms of increased teamwork (n = 11), communication (n = 13), peer relationships (n = 11), and patient safety and care (n = 4). Illustrative quotes included “Better communication and teamwork, developing understanding across interprofessional teams;” “Increase in communication and

safety which impacts patient care;" and "Increased interpersonal relationships, better communication, less gossip, improved teamwork."

Discussion

The purpose of this project was to enhance NGNs' abilities to identify and respond to NB. Though there was no statistically significant increase in civility scores, the quantitative and qualitative results of Kirkpatrick's levels 1-4 indicate that participants found that participants were able to apply knowledge and skills learned from the intervention to improve communication, peer relationships, teamwork, and patient safety and care. These results were consistent with the literature. Participants' training reactions matched Clark et al. (2013) with reports of the training being favorable, important, had realistic scenarios, and heightened awareness of incivility. Additionally, the participants' intended acquisition of knowledge, skills, attitudes, and confidence aligned with Roberts et al. (2018) and Razzi and Bianchi's (2019) findings of increased awareness and learned how to identify, respond, and manage uncivil behaviors. Finally, targeted outcomes from applying behaviors were similar to Howard and Embree (2020); Clark and Gorton (2018); and Clark et al. (2014) as participants reported applying learned behaviors into the practice setting, such as addressing incivility and NB and communicating clearly.

In addition, the CWCI score increased from baseline to its highest at 5 months after the intervention. Although the difference was not statistically significant in this project, several factors might have influenced the result. First, the sample size was small (N=34) and focused only on NGNs with six months to one year of experience. NGNs might have had less exposure to incivility than experienced nurses. Second, the participant's baseline CWCI scores were moderate to very civil, allowing less room for improvement. Furthermore, the educational

booster of concepts offered to participants at 2.5 months may have contributed to increased CWCI scores at five months. The increase of CWCI scores supports that spaced learning principles, which are presenting concepts over time, can promote memory and learning (Kohn, 2014).

The results of this project were similar to other studies in the literature. Quality improvement (QI) projects by Hudson (2019) and Armstrong (2017) showed no statistically significant change of CWCI and incivility scores before and after intervention. Hudson's (2019) project focused on a professional accountability program through peer and coach training to nurture positive communication (N = 890) for multiple hospitals comparing CWCI scores pre-intervention and 45- and 90-days post-implementation. Armstrong's (2017) project implemented the CREW educational program (N = 9) and compared Workplace Incivility Scale scores pre-test and 14 days post-test. This suggests that even with large or small sample sizes and varying timeframes from 14 days to 90 days post-intervention found no statistical difference in civility or uncivility scores which could indicate that this instrument might not be sensitive to change measurement as a result of civility training education.

Stoddard's (2017) DNP project implemented on nurses and unit secretaries (N = 48) working in healthcare found a non-significant increase of CWCI scores measured at baseline, two weeks, and five months after implementation. However, the investigators found a statistically significant increase of CWCI scores three months after implementation. Sanner-Stiehr and Ward-Smith's (2015) study regarding training nursing students to address disruptive behaviors using cognitive rehearsal training showed a statistically significant ($p<.001$) increase in self-efficacy scores from pre- to post-test. However, the study did not achieve a statistically significant increase between post-test and three-month follow-up test scores in the intervention

or control group. (Sanner-Stiehr & Ward-Smith, 2015). Previous studies on nurse civility training and measurement were mixed. Stoddard's (2017) project found a significant increase of scores three months post-intervention in experienced nurses, but Sanner-Stiehr and Wardsmith's (2015) study did not see a significant increase in scores for nursing students. The exposure to job stress may explain the difference in scores.

Sustainability and next steps

In the future, the NB training can be expanded on a larger scale to future nurse residency programs, interprofessional teams, leadership and management development, charge nurse, preceptor, and experienced nurse educational offerings. After COVID-19 social distancing restrictions relax, education can be provided in person. Outcomes measurement can be evaluated for timeframes greater than six months to determine long-term impact. Furthermore, other instruments that measure workplace bullying or civility can be explored to identify the best to detect behavior change.

Limitations

The results of the project must be considered in the context of the following limitations. First, the sample size was small; however, the project's purpose was to implement an evidence-based educational program to enhance NGNs' ability to identify and respond to NB. Also, the education was delivered using an online platform during the COVID-19 pandemic due to social distancing restrictions. In person training could be beneficial to promote social skill development. Another limitation was the inability to collect facility bullying reports to determine if the intervention impacted reported bullying incidents. The tracking of bullying reports post-intervention is a measurable outcome of the participants' response to NB. These behaviors are critical as managers rely on reports and documentation to determine the next steps in taking

corrective action. Lastly, job stress may have been a factor in the lack of change in civility scores. Hashemi et al. (2018) indicated that job stress is negatively associated with workplace incivility ($p = 0.008$). NGNs during orientation might be under less stress than experienced nurses. Although there were limitations, the results were consistent with other projects and studies in the literature.

Conclusions

Despite the non-significant change in civility scores, this project found that mixed educational methodologies using simulation role play and cognitive rehearsal provided NGN with skills to identify and respond to NB. Implementing educational boosters is recommended to promote memory and learning of concepts. For a systematic approach to address workplace bullying, educational intervention may be considered for leadership, managers, charge nurses, experienced nurses, and interprofessional teams. There is a need to also explore other scales to measure workplace climate. Further investigation of effective interventions to prevent and combat bullying across all settings is needed to promote civility and support a safe environment.

Figure 1

NWH Healing Phases and Questions

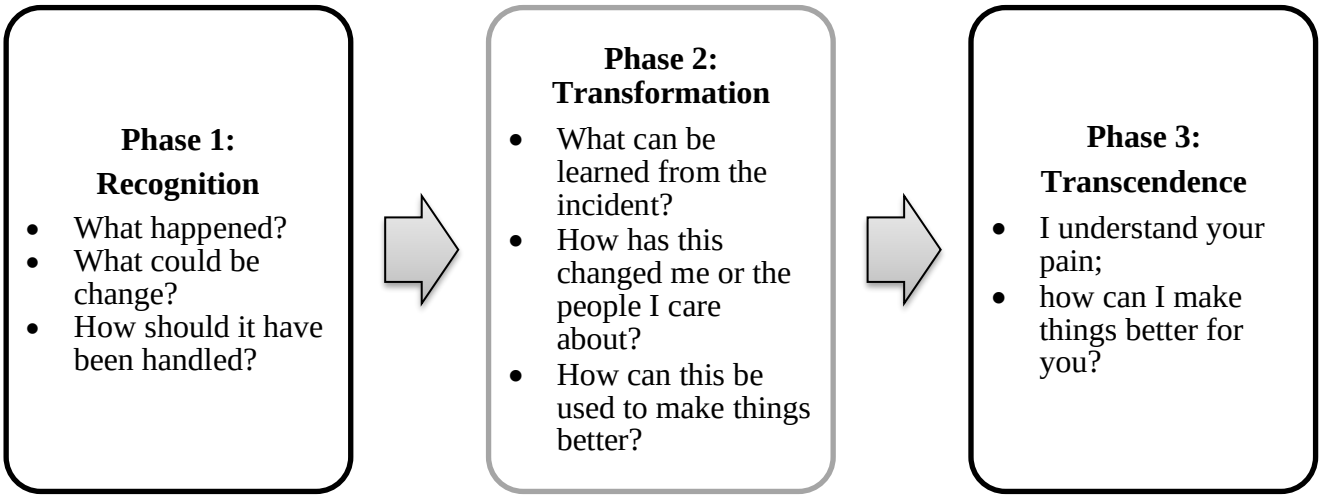

Table 1

NWH phases, Debriefing, and Learning Domains

NWH Theory Phases	Simulation Debriefing Questions	Learning Domains
Phase 1: Recognition →	1. How did this experience make you feel?	Affective domain
Phase 2: Transformation →	2. How did you feel in past situations when similar behaviors have occurred?	
Phase 1: Recognition →	1. Did you encounter any challenges while responding to some of these behaviors?	Cognitive domain
Phase 2: Transformation →	2. What other similar situations have you encountered in the past, and how did you respond in them?	
Phase 2: Transformation →	3. How could you apply these new response strategies to those past situations?	
Phase 3: Transcendence →	4. What are some other situations that could arise, and how could you apply these response strategies to responding to them?	

Table 2

Demographics (n = 36)

	Description	n	%
Gender	Female	30	83%
	Male	5	14%
	Non-binary	1	3%
Age	21-39 years old	33	92%
	40-55 years old	3	8%
Nursing Education	Baccalaureate	23	64%
	Master's degree	13	36%

Table 3

Kirkpatrick Level 1 and 2 (n = 31)

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I took responsibility for being involved in this training	3.23% (n=1)	0.00%	0.00%	35.48% (n=11)	61.29 (n=19)
This training held my interest	3.23% (n=1)	0.00%	0.00%	51.61% (n=16)	45.16% (n=14)
The presentation style of the facilitator contributed to my learning experience	3.23% (n=1)	0.00%	0.00%	35.48% (n=11)	61.29% (n=19)
The information in this training applies to my work	3.23% (n=1)	0.00%	0.00%	29.03% (n=9)	67.74% (n=21)
I would recommend this program to others	3.23% (n=1)	0.00%	0.00%	32.26% (n=10)	64.52% (n=20)
I know how to identify and manage workplace bullying incidents	3.23% (n=1)	0.00%	3.23% (n=1)	48.39% (n=15)	45.16% (n=14)
I can utilize the skills I learned to identify and manage workplace bullying right now	3.23% (n=1)	0.00%	9.68% (n=3)	41.94% (n=13)	45.16% (n=14)
I believe the information I learned from this course will be worthwhile to do on the job	3.23% (n=1)	0.00%	3.23% (n=1)	32.26% (n=10)	61.29% (n=19)

I think I can utilize the information learned from this course on the job	3.23% (n=1)	0.00%	3.23% (n=1)	35.48% (n=11)	58.06% (n=18)
I will utilize the information learned from this course on the job	3.23% (n=1)	0.00%	3.23% (n=1)	41.94% (n=13)	51.61% (n=16)

Figure 2

CWCI Scores

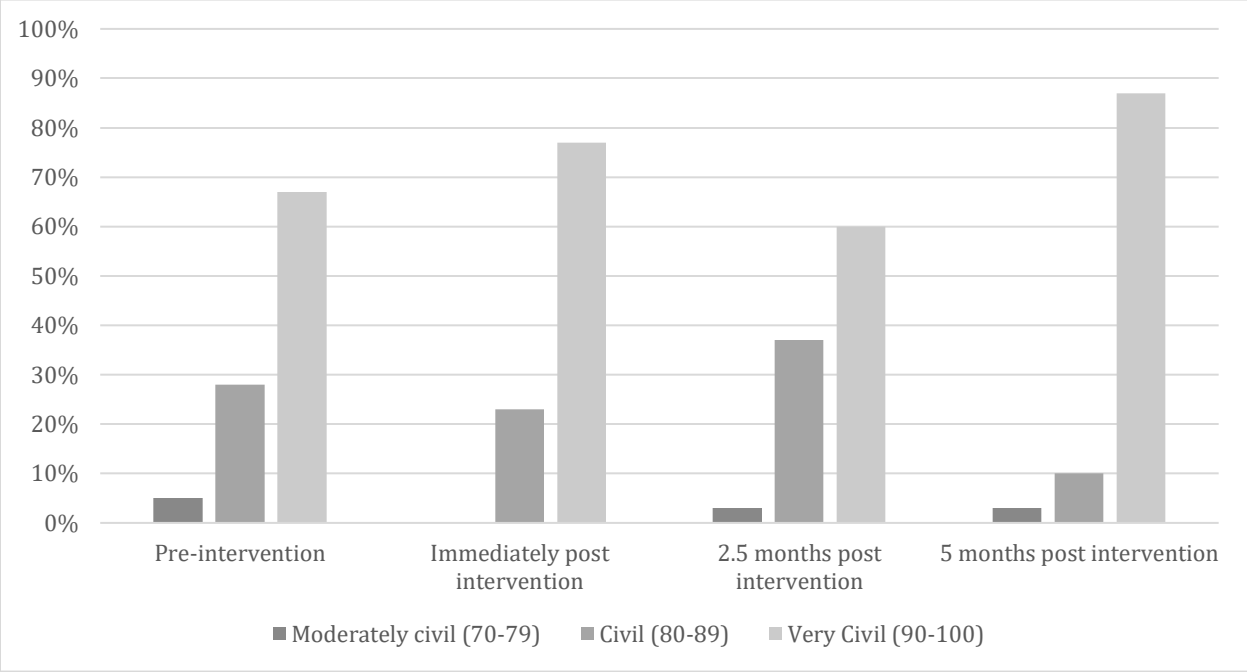

Table 4

CWCI Mean Rank Scores and Standard Deviation

	Mean	Std. Deviation	n
Pre-intervention	91.8889	6.74442	27
Immediate post-intervention	92.9630	6.02228	27
2.5 months post-intervention	92.7778	5.43729	27
5 months post-intervention	93.8148	5.64349	27

References

Abd-Elrhaman, E., & Ghoneimy, A. (2019). Effectiveness of educational program regarding professional nursing ethics on workplace civility. *International Journal of Nursing Didactics, 9,* 13-22. https://doi.org/10.15520/ijnd.v9i02.2439

Agency for Healthcare Research and Quality. (2020). Pocket guide: teamstepps. Retrieved from https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html#descscript

American Nurses Association. (2015). Incivility, bullying, and workplace violence. Retrieved from http://www.nursingworld.org/DocumentVault/Position-Statements/Practice/Position-Statement-on-Incivility-Bullying-and-Workplace-Violence.pdf

Armstrong, N. E. (2017). A quality improvement project measuring the effect of an evidence-based civility training program on nursing workplace incivility in a rural hospital using quantitative methods. *Online Journal of Rural Nursing and Health Care, 17*(1), 100-137. https://doi.org/10.14574/ojrnhc.v17i1.438

Arnetz, J., Fitzpatrick, L., Cotten, S., Jodoin, C., & Chang, C. (2019). Workplace bullying among nurses: Developing a model for intervention. *Violence Victims, 34*(2), 346-362. doi:10.1891/0886-6708.VV-D-17-00211

Ayasreh, I. R., Youssef, H. A., Ayasreh, F. A. (2015). Perception of nurses toward horizontal violence in health care settings in Taif City, Saudi Arabia. *International Journal of Science and Research, 4(*4), 1017-1023. Retrieved from https://www.researchgate.net/publication/274897179_Perception_of_Nurses_toward_Horizontal_Violence_in_ Health_Care_Settings_in_Taif_City_Saudi_Arabia

Berry, P., Gillespie, G., Gates, D., & Schafer, J. (2012). Novice nurse productivity following workplace bullying. *Journal Nursing Scholarship, 44*(1), 80-87. doi:10.1111/j.1547-5069.2011.01436.x

Bureau, J., Gagne, M., Morin, A., & Mageau, G. (2017). Transformational leadership and incivility: A multilevel and longitudinal test. *Journal of Interpersonal Violence, 36*(1-2), NP448–NP473. https://doi.org/10.1177/0886260517734219

Bureau of Labor Statistics. (2020). *Occupational outlook handbook, Registered Nurses*. U.S. Department of Labor. Retrieved from https://www.bls.gov/ooh/healthcare/registered-nurses.htm

Christie, W., & Jones, S. (2014). Lateral violence in nursing and the theory of the nurse as wounded healer. *Online Journal of Issues in Nursing, 19*(1). https://doi.org/10.3912/OJIN.Vol19No01PPT01

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

Clark, C. (2017). *Creating and sustaining civility in nursing education* (2nd ed.). Indianapolis, IN: Sigma Theta Tau International Publishing.

Clark, C. (2019a). Combining cognitive rehearsal, simulation, and evidence-based scripting to address incivility. *Nurse Educator, 44*(2), 64-68. doi:10.1097/NNE.0000000000000563

Clark, C. (2019b). Fostering a culture of civility and respect in nursing. *Journal of Nursing Regulation, 10*(1).

Clark, C., Ahten, S., & Macy, R. (2013). Using problem-based learning scenarios to prepare nursing students to address incivility. *Clinical Simulation in Nursing, 9*, e74-e83. doi:10.1016/j.ecns.2011.10.003.

Clark, C., Ahten, S., & Macy, R. (2014). Nursing graduates' ability to address incivility: Kirkpatrick's level-3 evaluation. *Clinical Simulation in Nursing, 10*, 425-431. http://dx.doi.org/10.1016/j.ecns.2014.04.005.

Clark, C., & Dunham, M. (2020). Civility mentor: A virtual learning experience. *Nurse Educator, 45*(4), 189-192. doi:10.1097/NNE.0000000000000757

Clark, C., & Gorton, K. (2019). Cognitive rehearsal, heartmath, and simulation: an intervention to build resilience and address incivility. The *Journal of Nursing Education, 58*(12), 690-697. doi:10.3928/01484834-20191120-03

Conti-O'Hare, M. (2002). *The theory of the nurse as a wounded healer: From trauma to transcendence.* Sudbury, MA: Jones and Bartlett Publishers.

Craft, J., Schivinski, E.L., & Wright, A. (2020). The Grim Reality of Nursing Incivility. *Journal for Nurses in Professional Development, 36*(1), 41–43. https://doi.org/10.1097/NND.0000000000000599

Crawford, C., Chu, F., Judson, L., Cuenca, E., Jadalla, A., Tze-Polo, L., & Garvida, R., Jr. (2019). An integrative review of nurse-to-nurse incivility, hostility, and workplace violence: A gps for nurse leaders. *Nursing Administration Quarterly, 43*(2), 138-156. doi:10.1097/NAQ.0000000000000338

Croft, R., & Cash, P. (2012). Deconstructing contributing factors to bullying and lateral violence in nursing using a postcolonial feminist lens. *Contemporary Nurse, 42*(2), 226-242. doi:10.5172/conu.2012.42.2.226

D'Ambra, A., & Andrews, D. (2014). Incivility, retention and new graduate nurses: An integrated review of the literature. *Journal of Nursing Management, 22*(6), 735-742. doi:10.1111/jonm.12060

Edmonson, C., & Zelonka, C. (2019). Our own worst enemies: The nurse bullying epidemic. *Nursing Administration Quarterly, 43*(3), 274-279. doi:10.1097/NAQ.0000000000000353

El-Aal, N., & Shousha, A. (2019). Factors associated with incivility behavior among post graduate nursing students. *Journal of Nursing and Health Science, 8*(5), 50-60. doi:10.9790/1959-0805095060

Embree, J., & White, A. (2010). Concept analysis: Nurse-to-nurse lateral violence. *Nursing Forum, 45*(3), 166-173. doi:10.1111/j.1744-6198.2010.00185.x

Etienne, E. (2014). Exploring workplace bullying in nursing. *Workplace Health Safety, 62*(1), 6-11. doi:10.1177/216507991406200102

Feeley, D. (2017). The triple aim or the quadruple aim: Four points to help set your strategy. Institute for Healthcare Improvement. Retrieved from http://www.ihi.org/communities/blogs/the-triple-aim-or-the-quadruple-aim-four-points-to-help-set-your-strategy

Gaba, D. (2004). The future vision of simulation in health care. *Quality and Safety in Health Care, 13* (1), i2-i10. doi:10.1136/qshc.2004.009878

Gilbert, R.T., Hudson, J.S., & Strider, D. (2016). Addressing the elephant in the room: Nurse manager recognition of and response to nurse-to-nurse bullying. *Nursing Administration Quarterly, 40*(3), E1–E11. https://doi.org/10.1097/NAQ.0000000000000175

Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *Journal of Continuing Education in Nursing, 35*(6), 257-263. https://doi.org/10.3928/0022-0124-20041101-07

Griffin, M., & Clark, C. (2014). Revisiting cognitive rehearsal as an intervention against

incivility and lateral violence in nursing: 10 years later. *Journal of Continuing Education in Nursing, 45*(12), 535-542. doi:10.3928/00220124-20141122-02

Howard, M., & Embree, J. (2020). Educational intervention improves communication abilities of nurses encountering workplace incivility. *Journal of Continuing Education in Nursing, 51*(3), 138-144. doi:10.3928/00220124-20200216-09

Hudson, R. (2019). *Peer accountability program to combat nurse incivility* (DNP Scholarly Project East Carolina University College of Nursing). Retrieved from the scholarship. http://hdl.handle.net/10342/7399

Johnson, S. L., & Rea, R. E. (2009). Workplace bullying: Concerns for nurse leaders. *The Journal of nursing administration*, *39*(2), 84–90. https://doi.org/10.1097/NNA.0b013e318195a5fc

Kang, J., Kim, J., & Yun, S. (2017). Effects of a cognitive rehearsal program on interpersonal relationships, workplace bullying, symptom experience, and turnover intention among nurses: A randomized controlled trial. *Journal of Korean Academy of Nursing*, *47*(5), 689. https://doi.org/10.4040/jkan.2017.47.5.689

Keller, R., Budin, W., & Allie, T. (2016). A task force to address bullying. *The American Journal of Nursing, 116*(2), 52-58. doi:10.1097/01.NAJ.0000480497.63846.d0

Kile, D., Eaton, M., deValpine, M., & Gilbert, R. (2019). The effectiveness of education and cognitive rehearsal in managing nurse-to-nurse incivility: a pilot study. *Journal of Nursing Management, 27*(3), 543-552. doi:10.1111/jonm.12709

Kim, J., Park, J., & Shin, S. (2016). Effectiveness of simulation-based nursing education depending on fidelity: A meta-analysis. *BMC Medical Education, 16*, 152. doi:10.1186/s12909-016-0672-7

King-Jones, M. (2011). Horizontal violence and the socialization of new nurses. *Creative Nursing, 17*(2), 80-86.

Kirkpatrick, J., & Kirkpatrick, W. (2016). *Kirkpatrick's four levels of training evaluation*. Alexandria, VA: Association for Talent Development.

Kirkpatrick Partners. (2009). The Kirkpatrick methodology – a brief history. Retrieved from https://www.kirkpatrickpartners.com/Our-Philosophy

Kohn, A. (2014). Brain science. Enable your brain to remember almost everything. Retrieved from https://learningsolutionsmag.com/articles/1423/brain-science-enable-your-brain-to-remember-almost-everything

Lasater, K., Mood, L., Buchwach, D., & Dieckmann, N. (2015). Reducing incivility in the workplace: Results of a three-part educational intervention. *The Journal of Continuing Education in Nursing, 46*(1), 15-24; https://doi.org/10.3928/00220124-20141224-01

Lee, H., Hsu, M., Li, P., & Sloan, R. (2013). 'Struggling to be an insider': A phenomenological design of new nurses' transition. *Journal of Clinical Nursing, 22*(5-6), 789-797. doi:10.1111/j.1365-2702.2012.04189.x

Matheson, L., & Bobay, K. (2007). Validation of oppressed group behaviors in nursing. *Journal of Professional Nursing, 23*(4), 226-234. doi:10.1016/j.profnurs.2007.01.007

McLeroy, K., Bibeau, D., Steckler, A., & Glanz, K. (1998). An ecological perspective on health promotion programs. *Health Education Quarterly, 15*, 351-377.

Myers, G., Cote-Arsenault, D., Worral, P., Rolland, R., Deppoliti, D., Duxbury, E., Sellers, K. (2016). A cross-hospital exploration of nurses' experiences with horizontal violence. *The Journal of Nursing Management, 24*(5), 624-633. doi:10.1111/jonm.12365

National League for Nursing. (2017). Tri-council for nursing issues proclamation on nursing

civility. Retrieved from http://www.nln.org/docs/default-source/newsroom/tri-council-civility-proclamation-draft-2-krk-bm-tri-092617.pdf?sfvrsn=2

Northam, S. (2000). Cognitive rehearsal. *Nurse Educator, 25*(1), 19-20. doi:10.1097/00006223-200001000-00013

Olsen, J., Aschenbrenner, A., Merkel, R., Pehler, S., Sargent, L., & Sperstad, R. (2020). A mixed-methods systematic review of interventions to address incivility in nursing. *Journal of Nursing Education, 59*(6), 319-326. doi:10.3928/01484834-20200520-04

PACERS. (2015). Civility tool-kit: resource to empower healthcare leaders to identify, intervene, and prevent workplace bullying. Retrieved from http://stopbullyingtoolkit.org/

Parker, K., Harrington, A., Smith, C. M., Sellers, K., & Millenbach, L. (2016). Creating a nurse-led culture to minimize horizontal violence in the acute care setting: a multi-interventional approach. *J Nurses Prof Dev, 32*(2), 56-63. doi:10.1097/NND.0000000000000224

Pfeifer, L. E., & Vessey, J. A. (2017). An integrative review of bullying and lateral violence among nurses in Magnet® Organizations. *Policy, politics & nursing practice*, *18*(3), 113–124. https://doi.org/10.1177/1527154418755802

Przychodzen, K. (2018). Lateral violence in nursing: how to prevent bullying and create a healthy work environment. National Commission on Correctional Health Care. Retrieved from http://www.corrections.com/news/article/47453-lateral-violence-in-nursing-how-to-prevent-bullying-and-create-a-healthy-work-environment

Press Ganey Associates. (2018). 2018 NDNQI RN Survey with practice environment scale. Retrieved from https://www.upstate.edu/nursing/documents/ndnqi_rn_survey_with_pratice_environment

_scale.pdf

Purpora, C., Cooper, A., Sharifi, C., & Lieggi, M. (2019). Workplace bullying and risk of burnout in nurses: A systematic review protocol. *JBI Database Systematic Review Implementation Reports, 17*(12), 2532-2540. doi:10.11124/JBISRIR-D-19-00019

Rainford, W., Wood, S., McMullen, P., & Nanya, P. (2015). The disruptive force of lateral violence in the health care setting. *The Journal for Nurse Practitioners, 11*(2), 157-164. doi:https://doi.org/10.1016/j.nurpra.2014.10.010

Razzi, Catherine C, & Bianchi, Ann L. (2019). Incivility in nursing: Implementing a quality improvement program utilizing cognitive rehearsal training. *Nursing Forum, 54*(4), 526-536.

Roberts, T., Hanna, K., Hurley, S., Turpin, R., & Clark, S. (2018). Peer training using cognitive rehearsal to promote a culture of safety in health care. *Nurse Educator, 43*(5), 262-266. doi:10.1097/NNE.0000000000000478

Rush, K., Adamack, M., Gordon, J., & Janke, R. (2014). New graduate transition programs: relationships with access to support and bullying. *Contemporary Nurse*. doi:10.5172/conu.2013.4287

Sanner-Stiehr, E. (2017). Using simulation to teach responses to lateral violence: Guidelines for nurse educators. *Nurse Educator, 42*(3), 133-137. doi:10.1097/NNE.0000000000000326

Sanner-Stiehr, E. (2018). Responding to disruptive behaviors in nursing: A longitudinal, quasi-experimental investigation of training for nursing students. *Nurse Educator Today, 68*, 105-111. doi:10.1016/j.nedt.2018.05.029

Sanner-Stiehr, E., & Ward-Smith, P. (2017). Lateral violence in nursing: Implications and strategies for nurse educators. *Journal of Professional Nursing, 33*(2), 113-118.

doi:10.1016/j.profnurs.2016.08.007

Sauer, P., Thompson, C., & Verzella, M. (2018). Empowering nursing students to address incivility. *Clinical Simulation in Nursing, 21*, 40-45. https://doi.org/10.1016/j.ecns.2018.06.004.

Smith, C., Gillespie, G., Brown, K., & Grubb, P. (2016). Seeing students squirm: Nursing students' experiences of bullying behaviors during clinical rotations. *Journal of Nursing Education, 55*(9), 505-513. doi:10.3928/01484834-20160816-04

Spence Laschinger, H., Leiter, M., Day, A., Gilin-Oore, D., & Mackinnon, S. (2012). Building empowering work environments that foster civility and organizational trust: Testing an intervention. *Nursing Research, 61*(5), 316-325. doi:10.1097/NNR.0b013e318265a58d

Stagg, S. J., & Sheridan, D. (2010). Effectiveness of bullying and violence prevention programs. *AAOHN journal: official journal of the American Association of Occupational Health Nurses, 58*(10), 419–424. https://doi.org/10.3928/08910162-20100916-02

Stagg, S.J., Sheridan, D.J., Jones, Ruth, A., & Speroni, K.G. (2013). Workplace bullying: The effectiveness of a workplace program. *Workplace Health & Safety*, *61*(8), 333–338. https://doi.org/10.3928/21650799-20130716-03

Stoddard, J. (2017). *Civility matters: Overcoming workplace incivility using an interactive education intervention.* The University of New Mexico Digital Repository. https://digitalrepository.unm.edu/dnp/1/

The Joint Commission. (2016). Quick safety 24: Bullying has no place in health care. Retrieved from https://www.jointcommission.org/en/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-24-bullying-has-no-place-in-health-care/bullying-has-no-place-in-health-care

Vessey, J. A., Demarco, R., & DiFazio, R. (2010). Bullying, harassment, and horizontal violence in the nursing workforce: The state of the science. *Annual Review of Nursing Research, 28*, 133-157. doi:10.1891/0739-6686.28.133

Workplace Bullying Institute. (2018). WBI U.S. workplace bullying survey. Retrieved from http://www.workplacebullying.org/wbiresearch/wbi-archive/#pubs

Appendix A

Training Description

2.75-hour training. Learning outcomes were determined to guide learning objectives and learning activities. Theoretical frameworks that guide the intervention are the Nurse as Wounded Healers, Kolb's experiential learning, and Knowles' adult learning principles. The evidence-based educational intervention includes a didactic session on nursing bullying, simulation scenarios using the cognitive rehearsal cue card, and debriefing. Cognitive rehearsal cue card and training agenda below.

Cognitive rehearsal cue card (Griffin & Clark, 2014, p. 540)

COMMON UNCIVIL BEHAVIORS AMONG NURSES WITH ASSOCIATED COGNITIVE REHEARSAL RESPONSES[a]

Uncivil Behavior	Verbal Response
Using nonverbal behaviors or innuendo (e.g., eye-rolling, making faces, deep sighing)	"I sense/see from your facial expression that there may be something you wish to say to me. It is OK to speak to me directly."
Name-calling, verbal affronts, demeaning comments, putdowns, sarcastic remarks	"I learn best from individuals who address me with respect and who value me as a member of the team. Is there a way we can structure this type of interaction?"
Using silent treatment or withholding important information	"It is my understanding that there was/is more information available regarding this situation. Please share any other important information since patient care depends on a full report."
Using anger, humiliation, and intimidation	"When the words that I hear make me fearful or shamed, I need to seek a respectful professional explanation. What was your intent?"
Spreading rumors, gossiping, failing to support, sabotaging a coworker, or sharing information you were asked to keep private	"I don't feel right talking about him/her/situation when I wasn't there and don't know the facts. Perhaps the information was taken out of context. I suggest you check it out with him/her."
Making fun of another nurse's appearance, demeanor, or personality trait	"She/he is a valuable member of the team and deserves our support. How can we be more inclusive and work more efficiently as a team?"
Failing to support or encouraging others to turn against a coworker	"I am not feeling like a valued coworker. Can we approach this differently? What helped you to fit in here?"
Taking credit for others' work, ideas, or contributions	"I didn't expect your nonsupport. Behaving this way is unprofessional and makes me feel disrespected. How can we work together and support one another?"
Distracting and disrupting others during meetings	"Can I speak with you about your sense of urgency in our meetings? It distracts me and interrupts my thoughts."

[a] Excerpts from Clark, 2013b; Dellasega, 2009; and Griffin, 2004.

Training Agenda

Topic	Time allotted
Introduction and learning objectives Professional organizations viewpoints Workplace violence definitions Statistics and prevalence	30 minutes
Contributing and precipitating factors Theories Consequences	30 minutes
Organizational policies Prevention and management of NB	20 minutes
Simulation, role-play, and cognitive rehearsal Present simulation scenarios Debrief and polling	65 minutes
Conclusions and takeaways Resources References	20 minutes
Total time	165 minutes

Appendix B

Clark Workplace Civility Index (Clark, 2017) Used with permission

Completing the Clark Workplace Civility Index: 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. Circle 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.

Ask yourself, how often do I:	(1) Never (2) Rarely (3) Sometimes (4) Usually (5) Always
1. Assume goodwill and think the best of others	1 2 3 4 5
2. Include and welcome new and current colleagues	1 2 3 4 5
3. Communicate respectfully (by e-mail, telephone, face-to-face) and really listen—	1 2 3 4 5
4. Avoid gossip and spreading rumors	1 2 3 4 5
5. Keep confidences and respect others' privacy	1 2 3 4 5
6. Encourage, support, and mentor others	1 2 3 4 5
7. Avoid abusing my position or authority	1 2 3 4 5
8. Use respectful language (no racial, ethnic, sexual, age, or religiously biased terms)	1 2 3 4 5
9. Attend meetings, arrive on time, participate, volunteer, and do my share	1 2 3 4 5
10. Avoid distracting others (misusing media, side conversations) during meetings	1 2 3 4 5
11. Avoid taking credit for another individual's or team's contributions	1 2 3 4 5
12. Acknowledge others and praise their work/contributions	1 2 3 4 5
13. Take personal responsibility and stand accountable for my actions	1 2 3 4 5
14. Speak directly to the person with whom I have an issue	1 2 3 4 5
15. Share pertinent or important information with others	1 2 3 4 5
16. Uphold the vision, mission, and values of my organization	1 2 3 4 5
17. Seek and encourage constructive feedback from others	1 2 3 4 5
18. Demonstrate approachability, flexibility, and openness to other points of view	1 2 3 4 5
19. Bring my 'A' Game and a strong work ethic to my workplace	1 2 3 4 5
20. Apologize and mean it when the situation calls for it	1 2 3 4 5

Scoring the Civility Index: Add up the number of 1-5 responses to determine your 'civility' score

90-100—Very civil
80-89—Civil
70-79—Moderately civil
60-69—Minimally civil
50-59—Uncivil
Less than 50—Very uncivil

Appendix C

Kirkpatrick Level 1 and 2 Evaluation: Post-Training Participant Survey

Instructions: Think about the course you just completed; please indicate what degree you agree with each statement using the rating scale.

	Strongly Disagree				Strongly Agree
"I took responsibility for being involved in this training."	1	2	3	4	5
"This training held my interest."	1	2	3	4	5
"The presentation style of the facilitator contributed to my learning experience."	1	2	3	4	5
"The information in this training applies to my work."	1	2	3	4	5
" I would recommend this program to others."	1	2	3	4	5
"I know how to identify and manage workplace bullying incidents."	1	2	3	4	5
"I can utilize the skills I learned to identify and manage workplace bullying right now."	1	2	3	4	5
"I believe the information I learned from this course will be worthwhile to do on the job."	1	2	3	4	5
"I think I can utilize the information learned from this course on the job."	1	2	3	4	5
"I will utilize the information learned from this course on the job."	1	2	3	4	5

(J. Kirkpatrick & W. Kirkpatrick, 2016, p.15 & 101)

Appendix D

Kirkpatrick Level Three and Four: 2.5- and 5-months post-training Participant Survey

Instructions: Think about the course you completed 2 months ago; please provide a detailed response to the questions below.

1. How have you used what you learned in the training on the job?
2. What helped you implement what you learned?
3. Describe any challenges you experienced in applying what you learned to your work.
    a. What are possible solutions to overcome them?
4. Describe any impact on your practice as a result of applying what you learned from the training (ie. an increase or decrease in: patient care, productivity, communication, peer relationships, teamwork, or other).

(J. Kirkpatrick & W. Kirkpatrick (2016), p. 113-115)