ORIGINAL RESEARCH

Addressing nursing incivility: A faculty development initiative

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ABSTRACT

Background/objective: Nursing incivility is a widespread issue experienced by more than 85% of nurses in the U.S. Approximately 30%-71% of nursing faculty consider incivility a moderate to severe problem. Incivility is commonly known as "horizontal violence" or "bullying" and can include behaviors such as minor annoyances, distractions, or acts of violence. Incivility has negative effects on faculty well-being, including physical/emotional distress, reduced job satisfaction, and increased turnover. This quality improvement (QI) project aimed to explore faculty perspectives on incivility and evaluate the effects of a multifaceted educational intervention in reducing nursing faculty-perceived frequency of student incivility behaviors.

Methods: A descriptive, pre–post design was used to assess changes in faculty-reported incivility using the Incivility in Nursing Education-Revised (INE-R) survey. Multifaceted interventions, incorporating multiple strategies such as increasing awareness, cognitive rehearsal, and reflective learning, were integrated into the educational intervention. The intervention was completed with nursing faculty, and the INE-R survey was utilized to measure faculty perceptions of the severity/frequency of student incivility behaviors before and after the intervention. Pre- and post-intervention data were collected and evaluated using the Wilcoxon Signed Rank Test and other descriptive statistics.

Results: The Wilcoxon Signed-Rank test comparing the median of the differences between pre- and post-composite scores revealed a statistically significant reduction in frequency ($Z = -2.10$, $p = .03$). The mean INE-R frequency scores decreased from 2.3 (SD = 2.3) pre-intervention to 1.9 (SD = 1.9) post-intervention, reflecting a 17.4% reduction in the perceived frequency of student incivility.

Conclusions: Nursing programs should sustain civility initiatives through ongoing multifaceted educational interventions integrated into faculty development and institutional policies. Expanding these interventions across programs and institutions can strengthen the culture of civility and promote positive change in nursing education.

Key Words: Faculty development, Incivility in nursing education, Nursing academia, Nursing incivility

1. INTRODUCTION

While nursing is inherently defined by kindness and caring, incivility within the field is a well-documented reality affecting clinical practice and nursing education. Nursing incivility is a widespread issue experienced by more than 85% of nurses in the United States.[1] In academia, 30 to 71% of nursing faculty consider incivility a moderate to severe problem.[2] Incivility is commonly known as "horizontal violence" or "bullying" and can include a spectrum of behaviors, from minor annoyances, distractions, or acts of violence.[3] Others define incivility as rude or disruptive behaviors that can cause significant distress to the target and may even develop into threatening circumstances.[4] Nursing incivility's devastating and far-reaching effects have recently become a

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significant concern. Incivility has a negative impact on faculty well-being, leading to physical and emotional distress, reduced job satisfaction, and increased turnover.[5]

This pervasive global problem has demanded the attention of numerous organizations. The American Nurses Association (2015) emphasizes the importance of addressing this issue in every facet of nursing, including nursing education.[6] Rather than a single approach, the most effective interventions use a multi-faceted strategy, combining awareness raising, hands-on skills development (cognitive rehearsal), and self/peer reflection.[5,7,8] In a recent survey, most faculty at a local Northwestern nursing college identified incivility as a top concern, highlighting the need for institutional attention. This faculty development initiative and quality improvement project will provide high-quality educational interventions for nursing faculty to reduce the faculty-perceived frequency of nursing incivility.

1.1 Aim

This quality improvement (QI) project aimed to explore faculty perspectives on incivility and evaluate the effects of a multi-faceted educational intervention in reducing nursing faculty-perceived frequency of student incivility behaviors at a nursing college. Changes in faculty-perceived incivility will be measured quantitatively using the Incivility in Nursing Education-Revised (INE-R) tool, both before and after the intervention. The project objective relates to the following PICOT question: In nursing faculty (P), how does an educational intervention on nursing incivility (I), compared to no intervention (C), affect faculty-reported occurrences and perceptions of nursing incivility (O) 3 months after implementation (T)? The objectives of this project included: (a) a 5% reduction in the mean score of faculty-perceived frequency of student-incivility behaviors, as measured by the INE-R tool, comparing within two weeks prior to the intervention and two months post-intervention, and b) a 75% participation rate among full-time nursing faculty for the entirety of the educational intervention.

1.2 Literature review

An extensive literature review revealed three themes: barriers/risk factors to nursing incivility, nursing faculty perceptions, and effective interventions to decrease nursing incivility.

1.2.1 *Barriers and risk factors*

Four articles noted that stress and workload are frequently cited as contributing factors to incivility.[9–11] Other barriers include the unjustified exertion of power or power imbalances, particularly among faculty[5,11] and the lack of institutional policies that foster a culture of civility.[5,11,12] Finally, societal and cultural norms, including communication and language differences, also contribute to incivility in nursing.[9,11,13]

1.2.2 *Nursing faculty perceptions*

Five articles revealed that faculty perceptions and experiences of incivility in nursing education are a pervasive problem with multifaceted dimensions and significant consequences. The prevalence and nature of incivility are widely acknowledged by faculty.[1,2] Faculty members experience incivility in a variety of forms, which include disruptive student behaviors such as engaging in distracting conversations, demonstrating lateness/inattentiveness in class, and exhibiting general taunts or disrespect.[8,11,14] Small et al. (2023) reported that 93% of faculty perceive incivility as a significant issue.[11] The impact of incivility on faculty is substantial. Emotional and psychological distress, including anxiety, depression, diminished self-confidence, and lowered morale, are frequently reported consequences.[5,7] Sherrod and Lewallen (2021) established a significant relationship between workplace incivility and physical ailments, specifically demonstrating that for every additional point increase in their Workplace Incivility Scale score, faculty reported a significant increase in headaches (b = 0.071, 95% CI [0.042, 0.101], $p < .001$), digestive problems (b = 0.021, 95% CI [0.010, 0.032], $p < .001$), and sleep disturbances (b = 0.042, 95% CI [0.015, 0.068], $p = .002$).[10]

1.2.3 *Effective interventions*

Six articles discussed multi-component educational interventions to combat incivility.[5,7,12] One critical intervention is to increase awareness of the issue and develop clear policies within the organization to establish a culture of respect and civility.[1,5,11,12,14] Implementing formal faculty training and mentorship programs is another effective strategy.[5,8,12,15,16] Abedini et al. (2023) found a significant reduction in perceived ($t(80) = 6.59$, $p < .05$) and actual ($t(80) = 6.80$, $p < .05$) incivility among nursing faculty and students (N = 97) following a civility management program.[15] Another virtual educational program on civility behaviors evaluated by Opsahl et al. (2021) resulted in a significant improvement in participants' perceived level of civil behaviors, as evidenced by a statistically significant increase in Clark Workplace Civility Index (CWCI) scores from pretest (M = 91.00) to posttest (M = 95.16) ($t(49) = -4.60$, $p \leq .000015$).[8] Other recommended interventions include cognitive rehearsal/role-playing and self/peer reflective learning.[7,8,17] Based on their mixed-methods systematic review, Olsen et al. (2020) found the most support for multi-faceted interventions incorporating educational strategies such as increasing awareness, skill application (cognitive rehearsal and role-playing), and reflective learning to enhance the learning process.[7]

Validated tools like the INE-R and CWCI are recommended for assessing nursing incivility in educational settings.[16,18] The INE-R shows strong reliability, with Cronbach's alpha coefficients ranging from 0.94 to 0.98 across its subscales, and validity supported by factor analyses ($p \leq 0.05$).[19] The CWCI also demonstrates good reliability (α = 0.82) and acceptable validity with factor loadings above 0.30.[20] Together, these tools capture the complexity of incivility and faculty perceptions and inform multi-component interventions. In summary, the literature highlights that incivility in nursing education is a complex phenomenon, encompassing various risk factors that impact faculty perceptions and necessitate multifaceted interventions for effective resolution.

2. METHODS

2.1 Study design

This QI project aimed to evaluate nursing faculty perceptions and experiences of incivility and the impact of a multi-component educational intervention on faculty-perceived frequency of student incivility behaviors. A descriptive, pre–post design was used to assess changes in faculty-reported incivility using the INE-R survey. Data were collected at two time points: within two weeks prior to the intervention (Time 1) and two months following the intervention (Time 2). This QI project followed the Standards for Quality Improvement Reporting Excellence (SQUIRE 2.0) guidelines to ensure a structured reporting of quality improvement processes and outcomes.[21]

2.2 Intervention

The intervention was a two-day educational program scheduled for August 2025, prior to the start of the fall 2025 school semester. It consisted of three integrated components: (a) Awareness and policy review: An online lecture introducing the concept of incivility in nursing education, including definitions, statistics, risk factors, and consequences. This session also reviewed specific campus policies related to professional conduct, emphasizing fostering a civil academic environment; (b) Cognitive rehearsal and role-playing: A live, interactive session incorporating evidence-based cognitive rehearsal techniques. Faculty will be engaged in scenario-based role-playing to practice responding to uncivil behaviors in academic settings; (c) Reflective Practice: A facilitated peer and individual reflection session utilizing the Clark Workplace Civility Index to promote critical thinking and self-awareness regarding civility in the workplace. Each component lasted about 1-2 hours. This multi-modal intervention addressed incivility by combining increased awareness, cognitive rehearsal, and reflective practice, aligning with recommendations for multi-component strategies.

2.3 Setting and participants

This QI project was conducted at a private nursing college in Midwestern Idaho. The target population comprised a purposive convenience sample of full-time nursing faculty teaching in the LPN, BSN, or Master's Entry Program in Nursing (MEPN). At the time of the project, the college employed 10 BSN/MEPN and 6 LPN faculty (N = 16). Although the two-day educational intervention was offered to all faculty, including part-time and per-diem instructors, only full-time faculty who met the study criteria were included in data collection and analysis. Inclusion criteria were: (1) full-time employment status; (2) active teaching in the LPN, BSN, or MEPN programs during the intervention period; and (3) completion of both the intervention and pre-/post-surveys. Exclusion criteria included: (1) individuals who did not meet the above inclusion criteria (e.g., non-nursing or general education faculty, or faculty at other campuses); and (2) eligible faculty who did not complete the full intervention and both surveys. Contextual factors at the project site included chronic faculty shortages, high turnover, general faculty burnout, and social/cultural differences between faculty and students.

An a priori power analysis conducted in G*Power using an effect size of .50, α = .05, power = .80, and df = 1 indicated that a minimum of 32 participants were required.[22] However, because the institution employed only 16 full-time nursing faculty, a census of the eligible full-time faculty (purposive convenience sample) was used. All full-time faculty meeting the inclusion criteria were invited to participate in data collection and outcome analysis. Demographic data collected included years of academic teaching experience (categorized), highest degree earned, age range, race, and gender identity. Sex was self-reported as male, female, or other. These variables were analyzed descriptively and explored in relation to faculty-reported levels of incivility.

2.4 Measurement tools

The INE-R instrument was used to measure faculty perceptions of the severity and frequency of student incivility behaviors. The INE-R Survey was selected for this project due to its strong psychometric properties, including demonstrated validity and reliability in nursing education settings.[19] Clark et al. (2015) reported high internal consistency with Cronbach's a $\geq$ .94 for lower and higher-level incivility subscales and total a of $\geq$ .96 for student behaviors and $\geq$ .98 for faculty behaviors.[19] Validity was supported through exploratory factor analysis, which revealed a two-factor structure (lower-level and higher-level incivility) with a good model fit.

2.5 Data collection and analysis

The INE-R asked respondents to rate the frequency of 24 uncivil student behaviors over the past two months using a four-point Likert scale: Never, Rarely, Sometimes, and Often. For analysis, responses were assigned to ordinal values (Never = 1 to Often = 4), and a composite incivility frequency score was calculated for each participant by summing responses across the student behavior items. These scores were then compared between pre-intervention (T1) and post-intervention (T2) time points. To evaluate the primary objective, a 5% reduction in the mean score of faculty-perceived frequency of student-incivility behaviors, the percentage change in the mean incivility score was calculated to assess practical significance and evaluate whether the reduction goal was met. To evaluate the secondary objective, achieving a 75% participation rate among full-time nursing faculty, attendance data were collected through sign-in sheets. The participation rate was calculated and interpreted descriptively.

The second part of the INE-R asked respondents to rate the level of incivility or severity for each of the same 24 behaviors using a four-point Likert scale: Not uncivil, Somewhat uncivil, Moderately uncivil, and Highly uncivil. In addition to the frequency and severity scales, the INE-R contains nine supplementary items in the third section, comprising Likert, categorical, and open-ended questions that explore the perceived prevalence, impact, and context of incivility. These items will be examined with descriptive statistics to broaden the picture of faculty views. Three project-specific open-ended questions were added: (1) faculty preparedness and confidence in addressing incivility (collected at both time points); (2) perceived usefulness of the intervention (post-intervention only); and (3) perceptions of when student incivility is most likely to occur in the school year (collected at both time points). INE-R responses, added questions, and demographic data were collected electronically and entered into SPSS v. 31 for statistical analysis. Descriptive statistics summarized the sample; ratio-level variables were evaluated with paired *t*-tests, nominal data with McNemar's test, and ordinal data with the Wilcoxon signed-rank test. Statistical significance was set at $p \leq .05$.

2.6 Ethical considerations

This project was reviewed by the University of Missouri Institutional Review Board (Project #2128801) and was determined not to constitute human subjects research. The activity was classified as a quality improvement initiative and did not require further IRB oversight. Additional approval was obtained from the project site organization prior to implementation. Participation was voluntary, and informed consent was obtained prior to completing the survey. Survey data were collected via Google Forms and exported into Microsoft Excel, where they were saved on an encrypted, password-protected laptop accessible only to the principal investigator. Data was then analyzed through SPSS. Data will be retained for five years after the intervention and then permanently deleted.

2.7 Timeline

The nursing faculty completed the first INE-R survey in July 2025, and the two-day educational intervention was conducted in mid-August 2025. The post INE-R survey was conducted in the first two weeks of October 2025. This research did not receive any specific grant from funding agencies in the public, commercial, or non-profit sectors.

3. Results

3.1 Demographics

Of the 16 full-time nursing faculty employed at the institution, 12 faculty members completed the survey at T1. Of these, eight participants attended the entire QI intervention and completed both surveys. Only those eight who attended the intervention and completed both surveys at T1 and T2 were included in the analysis. The age range of the eight faculty was 31 to 61+ years, with a mean score of 50.4 years (SD = 6.1) and a predominant age category of 41-50 years (50%, n = 4). Years of nursing academic teaching experience ranged from < 1 year to 10+ years, with a mean categorical score of 3.1 years (SD = 1.1), indicating that most participants had between 2 and 10 years of experience. The highest degree earned was predominantly a master's degree (87.5%, n = 7), followed by a bachelor's degree (12.5%, n = 1). The predominant race was White/Caucasian (75%, n = 6), with the remaining participants identifying as members of other racial or ethnic groups (25%, n = 2). The sample consisted of 62.5% females (n = 5) and 37.5% males (n = 3). Table 1 presents a summary of the demographic characteristics of the nursing faculty participants.

For the post-intervention analysis, Mann-Whitney U tests revealed no statistically significant associations between faculty perceptions of the severity of incivility and the highest degree earned ($p \geq .25$) or gender ($p \geq .07$). There were also no significant associations between faculty-perceived frequency of incivility and the highest degree earned ($p \geq .25$). However, Mann-Whitney U tests did reveal a significant association between faculty-perceived frequency of incivility and gender for two individual items: "Making rude gestures or other inappropriate non-verbal behaviors toward others" ($p = .036$) and "Skipping class or other scheduled activities" ($p = .036$). Kruskal-Wallis tests indicated no significant

associations between faculty perceptions of the severity of incivility and years of teaching experience ($p \geq .292$), age ($p \geq .25$), or race ($p \geq .130$). Likewise, there were also no significant associations between faculty-perceived frequency of incivility and years of teaching experience ($p \geq .145$), age ($p \geq .072$), and race ($p \geq .185$).

Table 1. Demographic characteristics of nursing faculty participants (N = 8)

Variable	Category	n	%
Age range	21-30	0	0
	31-40	1	12.5
	41-50	4	50
	51-60	1	12.5
	61+	2	25
Years of academic teaching experience	< 1 year	1	12.5
	1-2 years	0	0
	2-5 years	5	62.5
	5-10 years	1	12.5
	10+ years	1	12.5
Highest degree earned	BSN	1	12.5
	MSN	7	87.5
	DNP or PhD	0	0
Race	American Indian/Alaska Native	1	12.5
	Asian	0	0
	Black/African American	0	0
	Hispanic	1	12.5
	Native Hawaiian or other	0	0
	Pacific Islander	0	0
	White/Caucasian	6	75
	Two or more races	0	0
Gender	Female	5	62.5
	Male	3	37.5
	Other (specify)	0	0

Note. N = 8. Percentages are based on the total number of participants. No participants selected "Other" for gender.

3.2 Severity and frequency

When evaluating the INE-R, the Wilcoxon Signed-Rank Test was used to determine the effect of the intervention on faculty perceptions of student incivility, specifically the severity and frequency of uncivil student behaviors. For the severity subscale, results revealed a small-to-moderate but nonsignificant decrease in faculty-perceived severity of student incivility behaviors following the educational intervention. The median severity score decreased from Mdn = 2.98, IQR = 2.23-3.65 at pretest to Mdn = 2.44, IQR = 1.85-3.46 at posttest, suggesting that faculty perceived student incivility as less severe after the intervention. However, the Wilcoxon Signed-Rank Test comparing the median of the differences between pre- and post-composite scores was not statistically significant (Z = -1.18, p = .23).

For the frequency subscale, the Wilcoxon Signed-Rank Test revealed a large statistically significant decrease in faculty-perceived frequency associated with several individual items, including: "Sleeping or doing work unrelated to class activities" (p = .034, A = 0.81), "Using a computer, phone, or other media device during class, meetings, activities for unrelated purposes" (p = .023, A = 0.88), "Arriving late for class or other scheduled activities" (p = .011, A = 0.94), and "Skipping class or other scheduled activities" (p = .024, A = 0.88). The median frequency score decreased from Mdn = 2.17, IQR = 1.98-2.69 at the pretest to Mdn = 1.77, IQR = 1.58-2.08 at posttest, indicating that faculty perceived these behaviors as occurring less often after the intervention. The Wilcoxon Signed-Rank test comparing the median of the differences between pre- and post-composite scores revealed a statistically significant reduction in frequency (Z = -2.10, p = .03). The mean INE-R frequency scores also decreased from 2.3 (SD = 2.3) pre-intervention to 1.9 (SD = 1.9) post-intervention, reflecting a 17.4% reduction in the perceived frequency of student incivility. Table 2 presents the pre- and post-intervention INE-R composite scores for the severity and frequency subscales.

Table 2. Pre- and post-intervention INE-R composite scores (N = 8)

	Pre Mdn (IQR)	Post Mdn (IQR)	Z	*p*	Interpretation
Severity	2.98 (2.23-3.65)	2.44 (1.85-3.46)	-1.18	.23	Small, nonsignificant decrease
Frequency	2.17 (1.98-2.69)	1.77 (1.58-2.08)	-2.10	.03	Large, significant decrease

Notes. Z = Wilcoxon Signed-Rank Test statistic. $p < .05$ indicates statistical significance.

3.3 Perceived extent of incivility

To complement these quantitative findings, faculty's responses to the nine supplemental INE-R items provided additional insight into their experiences and perceptions of incivility. Faculty were asked to rate the extent to which incivility was a problem within their department or program. A Wilcoxon signed-rank test was conducted to evaluate changes in faculty perceptions of the overall extent of incivility from pre- to post-intervention. Faculty ratings showed a downward trend following the intervention. The median score decreased from Mdn = 3.00 (moderate problem) at the pretest to Mdn = 2.00 (mild problem) at the posttest, with the mode also shift-

ing from 3.00 to 2.00. Three participants (37.5%) reported lower post-test scores, five (62.5%) reported no change, and none reported higher scores. Although the change was not statistically significant (Z = -1.60, p = .25, r = .57), the moderate effect size suggests meaningful directional improvement in perceived civility.

3.4 Perceived source of incivility

Faculty were asked to indicate whether they believed students or faculty members were more likely to engage in uncivil behavior within their program at both the pre- and post-intervention periods. At pretest, 62.5% (n = 5) reported that students are much more likely to engage in incivility, 12.5% (n = 1) selected students are a little more likely, and 25% (n = 2) viewed both groups as about equally likely. Following the intervention, 50% (n = 4) reported that students are much more likely, 25% (n = 2) that students are a little more likely, and 25% (n = 2) again selected about equal. No participants indicated that faculty were more likely to engage in incivility at either time point.

3.5 Civility rating in program

Faculty were asked to rate the overall level of civility within their nursing program on a scale of 0 (absence of civility) to 100 (completely civil) at both pre- and post-intervention. The mean civility rating decreased from M = 66.25 (SD = 19.04) at pretest to M = 59.75 (SD = 30.53) at posttest, reflecting a 9.8% decrease. Four participants (50%) reported lower civility ratings at posttest, three (37.5%) reported higher ratings, and one (12.5%) reported no change. The Wilcoxon signed-rank test indicated that this difference was not statistically significant (Z = -0.17, p = .91).

3.6 Top strategies to improve civility

Faculty were asked to identify their top three strategies for improving the level of civility in nursing education at both pre- and post-intervention. Ten predefined options were provided from a list, with an opportunity to include additional strategies not listed. Before the intervention, most faculty (87.5%, n = 7) selected "role-modeling professionalism and civility" as the most effective strategy. After the intervention, three strategies tied as the most frequently selected: "role-modeling professionalism and civility," "raising awareness & providing civility education," and "providing training for effective communication and conflict negotiation" (50% each). These findings suggest that the intervention reinforced many of the evidence-based strategies incorporated into the faculty development program, highlighting the perceived importance of professional role-modeling, civility education, and communication/conflict training for sustaining a culture of civility in nursing education.

3.7 Uncivil encounter examples

Faculty members described examples of uncivil encounters they had experienced or witnessed within the previous two months, both before and after the intervention. At pre-intervention, faculty frequently cited student behaviors involving attendance and accountability issues, such as arriving late, leaving early, or skipping class, as well as failing to take responsibility. Other examples included excessive complaining, doing work unrelated to class, disrupting class, sending rude or demanding emails, being unresponsive to faculty communication, cheating, bullying or gossiping toward colleagues, and making implied or actual threats of harm. Faculty-to-faculty examples included unprofessional behaviors and unfair grading practices.

At post-intervention, faculty frequently identified behaviors related to being unprepared for class or failing to listen to feedback. Other examples included reports of class disruption, sending rude or demanding emails, threats of harm, bullying, gossiping, general disrespect, challenging faculty authority, using electronics unrelated to class, and requesting grade changes. The only faculty-to-faculty behavior reported was backstabbing.

3.8 Primary reason or cause for incivility

Faculty were asked to identify the primary reason or cause of incivility in nursing education at both pre- and post-intervention periods. At pre-intervention, faculty frequently identified a lack of accountability or discipline as the cause. Other examples included stress/anxiety, high-stakes student environment, entitlement, social media normalizing incivility as acceptable behaviors, lack of resources/support, inability to balance work/school/personal, and power imbalances between faculty and students. At post-intervention, faculty frequently identified stress/anxiety and a high-stakes student environment as causes. Other examples included burnout/overload, a lack of accountability, entitlement, and social media normalizing incivility as acceptable behaviors.

3.9 Consequence of incivility

Faculty were asked to identify the most significant consequence of incivility in nursing education. At pre-intervention, faculty frequently identified burnout or leaving the nursing profession as significant consequences. Other examples included violence/harm (physical/emotional) to individuals or patients, a decrease in respect for the nursing profession, hindering the student learning environment, and creating a toxic work environment. Post-intervention, faculty frequently identified violence/harm (physical/emotional) to individuals or patients. Other examples included burnout or leaving the nursing profession, a decline in respect for the profession,

course failure, and a failure to hold individuals accountable for their actions.

3.10 Promoting civility

Faculty were asked to identify the most effective way to promote academic civility. At pre-intervention, faculty frequently identified education and raising awareness as effective strategies. Other examples included providing coping resources for students, conducting curriculum audits for quality improvement, utilizing both positive and negative reinforcements, enforcing policies and setting clear early expectations, and role-modeling. At the post-intervention stage, faculty frequently identified role-modeling as an effective strategy, followed by the use of positive and negative reinforcement, enforcing policies, setting clear expectations early on, and educating or raising awareness.

3.10.1 *Program/department strengths*

Faculty were asked to identify the strengths the program/department possesses to help foster civility and a healthy learning environment. At pre-intervention, faculty frequently identified compassion and resources from faculty as a strength. Faculty also cited clear policies and expectations, supportive leadership, and deans as contributing factors. Following the intervention, faculty continued to emphasize accountability and faculty support, but placed a greater emphasis on policy clarity, expectations, and accessibility of leadership. Additional strengths included an open-door policy, role-modeling of professionalism, and recent education or training on incivility.

3.10.2 *Confidence, effectiveness & timing*

Three project-specific open-ended questions were added in addition to the INE-R survey items. The first question asked the faculty about their preparedness and confidence in addressing and managing incidents of incivility. Before the intervention, 50% of participants (n = 4) reported being unprepared or requiring more training. After the intervention, the proportion of faculty who felt highly prepared or confident increased from 0% to 50%, and those who felt unprepared or needed more training decreased from 50% to 12.5%. Overall, these results demonstrate an improvement in faculty confidence and preparedness to manage incivility following the intervention.

The second question, asked only during the post-intervention period, inquired about the benefits of the 3-part educational intervention in helping faculty manage and/or reduce incivility. Six faculty members (75%) found the intervention beneficial, one found it somewhat beneficial, and one found it to have little impact. The third question asked the faculty if there were specific times during the academic year when student incivility was more likely to occur. Student incivility was most frequently reported at the end of the semester or during the final exam period. Other commonly mentioned periods included the beginning of the semester and midterms. A few faculty members also noted that additional contributing factors played a role, rather than timing.

4. Discussion

The purpose of this QI project was to explore faculty perspectives on incivility and evaluate the effects of a multifaceted educational intervention in reducing nursing faculty-perceived frequency of student incivility behaviors within a nursing program. The primary objective, a 5% reduction in the mean score of faculty-perceived frequency of student-incivility behaviors, as measured by the INE-R tool, was achieved with a 17.4% decrease in the mean composite frequency score from pre- to post-intervention. This indicates that the education intervention effectively reduced faculty-perceived frequency of student incivility, likely by increasing awareness of incivility, enhancing communication and conflict-management skills, and encouraging consistent enforcement of behavioral expectations.

The secondary objective, achieving a 75% participation rate among full-time nursing faculty for the entirety of the educational intervention, was unmet, as only 56% of full-time faculty members completed all educational components. This limitation may be attributed to faculty workload, burnout, and recent turnover. Despite this, faculty demonstrated improved preparedness and confidence in addressing incivility, suggesting a meaningful practical impact on the program's learning culture. While there were only a few statistical changes noted for the INE-R severity and frequency or certain demographics, the overall directional improvement in civility perceptions and faculty-reported confidence indicates the intervention's positive effect on awareness and behavioral readiness. These findings suggest that formal faculty development initiatives focusing on civility education and training can contribute to more civil academic environments. No unanticipated negative consequences were identified during the project implementation. The results support the feasibility and benefit of implementing similar civility-focused interventions across other nursing education settings.

4.1 Recommendations

Based on the findings of this QI project, several recommendations are proposed to sustain and expand civility initiatives within nursing education. Nursing programs should continue implementing structured, multifaceted interventions that focus on civility education and training as a recurring component of professional development. Integrating civil-

ity education into new faculty orientation and annual development programs will reinforce expectations, strengthen professional accountability, and foster a culture of civility. Institutional leaders should incorporate civility standards and clear reporting processes into policies and procedures to ensure consistency and transparency when addressing uncivil behaviors. Strengthening leadership visibility, reinforcement, and recognition of civility efforts will further promote engagement and sustainability. Faculty should be encouraged to serve as exemplars for students and colleagues by modeling professionalism, accountability, and effective communication. Programs are encouraged to expand, evaluate, and replicate civility interventions across programs and campuses to determine scalability and impact. Including both faculty and students in future training programs can foster a sense of shared ownership. Finally, findings should be disseminated and shared within other sister institutions and nursing programs to encourage collaboration and promote widespread adoption of evidence-based strategies for fostering civility in nursing education.

4.2 Limitations

This quality improvement project was subject to several limitations that may affect the interpretation and generalizability of the findings. The small sample size, inherent to the limited number of full-time nursing faculty, resulted in an underpowered, convenience sample of eight participants, which restricts statistical power and the ability to detect smaller effect sizes. The short project time interval, constrained by the academic semester and program timeline requirements, also limited the ability to capture long-term outcomes or the sustainability of intervention effects. Although the PICOT question and supporting literature review referenced a three-month follow-up period, the outcome evaluation was conducted two months post-intervention due to these time constraints. Additionally, faculty workload, competing priorities, burnout, and recent turnover impacted participation and engagement in both the intervention and survey completion. Several newly hired faculty members had limited rapport and less exposure to the project or institutional culture, which may have influenced their level of participation.

5. Conclusion

This quality improvement project demonstrated that a multifaceted faculty development initiative can reduce faculty-perceived frequency of student incivility behaviors and enhance faculty confidence and preparedness to address such behaviors. The findings of this study highlight the importance of formal, structured civility education programs in fostering a civil and positive academic environment and enhancing professional communication among nursing faculty and students. Implementing similar initiatives in other nursing programs and institutions may strengthen academic culture, improve professional accountability, and contribute to a broader adoption of evidence-based strategies for managing and addressing incivility in nursing education.

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Authors contributions

Dr. Sherman, committee chair, provided overall project leadership, including guidance on study design, statistical analysis, and manuscript drafting and revisions. Dr. Ulbrich contributed to project oversight and manuscript revisions. Kerrie Downing provided guidance on study design and institutional implementation and assisted with the coordination of the scholarly project at the campus level. All authors reviewed and approved the final manuscript.

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The authors declare that they have no known competing financial interests or personal relationships that could have influenced the work reported in this paper.

Informed consent

Obtained.

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Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

DATA SHARING STATEMENT

No additional data are available.

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