Original Article

Interventions for Addressing Incivility among Undergraduate Nursing Students: A Mixed Study Review

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Abstract

Incivility in nursing education, in both the classroom and clinical placements is an area of growing concern and has been perpetrated by clinical placement preceptors, academic staff, students and patients. Effects of incivility include physical and psychological on the victims, and may ultimately lead to unsafe patient care. Little is known regarding effective interventions to prevent or mitigate the practice of incivility in the nursing education context.

The objective of the study was to conduct a mixed study review of literature to determine strategies used to address incivility and their outcomes among undergraduate nursing students. 12 studies met inclusion criteria. Multipronged educational interventions, mainly featuring aspects of Cognitive Rehearsal Therapy, were employed as strategies. All studies reported positive outcomes including increased knowledge and self-efficacy in recognising and managing uncivil behaviours among participants. Incorporating active learning strategies can be an effective tool in the management of uncivil behaviours and can be integrated in existing courses within the curriculum. However, there in need for more robust studies in the area, as indicated by low level evidence of reviewed studies.

Key words: Incivility, Bullying, Nursing Education, Interventions

Introduction

Incivility is the display of a set of behaviours deemed to be unacceptable or undesirable in a particular setting (Zhu et al. 2019). Behaviours may be overt or covert and have been found to occur along a continuum that includes unprofessional conduct, being bias, belittling, intimidation, humiliation and shouting at others on one end, with verbal and physical abuse on the extreme end (Clark 2013). Literature shows that the phenomenon has generally existed in health care and specifically the nursing profession (Bambi et al. 2018), However, growing evidence suggests that it is becoming an area of great concern in nursing education, both in the classroom and clinical placements (Vuolo 2018). In clinical placements, preceptors have been cited as the main perpetrators, as well as clinical instructors, fellow students and patients (Smith, Gillespie, Brown & Grubb 2016; Engelbrecht, Heyns & Coetzee 2017).

The impact of incivility is well documented. Psychological and physical symptoms such as feelings of hopelessness, low self-esteem, anxiety, fear, cardiac and abdominal disturbances and sleep disturbance have been cited. (Smith et al. 2016; Budden et al. 2017). These may interfere with student functioning and act as a barrier to effective socialisation of students into the profession, consequently leading to dissatisfaction with and attrition from nursing programs (Budden et al, 2017). Moreover, in a profession that embodies compassionate care and nurturing of clients, uncivil behaviours may be adopted by students leading to unsafe patient care (Engelbrecht, Heyns & Coetzee 2017).

Although little is known about incivility in the African nursing education context (Engelbrecht, Heyns & Coetzee 2017), anecdotal evidence in the form of student reflections and verbal indicates prevalence of the vice. There is therefore need to determine strategies to prevent or mitigate the effects of this pervasive behaviour.

The Review

The goal of this review was to synthesise literature on interventions to address incivility among undergraduate nursing students, in both clinical and classroom settings. The research questions were:

1. What types of interventions are used to address incivility among undergraduate nursing students?
2. What are the outcomes of interventions used to address incivility among undergraduate nursing students?

To answer these questions, a mixed study review was undertaken. A mixed study design enables integration of various study designs including quantitative, qualitative and mixed methods, in order to provide a clearer and richer understanding of interventions in health sciences (Pluye & Hong 2014). The stages of this review as put forward by Pluye and Hong (2014) were followed.

Stage 1: Formulation of Review Question: A question was formulated using the PICO (Population, Intervention, Comparison, Outcome) structure to facilitate search of studies and delineate key variables of the study. The question was: Among undergraduate nursing students (P), are interventions to address (I) incivility effective (O)?

Stage 2: Definition of eligibility criteria: The population of interest was studies in which the participants were undergraduate nursing students of any level and in either clinical or classroom settings. Postgraduate students were excluded as they may have already developed some coping mechanisms to incivility, due to their possible prior exposure to the clinical work environment. Quantitative, qualitative and mixed methods studies which reported any type of intervention as well as outcome measures were considered for inclusion. Studies also had to have been published in the English language. The time range was left open to enhance maximum access to all relevant studies, up to July 2019. Doctoral and Masters Theses were also considered. The study was exempt from ethical clearance as it consisted the review of already published literature.

Step 3: Application of an extensive search strategy: Two search strategies were employed in the review. Firstly, PubMed, SCOPUS and SAGE online databases were searched using key terms "Nursing student", "Incivility"/ "Bullying"/"Aggression", "Intervention"/ "Reduction strategy" and "Nursing education". A supplementary search on Google Scholar was also conducted. A second search constituted screening the bibliographies of selected studies for studies not captured in the initial search.

Step 4 and 5: Identification and Selection of relevant studies: The initial search resulted in 815 studies. Duplicate studies were removed and remaining study titles and abstracts were screened for relevance with regard to key words. Observational studies reporting prevalence or causes of incivility were excluded. Studies which included registered nurses or undergraduate students of other health related courses were also excluded from review. In total, 12 articles matched the eligibility criteria. Full texts of the selected studies were retrieved for data abstraction. Information including name and year of publication, population characteristics, intervention and outcomes measured were extracted and populated onto a template (table 1.1) for ease of synthesis. The flow chart for study selection process is outlined in figure 1.

Stage 6: Appraising quality of included studies: The Mixed Methods Appraisal Tool (Hong et. al. 2018) and Hierarchy of evidence for intervention studies as proposed by Fineout-Overholt et al. (2010) were used to evaluate the quality of studies. There was one level II study, three level III studies and eight level VI studies. Over 50% of studies were therefore considered as weak evidence based on the evaluation tool. Most studies were conducted in a single setting, with convenience sampling procedure being predominant. Further information is provided in table 1.1.

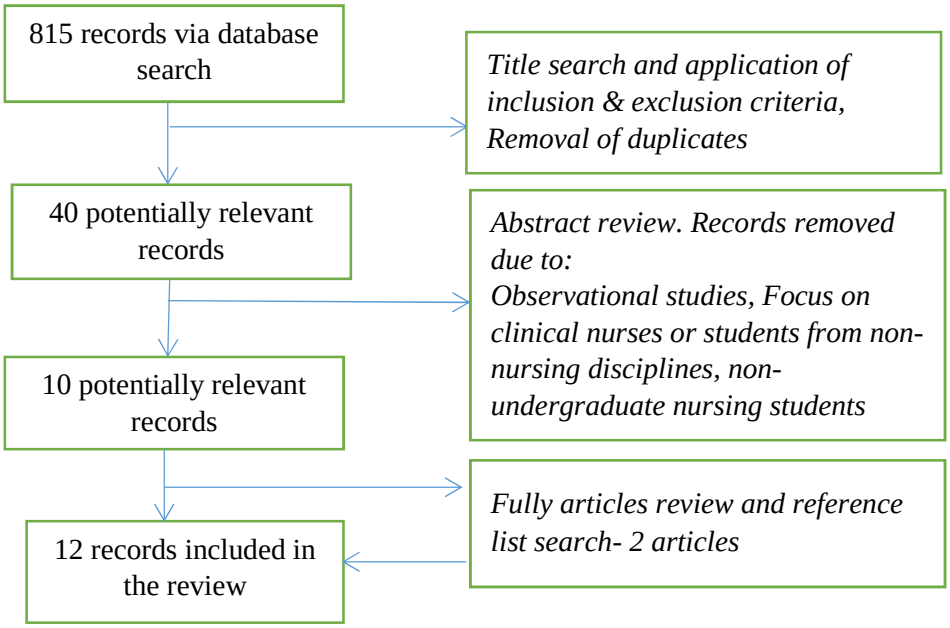

Fig1: Study selection process

Stage 7: Summary and Synthesis of Studies: Due to the variation in study designs, a convergent qualitative synthesis was utilised (Hong et al. 2017). This involves addressing the research question through integrating results of studies of quantitative, qualitative and mixed designs into themes by comparative evaluation. A narrative of the synthesis follows below.

Study Characteristics: Studies reviewed spanned four countries, United States (9), Canada (1), Australia (1) and Iran (1) and were published between 2012 and 2019. Four studies were quantitative, five qualitative and three employed mixed methodologies. Of the quantitative studies, one applied a true experimental design while the other three were quasi-experimental involving single or two groups. 50% of studies reported some theoretical underpinning for their work.

Studies were conducted mainly in single settings with sample sizes ranging from 58-333 participants and comprising mostly of senior undergraduate nursing students.

All but two interventions were multifaceted, with aspects of Cognitive Rehearsal Therapy featuring as the main component. Other interventions included a journal club and guided group discussions. Additionally, all but one study reported on the frequency and duration of the interventions which varied from single 1-hour session (Sanner-Stiehr & Ward-Smith 2015) to 2 hour- workshops delivered over a period of three semesters (Egues & Leinung 2014).

With regard to outcomes, self-reported self-efficacy, knowledge and satisfaction with the intervention were frequently reported. All quantitative studies reported statistically significant differences post intervention, while qualitative studies similarly reported improvement in participant's awareness of and ability to effectively respond to incivility.

Citation	Design	Intervention	Sample and Setting	Outcomes	Evidence level
Sanner-Stiehr & Ward-Smith 2015, USA	Randomised cluster control study, single blinded.	Intervention group: 1hour CRT intervention consisting of lecture, role-play, roleplay practice by participants, feedback and guided large group discussion Control group: Lecture guided group discussion on stress management	Final year students Intervention group:n=41 Control group:n=47. Female majority in both groups 2 private universities	Statistically significant increase in self-efficacy between baseline and post-test 1 (P=0.000) and Post-test 3 at 3 months (P=0.000)	Level II, Theory based. Limitation: convenience sampling, self-report
Abediny&Parvizi 2019, Iran	2 group quasi-experimental study with pre-test post-test design with randomization	Intervention group: 8 faculty led discussion sessions 50-60 minutes long on incivility and its management Control group: Self-directed learning with via instructional booklet	2nd and 3rd year students. Intervention group:n=41 Control group: n=41 Single university	Statistically significant change in perceived level of incivility in perceived level of incivility in both groups, but significantly higher in discussion group. (P<0.001). Significant difference occurrence rate of incivility between groups (P=0.01)	Level III, random allocation Limitations: Convenience sample,self-report. Intervention and comparison in same setting leading to possible contamination of the latter, theoretical basis unreported
Palumbo 2016, USA	Pre-test post-test design	9 E-learning modules uploaded onto school's online management system.	1st and 2nd year students n=110. Single university	Statistically significant increase in self-efficacy to identify and respond appropriately to incivility	Level III, Theory base Limitations: Instrument reliability and sampling procedure unreported, single site, self-report
Keber et al., 2012, USA	Pre-test post-test design	6 fifty minute biweekly journal club sessions consisting of review of article on incivility and discussion led by faculty and guest on fostering civility	Senior students n=79. Single university	Statistically significant increase in helpfulness (P=0.001) and problem solving (P=0.02)	Level III, Theory base Limitations: convenience sample, single site, self-report, post-test long after intervention i.e 4 months
Ulrich et al., 2017, USA	Qualitative exploratory design	Faculty developed simulation scenarios on incivility practiced by students taking up different roles. Was followed by individual and group reflection	Senior nursing students n=333 from five campuses in three universities.	Participants able to identify uncivil behaviour and negative impact of incivility.	Level VI, Rigor well described. Limitation: Theoretical basis unreported

		and large group debriefing on experiences of participating			
Clark, Ahten & Macy 2012, USA	Qualitative study	2 hour workshop consisting Problem Based Learning scenarios consisting lecture, video clips on incivility and appropriate response, case study and Small group debriefing session.	Senior nursing students n=65, Single university	Participants able to identify uncivil behaviour. Also noted the role of nurse manage in managing incivility	Level VI, Theory base, Rigor well described Limitation: Single setting
Gillespie et al., 2015, USA	Qualitative Descriptive study	Role play simulation on bullying scenario played by students in groups of 3 or 4 during community health and leadership units, followed by large group debriefing and individual reflections	Senior nursing students n=8, Two campuses of a single university	Participants able to identify uncivil behaviour and felt ready to support bullying targets. Noted need for better scripted or realistic instructions for roles	Level VI, Rigor well described Limitation: Single setting, Theoretical basis unreported
Fehr&Seibel 2016, USA	Qualitative exploratory	2 hour workshop with literature on incivility, lanyard with uncivil behaviour and appropriate response, group discussion and lecture on incivility, lanyard, role play, group and individual experience reflection	3rd year students n=58 Single university	Individual data: Increased knowledge, confidence and competence to respond to incivility Group data: identification of forms of incivility, sources, impact, usability of lanyard, take up anti-bullying champion role	Level VI, Rigor well described Limitations: Theoretical basis unreported, Single setting
Hogan et al., 2018, Australia	Qualitative exploratory design	Blended learning resource consisting of film clips simulating incivility in clinical settings and relevant literature links Followed by role play demonstration on effective response to incivility and patient aggression, roleplay practice by	Nursing students undertaking clinical practice subjects n=210 Large urban university	Tool/intervention: comprehensive, realistic Improved knowledge and skills in ability to recognise and manage incivility, patient aggression. Improved awareness of support sources.	Level VI, Rigor well described Limitations:Theoretical basis unreported, Single setting

		participants and debriefing			
Egues & Leinung 2014, USA	Mixed-methods?? with pre-test-post-test design	2 hour workshop consisting of group work discussion on case study, role play on strategies to enhance civility, reflection and journaling of experiences	4th year Hispanic, initially, n=230	10-33% increase in ability to recognize own and others participation in incivility. Increased awareness of and dedication to end incivility	Level VI Limitations: Single site, convenience sample, tool reliability unreported
Iheduru-Anderson (2014) USA	Mixed-methods?? with pretest-post-test design	4-hour seminar preceded by article reading by students, lecture on incivility, lanyard presentation, role play demonstration and practice by participants on effective response to uncivil behaviour. Reflective journaling on experience	Senior nursing students	Participants felt "empowered" and "happy" after participating in role play	Level VI Limitation: sample size, sampling technique unknown. Reliability of tool and rigor of qualitative component undisclosed. Data analysis procedure unreported and results of pre-test-post-test unreported
Martinez, (2017) USA	Mixed –methods with pretest-post test	4 hour Mental Health nursing simulation on workplace violence with a standardized patient, preceded by power point presentation on managing mental health workplace violence	Nursing students n=15 in a psychiatry clinical placement Large urban university	Students able to recognize signs of aggression in agitated patient, significance increase in mental health nursing clinical confidence ($p<0.0001$), Overall general increase in knowledge on workplace violence, but mixed results per question. Simulation experience noted as 'helpful' and 'good'	Level VI, Theory base, Rigor well elaborated Limitations: small sample size, single setting, tool validity and reliability unreported

Table 1.1 : Summary of reviewed studies

Synthesis; Synthesis was guided by review questions regarding the types of interventions applied to address incivility in nursing education and the outcomes which indicated that interventions were effective.

Types of Interventions: Studies revealed a multipronged approach to interventions, where more than one method was used to deliver content of the intervention. A key feature of the interventions was Cognitive Rehearsal Therapy (CRT), with 8 out of the 12 studies reporting incorporation of the strategy (Sanner-Stiehr & Ward-Smith 2015; Egues & Leinung 2014; Martinez 2017; Fehr & Seibel 2016; Iheduru-Anderson 2014; Hogan et al. 2018; Ulrich et al. 2017; Clark, Ahten & Macy 2013). Components of CRT included theoretical training through dissemination of reading material, lecture or case study discussion, demonstration through role play or video clips, participant role play practice, feedback on demonstration and debriefing though guided group discussion. It is worth noting that only one study included all the components of CRT (Sanner-Stiehr & Ward-Smith 2015).

In a number of studies, information was provided to participants, prior to active participation in a demonstration activity. Researchers in a cluster randomised control study conducted a lecture on behaviours that constituted incivility and their consequences to senior nursing students (Sanner-Stiehr & Ward-Smith 2015). Similarly, oral presentations and case studies were used to present information on incivility in four other studies on various incivility related issues (Fehr & Seibel 2016; Egues & Leinung 2014; Iheduru-Anderson 2014; Clark, Ahten & Macy 2013), while in another (Martinez 2017), power point presentations of evidence based interventions for work place violence were emailed to students. Lanyards, which consisted of cards indicating uncivil behaviour and effective responses, were also issued to participants (Fehr & Seibel 2016; Iheduru-Anderson 2014).

The second component of CRT was demonstration. Role plays were used to portray uncivil behaviours between nurses or nurses and students as well as effective and ineffective responses to incivility. Participants alternated between roles either as perpetrators or victims of incivility (Sanner-Stiehr & Ward-Smith 2015; Gillespie et al. 2015; Ulrich et al. 2017; Fehr & Seibel 2016; Egues & Leinung 2014). In two qualitative studies, video clip demonstrations simulating workplace incivility between nurses, or nurses and students were incorporated into the CRT intervention (Hogan et al. 2018; Clark, Ahten & Macy 2013).

Demonstration was closely followed by practice sessions among participants as the third CRT component. Students actively participated in the intervention by playing assigned roles as aggressors or victims of incivility based on scripted evidence issued as hand-outs or notes provided in the first phase, while researchers and faculty observed (Sanner-Stiehr & Ward-Smith 2015; Gillespie et al. 2015; Ulrich et al. 2017; Egues & Leinung 2014; Hogan, Orr, Fox, Cummins & Foureur 2018; Martinez 2017 Iheduru-Anderson 2014). Practice also involved appropriate responses to uncivil behaviours. The fourth component of the CRT was feedback on performance following role play practice. Only two studies reported provision of feedback to participants on their role play practice by faculty and researchers or standardised patients (Sanner-Stiehr & Ward-Smith 2015; Martinez 2017).

Debriefing was the fifth and final component of the CRT intervention and was reported in eight studies (Sanner-Stiehr & Ward-Smith 2015; Gillespie et al.2015; Ulrich et al. 2017; Egues & Leinung 2014; Hogan et al. 2018; Martinez 2017; Clark, Ahten & Macy 2013; Fehr & Seibel 2016). Debriefing mainly occurred in form of small or large group guided discussions following observation of video clips and role plays, or active participation in role play (Sanner-Stiehr & Ward-Smith 2015; Gillespie et al.2015; Ulrich et al. 2017; Hogan, Orr, Fox, Cummins & Foureur 2018; Martinez 2017; Clark, Ahten & Macy 2013; Fehr & Seibel 2016) or through journal reflections (Egues & Leinung 2014). This gave participants an opportunity to share and reflect on their experiences in participating in the intervention.

Three other interventions were reported apart from those based on CRT. An e-module which included video scenarios was uploaded onto an online management system targeting second and third year students. However, contents of the e-module were not described by the researcher (Palumbo 2016). Journal club sessions held during scheduled class time consisted of the main intervention in another study (Kerber et al.

2012). Lastly, in a 2-group quasi experimental study, group discussions on incivility were conducted in the intervention group, while the comparison was provided with an e-booklet on incivility (Abedini & Parvizy 2019).

Content of the interventions appeared to be mainly homogenous across studies. This included teaching on definition and behaviours consisting of incivility, the impact of incivility as well as effective and ineffective responses to uncivil behaviour (Table 1.1). Two studies included a component on managing aggressive patients (Hogan et al. 2018 & Martinez 2017). Notably, the content of the interventions appeared to concentrate on addressing incivility in the clinical workplace with only two studies focusing on both clinical and classroom settings (Palumbo 2016; Kerber et al. 2012).

Outcomes following interventions: Following interventions to address incivility, positive outcomes were reported in all studies design notwithstanding. Outcomes reported mostly included knowledge of and self-efficacy in identifying and responding to incivility (Sanner-Stiehr & Ward-Smith 2015; Ulrich et al. 2017; Egues & Leinung 2014; Hogan et al. 2018; Martinez 2017; Clark, Ahten & Macy 2013; Fehr & Seibel 2016; Palumbo 2016; Kerber et al. 2012). Satisfaction with the intervention or participation was reported in three studies (Hogan et al. 2018; Martinez 2017; Fehr & Seibel 2016).

A significant increase in self-efficacy to respond to incivility in clinical settings was reported by Sanner-Stiehr & Ward-Smith (2015) immediately following a CRT intervention as well as at three months post intervention. However, no significant increase was noted between the immediate and three-month post-test. No significant increase in self-efficacy was noted in the control group where a lecturer-guided discussion on stress management was given (Sanner-Stiehr & Ward-Smith 2015). In Palumbo's (2016) quasi-experimental study, a significant increase in first and second year student's self-efficacy to identify and respond to incivility following an e-module was reported. The reliability of the study tool was however not reported.

Similarly, two other quantitative studies reported a statistically significant change among participants following different interventions. A journal club intervention resulted in significant change in participants' ability to prevent incivility through rational problem solving and assisting others to cope with incivility (Kerber et al. 2012). Notably, the post-test in this study was carried out at 4 months to overcome test-retest bias. Abedini and Parvizy (2019) reported statistically significant change in participants' level of perception of uncivil behaviours and their occurrence following a guided group discussion on incivility. A self-directed learning resource provided in the comparison group yielded no significant change.

Qualitative and mixed studies equally reported positive outcomes following a variety of interventions, all based on CRT. Ability to recognize uncivil behaviours in themselves and others was noted from participant's case reflections in one study (Egues & Leinung 2014). Participation in role plays by students in different roles also improved their understanding of incivility, knowledge on its negative impact and ineffective and effective responses when faced with uncivil behaviour (Gillespie et al. 2015, Ulrich et al., 2017; Martinez 2017; Clark, Ahten & Macy 2013; Fehr & Seibel 2016). Self-efficacy in these studies was mainly reported as increased confidence to respond appropriately to incivility. In another study, participants reported feeling "empowered" to deal with incivility (Iheduru-Anderson 2014). However, description of the analysis, rigor and outcome reporting in this study was vague. Knowledge on sources of support in the clinical area following an intervention consisting of a blended learning resource was also reported in two qualitative studies (Hogan et al. 2018; Clark, Ahten & Macy 2013). Clark, Ahten and Macy (2013), additionally reported improvement in the participants' skills in dealing with aggressive patients.

Outcomes with regard to features of the intervention were reported in four studies. A blended learning resource which included video scenarios was evaluated as realistic (Hogan et al. 2018). Similarly, a CRT intervention which consisted of lanyards was noted as useful and practical for use, not only in school but also in clinical practice (Fehr & Seibel 2016) while in Martinez' (2017) study, participants noted that the presence of a standardised patient in the simulation experience particularly assisted them to practice their de-escalation skills. Contrary to

positive feedback in the aforementioned studies, students participating in role play simulating a bullying scenario felt that the intervention was not realistic enough and that further instruction was needed for the actors (Gillespie et al. 2015).

Discussion

The purpose of this mixed studies review was to explore interventions used to address incivility in nursing education as well as effectiveness of these interventions. Findings illustrate a preference for multifaceted educational interventions incorporating active learning strategies such as group discussions, case studies and role play. This may be an indication of the researchers' need to increase effectiveness of interventions to enable nursing students cope with or mitigate effects of incivility, whose prevalence appears to be increasing (Budden et al. 2017). Different components of interventions targeted participants with varied learning styles and engaged multiple senses, hence facilitate learning. Multiple interventions also appeared to target improvement of participants' cognitive, psychomotor and affective abilities with regard to managing incivility.

Another key feature of reviewed studies revealed the use of CRT-based interventions. CRT has its origins in Cognitive Behavioural Therapy and espouses the act of consciously thinking about how to respond in a situation, based previously acquired knowledge and skills on the appropriate way one ought to respond (Griff 2004). This, in the context of incivility, enables the tension created in such a situation to be diffused as the victim of aggression does not automatically react, but thinks through appropriate responses first. Effectively responding to an aggressor can have the positive effect of curtailing further uncivil behaviour (Griffin & Clark 2014). CRT has successfully been used to address uncivil behaviour among practising nurses (Armstrong 2018).

Although there was a wide variation of intervention characteristics with regard to duration and frequency, this did not appear to have any effect on the outcome. Interventions were also scheduled during normal class time, indicating that these activities could realistically be incorporated into the curriculum. Nearly all interventions focused on addressing incivility in the clinical setting. As students spend a considerable amount of time in clinical placements, a negative clinical learning environment perpetuated through incivility can have detrimental effects to their learning, hence the need to improve their ability to cope with the problem (Zhu et al. 2019). This focus on clinical areas also indicates that incivility may be more prevalent in these settings as compared to classroom settings. Moreover, majority of the participants were senior students and therefore the interventions may have been tailored for this population to enable build their ability to cope with incivility as they transitioned to clinical practice where "nurses eat their own" culture has been reported to be prevalent (Iheduru-Anderson 2014). Responses from reviewed studies, however, indicated that such interventions could be beneficial to all students regardless of training level.

Outcomes from interventions indicated increased knowledge and self-efficacy to manage incivility. This shows that educational interventions can be effective means of addressing incivility. Although studies did not report on the cost implication of interventions, most appeared to be simple and economical, yet realistic enough to yield positive outcomes hence could be applicable even in low resource settings.

Strengths and Limitations of review: The main strength of this review was the use of mixed study review design. Outcomes from quantitative studies were validated by qualitative study results which indicated mostly positive outcomes. Qualitative studies also provided a rich and elaborate description of the experiences of participants regarding the interventions.

However, several limitations are noted. Few studies met the inclusion criteria despite the extensive search. Most studies were conducted in single-source settings and included relatively small sample sizes that were conveniently selected, hence limiting generalizability of findings. Additionally, the decision to utilize mixed study review design precluded a meta-analysis from being conducted. Only six studies reported theoretical underpinnings of their interventions while the outcomes were based on participant self-report, hence increasing the risk of bias. Lastly, study designs appeared to have weak quality with only one level II study, while majority were level VI. Present limitations therefore call for cautious interpretation of

findings, despite positive outcomes being reported.

Implications for Practice and Recommendations: The outcomes from reviewed studies indicate that simple multifaceted educational interventions utilising CRT can be effective tools to assist undergraduate nursing students to manage incivility. However, there is need for research on effectiveness of such interventions in low resource countries to be conducted, as this can provide evidence for use in these settings. As most interventions were incorporated into scheduled courses, there needs to be a proactive approach to embed incivility prevention and mitigation learning activities within the curriculum, for example in communication skills and clinical related courses. Interventions can also be tailored to target nursing students at all levels of the program. Junior students attending their first clinical placement may benefit greatly. Negative clinical encounters can impact learning negatively, especially in this vulnerable group (Budden et al. 2017). Additionally, there is need to focus on preparation of preceptors in clinical supervision to prevent and mitigate incivility in the clinical learning to supplement content on clinical teaching methods which they mainly receive (Kamolo, Vernon & Toffoli 2017).

Limitations noted in this review point to a need for more robust research in this area. Well-designed studies including randomised controlled trials, use of multiple sites, incorporation of larger sample sizes and use of validated and reliable tools can provide a stronger body of evidence, on which basis policy actions can be taken. Studies including longer follow up, of a minimum of 6 months to determine sustainability of knowledge and skills gained to cope with incivility can also be helpful. Lastly, as incivility may also occur in classroom settings, there is need to equally focus on how this can be managed. Perpetrators of uncivil behaviour may be students, lecturers, clinical instructors or nurses in clinical areas. A whole system approach where interventions target all in the chain may help change incivility capture by raising awareness. Often, individuals engaging in incivility may not be aware that their behaviour in inappropriate.

Conclusion: Incivility continues to be a problem in nursing practice and nursing education. Simple multifaceted interventions, based on active learning strategies can help undergraduate nursing students be more cognisant of this behaviour in themselves and others and respond appropriately whenever faced with such encounters.

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