ADJUNCT NURSING FACULTY PERCEPTIONS OF AND REACTIONS TO UNETHICAL
OR DISHONEST NURSING STUDENT BEHAVIORS IN THE CLASSROOM AND
CLINICAL AREAS

By

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A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL
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To my mom and dad

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LIST OF ABBREVIATIONS

ANA	American Nurses Association
GRAT	Group Readiness Assessment Tool
IRAT	Individual Readiness Assessment Tool
NLN	National League for Nursing
RN	Registered Nurse
TBL	Team-Based Learning

Abstract of Dissertation Presented to the Graduate School
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Registered Nurses are expected to behave professionally and ethically by the society who trusts that they are competent to provide care. Nursing education programs must therefore include ethical development in their academic curricula. Yet a troubling finding is that nursing faculty members disagree on what constitutes unethical and dishonest nursing student behaviors. In an effort to mitigate student cheating, a top-down approach was designed to measure the impact of a specifically designed, brief training session on adjunct nursing faculty perceptions on identifying and dealing with dishonest and unethical behaviors. The three hour training session was rooted in Michaelsen's Team-Based Learning strategy, and was found to be positively significant related to improving understanding in a convenience sample of adjunct nursing faculty at a large, southern community college. Implications of these important findings for teaching and learning in adjunct nursing groups, as well as other adjunct groups outside nursing are discussed and recommendations for future study are offered.

CHAPTER 1
INTRODUCTION

Nursing students who cheat in school are likely to also cheat in the profession as Registered Nurses (Langone, 2007; Lewenson, Truglio-Londrigan, & Singleton, 2005; Stern & Havlicek, 1986; Wilk & Bowllan, 2011). If a student has cheated in nursing school and not learned requisite information to care for a human being safely, then that nurse can potentially become an unsafe and even dangerous practicing Registered Nurse, causing suffering, harm or even death to the patient. Faculty must therefore identify and deal with nursing student cheating, since it would be absolutely intolerable to allow an unprepared cheater to enter into the profession of nursing and potentially harm patients.

Perceptions of Unethical Behavior

This dissertation on the study of adjunct nursing faculty perceptions toward unethical nursing student behaviors begins with an introduction, followed by a literature review, methodology, results, and concludes with a discussion that includes implications. The study, conducted at a large southeastern United States state college nursing program, evaluated the impact of a faculty development session on: identification of unethical or dishonest nursing student behaviors; evaluation of the differences between individual faculty members and faculty group perceptions and the relationships between pre-intervention, and post-intervention, including a three month follow-up on faculty conceptualizations of unethical student behavior identification; and assessment of the awareness for professional expectation and follow through. It was predicted that a brief development session would result in an increased understanding as to what constitutes unethical nursing student behavior and what faculty actions are to be performed when an unethical nursing student behavior is discovered, and improve individual

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perceptions that faculty are willing to take action when dishonest or unethical nursing student behavior is discovered.

In the introduction, the definitions and the historical background on nursing education and professionalism in nursing are discussed. Chapter 1 provides a context for the significance of this study as well as the purpose and theoretical framework. The introduction ends in a brief description of the method of inquiry and a summary. The second chapter, the literature review, is a synthesis of published research and theory that underlies this study. The third chapter provides an explanation of the methodology associated with the study's data collection and analysis. Chapter 4 lists the results where findings associated with the data collection are detailed. Finally, Chapter 5 concludes with a discussion of the implications and significance of the findings, limitations associated with the study, and recommendations for future research.

Unethical Student Behavior

Not all bad behavior by nursing students is unethical behavior. Unethical behavior is a broad term that encompasses academic dishonesty and cheating behaviors, as these terms tend to interrelate in the literature (Correa, 2011; Gaberson, 1997). Clark and Springer (2007) identify incivility in nursing education as a broad range of behaviors including disapproving groaning noises, cheating on exams and even verbal abuse and physical contact. Daniel, Adams and Smith (1994) discuss fabrication and falsification of data, using deception to represent another's work as one's own work and label this as academic misconduct, which can be observed in both the classroom and the clinical areas. Cheating behavior, when performed in the student context for this study is academically dishonest behavior. Several of the terms can overlap, so this study will define these terms as follows:

- Unethical behaviors will be defined in the nursing student and nursing faculty context as a breach in conduct or behavior that is contrary to the standardized expectations and demands of the profession of nursing.

- Cheating and academic dishonesty, when defined in a student context is obtaining or receiving information that was not done within the learning objectives of the intended work and/or circumventing an intended process in order to gain a perceived advantage.

- Academic misconduct is another form of cheating or academic dishonesty, but is more structured and planned than academic dishonesty, and can rise to a higher level of teacher and school response.

- Ethical behaviors will be defined in the context of nursing as honest conduct or behavior that meets and can exceed the standardized expectations and demands of the profession of nursing, where the community places trust, and nurses work to maintain a positive professional reputation through their attitudes and actions.

- Professionalism is defined as the practice of individuals who have specific knowledge, training and experience that allows them to become licensed and provides unique and lawful services to a population that has come to expect those services to be delivered in a trustworthy, ethical manner.

- Academic integrity is a dedication to act on five basic values: honesty, trust, fairness, respect, and responsibility, even when faced with challenges and adversity (The Center for Academic Integrity, 1999) and is more than simply the opposite of academic dishonesty or academic misconduct.

For this study, unethical student behavior will include academic dishonesty and cheating behavior. Neither unethical behavior, academic dishonesty nor cheating behaviors are consistent with the standard expectations for ethical, professional behavior in the nursing profession.

Unethical student behavior is not a new subject, and studies conducted over the last several decades have reported that academic dishonesty, a form of unethical student behavior, is on the rise (Callahan, 2004; Hughes & McCabe, 2006a; Daniel et al., 1994; McCabe, 1999; McCabe & Treviño, 1996). Other studies have examined the numerous characteristics of academically dishonest students, including personality and intelligence characteristics, demographics, and courses taken. Each of these factors were found to be related to dishonest behaviors (Anderman & Murdock, 2007; Burris, McGoldrick, & Schuhmann, 2007; Davis, Drinan, & Gallant, 2009; Gewertz, 2007; Hilbert, 1988; Kerkvliet & Sigmund, 1999; McCabe, 1999; Pino & Smith, 2003; Trenholm, 2007; Whitley, 2001).

Unethical student behaviors are defined differently by both students and faculty (Higbee & Thomas, 2002; PeSymaco & Marcelo, 2003; Solomon & De Natale, 2000; Stern & Havlicek, 1986; Wajda-Johnson, Handal, Brawer, & Fabricatore, 2001). Faculty members, who must guide students in learning how to behave ethically (Glen, 1999) are not in agreement about defining cheating, academic dishonesty, or unethical student behaviors (Barrett & Cox, 2005; Birch, Elliott, & Trankel, 1999; Bradshaw & Lowenstein, 1990; Hughes & McCabe, 2006a; Pickard, 2006; Pincus & Schmelkin, 2003; Price, Dake, & Islam, 2001), which makes faculty response to unethical behaviors inconsistent, and assessment of unethical behaviors challenging.

Nursing Education and Professionalism

From the mid 1800's, the education of nurses in the United States was influenced by the quintessential standard set by Florence Nightingale's nursing schools in England (Dock & Stewart, 1931; Judd, Sitzman, & Davis, 2010; Palmer, 1985). Nightingale established hospital

training centers rather than standardized university training programs (Baly, 1986; Holliday & Parker, 1997; Palmer, 1985; Zilm, 1993). Nursing students not only received training in hospitals as apprentices, but also provided the majority of the client care. This free labor was justified as a function of training before the nursing programs eventually moved out of the hospitals and into the classrooms, and outside the direct supervision of physicians who ran the hospitals (Baumgart & Kirkwood, 1990; Hanson, 1991; Krampitz, 1983; Palmer, 1985; Ruby, 1999). The impact of wars and other social and educational issues have influenced the evolution of nursing training programs in hospitals, community colleges and upper level colleges since the first hospital based training programs were established in the 1850's (Joel, 2002; Palmer, 1985).

The American Nurses Association (ANA), founded in 1909 (Judd et al., 2010; Smith, 2009), is one of nursing's main professional organizations that guides the practice of nursing requiring nurses to be competent in the practice of nursing (American Nurses Association Professional Role Competence, 2008), yet the ANA has not been able to reach a consensus of its members regarding the minimum degree needed for entry into the practice of nursing today (Donley & Flaherty, 2008; Fairman & Okoye, 2011; Gosnell, 2002; Joel, 2002; Kidder & Cornelius, 2006; Mahaffey, 2002; Smith, 2009). Individuals completing a Diploma Registered Nurse program typically study for two to three years and complete most of the same coursework as the two year Associate Degree nurse but include a heavy concentration in clinical experiences and direct client care in the same hospital where they receive their training (Donley & Flaherty, 2008; Smith, 2009). Individuals with an Associate Degree in Nursing, who train primarily in community college settings which leads to entry into professional practice (Smith, 2009) were initially intended to ease the increased demand for nurses needed during and after World War II (Mahaffey, 2002; Petry, 1943; Smith, 2009). These two year degree nursing programs were

conceptualized to produce large numbers of nurses who would be employed as "bedside" nurses, allowing the upper level college trained four year baccalaureate nurses (Petry, 1943; Smith, 2009) to deliver and manage client care. All three programs; the two year, three year, and four year degree nursing programs produce graduates who are qualified to take the same licensing examination to become a registered nurse. Many hospitals however have not differentiated the roles between the three degrees while employing Registered Nurses. These varied levels of training, delegation of client care responsibilities, and entry into practice continue to be debated among nursing members today (Gosnell, 2002; Joel, 2002: Mahaffey, 2002; Smith, 2009).

Designation as a profession is recognized when groups distinguish themselves from disciplines and occupations by building their knowledge and practice on technical and scientific knowledge; competence that is evaluated by peers (Krampetz, 1983; Schriner & Harris, 1984); a community orientation and a code of ethics (Martinez, Desiderio, & Papakonstantinou, 2010; Starr, 1982); and moving the group practice forward with specializations within the field (Joel, 2002; Marriner-Tomey, 1990). The American Nurses Association (ANA) and National League for Nursing Accrediting Commission (NLNAC) leads the profession of Registered Nursing by establishing and supporting evidence based practice through the American Nurses Association Professional Standards (2012); competence through the American Nurses Association Professional Role Competence (2008) and the National League of Nursing Accreditation Commission Mission Statement and Goals (2012) and the accreditation of nursing programs (DeSilets, 1998). The ANA supports nurses in their ethical obligation to provide fair and just nursing care through the American Nurses Association Code of Ethics, Standard 7 (2010) with Interpretation and Application statements (Fowler, 2010; Viens, 1989). It also oversees nursing specialties through its American Nurses Association; American Nurses Credentialing Center

(2012), American Nurses Association Continuing Professional Development (2012), the

NLNAC's accreditation of specialized nursing programs (National League of Nursing

Accreditation Commission Purpose Statement, 2012) and its support for advanced nursing

degrees (Marriner-Tomey, 1990).

The National Council of State Boards of Nursing (NCSBN) provides the individual states a

common place to interact about public health, safety and welfare, including the national licensing

examination that students take to become registered in their state (National League of Nursing

Accreditation Commission Mission Statement and Goals, 2012). Following the completion of a

degree, continuing education is required to renew a registered nurse license in most states (Case

Di Leonardi & Biel, 2012), and is supported by the ANA (American Nurses Association

Continuing Professional Development, 2012) and by the National Council of State Boards of

Nursing (National Council of State Boards of Nursing Learning Extension, 2012).

Significance

Nursing puts us in touch with being human….Without even asking, nurses are invited into the
inner spaces of other people's existence; for where there is suffering, loneliness, the intolerable
pain of permanent change, there is a need for the kind of human service we call nursing.
—Diers, *Between Science and Humanity*

The American Nurses Association (ANA) has steadily focused on the ethical practice of

nursing in the context of a continually dynamic and changing field. The ANA states that the

ethical development of nursing students is a cornerstone in ethical nursing practice (Ludwick &

Silva, 1999) and American Nurses Association Code of Ethics for Nurses, Standard 7, (2010, p.

3) states "the registered nurse practices ethically". The Interpretive Statement #9.3 of the Guide

to the American Nurses Association Code of Ethics for Nurses (Fowler, 2010) describes nursing

as a profession that embodies the values, moral ideals, and moral requirements of the group.

Globally, the World Health Organization (2005, p. 3) identifies ethical client care as a core workforce competency.

Since registered nurses are expected to demonstrate ethical behavior, it is concerning that students who are preparing to become nurses have been discovered to behave unethically, given that unethical and cheating behaviors of both non-nursing and nursing students have subsequently been found to carry on into professional careers (Bradshaw & Lowenstein, 1990; Daniel et al., 1994; Davis et al., 2009; Elmore, 2009; Fass, 1986; Fontana, 2009; Gray & Smith, 1999; Hilbert, 1985; Langone, 2007; Lewenson et al., 2005; Truglio-Londrigan, & Singleton, 2005; Nonis & Swift, 2001; Petress, 2003; Stern & Havlicek, 1986; Wilk & Bowllan, 2011). In a review of both nursing student and non-nursing student ethical studies, it is reported the high stress demands of college that produces unethical behaviors are a strong predictor of unethical behavior later in high stress professions (Lovett-Hooper, Komarraju, Weston, & Dollinger, 2007; Lucas & Freidrich, 2005; Martin, Rao & Sloan, 2009).

The public, who trust that nurses are honest (Gallup Poll; Honesty/Ethics in Professions, 2012) and ethical (Kelly, 1998; McCrink, 2010), believe that college diplomas represent a level of accomplishment for students who have earned a degree (Davis et al., 2009). They develop disrespect and distrust for those professionals who are caught cheating. McCabe, Treviño, and Butterfield (2001a) emphasized that degrees and credentials signify to the public that a certain level of competence has been demonstrated, and that those who receive unearned credentials can undermine the community's confidence by graduating unqualified students into a profession (Sparks, 2011). Nurses have historically ranked as the most trusted profession (Gallup Poll; Honesty/Ethics in Professions, 2012), and episodes of cheating by nursing students or nursing faculties undermine the public trust in nurses (Randolph, 2007). The effects of cheating in

nursing school can have ramifications for students, faculty-student relations, clients, the nursing program, and the profession of nursing.

The effects of nursing school cheating can result in severe consequences for clients when students do not learn prerequisite information, which needs to be taught and measured carefully in the classroom and clinical areas. For example: if a student nurse had difficulty in independently calculating an accurate medication dosage and relied on a peer to complete the calculations, the instructor must identify this dishonest behavior and provide more instruction and guidance, and ensure student competency. Faculty does not identify and follow-up on episodes of dishonest behavior due to numerous reasons including a sense of: lack of administrative support (McCabe & Katz, 2009); follow-up is too much work (Parameswaran & Devi, 2006); a desire to help students who are otherwise struggling (Lewenson et al., 2005); or wanting students to "like" them (Throckmorton-Belzer, Keith-Spiegel, & Wrangham, 2001). Not taking action to deal with dishonest behavior allows students to continue cheating without guidance and intervention. Dishonest students are likely to continue to behave dishonestly as a registered nurse (Gaberson, 1997). Students who cannot independently calculate medication dosages accurately, and resort to cheating in school, will potentially be causing client harm as registered nurses.

Purpose of the Study

A fundamental assumption for this study was that before students can be trained or guided by faculty on learning how to behave ethically as a student, and carry this behavior into the profession of nursing, the faculty must uniformly agree on what ethical behavior actually consists of, understand how unethical student behavior impacts learning and competence, consistently deal with acts of unethical student behavior according to college policy, and implement strategies that will enhance ethical behavior. The purpose of this study was to

evaluate the impact of a brief faculty development session on: faculty perceptions of how prepared faculty were in identifying and dealing with dishonest and unethical nursing student behaviors, and faculty perceptions of taking action when dishonest or unethical nursing student behaviors are discovered, and faculty willingness to take action when dishonest or unethical nursing student behaviors are discovered. The hypotheses being tested were as follows:

Hypothesis #1: The null hypothesis states that the mean score for identification of dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is less than or equal to the mean score on the Pre-Intervention IRAT. The alternate hypothesis states that the mean score for identification of dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is greater than the mean score on the Pre-Intervention IRAT.

Hypothesis #2: The null hypothesis states that the mean score for the preparedness in dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is less than or equal to the mean score on the Pre-Intervention IRAT. The alternate hypothesis states that the mean score for the preparedness in dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is greater than the mean score on the Pre-Intervention IRAT.

Hypothesis #3: The null hypothesis states that the mean score for the willingness in dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is less than or equal to the mean score on the Pre-Intervention IRAT. The alternate hypothesis states that the mean score for the willingness in

dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is greater than the mean score on the Pre-Intervention IRAT.

A convenience sample of adjunct nursing faculty from an Associate in Science in Nursing program at a large southeastern community college in Florida was used. In this study, Bandura's social learning theory (1977) frames the design of the contextual factors of the faculty development group intervention on unethical behavior where individuals learn from members of a group.

The study intended to investigate faculty perceptions of unethical or dishonest nursing student behaviors. It also intended to analyze the relationships between pre and post-intervention faculty conceptualizations of unethical student behaviors, measured again three months after the learning intervention, and enhance the development of an environment of awareness for professional expectation and follow through. It was predicted that the faculty development session would result in a positive correlation of those who participated in the faculty development session and improvement in their understanding and agreement on what constitutes unethical nursing student behavior, and also what nursing faculty actions were to be performed when an unethical nursing student behavior is discovered, and an increase in their willingness to perform those actions.

Quantitative data was obtained at the beginning of the session identifying individual perceptions of the identification of dishonest or unethical nursing student behaviors, and perceptions of preparedness and willingness to deal with unethical or dishonest nursing student behaviors. The same questions were used in a second survey to enable the participants to analyze similarities and differences between individual adjunct faculty member and adjunct

faculty group perceptions and come to an improved agreement on how to deal with examples of unethical or dishonest nursing student behaviors. A third survey was used to obtain individual participants perceptions of identification, preparedness and willingness levels after the team and group work, and was studied for differences between pre- intervention and post- intervention faculty perceptions. A fourth survey was used at the end of the semester to measure faculty perceptions of unethical nursing student behaviors, and changes are described and discussed. This last evaluation was expected to enlighten the study by analyzing any significant change over time. It revealed the degree to which changes occurred between the learning session at the beginning of the semester until the follow-up survey at the end of the semester. Recommendations for future application and study using the team-based group learning system are discussed in Chapter 5.

Theory

Social learning theories emphasize interpersonal relationships that involve learners to observe, imitate, and model the behaviors of others, thereby internally processing (learning) the actions and relationships (Wenger, 2009), and yet even though something has been processed (learned) in this manner, behavior can go unchanged. The foundation for this inquiry was rooted in Bandura's social cognitive theory, based on the constructs of perceived self-efficacy, modeling and perceived collective-efficacy, which is particularly appropriate for training and learning in groups (Sweet & Michaelsen, 2007).

Contextual Components of the Study

Structured cooperative learning in groups has long been found to be an effective method of training students to work collaboratively (Slavin, 1996), and collaboration, or working and learning interdependently on a team, is a practice that can be taught in nursing school using team-based learning (Yang, Woomer, & Matthews, 2012). This study assessed the effectiveness

of a novel faculty development experience for adjunct nursing faculty at Palm Beach State College. Typically, adjunct nursing faculty members are practitioners who work part-time or less than 30 hours per week, as defined by the institution and must have a minimum of a bachelor's degree in nursing (National League of Nursing Accreditation Commission, Accreditation Manual, 2013). Using a Team-Based Learning (TBL) approach (Michaelson, Watson, Cragin & Fink, 1982; Parmalee & Michaelsen, 2010; Sibley & Parmalee, 2008), the brief intervention, hosted during a three hour afternoon session, attempted to promote a collaborative and constructivist interactive discussion, where faculty were able to voice their varied opinions about academic honesty and worked toward improving outcomes that could be applied in their teaching practices.

Team-based learning has been found to be particularly effective in medical education and has been used to discuss ethically oriented topics (Chung, Rhee, Baik, & Oh-Sun, 2009), and promoting engagement and high levels of satisfaction among participants (Baldwin, Bedell & Johnson, 1997; Bastick, 1999; Haidet & Facile, 2006; McMahon, 2010; O'Malley et al. 2003; Sisk, 2011; Thompson et al. 2007). Team-based learning has also been recently found to be an effective teaching tool in nursing education (Andersen, Strumpel, Fensom, & Andrews, 2011; Clark, Nguyen, Bray, & Levine, 2008; Feingold, Cobb, Givens, Arnold, Joslin, & Keller, 2008; Holleman, Poot, Mintjes-de Groot, & van Achterberg, 2009; Timmermans, Van Linge, Van Petegem, Van Rompaey, & Denekens, 2012).

Summary

Students behaving dishonestly or unethically in their academic endeavors have been studied for decades. The fact that student nurses behave unethically in school, which may then foreshadow unethical behavior as a registered nurse, is of concern to all who might use the services of a registered nurse. With faculty in disagreement about how to identify and deal with

unethical nursing student behavior, the trend for nursing students to continue to behave unethically is facilitated. Professional development is considered to be an effective manner in which to improve faculty management of unethical student behaviors (Andersen et al., 2011; Clark et al., 2008; Feingold et al., 2008; Holleman et al., 2009; Timmermans et al., 2012).

The training session for adjunct nursing faculty was projected to improve understanding about the ethical behaviors that are expected to be demonstrated in the profession of nursing, which when applied to the training and guidance of nursing students, would result in a more competent professional nursing workforce. The literature and research on unethical behaviors, nursing education, professionalism and ethics will be synthesized in Chapter 2, along with an explanation of the theory that grounds this study.

CHAPTER 2
REVIEW OF LITERATURE

Overview

This chapter will synthesize the published research that underlies the study of unethical and dishonest student behaviors. It will begin with the terms and examples used in the study, and continue with a description of unethical and dishonest student behavior studies. Included will be a discussion of the value of developing ethical student behavior and nursing faculty's role in nurturing ethical nursing student behavior. The next section will outline the history of unethical and dishonest student behavior studies, including international student perceptions and situational or contextual factors effecting unethical behaviors. Continuing in this section is a deeper review of the faculty's role in developing ethical student behavior, followed by a section on the history of nursing education, the development of nursing professionalism and ethics, and academic dishonesty in nursing. Faculty perceptions and reactions to unethical student behavior, and faculty turning a blind eye on (ignoring) unethical student behavior, and the impact of administrative support will be reviewed in this section. Finally, Chapter 2 will conclude in an overview of the application of the TBL tools developed by Michaelson, Watson, Cragin and Fink (1982) for group learning, and Albert Bandura's Social Cognitive Theory (Bandura, 1977, 1989).

The purpose of this study is to evaluate the impact of a faculty development session on: adjunct nursing faculty identification of unethical nursing student behavior, and perception of how prepared adjunct nursing faculty are in dealing with dishonest and unethical nursing student behaviors, and adjunct nursing faculty perceptions of taking action when dishonest or unethical nursing student behaviors are discovered. A convenience sample of adjunct nursing faculty from an Associate in Science in nursing program at a large southeastern community college in Florida was used. In this study, Bandura's social learning theory (1977) frames the design of the

contextual factors of the faculty development group session on unethical behavior where individuals learn from members of a group.

The study evaluated the differences between individual adjunct nursing faculty members and the adjunct faculty group identification of and perceptions of unethical nursing student behaviors, and the relationships between pre-intervention, post-intervention, and follow-up data on faculty conceptualizations of unethical student behaviors, and the development of an environment of awareness for professional expectation and follow through. It was predicted that a three hour faculty development session would result in a positive correlation of those who participate in the faculty development session (Tsui & Gao, 2006) in improving their understanding and agreement on what constituted unethical nursing student behavior, and also what nursing faculty actions are to be performed when an unethical nursing student behavior is discovered. It was anticipated that this positive outcome would be achieved due to the individual collaboration that was predicted to be developed during the team collaboration, re-awakening the spirit of caring about honest and ethical practice that initially attracts individuals to become nurses earlier in their professional careers (Day, Field, Campbell, & Reutter, 2005; Eley, Eley, Bertello and Rogers-Clark, 2012).

Unethical and Ethical Student Behaviors

The following section gives examples of definitions of the terms used in this study; discusses some unethical and dishonest characteristics that have been studied; and identifies some of the complicating factors that have confounded the study of unethical behaviors and academic dishonesty. In addition, the value of developing academic honesty as a foundation for professional honesty will be discussed. Finally, faculty's role in the training of nursing students will conclude this section.

Defining the Terms

Cheating behavior, when performed in the context of the nursing profession is unethical, but not all unethical behaviors qualify as cheating (Gaberson, 1997). Cheating behavior, when performed in the student context is the act of being academically dishonest, or may rise to the level of academic misconduct (Clark & Springer, 2007; Correa, 2011; Daniel et al., 1994; Gaberson, 1997). The terms can overlap, so this study will define these terms as follows:

- Cheating and academic dishonesty, when defined in a student context is obtaining or receiving information that was not done within the learning objectives of the intended work and/or circumventing an intended process in order to gain a perceived advantage. It can be planned or spontaneous and based on the context of the moment. For example: telling a lie is considered cheating if a student tells a teacher he was ill and unable to take an exam when he was not ill, and only sought to gain extra time to study more or discuss the exam with someone who had already taken the exam. Academic dishonesty will be used synonymously with cheating for this study.

- Academic misconduct is another form of cheating or academic dishonesty, but is more structured and planned than academic dishonesty, and can rise to a higher level of teacher and school response. For example: changing the grade on a transcript in order to secure admission to a school or employment at a job.

- Unethical behaviors will be defined in the nursing student and faculty context as a breach in conduct or behavior that is contrary to the standardized expectations and demands of the profession of nursing. For example: a statement would be unethical if a nurse told a client that a particular doctor was really the only one who was very good at a surgery the client was about have, or that the client was not able to have any more pain medication so the client had to continue to suffer longer. Plagiarism is also

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considered to be unethical behavior for a student who uses another's work without proper recognition. Plagiarism is a breach of the standardized rules that students must adhere to while attempting to produce papers for assignments.

- Ethical behaviors will be defined in the nursing student and faculty context as honest conduct or behavior that meets and can exceed the standardized expectations and demands of the profession nursing, where the community places trust, and nurses work to maintain the reputation through their professional attitudes and actions.

- Immoral behavior is still a breach in conduct or behavior, but not a break in the professional standard. Immoral behavior is more of a judgment of others in a cultural or community context. For example: a lie would be considered immoral if a husband told his wife he had did not come home on time because he had to stay late at work to finish an important business assignment when he really was meeting his mistress.

- Professionalism is defined in this study in the context of the nursing profession as follows: the practice within a specified group of individuals who have gained specific knowledge from education, training and experience that allows them to enter into (become licensed) and practice (perform their duties) to provide unique and lawful services to a population that has come to expect those services to be delivered in a trustworthy, ethical manner.

- Academic integrity in the nursing student and faculty context is a dedication to act on five basic values: honesty, trust, fairness, respect, and responsibility, even when faced with challenges and adversity (The Center for Academic Integrity, 1999) and is more than simply the opposite of academic dishonesty or academic misconduct.

It is imperative to help students develop academic integrity while they are within the academic setting in order to enable these behaviors to translate into the professions and the communities in which they will be practicing and living. Students, faculty, and administrators all play a vital role in ensuring that ethical behavior has been applied in the curriculum.

Unethical, Dishonest Characteristics and Complications Studies

Academic dishonesty, cheating, and unethical behaviors are not new subjects in academe (Crown & Spiller, 1998; Faulkender et al., 1994; Gaberson, 1997; Gardner, Roper, Gonzalez, & Simpson, 1988; Martin et al., 2009; McCabe & Treviño, 1993; Nuss, 1984; Stern & Havlicek, 1986). Studies conducted over the last several decades have reported that up to 88% of high school and college students have participated in some form of academic dishonesty during their education (Faulkender et al., 1994; Feinberg, 2009; Firmin, Burger, & Blosser, 2007; Gewertz, 2007; Mastin, Peszka, & Lilly, 2009; McCabe & Katz, 2009; Miller, Shoptaugh, & Parkerson, 2008; Stern & Havlicek, 1986; Vilchez & Thirunarayanan, 2011), and that academic dishonesty is on the rise (Callahan, 2004; Daniel et al., 1994; Hughes & McCabe, 2006b; McCabe, 1999). These studies have examined characteristics of academically dishonest students including; personality types (Davis et al., 2009); gender (Davis et al., 2009; Whitley, 2001); IQ and GPA (Hilbert, 1988; Kerkvliet & Sigmund, 1999); age (Anderman & Murdock, 2007); hard science versus liberal science students (McCabe, 1999; Trenholm, 2007); nursing versus non-nursing students (Brown, 2002; Clark & Springer, 2007; Gaberson, 1997; Glen, 1999; Hilbert, 1985; McCabe, 2009; McCabe & Katz, 2009); online versus face to face students (Gaberson, 1997; Harmon & Lambrinos, 2008; Hart & Morgan, 2010; McCabe, 1999; McCabe, 2009; Sparks, 2011; Straw, 2000), and teachers' impact on taking action against academic dishonesty (Keith-Spiegel, Tabachnick, Whitley, & Washburn, 1998; Petress, 2003; Roig, 2001; Sims,1995; Staats, Hupp, Wallace, & Gresley, 2009; Tellings, 2006; Throckmorton-Belzer et al., 2001). All of

these factors were found to be related to academic dishonesty; however the results and nature of the relationship varied significantly across each of the studies.

Complicating the study of academically dishonest student behaviors, or cheating, is how those behaviors are defined differently by both students and faculty (Higbee & Thomas, 2002; PeSymaco & Marcelo, 2003; Solomon & De Natale, 2000; Stern & Havlicek, 1986; Wajda-Johnson et al., 2001). Carter and Punyanunt-Carter (2006) studied student opinion about faculty response to student cheating behavior and found that students also disagreed on what was an appropriate response to confirmed acts of cheating.

Specifically, faculty members are not in agreement amongst each other about how collaboration between students in the college setting is interpreted (Barrett & Cox, 2005; Kohn, 2007). Some faculty encourages collaboration between students while others may label student collaboration as dishonest (Barrett & Cox, 2005; Cole & McCabe, 1996; Graham, Monday, O'Brian & Steffen, 1994; Muldoon, 2011; Price et al., 2001). Higbee and Thomas (2002) and PeSymaco and Marcelo (2003) each found varied levels of faculty agreement about whether turning in the same paper twice in two different courses, or talking to another student who has already taken an exam, is academically dishonest. This lack of agreement between faculty members about what constitutes academic dishonesty contributes to student miscommunication about what is considered academically dishonest behavior in both face to face and online classes (PeSymaco & Marcelo, 2003).

The Value of Developing Ethical Student Behavior

The value of developing ethical student behavior is at the foundation for ethical professional behavior. Academic integrity is an integral part of education (Beckett, Gilbertson, & Greenwood, 2007), and an essential component of developing an ethical approach to becoming an ethical professional. Since student cheating in the classroom may be indicative of

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cheating later in a profession or career (Bouville, 2010; Bradshaw & Lowenstein, 1990; Daniel et al., 1994; Gray & Smith, 1999; Martin et al., 2009; Nonis & Swift, 2001) students who are able to be dishonest through school can graduate without the moral, ethical and social skill sets that will be required in the professions in which they are trying gain entrance (Gaberson, 1997; Lewenson et al., 2005; Parameswaran & Devi, 2006; Sparks, 2011; Stern & Havlicek, 1986; Sternberg, 2011) and in the leadership roles that they will assume within their society (Resick et al., 2011). Faculty must therefore include ethical development into the academic curriculum (Cartwright, Davson-Galle & Holden, 1992).

Nursing Faculty Role in Developing Ethical Nursing Student Behavior

The nursing faculties' role includes training students in the profession and ethics of nursing (Ludwick & Silva, 1999) and to prepare them to contribute to health care quality and safety (National League of Nursing; The Four Core Values, 2011) as professional nurses. Ethical nursing occurs when a "good nurse does the right thing" (Kelly, 1992, p. 11). When nursing students do not actually learn requisite lessons due to academically dishonest behaviors, they not only circumvent the traditional assessments in school, they also may not have internalized the necessary skills to conduct themselves as professional and ethical nurses after graduation (Bouville, 2010; Randolph, 2007; Stern & Havlicek, 1986). Unethical nurses can harm the clients they care for, the profession of nursing, the schools from which they graduate and themselves. Ethical nurses are more likely to properly care for clients as expected, and be a credit to the profession, their schools and themselves (White, 2001).

A History of Unethical and Dishonest Student Behavior

The following section will describe the background of some unethical student behavior studies, the personal characteristics of who is dishonest, including why and how students are dishonest, and a discussion of unethical and dishonest student behaviors and perceptions that

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have been reported in the literature. Next, some differences between North American and international students' perception of cheating and unethical behavior will be explored. Finally, this section will conclude with the situational or contextual factors that influence academically dishonest or unethical student behaviors.

Unethical Student Behavior Studies

Academic dishonesty has been studied in the literature for almost a century (Brown & Emmett, 2001; Correa, 2011; Crown & Spiller, 1998; Spiller & Crown, 1995). Research into these unethical student behaviors stems from a society and faculty concern that students who cheat their way through school could graduate without the skills required to be ethical and competent professionals (Kasprzak & Nixon, 2004; McCabe et al., 2001a). Many of the studies that investigated academic dishonesty used the term "cheating"; however some of these researched "cheating" behaviors are considered in this study as unethical behaviors. These past studies are significant because correlations between student cheating and professional cheating have been established in several professions including business (Elmore, 2009; Martin et al., 2009; Nonis & Swift, 2001; Parameswaran & Devi, 2006; Petress, 2003), medicine (Papadakis et al., 2005), and nursing (Baxter & Boblin, 2007; Langone, 2007; Lewenson et al., 2005; Semple, Kenkre, & Achilles, 2004; Solomon & DeNatale, 2000; Stern & Havlicek, 1986).

The majority of the studies report using a self-report methodology (Black, Greaser, & Dawson, 2008; Brown, D., 2002; Hart & Morgan, 2010; Higbee & Thomas, 2002; Hilbert, 1985, 1988; McCabe, Treviño, & Butterfield, 1999; Stuber-McEwen, Wiseley, Hoggatt, 2009); however other forms of inquiry are also reported, including Randomized Response (Grijalva, Nowell, & Kerkvliet, 2006; Kerkvliet & Sigmund, 1999; Ostapczuk, Moshagen, Zhao, & Musch, 2009; Scheers & Dayton, 1987), qualitative interview (McCabe, 1999), Multidimensional Scaling (MDS) or pairing of dishonest behaviors (Pincus & Schmelkin, 2003), and actual

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deception (Gardner et al., 1988; Kerkvliet & Sigmund, 1999; Nowell & Laufer, 1997; Tittle & Rowe, 1974). Standing and Shearson (2010) considered the order that items were presented on a questionnaire and demonstrated that item order is a rarely studied example of methodological bias in examining student cheating behaviors. Each of these methods discusses strengths and weaknesses.

Who, Why and How

Numerous studies have considered the personal characteristics of students who either participate in or report that they participate in dishonest behaviors in order to mitigate dishonest and unethical student behaviors (Burrus et al., 2007; Franklyn-Stokes & Newstead, 1995; Hughes & McCabe, 2006b; McCabe & Treviño, 1993; McCabe, Treviño & Butterfield, 1999; McCabe, Treviño & Butterfield, 2001b; Newstead, Franklyn-Stokes & Armstead, 1996; Trushnell, Byrne & Simpson, 2011). The following section will describe who has been reported to be dishonest or unethical, and why and how it is done. Many of these characteristics will overlap.

Who is an unethical or dishonest student?

At one time psychologists thought that there was a particular personality type that lent itself toward dishonest behaviors (Davis et al., 2009) however this has not been empirically demonstrated. Rather, studies have looked at male/female relationships, with men behaving dishonestly slightly more than women (Anderman & Murdock, 2007; Davis et al., 2009), and women having more negative attitudes about dishonest behaviors (Whitley, 2001). Students with a higher IQ or GPA are dishonest less frequently than lower IQ students (Davis et al., 2009; Hilbert, 1988; Kerkvliet & Sigmund, 1999).

Burris et al. (2007) found that pre and post-survey results of college students who were given a definition of cheating were more likely to self-report cheating behaviors after the

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definition had been provided, which correlates with Standing and Shearson's results of item order on a self-reported cheating questionnaire study published in 2010. Anderman and Murdock (2007) reported that cheating and age are not correlated in a linear relationship, as cheating increases during K-12, and diminishes through college, graduate school, and professional school, which is charted as a curvilinear effect increasing through elementary and high school, and diminishing through college. The hard science courses that usually use objective tools to measure learning have more dishonest students than liberal science courses that involve essay tests according to Anderman and Murdock (2007), McCabe (1999), and Trenholm (2007). Students with high efficacy are less likely to be academically dishonest, and conversely students with low efficacy are more likely to be dishonest, and under contextual situations like increased stress, have a significantly more positive, acceptable attitude about dishonesty (Anderman & Murdock, 2007; Gewertz, 2007) and ironically, past cheaters are likely to have expectations of success in the future. Finally, Milliron and Sandoe (2008) find that college cheating is pervasive throughout the Net Generation, and these students have no distinguishing characteristics since the behavior is widespread across the entire generation.

Why and how are students unethical or dishonest?

It has been reported by Davis et al. (2009), Sparks (2011), and Raines, Ricci, Brown, Eggenberger, Hindel & Schiff, 2011) that students frequently behave dishonestly to achieve a better grade than what the student thought could be earned on their own without dishonest behavior, however cheating has been shown to be influenced by many factors (McCabe & Katz, 2009; McCabe et al., 2001a, 2001b; Shipley, 2009; Stern & Havlicek, 1986; Sternberg, 2011; Walker & Townley, 2012; Whitley, 2001; Wotring & Bol, 2011; Wowra, 2007). Several confounding variables may influence why students, who indicate that they understand what academic dishonesty (cheating) is, and that it is unacceptable, still go on to become cheaters.

These complex issues have been frequently studied in an effort to find a cause for academic dishonesty to thereby design a remedy to mitigate dishonest behaviors or devise curriculum to enhance integrity (academic honesty). McCabe and Treviño (1996) argue that students who have lived in a society that is frequently fraught with reports of ethical misconduct have a disconnect between the "real world" and standards of academic dishonesty, seeming to believe that getting the degree in order to pursue a career, no matter how that degree is obtained, is the ultimate educational experience (Sapp, 2002; Xueqin, 2002). All of the reported studies agree that there is no single reason why students are academically dishonest.

Some students simply do not view academically dishonest behaviors as cheating (Gaberson, 1997; McCabe, 1999; Tanner, 2004; Wajda-Johnston et al., 2001). Some high school students rationalize their academic dishonesty by blaming others, including society, parents, schools and teachers, while others students hold the belief that cheating is a normal part of everyday life, and everybody does it (Gaberson, 1997; McCabe, 1999; PeSymaco & Marcelo, 2003). Some studies describe students' rationalization of academically dishonest behaviors as being driven by pressures from parents, employers, schools and peers to achieve high grades (Christe, 2003; Davis et al., 2009; Gomez, 2001; Laird, 2001; Wowra, 2007).

International Students' Differences in Perception

Non-native students, particularly those who speak English as a second language, may have a culturally different view of plagiarism and academic dishonesty than Western students (Amsberry, 2010; Correa, 2011; Mundava & Chaudhuri, 2007; Russikoff, Fucaloro, & Salkauskiene, 2003; Sapp, 2002). To successfully earn the qualification to attend undergraduate or graduate studies in the United States is a life changing opportunity for a foreign student. These high achievers, who have competed with their peers throughout their lives to obtain an offer to study in the United States, can misunderstand what Western schools believe is academic

dishonesty. In a study by Marcus (2011), one in 53 international students had been charged with academic dishonesty compared to one in 1,122 Canadian students. Being accused of academic dishonesty can result in expulsion from the school and being returned to their home country in disgrace (Marcus, 2011).

Western students are encouraged to critically think, to discuss and challenge, even to question their instructors. Asian students however are taught to memorize material and never question the teacher, even if that teacher is wrong (Badke, 2002). In cultures where individualism is non-existent, and collectivism is the social context, students from China, Poland, Russia, and Latvia do not understand how the thoughts and words of one person belong to that one person, and therefore struggle with the requirement to cite others' work in Western schools (Amsberry, 2010; Correa, 2011; Lupton, Chapman, & Weis, 2000; Russikoff, Fucaloro, & Salkauskiene, 2003; Sapp, 2002; Xueqin, 2002). Marcus (2011) reports that Chinese students believe they are honoring the author when using that person's words without citing a reference.

Situational or Contextual Factors

Some researchers have reported that the more consistently a teacher or a peer will take action when dishonest behavior is discovered and the more severe the penalty, the less likely the student will behave dishonestly (Christe, 2003; Davis et al., 2009; Gomez, 2001; Harmon & Lambrinos, 2008; Laird, 2001; Miller, Shoptaugh, & Wooldridge, 2011; Wowra, 2007). Several studies discuss the lack of faculty involvement, or a feeling that students can get away with dishonest behavior, as a significant factor in students' cheating (Christe, 2003; Correa, 2011; Fontana, 2009; McCabe, 1999; Miller et al., 2011; Staats et al., 2009; Stearns, 2001).

Students have reported feeling compelled to help another student to behave dishonestly to be successful because of a personal friendship, pity, competition, or a perceived lack of "teaching" from the instructor (Christe, 2003; Davis et al., 2009). It has been frequently reported

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by students that it is all but impossible to "rat on" (inform on a peer to an instructor) another student, causing major reluctance in reporting known acts of dishonesty by friends and peers, thereby allowing students to be openly dishonest without negative consequences (Cole & McCabe, 1996; Kerkvliet & Sigmund, 1999; McCabe, 1999; McCabe et al., 2001b; Wryobeck & Whitley, 1999). Firmin et al. (2007) report that students who witness dishonesty on an exam go through five cognitive stages in order to process the behavior before it can be neutralized, starting with recognition of the observed cheating behavior; shock and disbelief; rationalization; realization and finally resolution. Often, cheating students know that academically dishonest behaviors are wrong (Snyder, 2004; Stuber-McEwan et al., 2009) and may seek to neutralize the cognitive dissonance caused by their cheating behaviors (McCrink, 2010; Stern & Havlicek, 1986). Students who perceive other students behaving dishonestly are more likely to neutralize their attitude, or justify the academically dishonest behavior and therefore might not find it as morally reprehensible (Gomez, 2001; O'Rourke, Barnes, Deaton, Fulks, Ryan, & Rettinger, 2010).

Wryobeck and Whitley (1999) found that dishonest students are often viewed more harshly than their accomplices by their peers, seeming to make a distinction about a dishonest behavior, and assisting in a dishonest behavior. The more likely the dishonest person is a friend, or is seen as a sympathetic person, the less likely peers will be to report the dishonest person, and more likely to abet dishonest behaviors. A lack of an honor code (McCabe & Treviño, 1993; Wajda-Johnston et al., 2001) has been reported to contribute to increased dishonesty, and involvement in an athletic or a Greek organization has been linked by Wajda-Johnston et al. (2001) to an increased tendency for dishonest behavior. McCabe (1999) also found that students in large crowded classrooms feel that it was easier to be dishonest than when in a smaller, monitored

classroom. Academic dishonesty is therefore less likely to happen when students are more closely monitored in smaller classes.

Nursing Education and Nursing Student Behavior

Nurses have been developing formal, structured educational programs to train students since the 1800's, promoting their profession through standardized education, a code of ethics, peer review and continuing education (Starr, 1982). This training is intended to prepare student nurses to become qualified registered nurses who will be responsible for the delivery of client care, including not only the planning and delivery of client care, but the documentation of that care on the legal record, the administration of narcotic medications, the complete and honest communication with the rest of the health care team, and even contribute to life and death decisions (Wilkinson & Treas, 2011). Unethical nursing student behaviors are a concern to faculty and society since graduates who have not actually mastered required material can then be licensed to practice on the society, but may not be competent to practice on the society (Bailey, 2001; Elmore, 2009; Fass, 1986; Langone, 2007; Petress, 2003). An important impact that dishonest students have on nursing educational programs is the improper holding of a student seat in a nursing program, thereby excluding a qualified student from entering the program and becoming a graduate nurse who will then become a professional registered nurse. Consequently, nursing students who are initially successful due to dishonest behaviors can later fail out of the program, causing student and faculty disappointment, and a delay in placing a qualified candidate into the program (Gaberson, 1997) and subsequently into the profession.

The Evolution of the Profession of Nursing and Professional Nursing Education

From the mid 1800's when Charles Dickens portrayed a nurse as drunken and dishonest (Judd et al., 2010), Florence Nightingale was able to positively influence and transform that belief into the idea that nursing was a career that good women could participate in for the benefit

of the community (Holliday & Parker, 1997; Palmer, 1985; Zilm; 1993). Nightingale enjoyed national hero status after intervening in the physician dominated world of client care and successfully nursing wounded British soldiers in the Crimean War (Holliday & Parker, 1997), decreasing the mortality rate by 46% (Wilkinson & Treas, 2011). She used that popularity to focus the public's attention on changing perceptions about nurses and nursing training. She was not successful in moving the nursing training out of hospitals where students exchanged their free labor for their nursing training (Baly, 1986; Ruby, 1999; Zilm, 1993), but increasingly more women were personally called to care for the sick and injured in more than a voluntary capacity (Holliday & Parker, 1997). The hospitals continued to be dominated by mostly male physicians (Baly, 1986; Palmer, 1985) who depended on female nursing students who were apprenticed to do what the doctors ordered, without an understanding of why the task should be done (Hanson, 1989; Ruby, 1999).

Nursing in the United States was influenced by the standard set by Nightingale in England, and the training of nurses continued to be directly tied to hospitals for decades (Hanson, 1989). After the Civil War in the United States, citizens moved from the rural farmlands into the cities, adding to the influx of immigrants where the populations exploded. This resulted in overcrowding of the poorest parts of the cities and creating more health problems. Again, nursing developed a way to intervene by creating a public health nursing service for indigent inner city dwellers who had no other recourse to receive healthcare (Hanson, 1989). These efforts were again stalled by the mostly male physicians, and hospital administrators and trustees who saw this nursing movement as a means to deny the hospitals of revenue, so the physicians lobbied to put a stop to the public health nursing movement (Baumgart & Kirkwood, 1990).

In the continuing struggle to demonstrate professionalism, the Nurses' Associated Alumnae of the United States and Canada, the precursor to today's American Nurses Association (ANA), was founded in 1896 with the intent to license nurses (Egenes & Burgess, 2001). This sparked statewide interests to develop a nurse practice act outlining standards for licensure in each state. Of concern was a lack of consistency about the training for nurses, and the standards used to select candidates for entrance into training (Palmer, 1985; Ruby, 1999). Some schools required physical strength as a prerequisite to enter school; some had no requirements, including no academic requirements. This resulted in the formation of the American Society of Superintendents of Training Schools of Nursing, the precursor for today's National League for Nursing (NLN) (Egenes & Burgess, 2001). Universities began to offer more scientific didactic education, but these programs lacked a leader who could outline a consistent recommendation for even the entrance into a nursing program, and certainly there was no agreement on what the curriculum should include in the nursing program. Programs varied at that time from two to five years in length. So while the nursing leaders disagreed and stalled the progress, other professions painfully birthed their tenets and guidelines and moved closer to what we today consider a profession (Egenes & Burgess, 2001; Hanson, 1989).

In 1909, the Nurse's Associated Alumnae of the United States and Canada became the American Nurses Association (Judd, et al., 2010). Critical articles against the reform of nursing education moving out of the hospitals and into the universities were published in favor of the physicians' stand in the American Journal of Nursing. Doctors expressed the concern that educating nurses would be dangerous and encourage nurses to challenge a doctor's orders, and that higher education would diminish a nurse's disposition toward executing the menial tasks involved with total client care (Hanson, 1989).

War again played a part in the progress of nursing becoming a profession. Leaders and politicians in both World War I and World War II were able to influence the development of nursing toward the goal of professionalism requiring a plan to graduate thousands more nurses to care for anticipated soldier injuries (Orsolini-Hain & Waters, 2009). Private foundations and the Federal Government offered money and support, and nursing students found that classes were being given in both the hospital and the university setting to build a foundation of knowledge. This resulted in a two year *technical* (terminal) nursing degree that was intended to replace the longer three year hospital programs. These nurses were intended to serve as team members under the leadership of a registered *professional* baccalaureate qualified nurse. The reality for the competent Associate Degree Nurse evolved quickly into filling leadership positions, and no practical distinction was made by the Institute of Medicine (Fairman & Okoye, 2011) or hospitals in hiring or staffing the wards with 2, 3, or 4 year degree nurses (Orsolini-Hain & Waters, 2009).

In the past 40-50 years, the evolution of the profession of nursing regarding the education, training and licensing of its nursing graduates has been debated, and is still not agreed upon between nursing leadership and advocates of each program (American Nurses Association Position Statement, 2012; Donley & Flaherty, 2008; Gosnell, 2002; Joel, 2002; Mahaffey, 2002; Petry, 1943; Smith, 2009). The core nursing curricula are similar for all three programs, and hospitals have been slow to acknowledge differences in qualifications, therefore states and the national professional nursing organizations have unsuccessfully struggled to influence the minimal entrance into professional practice at the suggested baccalaureate level.

The ANA through the American Nurses Credentialing Center for Accreditation (2013) and the NLN through the National League for Nursing Accreditation Commission Purpose Statement

(2012) have published criterion benchmarks and standards in which nursing teaching programs must adhere in order to continue offering their programs. These regulatory boards are nationally recognized, but each state has a professional licensing board that also regulates how a student can become a nurse, what the scope of practice is and how that nurse must perform in order to maintain the state registered nurse license, including lifelong learning known as continuing education (DeSilets, 1998; Stein, 1998).

A History of Nursing Ethics

Historically, nursing students and practicing registered nurses have been found to have a strong "caring" personality (Day et al., 2005; Eley et al., 2012). Being traditionally a female dominated profession, Noddings feminist approach compared the responsibility of the delivery of nursing care to strangers as similar to a mother caring for her child and described this as ethical caring (McAlpine, 1996). Although ethics has been abundantly discussed in the literature (Baxter & Boblin, 2007; Faulkender et al., 1994; Feinberg, 2009; McAlpine, 1996) and encouraged to be included in academic curricula (Bond, Mandleco, & Warnick, 2004; Dinç & Görgülü, 2002), ethics in nursing is an evolving concept (Fowler, 2010; Turner & Rufo, 1992) that is foundational for professional identity.

The first code of ethics in nursing was introduced in 1893 by Lystra Gretter as a pledge for students to make at graduation, and was named in honor of Florence Nightingale (Fowler, 2010). The recitation of the Nightingale pledge is a tradition that is still practiced in nursing graduation classes today. The code evolved to reflect the changes in society and the role of women specifically. The first iterations of the nursing code of ethics of 1903 stated that while ethical standards were to be promoted, those standards included not only caring for the sick, but also listed Christian morality, obedience, submission to the rules, social etiquette and loyalty to the physician (Viens, 1989). The code of ethics in the mid-1920s evolved by listing involvement in

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the nursing organization and continued education as prerequisite for the profession, yet continued to list the proper ethical behaviors of a nurse to include being obedient, trustworthy, loyal and adept in social etiquette. By mid-century, World War II had influenced nursing to abandon its blind loyalty to the physician and proper social etiquette, and include the concepts of disease prevention and health promotion as being as important as caring for the sick and injured. All terminology relating to the nurse's personal ethics and physicians had been removed by 1968 (Fowler 2010), and was replaced by the nurse's responsibility to the client's care, safety and autonomy (Davis, 1991), society, and the nursing profession (Viens, 1989).

Today, the 2001 Code of Ethics for Nurses with Interpretive Statements described by the ANA (Fowler, 2010) warns that the statements are not directives about how to address specific events or changes, but rather a means by which a registered nurse can approach a category of concerns (Fowler, 2010, p. xvii). This format intentionally avoids mandating specifics about how much each category must be weighted or considered, allowing the code of ethics to be consistent, yet flexible enough to respond to change (Fowler, 2010).

The major principles of nursing ethics that are included in the training of nursing students today (Turner & Rufo, 1992; Wilkinson & Treas, 2011) include the following:

- Autonomy: the client's right to be responsible for his or her own health. Nurses therefore cannot paternalistically make all decisions for a client. Autonomy is accomplished by educating the client and obtaining informed consent.

- Beneficence: the concept of 'doing good' for the client. Nurses practice beneficence when they consider the impact of treatments versus the harm that they can cause.

- Nonmaleficence: the prevention of harm by the stopping of something that is detrimental to the client. Prevention of a fall for a client who is at risk is an example of nonmaleficence.

- Justice: the proper use of resources in the care of a client. Allocation of resources for client care, when those resources are not endless, is the ethical dilemma that nurses must consider when caring for clients with limited funds or insurance. Using under qualified staff to deliver client care is another example of an ethical problem.

- Veracity: the concept of being honest and telling the truth. A dilemma can occur when the nurse must decide how much of the truth should be shared with the client. This concept can also include the act of whistleblowing on peers, colleagues or institutions.

- Fidelity: the principle of keeping all the other ethical principles balanced. It involves being trustworthy and dependable; to do what is supposed to be done for the good of the client. It requires the nurse to keep the needs of the client above the need of self.

The ethical problems that nurses encounter in practicing nursing each day have evolved over the past century, as outlined by the Nursing Code of Ethics (Fowler, 2010). The Code of Ethics is a scrutinized guideline that helps registered nurses to practice ethically, and registered nurse educators to model and direct the behavior that will help nursing students to practice ethically. This study will focus on the nursing faculty improving their agreement on what cheating is, and their understanding of what to do for unethical or dishonest nursing student behaviors by reporting an improved perception of the ethical concepts of veracity, or being truthful; and fidelity, or being trustworthy and dependable.

Academic Dishonesty in Nursing

Research indicates that associate degree and baccalaureate nursing students cheat at the same rate as non-nursing students (Bailey, 2001; Brown, 2002). Hilbert (1985) examined unethical classroom behaviors, including copying without referencing, turning in someone else's' work as their own, and submitting a purchased paper, and found a positive correlation with unethical clinical behaviors, including the recording of medications and treatments as being

done when they were not done, not reporting a client incident, and coming to the clinical area

under the influence of drugs or alcohol. Daniel et al. (1994) found while using Maslow's Need-

Goal Motivation Model, many variables (peers' maturity, academic commitment, and

neutralizing attitude) had a positive relationship with their baccalaureate peers' expectation of

involvement in various acts of academic dishonesty. Specific clinical dishonest behaviors

discussed included falsifying client records (Baxter & Boblin, 2007; Langone, 2007) non-

reporting of medication errors (Gaberson, 1997), and the documentation of treatments that were

never performed (Bailey, 2001; Wilk & Bowllan, 2011). The increased use of technology by

nurses contributed to an increase in what Harper (2006, p. 672) termed "high tech cheating" in

the workplace where computers are used to document client care.

Gaberson (1997, p. 14) states that even if nursing student "cheating is inevitable", faculty

must respond with the appropriate disciplinary reactions, and tactics to avoid future dishonest

actions. Gaberson studied the impact that students' academic dishonesty has on clients who can

then be harmed; the faculty student-relationship which should be based on trust and respect

which can be destroyed; the peers who resent dishonest students progressing without investing

the effort to learn; the nursing program's reputation that can be irreparably damaged; and the

registered nurse who is not able to make appropriate ethical judgments because these skills have

not been acculturated as a nursing student. Each of these student concerns could impact future

professional practice, and several strategies were offered to enable academic honesty in nursing

students, including: development of moral character and moral decision making skills, role

modeling, and developing and enforcing an academic integrity policy.

McCabe (2009) postulates that the pervasive use of the internet today suggests that

academic cheating must be empirically studied in all disciplines to determine the extent to which

cheating is actually taking place. McCabe's nearly two decades of academic ethics research lead to a study of nursing ethics. He found that nursing students cheat less than non-nursing students in two areas: 'falsely delaying an exam', and 'using unauthorized crib notes'; and cheated more in two areas: 'collaboration', and 'getting information from someone who has already taken a test'. McCabe also notes that undergraduate overall nursing students self-reported cheating at 58% compared to undergraduate non-nursing students at 72%. Nursing graduate students reported cheating at 47% compared to non-nursing graduate students who reported cheating at 48%.

Faculty and their Responses

During episodes of student cheating, faculty members respond with many different reactions, some of which may be consistent with official academic policies and some of which may not (Pincus & Schmelkin, 2003; Price et al., 2001; Simon et al., 2003; Sims, 1995). Inconsistent application of academic policy can undermine the college, the program, the students and the instructor. Some faculty reactions have even been reported to directly increase student academic dishonesty (Kohn, 2007; Levy & Rakovski, 2006; McCabe & Pavela, 2004; Semple, et al., 2004) including student perceptions of a lack of faculty involvement in classroom proceedings, being given a boring or unreasonable assignment, or being administered an identical assignment or exam that has been given for several previous semesters.

Adjunct Faculty

The definition of the part time adjunct faculty role is not universally defined (Creech, 2008). The Bureau of Labor Statistics (2012-2013) classifies part-time employees as working less than 35 hours per week, but this number can vary, depending on the definition and needs of an institution (Green, 2007). One half (McLaughlin, 2005) to two thirds (Wallin, 2004) of the faculty at community colleges consist of part-time faculty. This majority ratio has been

increasing in the last few decades (Charlier & Williams, 2011; Creech, 2008; Dedman & Pearch, 2004; Gaillard-Kenny, 2006), and is projected to continue to grow as more students enroll in face to face, online, and blended college courses (The Bureau of Labor Statistics, 2012-2013).

Part-time or adjunct faculty (Caprio, Dubowsky Warasila, Cheatwood, & Costa, 1998) enters into the teaching arena for many reasons. Practitioners and instructors who teach part time can supplement their income without the constraints of a full time commitment, adjusting their workloads when changes are desired (Green, 2007). Some part time employees find satisfaction in giving back to the community and to the development of future practitioners (Dedman & Pearch, 2004; McLaughlin, 2005) whereas some professionals enjoy the limited teaching responsibilities that help to keep them active and intellectually stimulated after retirement from their professional careers. Some adjuncts view a part-time position as a pathway to a full-time tenured teaching position (McLaughlin, 2005), and others use the part-time teaching job as a way to ease away from their children, and to relate with other adults (Green, 2007). Some adjunct faculty are willing to work on weekends and in the evenings after their full time job, and these hours are attractive for the non-traditional students who must also hold down a job during the day (Caprio et al, 1998; Gaillard-Kenny, 2006).

Adjunct faculty has played a major role in staffing the teaching positions at academic institutions across the nation, particularly in the community colleges. Studies have been conducted recently to analyze the impact of this growing teaching group at all levels of teaching institutions to assess the full-time tenured faculty-to-adjunct faculty ratios, but there exists confusion about roles, hours scheduled versus hours worked, and adjunct contributions to teaching, service, and research (Creech, 2008). Administrators value adjuncts for their scheduling flexibility and filling last minute gaps in staffing without the commitment of using

contracted faculty when the student census or budgetary cuts drop the enrollment census (Caprio et al., 1998). Adjunct faculty educators are less expensive than full-time tenured educators (Caprio et al., 1998; Creech, 2008; Dedman & Pearch, 2004; McLaughlin, 2005; Wallin, 2004), and adjuncts frequently bring current, professional expertise to the classroom since many of them are also specialists in their field of practice (Bedford, 2009; Caprio et al., 1998; McLaughlin, 2005)

There is a registered nurse shortage of over one half million qualified nurses projected to occur by the year 2020 (Bureau of Labor Statistics, 2012-2013), yet 75,587 qualified nursing students were turned away from nursing schools in 2011 (Rosseter, 2012). Full time nursing faculty could not realistically conduct both the classroom and clinical components of nursing training exclusively without sharply increasing their numbers; therefore a team effort of full-time and part-time faculty in the nursing curriculum has evolved. Nursing adjunct faculty is valued for their clinical expertise by full time faculty where the adjunct faculty teaches the bulk of the clinical assignments.

One contributing factor to not enrolling qualified student candidates into nursing school is the shortage of nursing faculty (Faculty Shortages in Baccalaureate and Graduate Nursing Programs: Scope of the Problem and Strategies for Expanding the Supply, 2005; Rosetter, 2012), and contributing to this shortage is the median age of the nursing workforce, which is about 46 years old (Faculty Shortages in Baccalaureate and Graduate Nursing Programs: Scope of the Problem and Strategies for Expanding the Supply, 2005). Hinshaw (2001) refers to this as the "greying out" of faculty who are retiring without a pipeline of younger qualified educator replacements. Using the adjunct nursing faculty in the clinical setting is a means in which more qualified students can be enrolled to become nurses, replenishing the retiring supply of aging

nurses, and potentially contributing to the preparation of qualified graduates who will be needed in the future.

Faculty Turning a Blind Eye

Many institutions of learning have academic standards that students are required to put into practice (DeAngelis, 2011; McCabe, et al., 2001a; McCabe & Pavela, 2004; Whitley & Keith-Spiegel, 2001). These standards can vary among institutions, but they are published in order to guide both students and faculty in the expectations for conduct. Study results however demonstrate that as many as one third (Correa, 2011) to one half (Milliron & Sandoe, 2008) of faculty do not follow the published procedures for episodes of academic dishonesty due to a lack of knowledge about the procedures, an opinion that the procedures are too complicated, or the penalties to students are too harsh, or just a belief that the first time offender can be dealt with in a less formal, one-on-one manner with the faculty member not following the expected published procedures (Correa, 2011; Fontana, 2009; Wideman, 2011). The significance of this finding is that studies have also shown that faculty who relax the rules of academic honesty will be seen as promoting an environment that is safe for dishonest students, causing honest students to either resent that treatment or become cheaters themselves (Firmin et al., 2007; Hughes & McCabe, 2006b; Ryan, 1998).

A contributing factor toward this faculty confusion stems from nursing education's late entry into higher education and a lack of educational preparedness (Findlow, 2012). Findlow asserts that the entry of nursing education into the university has removed nursing from vocational to professional status with a preponderance of "mature and female students and practitioners" (p. 121), but potentially lacking the faculty preparation necessary to make this transition successfully. Coren (2011) found that 40.3% of faculty preferred to deal with episodes of student cheating by simply ignoring the behavior and excusing themselves by explaining that

there was a lack of evidence, or the offense was trivial in their opinion, or that they just did not have the time. Coren (2011) also found that faculty who were more likely to ignore the dishonest behavior had high stress levels when confronting students, especially if there was a concern that the student would become emotional. Parameswaran and Devi (2006) point out that before students can be reprimanded, the faculty needs to be consistently using the institution's academic standards uniformly. Fear of student retaliation or legal ramifications by students and their lawyers was another concern (Hard, Conway, & Moran, 2006; Keith-Spiegel et al., 1998).

Lewenson et al. (2005) described an adjunct faculty member who lacked follow through on a blatant episode of cheating. A student who had witnessed the incident, but did not participate, informed a faculty member about an adjunct faculty member's behavior during a test. The adjunct had allowed collaboration on an exam between some students, and explained that she did not think this was cheating because the participating students were at a disadvantage due weak language skills, and she was "only trying to help". This variation in the interpretation of the academic standards and the inequity of follow through is a confounding factor that impacts the amount of cheating that occurs in the classroom and the clinical setting, and the ability of students to behave ethically.

Faculty Reaction Studies: Overworked and Under Supported

When faculty deny that students cheat, this attitude of denial or simply a lack of awareness on the part of the faculty has resulted in an underestimation of how much cheating is actually occurring (Hard et al., 2006; Volpe, Davidson, & Bell, 2008; Wajda-Johnston et al., 2001). Faculty ignore academic dishonesty in students due to fear of repercussions (Jeffreys & Stier, 1995; Throckmorton-Belzer et al., 2001); a feeling of "what you don't know can't hurt you" (Tellings, 2006, p. 363); or a generalized fear of insufficient evidence combined with a lack of administrative support (Keith-Speigel et al., 1998; Parameswaran & Devi, 2006; Petress, 2003;

Schneider, 1999; Staats et al., 2009). Wajda-Johnston et al. (2001) found faculty perception of cheating is much lower at 0-10% and Koljactic & Silva (as cited in Hard et al., 2006, p. 1059) also found faculty perception lower. Hard et al. (2006) found a positive correlation between faculty beliefs of student dishonesty and the amount of preventative measures that faculty members were likely to initiate or dishonest student behaviors likely to be challenged. McCabe and Pavela (2004) surveyed over 2500 faculty to find that less than two-thirds had even published academic integrity expectations in their syllabi, and Roig (2001) and Cole and McCabe (1996) found faculty could not identify what plagiarism was, and therefore did not follow-up on incidents of student plagiarism.

Faculty Lacks Agreement on what Constitutes Unethical Student Behavior

Several authors (Higbee & Thomas, 2002; Muldoon, 2011; Pincus & Schmelkin, 2003) have found that faculty disagrees on how to consider student collaboration on assignments that have been directed to be individually completed. Some faculty find that collaboration can be a form of social support to assist classmates in the learning process and the development of teamwork skills (Barrett & Cox, 2005), while others believe that collaboration can be interpreted as cheating under certain circumstances (Misra, McKean, West, & Russo, 2000; Nuss, 1984; Pickard, 2006; Pincus & Schmelkin, 2003; Price et al., 2001). When faculty cannot come to agreement about what constitutes unethical student behavior, it is unlikely that ethical behavior will be modeled or taught consistently by the faculty. This inconsistency can cause student confusion when trying to be successful in practicing ethically as a student, and eventually as a registered nurse.

Purpose of the Study

In a review of the literature on unethical nursing student behavior, its impact on the profession of nursing, both non-nursing students and nursing students have been discussed.

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Faculty and administrative reactions and support have also been reported in an effort to try to learn how to mitigate student cheating (Lewenson et al., 2005). A fundamental premise for this study was that before students can be trained or guided by faculty into learning how to behave ethically as a student, and carry this behavior into the profession of nursing, the faculty must uniformly agree on what ethical behavior actually consists of, understand how unethical student behavior impacts learning and competence, consistently deal with acts of unethical student behavior according to college policy, and implement strategies that will enhance ethical behavior.

The purpose of this study was to evaluate the impact of a training session in adjunct nursing faculty interpretation and reaction to dishonest or unethical nursing student behaviors, and on adjunct nursing faculty preparation and willingness to follow through on academically dishonest and unethical nursing student behaviors. It was believed that a training class in unethical behavior would enhance adjunct nursing faculty perception of unethical student behavior, and help to develop an environment of awareness of professional expectation and follow through for training nursing students in the ethical practice of the profession of nursing.

Team-Based Learning

In an effort to mitigate student unethical and dishonest behaviors, faculty must include ethical and honest behavior training into the nursing curriculum in order for the profession of nursing to enjoy ethical practitioners. A successful method that has been used since the 1970s is Larry Michaelsen's Team-Based Learning (TBL) strategy for teaching large numbers of multidisciplinary students (see Figure2-1), taking advantage of the collaboration of small working teams (Bastick, 1999; Michaelsen, Knight, & Fink, 2002; Michaelsen, Watson, Cragin, & Fink, 1982; Sibley & Parmelee, 2008). Using small, carefully selected teams can facilitate active learning, critical thinking, problem solving and participation, rather than traditionally

lecturing to one large passive group of students (Hadjioannou, 2007; Rider & Brashers, 2006; Sweet & Michaelsen, 2007). Typically, that one large group is seated in an enormous auditorium style lecture hall where a diverse student audience includes age ranges and life experiences from the late teens to the elderly; many may not speak English as a first language as students come from international locations; and many may also be working full or part time increasing their daily commitments and workload. This diversity of students can be a challenge in any classroom, but is used as an advantage in TBL (Michaelsen et al., 2004).
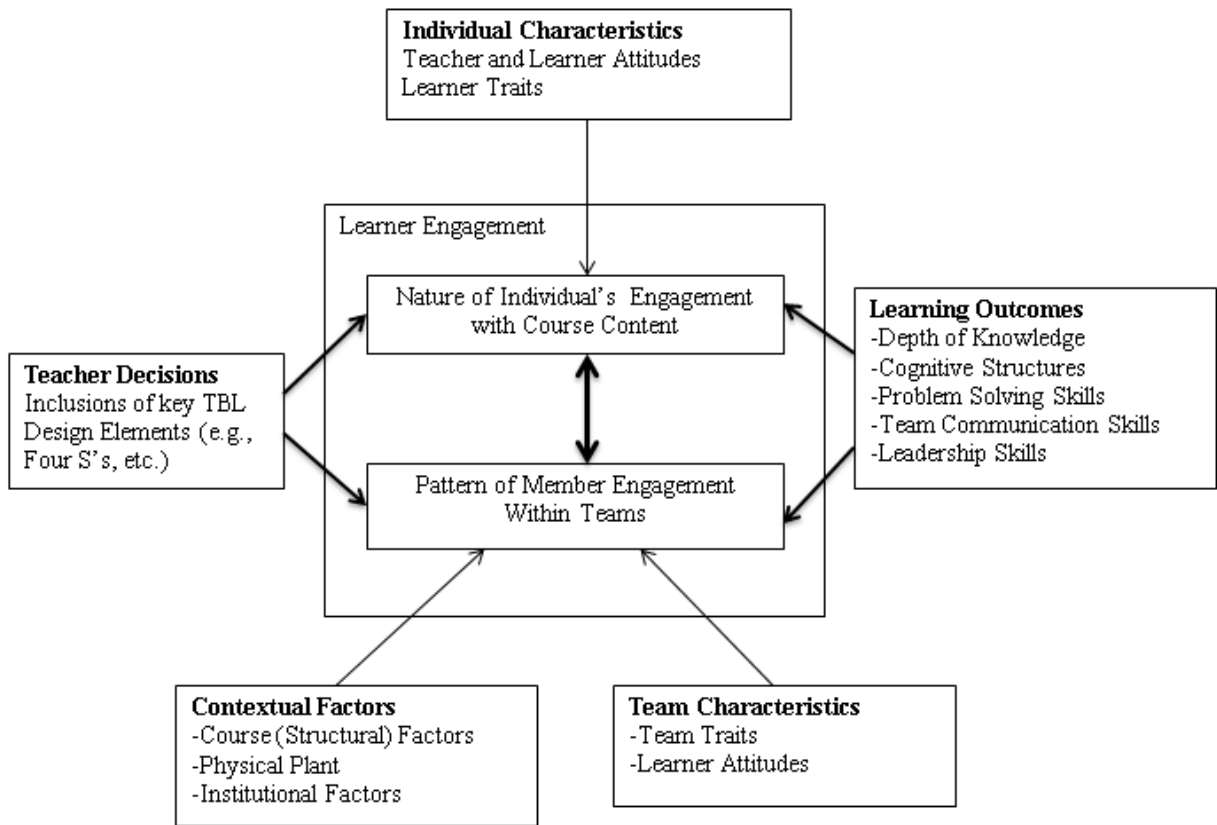
Figure 2-1 Conceptual Model for Team-Based Learning. Adapted from Team-Based Learning for Health Professions Education: A Guide to Using Small Groups for Improving Learning, p. 124, by L. Michaelsen, D. Parmelee, K. McMahon, R. Levine, D. Billings (Eds.). Copyright 2008 by Stylus Publishing. Reprinted with permission (see Appendix C).

With vast amounts of materials that are to be learned by the students in a specified timeframe, many capable students who use their established studying skills of reading, listening, note taking, memorizing and testing (Michaelsen et al., 1982) struggle to keep up with the course schedule and can become discouraged and sometimes unsuccessful. The use of TBL is a strategy that has been successfully implemented with positive results in medical training (Chung et al., 2009; Haidet & Fecile, 2006; McMahon, 2010; O'Malley et al., 2003; Parmelee & Michaelsen, 2010; Thompson et al., 2007), health care policy development (Rider, Brashers, & Costanza, 2008), and nursing programs (Andersen et al., 2011; Clark et al., 2008; Feingold et al., 2008; Holleman et al., 2009; Timmermans et al., 2012).

Michaelsen's Team-Based Learning strategy has four main components:

1. Permanent team assignments; these are assigned by the instructor after gathering some information about the members. Assignments are based on an attempt to diversify the group of 5 to 7 members, engaging participants with various degrees of experience.

2. Readiness Assurance Process; there are 4 levels of readiness starting with the individual student coming to the class having prepared by completing assignments before the team meets to proceed with the next level of application. The individual student will complete and submit a short multiple choice quiz. Then the group will complete the same quiz and collaborate on the answers, using whatever resources are available to answer the questions in the timeframe. Both of these grades are assigned to the individual, so helping the team be successful also helps the individual. The team answers are shared with the entire group, and answers are offered by the faculty. If the team feels that a quiz question answer should be appealed, a structured system is in place to present the appeal for faculty consideration. This effort helps students to build stronger teams that can communicate their concerns in an articulate fashion. Finally, the lecturer (expert) will review the process as it unfolds, and spend the end of the allotted time clarifying salient points that had been omitted or brought up as confusing or misunderstood. Once the expert is assured that the students are ready, application activities are introduced to use the information that has been learned.

3. Application Activities; these consist of case studies or realistic data that are presented as real problems for processing and determining a final outcome. In nursing, this could be a case study, a list of client lab values, or client complaints that requires the team to develop an individualized nursing care plan. Guidelines for the development of these activities by faculty follow the 4 S's, which are:

    A. A Significant problem is one that students would encounter in 'real life'

B.   The <u>S</u>ame problem must be presented to the entire class in order to make comparisons when the exercise is completed.

C.   A <u>S</u>pecific choice is the students' direction to determine an exact answer. The more specific the choice is, the deeper the team's thought processes.

D.   A <u>S</u>imultaneous report by the entire group of teams allows all to focus on the presentation of the specific choice without leaving the slower student teams behind.

These four steps promote individual deep thinking and engaging, content focused discussions (Parmelee & Michaelsen, 2010).

4.   Peer Evaluation; the final component of the TBL strategy is to have the students evaluate their peer team members with feedback that will be anonymously shared with the individual students.

Each of these components ensures that both students and faculty are implementing the strategy for optimal results. Some students have occasionally complained about the peer review process being concerned about receiving a portion of their course grade from a student peer instead of a teacher, however the vast majority of student and faculty respondents report improved learning and enthusiasm for the studied subject (Feingold et al., 2008; Parmelee & Michaelsen, 2010). The current study in unethical or dishonest nursing student behaviors in the classroom and clinical areas adapted the TBL strategy to determine the effects of a brief learning session on adjunct nursing faculty perceptions of and reactions to unethical and dishonest nursing student behaviors, which is described in Chapter 3.

Social Cognitive Theory

There are generalized categories of learning theories that have evolved over several decades, including behaviorist theories, humanist theories, cognitive theories, constructivist theories and social learning theories. The behaviorist approach to learning, which was influenced by Thorndike (1913), Pavlov (1927), and Skinner (1974), proposed that learning was an observable change that was caused by an external environmental stimulus, and that the

measure of learning could be seen in the change of the learner's behavior (Olson & Hergenhahn, 2005). The humanist theories developed by Maslow (1943) and Rogers (1951) consider learning from a human potential for growth perspective (Merriam, Caffarella, & Baumgartner, 2007) where people are inherently good and strive for higher levels of functioning. The behaviorist approach was questioned by the cognitivists including Piaget and Gagne (1970), who claimed that not all learning could be outwardly seen, and that learning was an internal process, therefore information could be learned without a change in behavior (Merriam, et al., 2007). Constructivist advocates then believed that learning was done when the learner observed and actively processed and interpreted information according to one's own personalized reality, and consequently that learner tried to build coherent, organized knowledge from the processed information (Mayer, 2004; Van Der Veer, 1986). These schools of thought, when thoroughly reviewed, contain areas where they overlap, but are still effective in explaining how students learn. Behaviorist methods can be used to teach the "what" (facts), cognitive methods can be used to teach the "how" (processes and principles), and humanist and constructivist methods can be used to teach the "why" (personal meaning) (Olson & Hergenhahn, 2005).

Social learning theories focus on the learning that is done within a social context, and combine elements from both the behaviorists and cognitivists (Merriam, et al., 2007). Learners in the social group learn from one another by observation, imitation, and modeling (Ormrod, 1999). Albert Bandura is considered to be one of the leading theorists on social learning. His Social Learning Theory, which today has been updated to include a focus on self-efficacy, or one's own estimation of a personal level of competence in a particular environment, is now labeled the Social Cognitive Theory to address the thinking and processing portion that contributes to human motivation, affect, and action (Merriam, et al., 2007). Bandura's Social

Cognitive Theory can be applied to explain how the use of Team-Based Learning (TBL) can be designed to provide professional development to a group of faculty members (Hirsh, 2009). Since people learn from observing other's behavior and the consequences of those behaviors, those people will be influenced by the expectations of others on the team in TBL (Michaelsen, Parmalee, McMahon, & Levine, 2008).

Social Cognitive Theory describes learners observing the behaviors of others in a group, and learning these observed behaviors by paying attention, retaining or remembering, behaviorally rehearsing, and feeling motivated; activities which will ultimately culminate in the learner engaging in and understanding the studied subject (Michaelsen, et al., 2008). In the Conceptual Model for TBL, Michaelsen et al. (2008, Figure 10.1, p. 124) diagrams TBL with two central features for learner engagement including the individual's engagement with the course content, which is accomplished by coming to the team meeting prepared to contribute by having completed the pre-class assignments, and the individual's engagement within the team with an anticipation of the team's support and reinforcement when the learner is able to contribute satisfactorily to the team effort. Careful design by the expert instructor of these two core learner engagement activities enables the team to process at a higher level that is unachievable at an individual level, enhancing the learning potential of all the participants in the group (Michaelsen et al., 2004).

Summary

Unethical student behavior is of concern to faculty, schools, professions and society. Determining why students are dishonest, exploring faculty's turning a blind eye on unethical student behavior, and how these concerning behaviors apply to nursing students has been discussed in this study. Improving ethical student behavior is a curricular goal that can be taught dependably only when faculty can agree on what constitutes unethical behavior, and consistently

follow-up on dishonest behaviors. A learning session on adjunct faculty identification and perceptions of unethical nursing student behavior and adjunct faculty follow through on academically dishonest and unethical nursing student behaviors was presented in this study. It was hypothesized that a faculty development group session on unethical behavior would enhance adjunct nursing faculty perception of unethical student behavior, assist those faculty in the development of common conceptualizations of unethical student behaviors, and help adjunct nursing faculty to develop an environment of awareness of professional expectation and follow through while training nursing students in the ethical practice expected in the profession of nursing. This was accomplished by using the Team-Based Learning strategies developed by Michaelsen (et al., 1982) which was delivered to the adjunct nursing faculty at Palm Beach State College in southeast Florida in the spring of 2013. The methods that were used are described in Chapter 3.

CHAPTER 3
METHODOLOGY

Overview

Nursing students who cheat in school are likely to become registered nurses who cheat in the profession of nursing (Langone, 2007; Lewenson, Truglio-Londrigan, & Singleton, 2005; Stern & Havlicek, 1986; Wilk & Bowllan, 2011), and this can result in pain, suffering, and even death to patients who are entrusted to their care. It is therefore imperative that nursing faculty identify and deal with nursing student cheating while the student is learning how to practice as a professional registered nurse.

Nursing educators are challenged to find the most effective teaching techniques to engage nursing students to act honestly and ethically. Research on the effects of adjunct nursing faculty education after a faculty development session on identification, preparation for and willingness to act on unethical nursing students' behaviors will add to the growing literature. In this chapter, the research design, the population and sample, instrumentation, data collection methods and procedures, data analysis procedures, and limitations for this study are described.

The purpose of this study was to evaluate the impact of a faculty development session on: faculty identification of unethical nursing student behaviors; perception of how prepared faculty are in dealing with dishonest and unethical nursing student behaviors; and faculty perceptions of their willingness to take taking action when dishonest or unethical nursing student behaviors are discovered. The questions being studied were as follows:

Question #1: How does a faculty development session impact the adjunct nursing faculty in their identification of dishonest or unethical nursing student behaviors?

Question #2: How does a faculty development session impact the preparedness of adjunct nursing faculty in dealing with dishonest or unethical nursing student behaviors?

Question #3: How does a faculty development session impact the willingness of adjunct nursing faculty in dealing with dishonest or unethical nursing student behaviors?

The hypotheses being tested were as follows:

Hypothesis #1: The null hypothesis states that the mean score for identification of dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is less than or equal to the mean score on the Pre-Intervention IRAT. The alternate hypothesis states that the mean score for identification of dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is greater than the mean score on the Pre-Intervention IRAT.

Hypothesis #2: The null hypothesis states that the mean score for the preparedness in dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is less than or equal to the mean score on the Pre-Intervention IRAT. The alternate hypothesis states that the mean score for the preparedness in dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is greater than the mean score on the Pre-Intervention IRAT.

Hypothesis #3: The null hypothesis states that the mean score for the willingness in dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is less than or equal to the mean score on the Pre-Intervention IRAT. The alternate hypothesis states that the mean score for the willingness in dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the

follow-up IRAT three months after the intervention is greater than the mean score on the Pre-Intervention IRAT.

A convenience sample (Patton, 1987) of adjunct nursing faculty from an Associate in Science in Nursing program at a large southeastern community college in Florida was used. In this study, Bandura's Social Learning Theory (1977) framed the design of the contextual factors of the faculty development group session on unethical behavior where individuals interacted with and learned from members of a group. The venue was a state college associate degree nursing program, which favored the professional development of the adjunct nursing faculty by supporting the three hour session, which was presented during a scheduled pre-semester orientation. Participants first attended a mandatory two hour orientation that included information about faculty administrative responsibilities, and then volunteered to attend the learning session where adjunct faculty members were paid their hourly wage to participate.

The research question guiding this study was: how does a three hour training session impact adjunct nursing faculty identification of dishonest or unethical nursing student behaviors and faculty perception of preparedness and willingness to take expected action when dishonest or unethical nursing student behaviors in the classroom and the clinical areas are discovered? The study evaluated the differences between individual adjunct faculty members' perceptions of unethical nursing student behaviors, and the relationships between pre- intervention and post-intervention individual participants' conceptualizations of unethical nursing student behaviors. A follow-up survey was administered at the end of the semester to obtain self-reported perceptions of the lesson impact. It was predicted that the adjunct nursing faculty development session would result in an improved understanding as to what constituted unethical nursing student behavior, what nursing faculty actions were to be performed when an unethical nursing

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student behavior was discovered, and improve individual perceptions that faculty are willing to take action when dishonest or unethical nursing student behavior was discovered.

Research Design

This study utilized a quantitative design (Creswell, 2009) approach for this project. Data was obtained using three separate 25 question surveys during one three hour learning session. A hard copy follow-up survey of the 25 questions was administered to available participants three months after the training session, and was used to measure self-reports of change of behavior and attitude.

Population and Sample Participants

The population from which the sample was selected consists of part time adjunct nursing faculty members who teach nursing in the clinical facilities and/or the nursing skills laboratory. This population excludes adjunct nursing faculty who may lecture in the classroom. The study invited a convenience sample of adjunct nursing faculty in an Associate Degree nursing program in a large community college. The sample for this study consisted of forty-one (N=41) adjunct nursing faculty members with zero to 22 years of teaching experience from one Associate in Science in Nursing community college Registered Nurse program at Palm Beach State College in Lake Worth, located in southeastern Florida where this researcher works with adjunct faculty in the teaching of nursing students. The nonprobability process of convenience sampling was used to identify and include all adjunct nursing faculty volunteer members who attended the biannual semester orientation for adjunct nursing faculty as members of the nursing clinical and skills lab faculty population. The researcher obtained Institutional Review Board (IRB) approval from the University of Florida, Gainesville Florida (Appendix J), and Palm Beach State College, Lake Worth, Florida (Appendix K) to conduct the study. The researcher gathered the data to ensure that no participants were harmed or injured. No adjunct skills lab or clinical faculty

members were excluded. These entirely female (100%), part-time faculty participants were baccalaureate, masters and doctoral degree nursing faculty who taught in the two year degree nursing program in either or both the clinical and skills lab areas in the community college context.

Instrumentation

The following section will discuss the adjusted Team-Based Learning (TBL) application, including the Individual Readiness Assurance Tool (IRAT), the Group Readiness Assurance Tool (GRAT), the final IRAT, and the follow-up IRAT instrument, the lesson, and the application activities used to elicit data during the studied TBL training session for nursing adjunct faculty members. TBL is a teaching technique for large groups of students that has been developed and instituted successfully for decades in many teaching institutions and businesses both in the United States and internationally (Bastick, 1999; Haidet & Facile, 2006; McMahon, 2010; Sibley & Parmalee, 2008; Sweet & Michaelsen, 2007; Thompson et al., 2007), and is beginning to also be studied in nursing (Andersen et al., 2011; Clark et al., 2008; Feingold et al., 2008; Timmermans et al., 2012), and has been successfully implemented in both full semester courses and a single workshop (Haidet & Fecile, 2006). Gail A. Hilbert's 1985 study on self-reported events and opinions of cheating by nursing students in the nursing clinical and classroom courses is the basis for the 25 survey questions used in this study on the individual IRAT, the GRAT, the final IRAT, and the follow-up IRAT.

The Team-Based Learning Method

The Team-Based Learning (TBL) method of instruction was first published in 1982 by Larry Michaelsen (Michaelsen et al., 1982). Michaelsen developed group learning experiences specifically for large numbers of students to enhance learning at the application level by helping students develop into teams which resulted in an improved responsibility for individual learning.

TBL has been successfully utilized in the training of a diversity of numerous groups. Instructors apply a series of carefully constructed steps (Andersen et al., 2011; Bastick, 1999; Chung, et al., 2009; Clark, et al., 2008; Feingold, et al., 2008; Haidet & Fecile, 2006; Michaelsen et al., 1982; Rider, et al., 2006; Rider, et al., 2008; Sibley & Parmalee, 2008; Sweet & Michaelsen, 2007; Timmermans, et al., 2012; Thompson, et al., 2007) to groups as large as 175 or 200 students (Michaelsen et al., 1982). In a review of seventeen studies of TBL that had been applied in nursing, medicine, and business from 2003 to 2011, Sisk (2011) found general student satisfaction for improved engagement and higher test scores, and recommended further study. The following section will describe the sequence of developing a Team-Based Learning session, beginning with the design of the session to be developed, and the four components of the TBL design that incorporate individual readiness assurance activities, team selection, team application activities, and final evaluation (McMahon, 2010; Michaelsen, 1982; Michaelsen et al., 2008; Parmelee & Michaelsen, 2010; Sweet & Michaelsen, 2012).

Course design

The training session was designed to be presented in a single three hour seminar during a biannual pre-semester orientation for adjunct nursing faculty members, and presented in a large lecture room with a computer and audio visual equipment. Groups chose work spaces with either individual movable desks and chairs, or a large fixed desk and movable chairs. The training session was 'backwards designed' by first determining the learning outcomes for the session by asking what the faculty members would be able to do when the session was completed, and then the course was designed to teach those learning outcomes. The training session was intended to be completed within the three hour timeframe. The learning outcomes included: The faculty will:

1.   locate the list of student behaviors that warrant disciplinary action.

2.   define the student behaviors that warrant disciplinary action.

3.   identify personal perceptions of how to manage unethical student behaviors.

4.   review personal preparation levels of dealing with unethical student behaviors.

5.   discuss the steps involved in the student disciplinary process.

6.   value the need for faculty concurrence in dealing with unethical or dishonest student behaviors.

The training session was intended to help faculty members learn how to identify, react to, and deal in a consistent manner with unethical and/or dishonest nursing student behavior, and bring a sense of agreement on how to actualize the steps of the disciplinary process. This was intended to be achieved by helping faculty members agree on and value consistency in identifying and acting on known or typical episodes of unethical or dishonest student behavior.

Reading assignments were provided to each faculty member prior to the training session via the college email system. The reading assignments were designed to help faculty prepare for participation in the training session prior to attending, and to help the faculty member to achieve several of the learning outcomes; prepare for the Individual Readiness Assurance activities; assist in faculty members' ability to successfully participate in the Group Readiness Assurance activities; and effectively complete the application activities.

Readiness assurance activities

After Informed Consents (Appendix: A) were gathered and anonymity of participants had been assured, the pre-intervention Individual Readiness Assurance Tool (IRAT) (Appendix: B) was given to each participant by the instructor at the beginning of the session. The 25 question instrument used to gather data for the Individual Readiness Assurance Tool (IRAT) and the Group Readiness Assurance Tool (GRAT) was developed from Hilbert's (1985) survey on self-reported events of cheating by nursing students and their opinions about behaviors that were or

were not considered cheating in the nursing clinical and classroom courses. The pre-instruction

IRAT was used to determine demographic information and to determine how faculty members

self-reported their perceptions on 25 dishonest or unethical nursing student behaviors. The

Individual Readiness Assurance Tool (IRAT) is detailed in the Instrumentation section below.

The purpose of this activity was to determine individual demographics for team assignments, and

to gather an individual baseline of faculty response data. The IRAT was completed at the

beginning of the session, after faculty members had the opportunity to pre-read the assignment

on their own time. The IRAT was used to help in achieving learning outcomes 1 through 3, and

possibly 4, listed here:

1.   Locate the list of student behaviors that warrant disciplinary action.
2.   Define the student behaviors that warrant disciplinary action.
3.   Identify personal perceptions of how to manage unethical student behaviors.
4.   Review personal preparation levels of dealing with unethical student behaviors.

Faculty members were also able to draw upon any experiences that had evolved through

their individual teaching careers while responding on the IRAT. Once the IRAT was completed,

it was collected and reviewed by the researcher and the instructor to assign participants to a

team.

The PowerPoint lesson

A brief PowerPoint lesson was presented after the first IRAT was accomplished. The part

of the lesson was designed to review the Learning Outcomes and to describe where to find the

information that was assigned as a pre-reading assignment. This time was used by faculty

members to clarify any questions or concerns about the training session, the readings, or their

role/responsibility in dealing with episodes of unethical or dishonest nursing student behaviors.

Team selection

Team selection was a random activity, completed by the instructor who first determined the number of participants, and computed the number of teams that were to be created so that each team consisted of five to seven participants. Teams were then carefully designed by the instructor, who reviewed answers to demographic item number eight on the IRAT. Respondents were sorted into groups based on their completing, partially completing, or not completing the reading assignments before the learning session, and then randomly assigned to teams. Each team therefore consisted of a diversity of respondents who had totally, partially or had not prepared for the session by reading the assigned pages.

Teams next selected a work space either in the lecture hall or the adjoining rooms and moved into that space to complete the next section of the session; the teams' Group Readiness Assurance Test. Individual participants were allowed to move their desks and chairs into a convenient configuration for verbal and visual communication between each team member.

Team application activities

Each new team, consisting of five to seven participants, was then issued one Group Readiness Assurance Test (GRAT) for the entire team, and team members reconsidered the same questions that had been completed by the individual faculty members. The teams worked independently to complete one GRAT per team by coming to a team agreement on each of the 25 questions.

In coming together as a team to answer the same questions that were completed individually, faculty members were able to discuss their own interpretations of the questions, clarify concerns, share experiences, and eventually come to a consensus for at least the sake of the assignment on the Unethical or Dishonest Behavior column. This was designed to facilitate discussion and help achieve learning outcomes 4, 5 and 6, listed here:

4.	Review personal preparation levels of dealing with unethical student behaviors.
5.	Discuss the steps involved in the student disciplinary process.
6.	Value the need for faculty concurrence in dealing with unethical or dishonest student behaviors.

When all the teams had completed the task, each team was asked to present their results to the entire group, with immediate feedback from the class and the instructor. Discrepancies or gaps in team information were clarified by the instructor during and after the discussions, and when faculty participants still disagreed, teams were encouraged by the instructor to present their rationale for class and instructor review. These appeals for consideration were verbally resolved as quickly as possible to ensure that faculty participants had a clear understanding of the information (the first 3 learning outcomes) in order to proceed to the next activity which incorporated the application of the learned information. The instructor moved between the teams to observe the interaction of the faculty participants as individuals and team members during the GRAT assignment, facilitating the interactions and answering questions about the learning outcomes.

Once the faculty teams' readiness was assured, higher level application activities were introduced to the teams using the 4 S's (Sweet & Michaelsen, 2012). These activities were designed to reflect problems that were significant to this class of adjunct faculty members; specific choices that reflected the training session concepts (for example: using the Faculty Handbook and/or the Nursing Student Handbook(s) to identify which faculty action was the best to deal with dishonest or unethical student behaviors), and listing supporting evidence and including an explanation as to why that faculty action was chosen as the best; all teams were assigned the same problem to resolve so comparisons were possible and meaningful; and team reports were delivered simultaneously so that all faculty participants were involved in the discussion rather than some participants finishing their team work while others were reporting.

Evaluation

Peer evaluation and grading, which is a component of TBL for students who are learning during multiple class meetings and requiring a grade for achievement, were not included for this session. Peer evaluation of team dynamics and evolution would be of limited value in this study due to only meeting once instead of meeting during multiple sessions throughout a semester, and having no grading requirement during this one meeting.

The IRAT and GRAT Instrument Used

The current instrument was derived from the "Opinions about and Extent of Involvement in Unethical Behaviors" tool that was developed by Hilbert (1985). Hilbert's self-reported survey was administered to nursing students and listed 22 unethical behaviors; 11 from the classroom and 11 from the clinical setting. Hilbert states (pg. 231) that content validity was assumed. The Hilbert list of behaviors required respondents to not only indicate a perception of unethical behavior using a yes/no scale, but also how many times the student had engaged in each behavior in the current school year. Hilbert reported an internal consistency calculation with a coefficient alpha for the 22 item tool of 0.668. Hilbert performed a series of t tests to compare the reports of unethical behaviors and gender, and unethical behaviors for transfer or non-transfer students. Hilbert also performed a Pearson correlation on age and particular unethical behaviors, finding that younger students were more likely to help another student when individual work was required by the instructor. Finally, Hilbert also found two significant results through a series of chi-square tests. First, there was a significant relationship between students who identified a behavior as cheating, and then having done that cheating behavior; and second, there was a significant direct relationship between classroom dishonesty and clinical setting dishonesty.

The current Individual Readiness Assessment Tool (IRAT) survey used in gathering

quantitative evaluation data during the current training session (Appendix B) included most of

Hilbert's questions, and six demographic questions including; gender, age, years of teaching

nursing in clinical or skills lab areas, nursing employment status outside of the college teaching

responsibilities, an opinion of how likely a faculty member would take required follow-up action

when an episode of dishonest or unethical nursing behavior is discovered, and the name of the

elementary school where the participant attended school. A seventh and eighth question required

a self-report of the number of times that the faculty member took action on dishonest or unethical

student behavior, and fulfillment of the assigned reading as a yes, no, or partial completion of the

reading. The participant circled the appropriate answers and wrote in the name of their

elementary school. The demographic questions were followed by 13 questions about classroom

dishonest or unethical behaviors, and 12 questions about clinical dishonest or unethical

behaviors, totaling 25 questions. Each of the 25 questions was posed for the following three

categories: identification, preparedness, and willingness, totaling 75 responses per survey.

A few modifications of Hilbert's 1985 tool were made for the current survey (Appendix

B). The classroom portion of Hilbert's tool listing 11 questions had "quizzes" removed from the

first five questions, as quizzes are not offered at the institution. "Electronic copies of exams"

was included with hard copies of exams in Question 1, as all nursing courses routinely deliver

electronic exams rather than paper and pencil exams. Question 2 was altered to include

discussion of a test with another student who has not yet taken the test, rather than Hilbert's

question about copying from another test. Question 4 was expanded to include unauthorized use

of technology. Question 8 was adjusted by changing the purchasing of an assignment from a

research firm to the more current term: a paper mill. Question 10 was an added question asking

about helping a classmate who was falling behind even though "Individual Work Only" instructions had been given. Question 11 was altered to ask about making a graded paper accessible to others instead of doing another's work, and Question 13 was added to ask about reporting mistakes. Questions 3, 5, 6, 7, 9, and 12 were unchanged.

The clinical portion of the survey had adjustments from the Hilbert tool also. Question 1 added "calling out sick" (contacting the clinical setting to advise that work will be missed) for a clinical assignment not only for being personally sick, but also due to a sick child when the neither the student nor the child was sick. Participation in clinical under the influence of prescription medications in Question 2 was extended to include over the counter medications. Question 3 asked about avoiding disagreeable client care, replacing breaking a client's belongings. Question 4 added the phrase "even if no harm occurred" to a question about not reporting an incident involving a client. Question 5 substituted the recording of falsified client data for taking hospital "greens". Question 6 asked about using facility resources for personal use, replacing Hilbert's question about eating food designated for a client. Question 12 was the additional item, again asking about reporting mistakes. Questions 7, 8, 9, 10, and 11 were unchanged.

These 25 questions had been piloted in an earlier survey, but were mainly derived from Hilbert's 1985 tool. Internal consistency of the piloted questions was measured through the use of Cronbach's alpha (Polit & Beck, 2004). Alpha reliability was calculated for the entire survey and each of the two subsections (Classroom and Clinical) for both the Student and Faculty version of the survey. Omnibus reliability for the faculty survey was $\alpha = .881$, the first subsection related to 'Faculty Classroom' had a reliability of .704, and the second subsection related to 'Faculty Clinical' had a reliability of .919. Nursing student data resulted in an

omnibus reliability for the student survey with an $\alpha = .852$, the first subsection related to 'Student Classroom' had a reliability of .863, and the 'Student Clinical' subsection had a reliability of .904. Nursing students will not be included in the present study. These results demonstrate that the current tool is a reliable assessment of both student and faculty perceptions of academic dishonesty. Current study reliability will be reported in Chapter 4.

The studied questions were ranked on a Likert rating scale of 1 through 5, rather than Hilbert's yes or no scale. The scale lists the following descriptors while rating identification of unethical or dishonest behavior; preparedness to take action; and willingness to take action as follows: 1. Not at all; 2. A little bit; 3. Sometimes; 4. Mostly; and 5. Extremely. The addition of the Likert scale helped elicit variance, and provide a richer, deeper data set rather than a forced yes or no response about the honesty or ethics of the questions as Hilbert first presented them. The 13 classroom questions were listed on one side of one page, and the 12 clinical questions were listed on the back of the same page. A cover sheet with directions on how to complete the classroom and clinical questions was stapled to the survey. Directions were also given verbally by the instructor. This one page form is identified as the IRAT (Appendix: B).

The GRAT was a derivative of the IRAT, listing the same questions, but omitting the demographic and elementary school responses. The teams were instructed to come to an agreement on the same Likert scale, but were allowed to average the individual scores if the team could not agree by the end of the scheduled timeframe. Twenty to thirty minutes were allotted for this session.

The IRAT and GRAT were followed by a brief training session, proctored by the instructor. This time was used to deliver feedback and clarify any remaining concerns or

questions in order to ensure consistency between the individuals. Five to ten minutes were allotted for this session.

The final IRAT Evaluation was repeated using the same 13 classroom and 12 clinical questions from the IRAT. The respondent's elementary school was again required so the pre-session IRAT and final IRAT evaluation results could be paired. The order of the classroom and clinical final IRAT questions was randomly scrambled in each section. The individual respondents were again requested to identify the behaviors as unethical or dishonest, preparedness to take action, and willingness to take action using the 1 through 5 Likert rating scale. Ten to fifteen minutes were allotted for this session.

Application Exercises

After optimal learning had been assured by using the IRAT, the GRAT, and after the feedback interval that followed the GRAT, faculty participants applied the learned material and worked in the same teams to process three case studies, described below. All teams received identical case studies (Appendix D) that described a dishonest or unethical episode of nursing student behavior. Three case studies were completed consecutively, each team using approximately one hour for this application portion of the learning session. The teams each processed the case studies independently and used information that had been learned and reviewed, and collaborated with members of the team to recommend an action that the faculty should take. All teams then presented their recommendations of proper faculty action (follow-up), facilitated by the instructor. The presentation took the form of a gallery walk, in which teams used a large piece of paper to outline their course of action in response to each case. They then posted their responses for other teams to review, discuss and critique. This section took 45 minutes. The three case studies (Appendix G) were developed from the results of the Perceptions of Cheating in the Classroom and Clinical survey (Marshall, 2012). The case studies

included: a clinical instructor who suspects a clinical student of falsifying the documentation of vital signs on the medical record; a clinical instructor who is informed of two students who are discussing a recent lecture test, including test questions and possible answers, when one of the students has not yet taken that test; and a clinical instructor who observes a student performing in an impaired manner.

Final Surveys

At the conclusion of the three hour training session, the instructor distributed the final Evaluation IRAT, instructing the participants to fill out the elementary school name and the 25 classroom and clinical questions. The IRAT was then collected in an anonymous manner by the instructor. The faculty participants were verbally thanked for their participation and final questions were answered by the instructor before participants were released.

A follow-up survey was administered to 31 (82%) of the remaining 38 participants who attended one of three staff meetings three months after the training session. The follow-up survey was administered toward the end of the same semester, using the same 25 questions on identification, preparedness and willingness to take action on unethical or dishonest nursing student behaviors. The questions were listed on the survey in a randomized manner and surveys were again collected anonymously to protect the identity of the respondents.

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Data Analysis

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The purpose of this study was to add to the knowledge base and to test a new idea in nursing faculty training by evaluating the impact of a faculty development session on: faculty identification of unethical or dishonest nursing student behaviors, faculty perception of how prepared faculty are in dealing with dishonest and unethical nursing student behaviors, and faculty perceptions of taking action when dishonest or unethical nursing student behaviors are discovered. It was predicted, based on medical, business, and nursing student groups'

improvements reported in the literature, that the adjunct nursing faculty development session would also result in faculty member improvement in learning about identifying, reacting to, and perceiving unethical nursing student behaviors.

A quantitative method approach was utilized to optimize the significance of the researcher's interpretations of the data. The quantitative data, obtained at the beginning and end of the development session, was used as baseline data that was then compared to quantitative data that was collected at the three month follow up. A review of the hypotheses being tested follows:

Hypothesis #1: The null hypothesis states that the mean score for identification of dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is less than or equal to the mean score on the Pre-Intervention IRAT. The alternate hypothesis states that the mean score for identification of dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is greater than the mean score on the Pre-Intervention IRAT.

Hypothesis #2: The null hypothesis states that the mean score for the preparedness in dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is less than or equal to the mean score on the Pre-Intervention IRAT. The alternate hypothesis states that the mean score for the preparedness in dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is greater than the mean score on the Pre-Intervention IRAT.

Hypothesis #3: The null hypothesis states that the mean score for the willingness in dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is less than or equal to the mean score on the Pre-Intervention IRAT. The alternate hypothesis states that the mean score for the willingness in dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is greater than the mean score on the Pre-Intervention IRAT.

The study evaluated the differences between individual faculty members and faculty teams' identification and perceptions of unethical student behaviors, and the relationships between pre-intervention IRAT surveys and final IRAT surveys on faculty conceptualizations of unethical student behaviors, and the development of an environment of awareness for professional expectation and follow through. It was predicted that the adjunct nursing faculty development session, using an adapted Team-Based Learning (Michaelson et al., 1982) approach would result in a positive correlation of those who participated in the faculty development session in improving their understanding and agreement on what constitutes unethical nursing student behavior, and also what nursing faculty actions are to be performed when an unethical nursing student behavior is discovered, and report an increased willingness to take action when unethical or dishonest nursing student behavior is discovered. Improvement was anticipated after the intervention, and results were again analyzed at the three month follow-up to study if the intervention effect remained the same or changed.

The quantitative IRAT results were compared across the entire group for a baseline of data. The initial IRAT survey items were compared with the final IRAT items for each participant, using the elementary school as the identifier to pair the surveys for each of the 75 items on the

identification of unethical or dishonest behaviors, preparedness and willingness. Three months later, the final and follow-up IRAT tools were again compared by pairing the 75 responses based on the self-reported elementary school identification on each survey.

It should be noted that in the design of TBL by Michaelsen et al., (1982) there is an appeal step built into the process, utilized after the GRAT. The purpose of the appeal is to allow team members who have concurred on an answer to put together a rational presentation challenging an incorrect answer. This step reinforces processing and learning information, and improves communications, but it is designed to help in the grading process. Since this faculty member group is not being graded, a feedback/clarification session was scheduled to ensure learning had taken place before moving to the application case studies, and the respondents were not be awarded a grade.

Limitations

In using the most available group of adjunct nursing faculty available, no guarantee could be made that the group that was studied was representative of the population from which it was drawn. This results in a low external validity of the study, and therefore generalizations to the population must be made with a full description of the study parameters so that judgments can be made about the amount of bias that might skew the results. To address this concern, the study might be replicated in future studies to add to the body of knowledge about team based group learning methods being applied to nursing faculty to enhance learning.

Researcher influence during the IRAT, GRAT, the case studies discussions and the final IRAT evaluation was possible since the researcher/instructor was present in the room when the data was being recorded by the participants. Participants could have changed their reactions and discussions during the researcher/instructor observation. The instructor's goal was to instruct and guide students, but this was challenged by the need to minimize researcher influence by not

interfering nor interrupting the learning process during the team development sessions. Being cognizant of the difference between the instructor and researcher role helped minimize the anticipated influence.

Summary

This descriptive study was designed to increase the knowledge base about the efficacy of a single group training session in teaching an adjunct nursing faculty group about identifying and being prepared for and willing to take action when dishonest or unethical nursing student behaviors are observed. It was presented in a three hour development session for a convenience sample of adjunct nursing faculty, at Palm Beach State College in Lake Worth, Florida. The purpose was to train adjunct nursing faculty, using an innovative training method that has been discussed in the literature and used successfully in the training of other large groups, but has not been heretofore studied nor reported on adjunct nursing faculty.

CHAPTER 4
RESULTS

Overview

The purpose of this study was to evaluate the impact of a brief faculty development session on: adjunct nursing faculty perceptions of identifying dishonest and unethical nursing student behaviors; faculty perceptions of their preparation for taking action when dishonest or unethical nursing student behaviors are discovered; and, faculty willingness to take action when dishonest or unethical nursing student behaviors are discovered. This study included questions on behaviors in both the classroom and the clinical context. This chapter will describe the findings of the study. It will begin with a description of the sample, followed by inferential analysis of the hypothesis tests.

Demographic Explanation of the Sample

The sample consisted of adjunct faculty members recruited from one large southern state college Associate Degree in Nursing program. Following a mandatory two hour orientation routinely administered at the beginning of each semester for all new and returning nursing adjunct faculty members, 42 adjunct faculty members were invited to participate in the study. A brief description of the study was provided and the prospective participants were notified that those who remained for the session would be compensated for their participation by the state college at their standard hourly rate. Forty-one volunteers (98%) chose to participate and were given the Informed Consent to sign. Thirty-eight participants (90%) completed the entire training session. Following the collection of the signed Informed Consents the training session was initiated. The entire training session was completed within the scheduled three hour timeframe.

Demographic information was gathered from the pre-intervention IRAT or pretest, and results can be reviewed in Table 4-1. Questions included self-reporting of gender, age, teaching experience, employment status, and how often action was taken when dishonest or unethical behaviors were discovered. Thirty-eight of the 41 participants completed the post-intervention final Evaluation IRAT (Individual Readiness Assurance Test) at the conclusion of the training session, resulting in 38 pairs of pre-intervention IRAT surveys and three unpaired IRATs due to three participants leaving the training session before completing the final IRAT evaluation. The follow-up survey results were obtained three months after the initial training period resulting in 31 (82%) of the 38 original post survey participants. Four of the 31 surveys were drastically incomplete, yielding 27 usable follow-up surveys that could be paired with the pre-intervention IRAT and post-intervention final IRAT for the ANOVA analysis. Follow-up surveys were delivered to participants during mid and late semester team meetings and attrition was attributed to faculty no longer working at the college or not attending the on campus meetings.

Descriptive Analysis

Instrument

The specific details of the survey development and the survey administration can be found in Chapter 3. The survey was comprised of 25 questions which sought faculty perceptions of their ability to identify dishonest and unethical nursing student behaviors; an additional 25 questions explored faculty perceptions of preparedness to take action when dishonest or unethical nursing student behaviors are discovered; and the final 25questions gathered faculty perceptions of their level of willingness to take action when dishonest or unethical nursing student behaviors are discovered.

The same instrument was used to gather data for the pre-intervention IRAT, the group GRAT, the post-intervention final IRAT, and the follow-up IRAT (Appendix B). The instrument

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was adapted from Hilbert's (1985) assessment of self-reported cheating by nursing students and their opinions about behaviors that were or were not considered cheating in the nursing clinical and classroom courses. The tool had been piloted, subjected to construct validation by a team of experts, and was used during an earlier study (Marshall, 2012) to identify faculty and student perceptions of dishonest behavior. Likert scores from the four survey tools have been summarized in: IRAT Survey Results (Appendix E), GRAT Survey Results (Appendix F), Final IRAT Survey Results (Appendix G), and the follow-up IRAT Survey Results (Appendix H). Means, standard deviations, and variances for the pre-intervention IRAT, the GRAT, the final IRAT, and the follow-up IRAT are summarized in Appendix I.

Internal consistency was measured through the use of Cronbach's alpha (Polit & Beck, 2004), and found to be a reliable instrument (with reliabilities ranging from .72-.97), see Table 4-2. The omnibus reliability of the combined classroom and clinical area ranged from .88 to .97 for each of the assessment categories.

Instrument Results

Each of the three survey administrations during the intervention measured the participants' perception of their ability to identify unethical or dishonest nursing student behavior, preparedness to take action when unethical or dishonest nursing student behavior was discovered, and willingness to take action when unethical or dishonest nursing student behavior was discovered. Twice the tool measured the faculty perceptions as individuals, and once, during the GRAT, as a team activity. Although the entire group was instructed and/or debriefed after each of the three intervention surveys, the GRAT was included in the lesson plan as part of the actual intervention, and was examined in this study as a comparison between the pre-intervention and post-intervention means (Table 4-3).

The means for the IRAT, GRAT, and final IRAT survey tools were higher each time the tool was given, and the standard deviation generally became smaller, indicating an increasing agreement on the identification, preparedness and willingness levels of the participants each time the tool was given, see Table 4-3. The follow-up survey means that were obtained three months after the intervention were universally smaller than the post-intervention final IRAT means that were obtained at the conclusion of the intervention, but were higher than the pre-intervention IRAT means.

Participants contributing within teams using the GRAT were not individually identified, and therefore comparisons can only be generalized and cannot be paired directly with post-intervention final IRAT means. The group intervention GRAT means and the post-intervention final IRAT means are identical for Willingness and Preparedness on the GRAT and the final IRAT, see Table 4-3. These identical results may be the consequence of individuals being unable to distinguish between being prepared to take action and being willing to take action in future situations when unethical or dishonest student behaviors are discovered, or by being influenced by the group conclusions. This will be discussed in Chapter 5.

Inferential Analysis of Research Questions

A one-tail dependent groups paired samples *t* test was used to compare mean pre-intervention IRAT scores with mean post-intervention final IRAT scores. Subsequently, three months after the intervention, follow-up data was gathered and analyzed. A one-way within subjects ANOVA with repeated measures was calculated for the classroom, clinical, and omnibus sections of each of the three hypotheses. This analysis allows inferences about how a brief development session may or may not have impacted faculty perceptions. The following section presents the analysis of the data gathered during and after that training session.

How does a faculty development session impact the adjunct nursing faculty in their identification of dishonest or unethical nursing student behaviors? The null hypothesis for Question 1 was: The mean score for identification of dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is less than or equal to the mean score on the Pre-Intervention IRAT. The alternate hypothesis for Question 1 was: the mean score for identification of dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is greater than the mean score on the Pre-Intervention IRAT.

Classroom Identification

A paired samples *t* test was conducted to evaluate the differences between the mean pre-intervention IRAT and the mean post-intervention final IRAT scores for identification of dishonest or unethical nursing student behavior in the classroom, see Figure 4-1. The test was significant, $t(36) = 3.02$, $p = .003$. The mean score post-intervention was higher than the mean score pre-intervention. The standardized difference in means, $d = 0.72$, indicated a large (Green, Salkind, & Akey, 2000) effect size.

A one-way within subjects ANOVA with repeated measures was conducted with the factor being the pre-intervention IRAT survey, the post-intervention final IRAT survey, and the follow-up time periods; and the dependent variable being the IRAT scores for the identification of dishonest and unethical nursing student behavior. The means and standard deviations for the IRAT scores are presented in Table 4-4. A one-tail *F* test for the multivariate ANOVA indicated a significant time effect, $F(2, 25) = 6.12$, $p = .004$, multivariate $\eta 2 = .33$, a large (Green et al., 2000) effect size. The null hypothesis was rejected; indicating that the team based group training

intervention significantly improved nursing adjunct faculty ability to identify unethical or dishonest nursing student behavior in the classroom.

A follow-up within-subjects repeated contrast indicated a significant increase between the mean pretest and the mean posttest, $F(1, 26) = 10.27$, $p = .002$, partial $\eta2 = .28$, a large (Green et al., 2000) effect size. A second follow-up within-subjects repeated contrast indicated no significant difference between the posttest and the follow-up test, $F(1, 26) = 1.93$, $p = .177$. The results suggest the intervention significantly improved participants' ability to identify dishonest and unethical nursing student behavior in the classroom and their ability to identify that behavior did not significantly change at the three month follow-up period, see Figure 4-2.

Clinical Identification

A paired samples t test was conducted to evaluate the differences between the mean pre-intervention IRAT and the mean post-intervention final IRAT scores for dishonest or unethical nursing student behavior in the clinical area, see Figure 4-3. The test was significant, $t(35) = 3.47$, $p < .001$. The mean score post-intervention was higher than the mean score pre-intervention. The standardized difference in means, d = 0.81, indicated a large (Green et al., 2000) effect size.

A one-way within subjects ANOVA with repeated measures was conducted with the factor being the pre-intervention IRAT survey, the post-intervention final IRAT survey, and the follow-up time periods; and the dependent variable being the IRAT scores for the identification of dishonest and unethical nursing student behavior. The means and standard deviations for the IRAT scores are presented in Table 4-5. A one-tail F test for the multivariate ANOVA indicated a significant time effect, $F(2, 21) = 10.65$, $p < .001$, multivariate $\eta2 = .50$, a large (Green et al., 2000) effect size. The null hypothesis was rejected; indicating that the team based group training

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intervention significantly improved nursing adjunct faculty ability to identify unethical or dishonest nursing student behavior in the clinical area.

A follow-up within-subjects repeated contrast indicated a significant increase between the mean pretest and the mean posttest, $F(1, 22) = 21.21$, $p < .001$, partial $\eta2 = .49$, a large (Green et al., 2000) effect size. A second follow-up within-subjects repeated contrast indicated no significant difference between the posttest and the follow-up test, $F(1, 22) = 1.18$, $p = .289$. The results suggest the intervention significantly improved participants' ability to identify dishonest and unethical nursing student behavior in the clinical area and their ability to identify that behavior did not significantly change at the three month follow-up period, see Figure 4-4.

Omnibus Identification

A paired samples t test was conducted to evaluate the differences between the mean pre-intervention IRAT and the mean post-intervention final IRAT scores for dishonest or unethical nursing student behavior in the classroom and clinical area combined, see Figure 4-5. The test was significant, $t(37) = 4.44$, $p = <.001$. The mean score post-intervention was higher than the mean score pre-intervention. The standardized difference in means, $d = 0.97$, indicated a large (Green et al., 2000) effect size.

A one-way within subjects ANOVA with repeated measures was conducted with the factor being the pre-intervention IRAT survey, the post-intervention final IRAT survey, and the follow-up time periods; and the dependent variable being the IRAT scores for the identification of dishonest and unethical nursing student behavior. The means and standard deviations for the IRAT scores are presented in Table 4-6. A one-tail F test for the multivariate ANOVA indicated a significant time effect, $F(2, 23) = 25.30$, $p = <.001$, multivariate $\eta2 = .69$, a large (Green et al., 2000) effect size. The null hypothesis was rejected; indicating that the team based group training

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intervention significantly improved nursing adjunct faculty ability to identify unethical or dishonest nursing student behavior in the classroom and clinical area combined.

A follow-up within-subjects repeated contrast indicated a significant increase between the mean pretest and the mean posttest, $F (1, 24) = 49.85$, $p = <.001$, partial $\eta2 = .68$, a large (Green et al., 2000) effect size. A second follow-up within-subjects repeated contrast indicated no significant difference between the posttest and the follow-up test, $F (1, 24) = 2.94$, $p = .099$. The results suggest the intervention significantly improved participants' ability to identify dishonest and unethical nursing student behavior in the classroom and clinical combined areas, and their ability to identify that behavior did not significantly change at the three month follow-up period, see Figure 4-6.

Research Question #2: Preparedness

How does a faculty development session impact the adjunct nursing faculty in their preparedness in dealing with dishonest or unethical nursing student behaviors? The null hypothesis for Question 2 was: The mean score for the preparedness in dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is less than or equal to the mean score on the Pre-Intervention IRAT. The alternate hypothesis for Question 2 was: the mean score for the preparedness in dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is greater than the mean score on the Pre-Intervention IRAT.

Classroom Preparedness

A paired samples *t* test was conducted to evaluate the differences between the mean pre-intervention IRAT and the mean post-intervention final IRAT scores of the faculty in dealing with dishonest or unethical nursing student behavior in the classroom, see Figure 4-7. The test

was significant, t (35) = 3.60, $p < .001$. The mean score post-intervention was higher than the mean score pre-intervention. The standardized difference in means, d = 0.84, indicated a large (Green et al., 2000) effect size.

A one-way within subjects ANOVA with repeated measures was conducted with the factor being the pre-intervention IRAT survey, the post-intervention final IRAT survey, and the follow-up time periods; and the dependent variable being the IRAT scores for the identification of dishonest and unethical nursing student behavior. The means and standard deviations for the IRAT scores are presented in Table 4-7. A one-tail F test for the multivariate ANOVA indicated a significant time effect, F (2, 24) = 5.22, $p = .007$, multivariate η2 = .30, a large (Green et al., 2000) effect size. The null hypothesis was rejected; indicating that the team based group training intervention significantly improved nursing adjunct faculty preparedness to deal with unethical or dishonest nursing student behavior in the classroom.

A follow-up within-subjects repeated contrast indicated a significant increase between the mean pretest and the mean posttest, F (1, 25) = 9.76, $p = .002$, partial η2 = .28, a large (Green et al., 2000) effect size. A second follow-up within-subjects repeated contrast indicated no significant difference between the posttest and the follow-up test, F (1, 25) = 3.23, $p = .084$. The results suggest the intervention significantly improved participants' preparedness to deal with dishonest and unethical nursing student behavior in the classroom and their preparedness perception to deal with that behavior did not significantly change at the three month follow-up period, see Figure 4-8.

Clinical Preparedness

A paired samples t test was conducted to evaluate the differences between the mean pre-intervention IRAT and the mean post-intervention final IRAT scores of the preparedness of the faculty in dealing with dishonest or unethical nursing student behavior in the clinical area, see

Figure 4-9. The test was significant, $t(35) = 3.85$, $p = <.001$. The mean score post-intervention was higher than the mean score pre-intervention. The standardized difference in means, $d = 0.88$, indicated a large (Green et al., 2000) effect size.

A one-way within subjects ANOVA with repeated measures was conducted with the factor being the pre-intervention IRAT survey, the post-intervention final IRAT survey, and the follow-up time periods; and the dependent variable being the IRAT scores for the identification of dishonest and unethical nursing student behavior. The means and standard deviations for the IRAT scores are presented in Table 4-8. A one-tail F test for the multivariate ANOVA indicated a significant time effect, $F(2, 21) = 4.70$, $p = .011$, multivariate $\eta2 = .31$, a large (Green et al., 2000) effect size. The null hypothesis was rejected; indicating that the team based group training intervention significantly improved nursing adjunct faculty preparedness to deal with unethical or dishonest nursing student behavior in the clinical area.

A follow-up within-subjects repeated contrast indicated a significant increase between the mean pretest and the mean posttest, $F(1, 22) = 9.53$, $p = .003$, partial $\eta2 = .30$, a large (Green et al., 2000) effect size. A second follow-up within-subjects repeated contrast indicated no significant difference between the posttest and the follow-up test, $F(1, 22) = .66$, $p = .425$. The results suggest the intervention significantly improved participants' preparedness to deal with dishonest and unethical nursing student behavior in the clinical area and their preparedness to deal with that behavior did not significantly change at the three month follow-up period, see Figure 4-10.

Omnibus Preparedness

A paired samples t test was conducted to evaluate the differences between the mean pre-intervention IRAT and the mean post-intervention final IRAT scores of the preparedness of faculty in dealing with dishonest or unethical nursing student behavior in the classroom and

clinical areas combined, see Figure 4-11. The test was significant, $t(36) = 4.07$, $p = <.001$. The mean score post-intervention was higher than the mean score pre-intervention. The standardized difference in means, d = 0.92, indicated a large (Green et al., 2000) effect size.

A one-way within subjects ANOVA with repeated measures was conducted with the factor being the pre-intervention IRAT survey, the post-intervention final IRAT survey, and the follow-up time periods; and the dependent variable being the IRAT scores for the identification of dishonest and unethical nursing student behavior. The means and standard deviations for the IRAT scores are presented in Table 4-9. A one-tail F test for the multivariate ANOVA indicated a significant time effect, $F(2, 22) = 6.25$, $p = .004$, multivariate η2 = .36, a large (Green et al., 2000) effect size. The null hypothesis was rejected; indicating that the team based group training intervention significantly improved nursing adjunct faculty preparedness to deal with unethical or dishonest nursing student behavior in the classroom and clinical area combined.

A follow-up within-subjects repeated contrast indicated a significant increase between the mean pretest and the mean posttest, $F(1, 23) = 11.25$, $p = .002$, partial η2 = .33, a large (Green et al., 2000) effect size. A second follow-up within-subjects repeated contrast indicated no significant difference between the posttest and the follow-up test, $F(1, 23) = .96$, $p = .337$. The results suggest the intervention significantly improved participants' preparedness to deal with dishonest and unethical nursing student behavior in the classroom and clinical areas combined and their preparedness to deal with that behavior did not significantly change at the three month follow-up period, see Figure 4-12.

<div align="center">

Research Question #3: Willingness

</div>

How does a faculty development session impact the adjunct nursing faculty in their willingness in dealing with dishonest or unethical nursing student behaviors? The null hypothesis for Question 3 was: The mean score for the willingness in dealing with dishonest or

unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is less than or equal to the mean score on the Pre-Intervention IRAT. The alternate hypothesis for Question 3 was: the mean score for the willingness in dealing with dishonest or unethical nursing student behavior by adjunct nursing faculty on the follow-up IRAT three months after the intervention is greater than the mean score on the Pre-Intervention IRAT.

Classroom Willingness

A paired samples t test was conducted to evaluate the differences between the mean pre-intervention IRAT and the mean post-intervention final IRAT scores of the faculty to deal with dishonest or unethical nursing student behavior in the classroom, see Figure 4-13. The test was significant, $t(35) = 2.98$, $p = .003$. The mean score post-intervention was higher than the mean score pre-intervention. The standardized difference in means, d = 0.71, indicated a large (Green et al., 2000) effect size.

A one-way within subjects ANOVA with repeated measures was conducted with the factor being the pre-intervention IRAT survey, the post-intervention final IRAT survey, and the follow-up time periods; and the dependent variable being the IRAT scores for the identification of dishonest and unethical nursing student behavior. The means and standard deviations for the IRAT scores are presented in Table 4-10. A one-tail F test for the multivariate ANOVA indicated a significant time effect, $F(2, 25) = 3.40$, $p = .025$, multivariate $\eta 2 = .21$, a large (Green et al., 2000) effect size. The null hypothesis was rejected; indicating that the team based group training intervention significantly improved nursing adjunct faculty willingness to deal with unethical or dishonest nursing student behavior in the classroom.

A follow-up within-subjects repeated contrast indicated a significant increase between the mean pretest and the mean posttest, $F(1, 26) = 6.14$, $p = .01$, partial $\eta 2 = .19$, a large (Green et

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al., 2000) effect size. A second follow-up within-subjects repeated contrast indicated no significant difference between the posttest and the follow-up test, $F(1, 26) = 1.73$, $p = .200$. The results suggest the intervention significantly improved participants' willingness to deal with dishonest and unethical nursing student behavior in the classroom and their willingness to deal with that behavior did not significantly change at the three month follow-up period, see Figure 4-14.

Clinical Willingness

A paired samples *t* test was conducted to evaluate the differences between the mean pre-intervention IRAT and the mean post-intervention final IRAT scores of the faculty to deal with dishonest or unethical nursing student behavior in the clinical area, see Figure 4-15. The test was significant, $t(34) = 4.79$, $p = <.001$. The mean score post-intervention was higher than the mean score pre-intervention. The standardized difference in means, d = 0.94, indicated a large (Green et al., 2000) effect size.

A one-way within subjects ANOVA with repeated measures was conducted with the factor being the pre-intervention IRAT survey, the post-intervention final IRAT survey, and the follow-up time periods; and the dependent variable being the IRAT scores for the identification of dishonest and unethical nursing student behavior. The means and standard deviations for the IRAT scores are presented in Table 4-11. A one-tail *F* test for the multivariate ANOVA indicated a significant time effect, $F(2, 22) = 9.82$, $p < .001$, multivariate η2 = .47, a large (Green et al., 2000) effect size. The null hypothesis was rejected; indicating that the team based group training intervention significantly improved nursing adjunct faculty willingness to deal with unethical or dishonest nursing student behavior in the clinical area.

A follow-up within-subjects repeated contrast indicated a significant increase between the mean pretest and the mean posttest, $F(1, 23) = 19.56$, $p = <.001$, partial η2 = .46, a large (Green

et al., 2000) effect size. A second follow-up within-subjects repeated contrast indicated no significant difference between the posttest and the follow-up test, F (1, 23) = .25, p = .621. The results suggest the intervention significantly improved participants' willingness to deal with dishonest and unethical nursing student behavior in the clinical area and their willingness to deal with that behavior did not significantly change at the three month follow-up period, see Figure 4-16.

Omnibus Willingness

A paired samples t test was conducted to evaluate the differences between the mean pre-intervention IRAT and the mean post-intervention final IRAT scores of the deal with dishonest or unethical nursing student behavior in the classroom and clinical areas combined, see Figure 4-17. The test was significant, t (35) = 3.82, p < .001. The mean score post-intervention was higher than the mean score pre-intervention. The standardized difference in means, d = 0.86, indicated a large (Green et al., 2000) effect size.

A one-way within subjects ANOVA with repeated measures was conducted with the factor being the pre-intervention IRAT survey, the post-intervention final IRAT survey, and the follow-up time periods; and the dependent variable being the IRAT scores for the identification of dishonest and unethical nursing student behavior. The means and standard deviations for the IRAT scores are presented in Table 4-12. A one-tail F test for the multivariate ANOVA indicated a significant time effect, F (2, 23) = 4.88, p = .009, multivariate η2 = .30, a large (Green et al., 2000) effect size. The null hypothesis was rejected; indicating that the team based group training intervention significantly improved nursing adjunct faculty willingness to deal with unethical or dishonest nursing student behavior in the classroom and clinical area combined.

A follow-up within-subjects repeated contrast indicated a significant increase between the mean pretest and the mean posttest, F (1, 24) = 10.13, p = .002, partial η2 = .30, a large (Green et

al., 2000) effect size. A second follow-up within-subjects repeated contrast indicated no significant difference between the posttest and the follow-up test, F (1, 24) = .46, p = .504. The results suggest the intervention significantly improved participants' willingness to deal with dishonest and unethical nursing student behavior in the classroom and clinical areas combined and their willingness to deal with that behavior did not significantly change at the three month follow-up period, see Figure 4-18.

Summary of Findings

This chapter presented the findings of the analysis of this study. The null hypothesis was rejected for each of the three parts of the three study questions with a large effect size for every studied variable and indicates that the brief training session had a statistically significantly positive impact on the adjunct faculty members' perception of identifying unethical or dishonest behaviors, and their perceptions of being prepared and willing to take action when unethical or dishonest behaviors are discovered in both the classroom and clinical areas. This improved perception continued for three months between the post-intervention final survey and the follow-up survey. These findings will be discussed in Chapter 5, along with the study impact and conclusions, the limitations of the study, and recommendations for further research.

Table 4-1 Demographic Information for IRAT Participants

Characteristic	Number (N=41)
Gender	
Male	0
Female	41 (100%)
Age	
26-30	2 (5%)
31-35	2 (5%)
36-40	3 (7%)
41-45	7 (17%)
46-50	6 (15%)
51-55	5 (12%)
Over 55	11 (27%)
Not reported	5 (12%)
Teaching Experience	
0-1	4 (10%)
2-4	14 (34%)
5-7	10 (24%)
8-10	4 (10%)
11-15	3 (7%)
16+	6 (15%)
Working outside of adjunct role	
Yes	22 (54%)
No	19 (46%)
Takes action on unethical/dishonest behavior	
Never	2 (5%)
Occasionally	14 (34%)
Sometimes	6 (14%)
Usually	6 (14%)
Always	13 (32%)
Number of actions last semester	
0	21 (51%)
1	8 (20%)
2	8 (20%)
3	2 (5%)
4+	1 (2%)
Completed the reading assignment	
All	17 (41%)
Partially	7 (18%)
None	17 (41%)

Table 4-2 Cronbach's alpha of Classroom and Clinical Area Scores

Instrument	Cronbach's alpha
Classroom Identification	0.85
Classroom Prepared	0.97
Classroom Willingness	0.96
Clinical Identification	0.94
Clinical Prepared	0.90
Clinical Willingness	0.72
Omnibus Identification	0.88
Omnibus Prepared	0.97
Omnibus Willingness	0.94

Table 4-3 Survey Mean Scores in the Classroom and Clinical

| Question Items | Mean (Standard Deviation) | | | |
	PRE IRAT	GRAT	POST IRAT	FOLLOW UP
Classroom Identifying Unethical-Dishonest Behavior	4.64 (.61)	4.85 (.19)	4.94 (.12)	4.88 (.16)
Classroom Preparedness to take action	4.50 (.79)	4.82 (.17)	4.94 (.09)	4.83 (.25)
Classroom Willingness to take action	4.61 (.72)	4.82 (.17)	4.94 (.09)	4.88 (.22)
Clinical Identifying Unethical-Dishonest Behavior	4.57 (.63)	4.86 (.13)	4.92 (.13)	4.83 (.18)
Clinical Preparedness to take action	4.56 (.60)	4.83 (.11)	4.93 (.10)	4.88 (.17)
Clinical Willingness to take action	4.70 (.32)	4.83 (.11)	4.93 (.10)	4.88 (.18)

Table 4-4 Classroom Identification of Unethical or Dishonest Behavior

Classroom Identification	Mean	Std. Deviation	N
Pre-Intervention	4.75	.32	27
Post-Intervention	4.94	.09	27
Three Month Follow-Up	4.89	.16	27

Table 4-5 Clinical Identification of Unethical or Dishonest Behavior

Clinical Identification	Mean	Std. Deviation	N
Pre-Intervention	4.65	.28	23
Post-Intervention	4.91	.12	23
Three Month Follow-Up	4.86	.17	23

Table 4-6 Omnibus Identification of Unethical or Dishonest Behavior

Omnibus Identification	Mean	Std. Deviation	N
Pre-Intervention	4.69	.19	25
Post-Intervention	4.93	.09	25
Three Month Follow-Up	4.87	.16	25

Table 4-7 Classroom Preparedness to Deal with Unethical or Dishonest Behavior

Classroom Preparedness	Mean	Std. Deviation	N
Pre-Intervention	4.39	.90	26
Post-Intervention	4.94	.09	26
Three Month Follow-Up	4.84	.25	26

Table 4-8 Clinical Preparedness to Deal with Unethical or Dishonest Behavior

Clinical Preparedness	Mean	Std. Deviation	N
Pre-Intervention	4.51	.63	23
Post-Intervention	4.92	.12	23
Three Month Follow-Up	4.87	.18	23

Table 4-9 Omnibus Preparedness to Deal with Unethical or Dishonest Behavior

Omnibus Preparedness	Mean	Std. Deviation	N
Pre-Intervention	4.42	.73	24
Post-Intervention	4.93	.09	24
Three Month Follow-Up	4.89	.14	24

Table 4-10 Classroom Willingness to Deal with Unethical or Dishonest Behavior

Classroom Willingness	Mean	Std. Deviation	N
Pre-Intervention	4.55	.81	27
Post-Intervention	4.94	.08	27
Three Month Follow-Up	4.88	.23	27

Table 4-11 Clinical Willingness to Deal with Unethical or Dishonest Behavior

Clinical Willingness	Mean	Std. Deviation	N
Pre-Intervention	4.67	.30	24
Post-Intervention	4.91	.11	24
Three Month Follow-Up	4.89	.19	24

Table 4-12 Omnibus Willingness to Deal with Unethical or Dishonest Behavior

Omnibus Willingness	Mean	Std. Deviation	N
Pre-Intervention	4.59	.53	25
Post-Intervention	4.93	.08	25
Three Month Follow-Up	4.90	.17	25

Classroom Identification
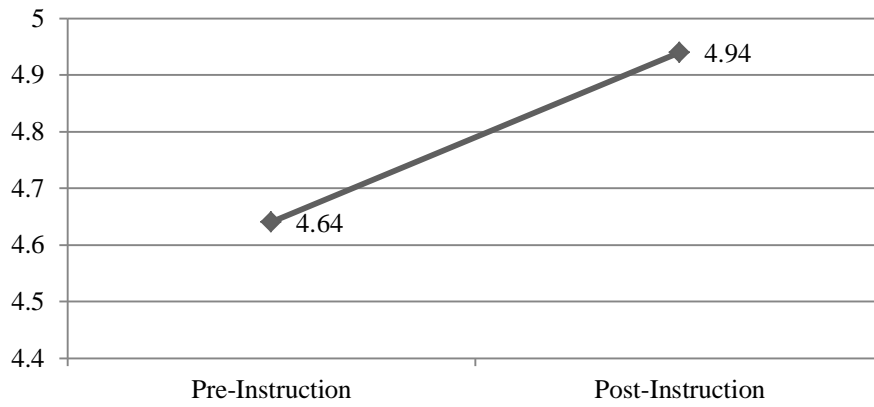
Figure 4-1 Differences in Identification of Classroom Dishonest or Unethical Behaviors Pre-Intervention and Post-Intervention

Classroom Identification
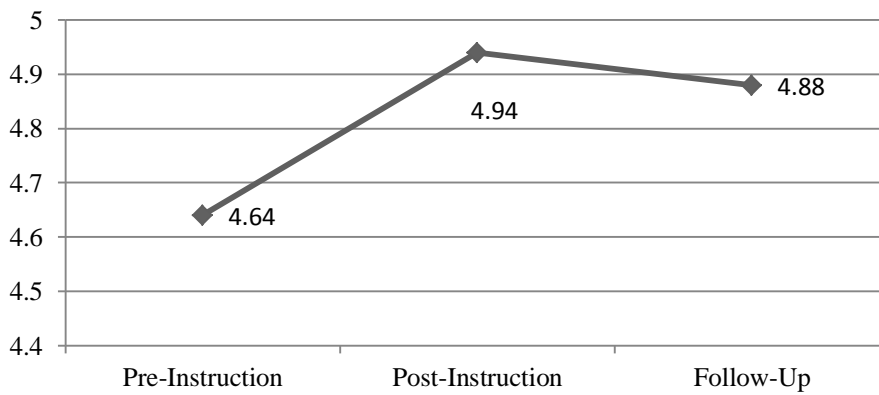
Figure 4-2 Differences in Classroom Identification of Dishonest or Unethical Behaviors Pre-Intervention, Post-Intervention and Three Month Follow Up

Classroom & Clinical Identification
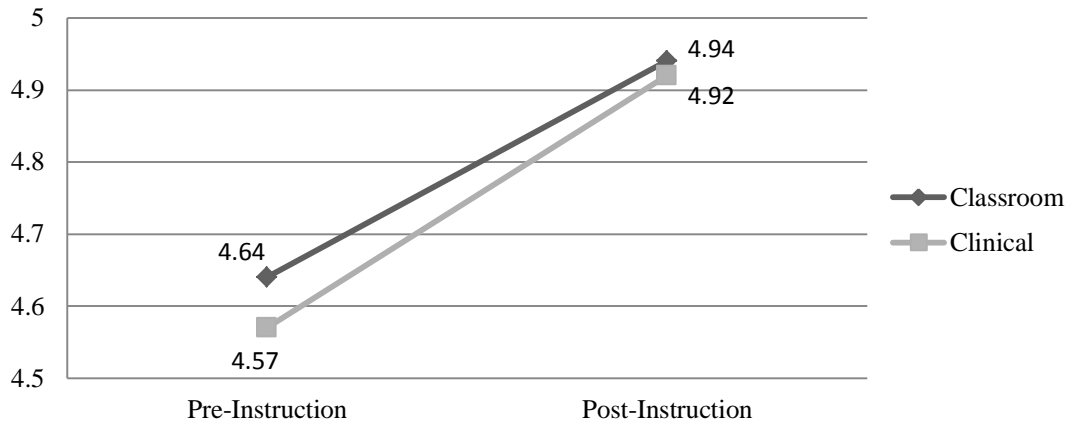
Figure 4-3 Differences in Identification of Classroom and Clinical Dishonest or Unethical Behaviors Pre-Intervention and Post-Intervention

Classroom & Clinical Identification
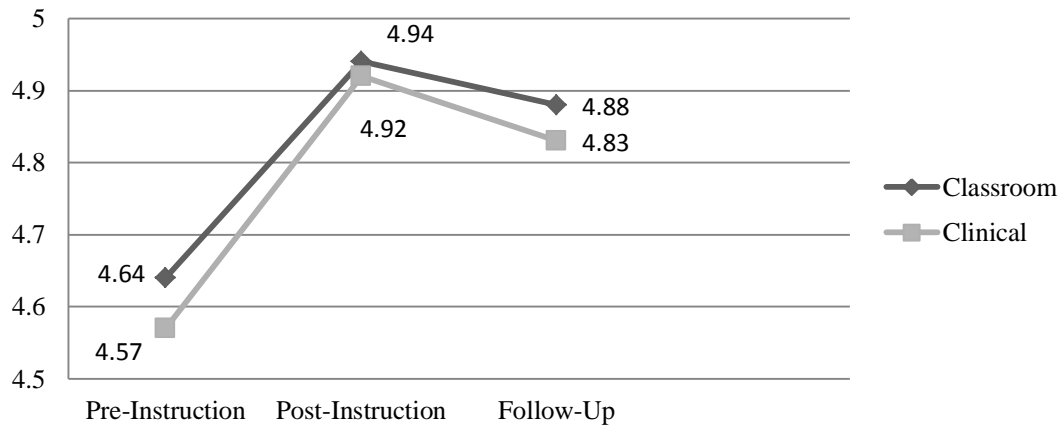
Figure 4-4 Differences in Classroom and Clinical Identification of Dishonest or Unethical Behaviors Pre-Intervention, Post-Intervention and Three Month Follow Up

Classroom, Clinical, & Omnibus Identification
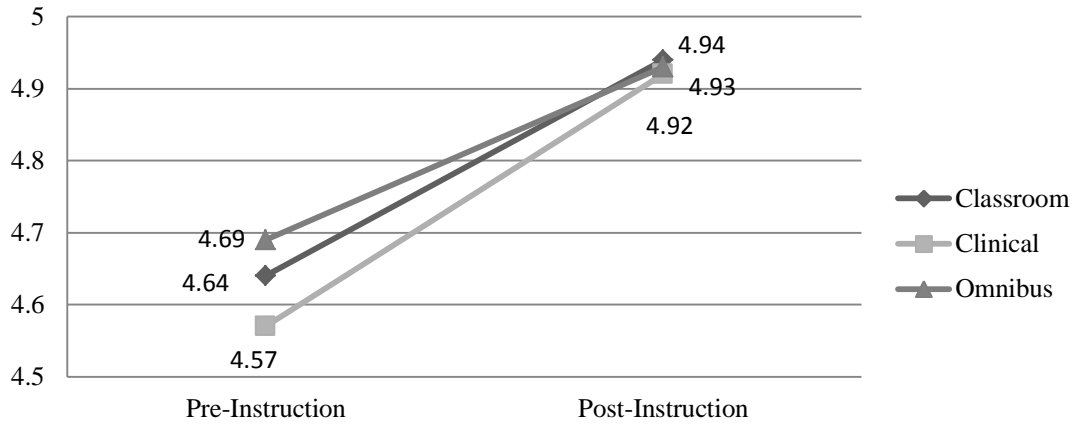
Figure 4-5 Differences in Classroom, Clinical, and Omnibus Identification of Dishonest or
Unethical Behaviors Pre-Intervention and Post-Intervention

Classroom, Clinical, & Omnibus Identification
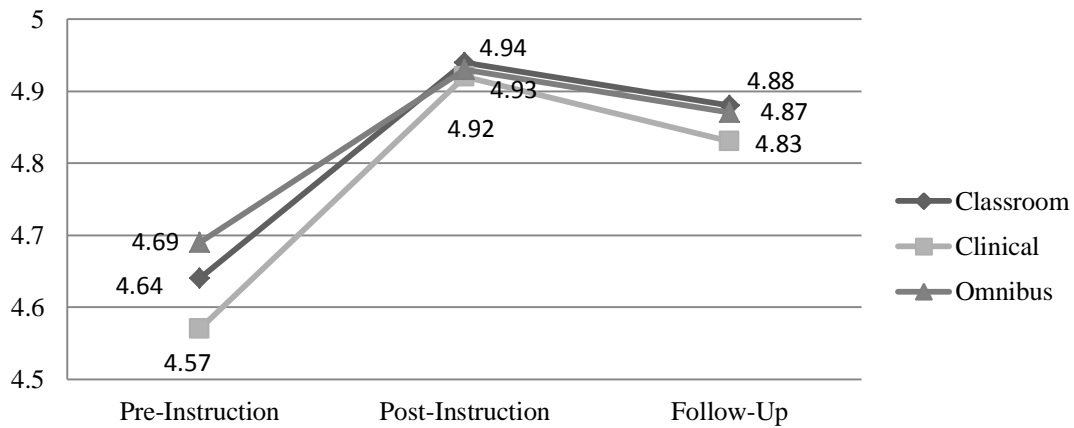
Figure 4-6 Differences in Classroom, Clinical and Omnibus Identification of Dishonest or
Unethical Behaviors Pre-Intervention, Post-Intervention and Three Month Follow Up

Classroom Preparedness
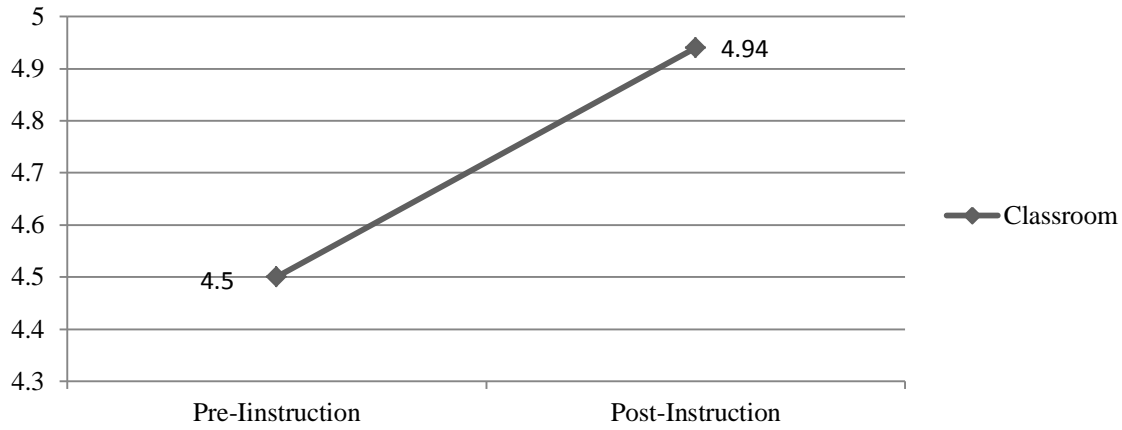
Figure 4-7 Differences in Classroom Preparedness to Take Action on Dishonest or Unethical Behaviors Pre-Intervention and Post-Intervention

Classroom Preparedness
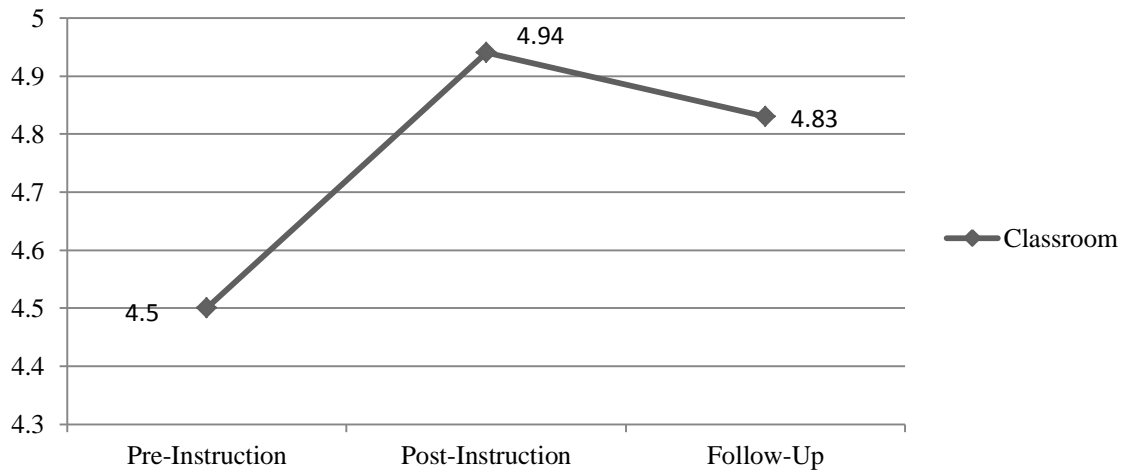
Figure 4-8 Differences in Classroom Preparedness to Deal with Dishonest or Unethical Behaviors Pre-Intervention, Post-Intervention and Three Month Follow Up

Classroom & Clinical Preparedness
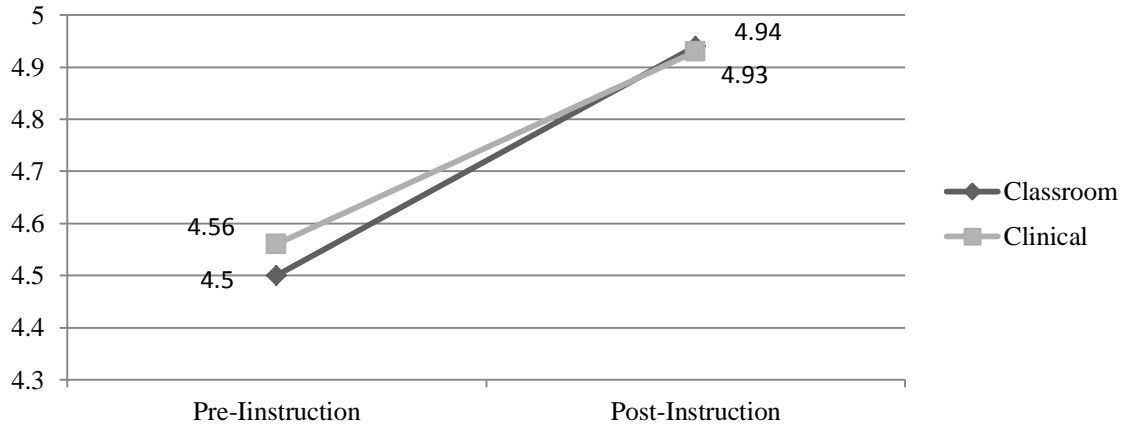
Figure 4-9 Differences in Classroom and Clinical Preparedness to Take Action on Dishonest or
Unethical Behaviors Pre-Intervention and Post-Intervention

Classroom & Clinical Preparedness
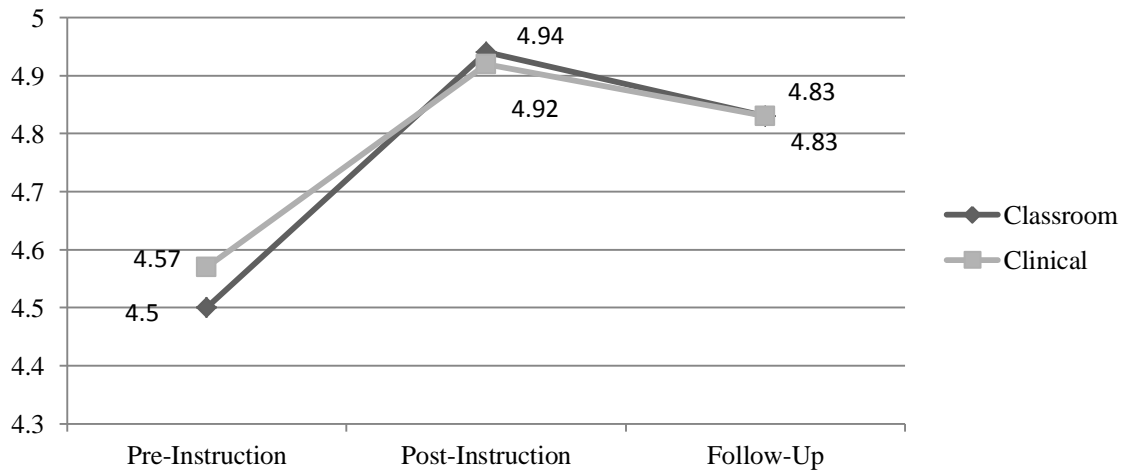
Figure 4-10 Differences in Classroom and Clinical Preparedness to Deal with Dishonest or
Unethical Behaviors Pre-Intervention, Post-Intervention and Three Month Follow Up

Classroom & Clinical Omnibus Preparedness
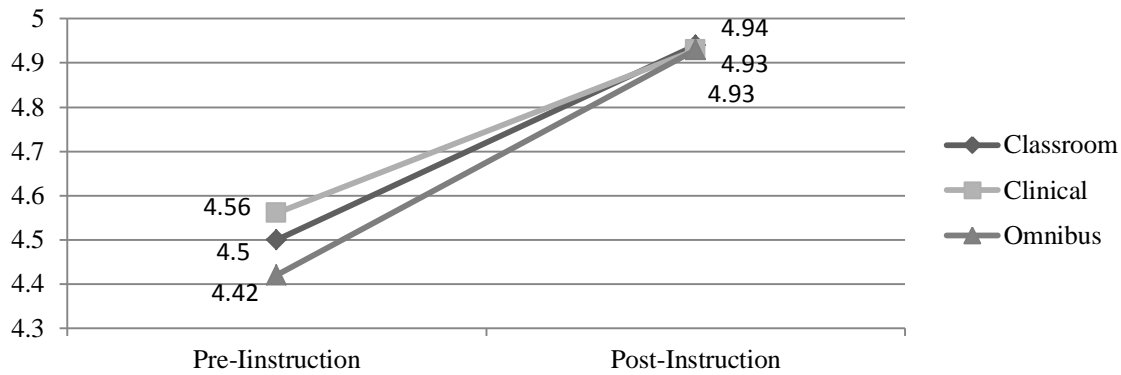
Figure 4-11 Differences in Classroom, Clinical, and Omnibus Preparedness to Take Action on Dishonest or Unethical Behaviors Pre-Intervention and Post-Intervention

Classroom, Clinical, & Omnibus Preparedness
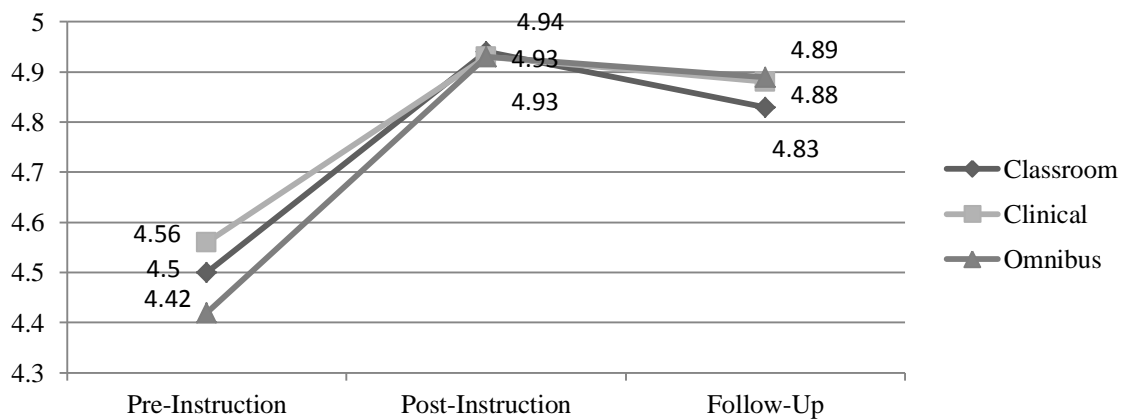
Figure 4-12 Differences in Classroom, Clinical and Omnibus Preparedness to Deal with Dishonest or Unethical Behaviors Pre-Intervention, Post-Intervention and Three Month Follow Up

Classroom Willingness
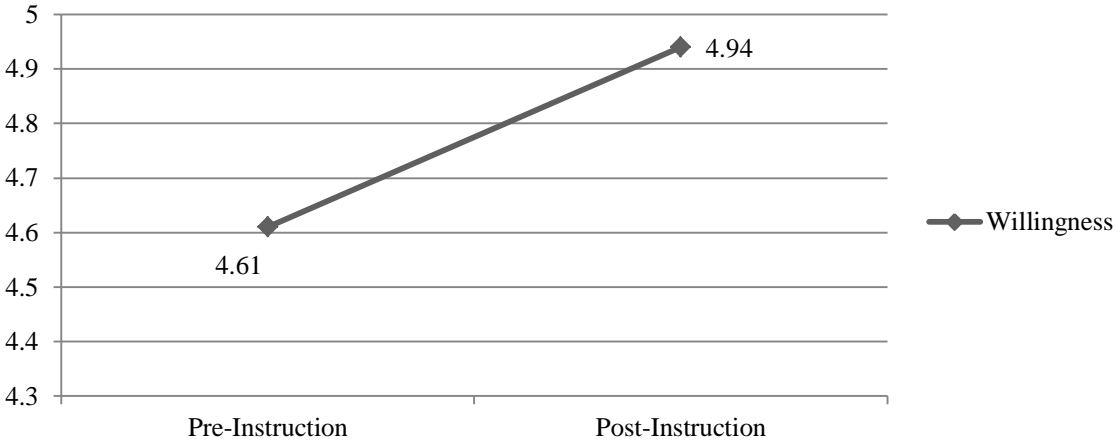
Figure 4-13 Differences in Classroom Willingness to Take Action on Dishonest or Unethical Behaviors Pre-Intervention and Post-Intervention

Classroom Willingness
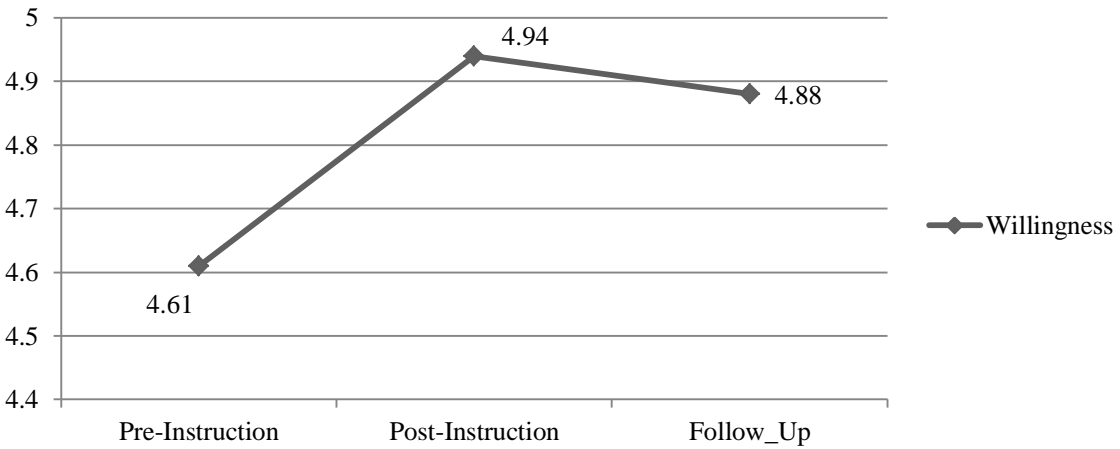
Figure 4-14 Differences in Classroom Willingness to Deal with Dishonest or Unethical Behaviors Pre-Intervention, Post-Intervention and Three Month Follow Up

Classroom & Clinical Willingness
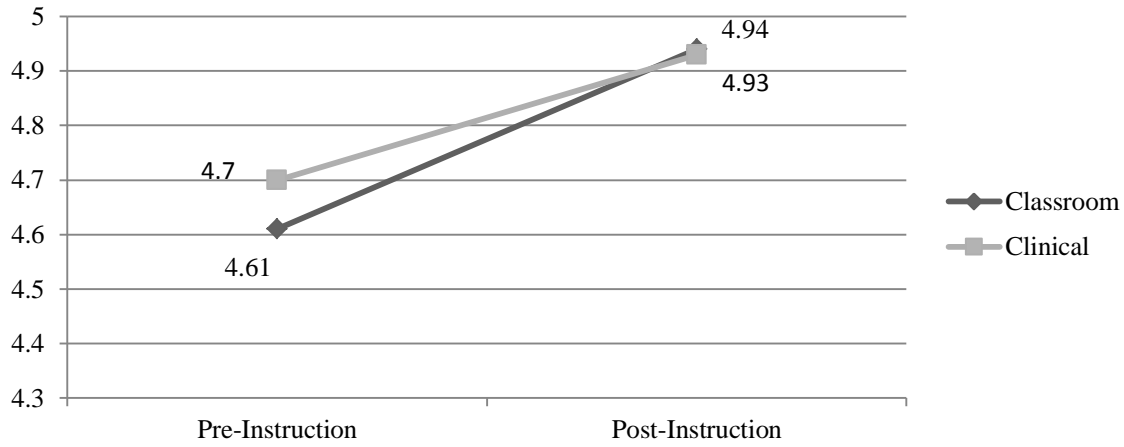
Figure 4-15 Differences in Classroom and Clinical Willingness to Take Action on Dishonest or Unethical Behaviors Pre-Intervention and Post-Intervention

Classroom & Clinical Willingness
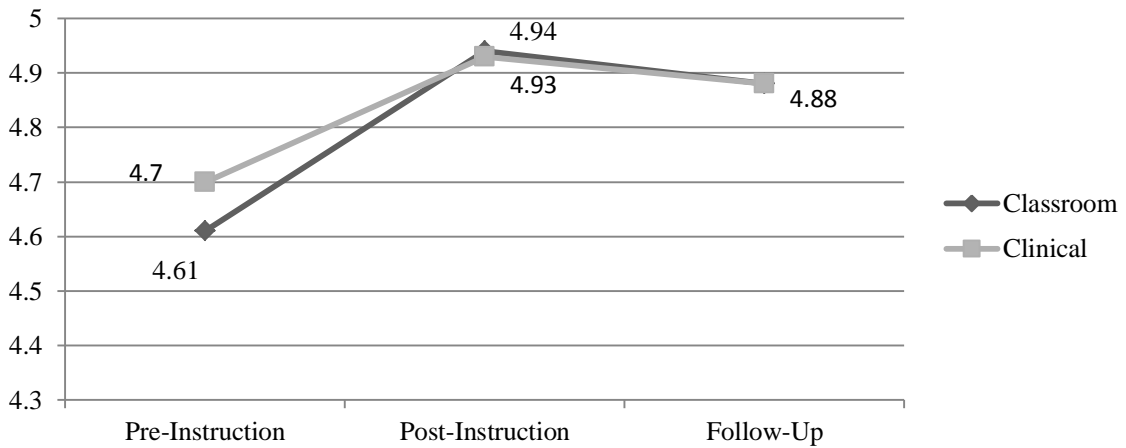
Figure 4-16 Differences in Classroom and Clinical Willingness to Deal with Dishonest or Unethical Behaviors Pre-Intervention, Post-Intervention and Three Month Follow Up

Classroom, Clinical, & Omnibus Willingness
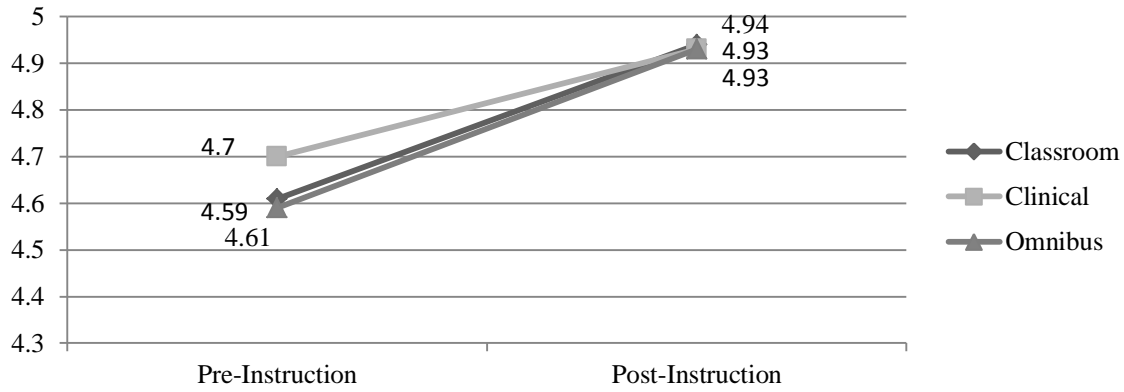
Figure 4-17 Differences in Classroom, Clinical, and Omnibus Willingness to Take Action on Dishonest or Unethical Behaviors Pre-Intervention and Post-Intervention

Classroom, Clinical, & Omnibus Willingness
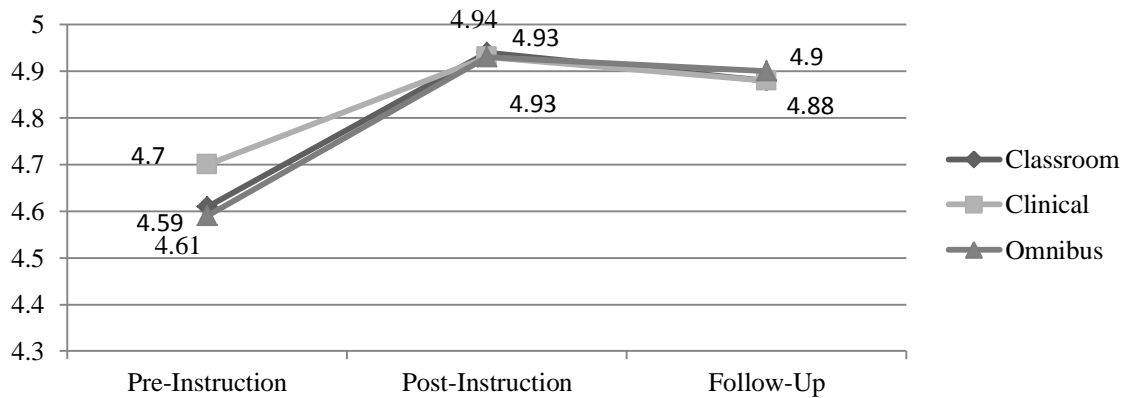
Figure 4-18 Differences in Classroom, Clinical and Omnibus Willingness to Deal with Dishonest or Unethical Behaviors Pre-Intervention, Post-Intervention and Three Month Follow Up

CHAPTER 5
CONCLUSIONS

Overview

This three part study examined the impact of a brief team based group training session on adjunct nursing faculty perceptions of dishonest or unethical nursing student behaviors in both the classroom and the clinical contexts. Currently, Team-Based Learning has been utilized successfully to train diverse student and customer groups (Michaelsen, et al., 2004), however there are no published studies that have investigated applying a brief team based group learning approach for the instruction of nursing adjuncts in the identification, preparedness and willingness to deal with unprofessional behaviors.

Often, unethical student behaviors are perceived and defined differently by faculty and students (Higbee & Thomas, 2002; PeSymaco & Marcelo, 2003; Solomon & De Natale, 2000; Stern & Havlicek, 1986; Wajda-Johnson, Handal, Brawer, & Fabricatore, 2001). In addition to this disconnect, faculty members frequently fail to agree about the specific actions that constitute unethical or dishonest behavior (Barrett & Cox, 2005; Birch et al, 1999; Bradshaw & Lowenstein, 1990; Hughes & McCabe, 2006a; Pickard, 2006; Pincus & Schmelkin, 2003; Price, Dake, & Islam, 2001). Lack of faculty agreement on what constitutes cheating, and what to do about it, can result in a faculty who relax the rules of academic honesty and are then seen as promoting an environment that is safe for dishonest students, causing honest students to either resent that treatment or become cheaters (Firmin et al., 2007; Hughes & McCabe, 2006b; Ryan, 1998). This lack of consistency in dealing with dishonesty places honest students at a disadvantage when their honest work is compared to a dishonestly produced piece (Ryan, 1998). Team learning strategies that incorporate relevant, participative activities to improve an individual's knowledge has resulted in deeper agreement and cognition (Ahles & Bosworth,

2004; Bergman, Rentsch, Small, davenport & Bergmen, 2012; Berland & Lee, 2012; Parmalee & Michaelsen, 2010; Sweet & Michaelsen, 2007).

In an effort to understand and potentially address the faculty lack of consensus, adjunct nursing faculty perceptions were studied. Data was collected using a self-reporting survey tool which was administered three times: immediately prior to, after, and then three months following group training. Quantitative analysis was conducted to ascertain the impact of the team based group learning session on nursing adjunct faculty perceptions. It was anticipated that the team based group training session would positively impact learning for this sample of adjunct nursing faculty, improving individual understanding and group consensus. This chapter will discuss the results of the analysis, and the implications for the use of team based group learning in the training of adjunct nursing faculty, and the broader potential applications related to the findings from this study regarding veracity and fidelity.

Research Question 1 Discussion

How does a faculty development session impact the adjunct nursing faculty in their identification of dishonest or unethical nursing student behaviors? It is not uncommon for development sessions, targeting collegiate faculty, to result in an increased understanding of practice (Desimone, Porter, Garet, Yoon, & Birman, 2002; Desimone, 2011, Ruiz, 2010; Wallin, 2005). Survey data was collected in this study of a development session to measure adjunct nursing faculty's perceptions of their ability to identify dishonest or unethical nursing student behaviors. Results were analyzed to evaluate the impact of a brief team based group training session by collecting a baseline measure related to faculty perceptions. Data from pre-session training was compared with perceptions at the conclusion of the training session. Those results were then compared with perception data three months after the training session. Faculty historically are not in agreement about their perceptions of identifying dishonest or unethical

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student behaviors (Coren, 2011; Fontana, 2009; Jeffreys & Stier, 1995; Lewenson et al.,2005; Milliron & Sandoe, 2008; Throckmorton-Belzer et al., 2001; Wideman, 2011), but it was anticipated that there would be a positive effect on nursing adjunct faculty perceptions of their ability to identify what constitutes dishonest or unethical nursing student behaviors after the learning intervention.

Data from this study indicated that there was a positive, significant effect associated with the training session for identification of unethical or dishonest nursing student behaviors in the classroom ($p = .004$), the clinical area ($p = <.001$), and omnibus combination of classroom and clinical ($p = .<001$) which did not significantly decline in the three month follow-up results in the classroom ($p = .177$), the clinical area ($p = .289$) and the omnibus combination ($p = .099$). Post-intervention survey data, which was collected at the conclusion of the intervention, was compared to the pre-intervention survey data, and resulted in a large effect size (Green et al., 2000) in the classroom ($\eta2 = .28$), the clinical ($\eta = .49$) and the omnibus combination ($\eta2 = .68$).

The results from this brief, three hour group training session are consistent with published full semester group training session study results associated with Team-Based Learning in non-nursing populations, nursing student and faculty studies, and studies of adjunct faculty (Andersen & Strumel, 2011; Baldwin, 1997; Clark et al., 2008; Haidet & Fecile, 2006; Feingold et al., 2008; Rider et al., 2008; Sweet & Michaelsen, 2007; Thompson et al., 2007; Timmermans et al., 2012; Yang, Woomer, & Matthews, 2012;) in that perceptions of knowledge were improved. The group training session included opportunities for participants to review their peers' and their own knowledge about unethical and dishonest behaviors; reference the Nursing Student and Faculty Handbooks for examples of cheating; discuss relevant issues with colleagues; and work in teams that were each a smaller component of the larger group.

The individual faculty member's prior experiences and understanding were the foundation of their perceptions upon which the team intervention initiated a deeper understanding. Bandura's (1989) Social Cognitive Theory, based on the constructs of perceived self-efficacy, modeling and perceived collective-efficacy (Hirsh, 2009; Sweet & Michaelsen, 2007) can help explain the results that demonstrated significant improvement in learning. In this study participants were able to improve self-efficacy by discussing and clarifying their own perceptions, and accessing the actual definitions of dishonest behaviors in the Nursing Student and the Faculty Handbooks, ostensibly expanding their previous understanding in a realistic but low-stakes and collegial environment. Modeling was supported in the group activities when inexperienced individuals could discuss and compare their own understanding and ideas with those of their experienced peers, and collective efficacy was promoted by coming to an improved group agreement within each team and the entire group during the GRAT, the case study scenarios, and the team's best answer activity.

This study's findings also concur with published results about improvements in learning through professional development (Baker, 2010; Fitzgerald & Theilheimer, 2012; Hadre, 2010; Huston & Weaver, 2007) and team based learning (Andersen & Strumel, 2011; Feingold et al., 2008; Haidet & Fecile, 2006; Rider et al., 2008; Sibley & Parmalee, 2008; Sweet & Michaelsen, 2007; Thompson et al., 2007). As discussed, the results on the post-intervention final IRAT were significantly higher in the classroom, the clinical area, and the omnibus combination as compared to the pre-intervention IRAT results, and did not significantly differ from the follow-up intervention results. This analysis suggests that the brief team based group training session was an effective means in which to improve adjunct nursing faculty's perception of their ability

to identify unprofessional behaviors in nursing students, and this improvement did not erode significantly over a three month period within this group.

Research Question 2 Discussion

How does a faculty development session impact the preparedness of adjunct nursing faculty in dealing with dishonest or unethical nursing student behaviors? This study also measured the impact of the team based group training session on faculty perceptions of preparedness to take action when dishonest or unethical nursing student behaviors are discovered. It was anticipated that the training session would have a positive impact on faculty perceiving that they knew what to do (preparedness) when dishonest or unethical student behaviors were discovered. Kirkpatrick's four levels of evaluation model, as described in Naugle, Naugle, & Naugle (2000) explains that in order for training programs to be effective, students move through four levels, including: Level 1 is student satisfaction, or the feelings the students have about the training, called Reaction; Level 2 is learning proficiency, or the degree to which learning the required material occurred, called Learning; Level 3 is application skills, or the participants' ability to transfer training to their work, called Application or Behavior: and Level 4 is overall program effectiveness, or how the training impacted the organization's bottom line, called Results (Boyle & Crosby, 1997; Kirkpatrick, 1996; Watkins, Leigh, Foshay, & Kaufman, 1998). Participants were not surveyed about their satisfaction with the training (Level 1), however their perceptions of their level of knowledge, preparedness and willingness was measured and analyzed (Level 2). It should also be noted that the actual change in performance on the job (Level 3), and the impact to the organization (Level 4 and ostensibly in this study, on the profession of nursing) was not addressed, but could be studied at a later time.

To evaluate the impact of the team based group training session, a baseline of quantitative data was gathered related to the faculty perceptions of their level of preparedness before the

training and compared with perceptions after the session, (DeSilets & Dickerson, 2009) and again three months after the training session, which Kirkpatrick defines in Level 2 as measuring for the acquisition of knowledge, improving skills, or changing attitudes (Naugle et al., 2000). A successful intervention could potentially be applied to future training sessions for adjunct faculty, or other learner groups, to improve faculty understanding and facilitate a faculty member's knowledge to perform the recommended/required processes when dishonest or unethical student behavior is determined.

Data from this study indicated that there was a positive, significant effect associated with the training session comparing the pre-intervention IRAT with the post-intervention final IRAT for the preparedness in dealing with unethical or dishonest nursing student behaviors in the classroom ($p = .007$), the clinical area ($p = .011$), and omnibus combination of classroom and clinical ($p = .004$). Post-intervention survey data, which was collected at the conclusion of the intervention, was compared to the pre-intervention survey data, and resulted in large effect sizes (Green et al., 2000) in the classroom ($\eta2 = .28$) and clinical areas ($\eta2 = .30$) and in the omnibus combination ($\eta2 = .33$) Of interest is that in each of the three measured areas the results did not significantly decline in the three month follow-up survey data for the classroom ($p = .084$), the clinical area ($p = .425$) and the omnibus combination ($p = .337$). These results indicate that the gains in perception of knowing what to do (preparedness) i.e., the steps that are outlined in the Nursing Student and the Faculty Handbooks, did not diminish significantly after three months from what was gained during the training session. This positive learning outcome is also consistent with other studies on the professional development of faculty after training (Devlin-Scherer & Sardone, 2013; Huston & Weaver, 2008; Ruiz, 2010; Wallin & Smith, 2005).

Survey data was used to assess perceptions in preparedness to take action. This differs from a faculty member's perception of their ability to identify examples of cheating, studied in Question 1, in that preparedness to take action refers to the faculty members' knowledge about the expectations of the institution, administration or other faculty members in taking action about dishonest or unethical nursing student behavior(s). The participants were therefore responding to survey items about their level of knowledge of the behaviors or steps that they were to perform during a specific set of circumstances. As discussed earlier, Kirkpatrick's Levels 3 and 4 were not included in this study so the measurement of actual behavioral changes in responding to acts of dishonesty was not tracked to measure whether faculty members who did respond to dishonesty episodes did so in the manner that was outlined in the Nursing Student Handbook. Actual preparedness was not a component of this study and was not actually demonstrated; however the faculty perception of their levels of preparedness was measured.

This study's findings concur with the published results about improvements in learning through professional development (Baker, 2010; Fitzgerald & Theilheimer, 2012; Hadré, 2012; Huston & Weaver, 2008). As reported in Chapter 4, the results on the post-intervention final IRAT were significantly higher in the classroom, the clinical area, and the omnibus combination as compared to the pre-intervention IRAT results, but not significantly different from the follow-up intervention results. This indicates that adjunct faculty members' improved their perception of preparedness to deal with unethical or dishonest behavior during the training session to enforce the institution's policy on dishonesty and unethical behaviors, and that this significant gain from the intervention did not significantly decay during the three months after the intervention within this group. These outcomes suggest that the team based group training session was effective in significantly increasing faculty perception of being prepared to deal with

unethical or dishonest nursing student behavior with a large effect, and this improvement in perception did not erode significantly over a three month period within this group.

Research Question 3 Discussion

How does a faculty development session impact the willingness of adjunct nursing faculty in dealing with dishonest or unethical nursing student behaviors? Similar to the second research question, Question 3 sought to evaluate the manner in which a faculty development session impacted the adjunct nursing faculty's perception of willingness to take action when dishonest or unethical nursing student behaviors are discovered. Willingness to take action is the participant's perception of what they intend to do in the future (Chatzisarantis & Hagger, 2005). Ajzen (1991) describes intention as an indicator of how much effort a person plans to exert toward the performance of a particular behavior in the future. Behavioral intention, as described by Desouza & Czerniak (2003), is consequently a function of a cluster of beliefs or an attitude toward performing the behavior and the subjective norm, or influence of significant others if the behavior is or is not performed (Chatzisarantis & Hagger, 2005; Chen & Chen, 2006). The influence of others affects the perceived value or degree of importance of an issue, resulting in a high or low motivation to perform the behavior (Celuch & Dill, 2011; Randall, 1989). Faculty reported the perception of their willingness (intention to function in a particular manner) to take action, but actual implementation of the institution's policies on dishonest and unethical behaviors was not measured in this study.

In their theory of reasoned action Fishbein and Ajzen (1975) posit that people will consider the available information and the implications of their actions, and this will be done in a rational, sensible (Hausenblas, Carron, & Mack, 1997) and systematic manner (Randall, 1989). Ajzen (1991) continued to refine the theory of reasoned action by adding the concept of perceived behavioral control as an extension of the original theory, naming this the theory of planned

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behavior. Perceived behavioral control is the degree of ease or difficulty in conducting a behavior and indirectly effects behavioral intentions (Hausenblas et al., 1997). These three concepts: Attitude toward the behavior, subjective norms and perceptions of behavior can be used to examine the activities that occurred during the studied training session and begin to explain the significant, positive results.

Information and experiences were exchanged between the instructor, the team members and the group members during the activities. Collaboration and learning from peers has been articulated in the literature (Colbert, Brown, Choi & Thomas, 2008; Devlin-Scherer & Sardone, 2013; Fitzgerald & Theilheimer, 2012; Huston & Weaver, 2008) as a means to improve retention and achievement, and although retention was not studied, achievement of the learning outcomes was accomplished. Team and group collaboration and reflection seem to have occurred during the GRAT team activity, the presentations, the solved case study problems, and the concluding discussions on the "best" practice. This opportunity for collegial discourse enabled the individual faculty participants to not only increase their understanding (learn) from the didactic portion of the training session, but from their team and group members. Returning to the original assumption of the theory of reasoned action where people will consider the available information to develop their beliefs and attitudes, which then translate into intentions, and on into actions, it can be probably surmised that the increased agreement resulted from learning during the training session, and therefore helped participants increase their behavioral intentions. This translates into understanding that an improvement in the perception of willingness (as determined by analysis of the study data) will possibly result in an improvement in behavior. Without actually measuring the actions that a faculty member undertakes when dishonest or unethical nursing

student behavior is discovered, willingness was interpreted in this study as the perception of willingness, or the intention to behave in a particular manner, which significantly increased.

Data from this study indicated that there was a positive, significant effect associated with the training session for the willingness to deal with unethical or dishonest nursing student behaviors in the classroom ($p = .025$), the clinical area ($p = <.001$), and omnibus combination of classroom and clinical ($p = .009$). Post-intervention survey data was compared to the pre-intervention data, and resulted in large effect size (Green et al., 2000) in the classroom ($\eta2 = .19$), the clinical areas ($\eta2 = .46$), and in the omnibus combination ($\eta2 = .30$). This post-intervention final IRAT result showing improvement in perception of willingness to take action when compared to the pre-intervention IRAT results again did not significantly decline in the three month follow-up results in the classroom ($p = .20$), the clinical area ($p = .621$) and the omnibus combination ($p = .504$),and, compares positively to findings in the literature where groups have been studied to improve faculty participant learning (Baker, 2010; Fitzgerald & Theilheimer, 2012; Hadré, 2012; Huston & Weaver, 2008).

Again, the results on the post-intervention final IRAT survey were significantly higher in the classroom, the clinical area, and the omnibus combination as compared to the pre-intervention IRAT results, but not significantly different from the follow-up IRAT. Since the post-intervention IRAT was significantly higher than the pre-intervention, and the follow-up intervention results were not significantly different from the post-intervention test, the Question 3 results indicate that faculty members' improved their perception of their willingness to deal with unethical or dishonest behavior and that this significant gain from the intervention did not significantly decay during the three months after the intervention within this group.

Implications for Nursing Practice

Team-Based Learning (TBL) has been specifically used successfully to train medical students, business students, nursing faculty and nursing students (Baldwin et al., 1997; Chung, et al., 2009; Holleman, et al., 2009; Michaelsen, et al., 2004; Michaelsen, et al., 2008; Rider et al., 2008; Timmermans et al., 2012). An analysis of the willingness data again indicates that the team based group training session was an effective context to significantly increase faculty perception of being willing to deal with unethical or dishonest nursing student behavior with a large effect size, and this improvement in perception did not erode significantly over a three month period within this group of adjunct nursing faculty.

Students who are dishonest during their schooling are more likely to be dishonest in their professions (Bradshaw & Lowenstein, 1990; Daniel et al., 1994; Davis et al., 2009; Elmore, 2009; Fass, 1986; Fontana, 2009; Gaberson, 1997; Gray & Smith, 1999; Hilbert, 1985; Langone, 2007; Lewenson et al., 2005; Nonis & Swift, 2001; Petress, 2003; Stern & Havlicek, 1986; Wilk & Bowllan, 2011). Nursing students who cheated their way through school and graduate to become registered nurses may not have mastered the necessary information to deliver safe patient care, and can actually be a danger to their patients (Langone, 2007; Lewenson, Truglio-Londrigan, & Singleton, 2005; Stern & Havlicek, 1986; Wilk & Bowllan, 2011). Registered nurses are expected to behave professionally and ethically by society (Gallup Poll; Honesty/Ethics in Professions, 2012; Kelly, 1998; McCrink, 2010),), and expected to practice with veracity and fidelity by their professional nursing organization; the ANA (American Nurses Association Code of Ethics for Nurses, Standard 7, 2010, p. 3). Therefore, nursing education programs must include ethical development in their academic curricula (Cartwright et al., 1992; Ludwick & Silva, 1999; National League of Nursing; The Four Core Values, 2011). Yet nursing faculty members disagree on what constitutes unethical and dishonest nursing student behaviors

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(Barrett & Cox, 2005; Cole & McCabe, 1996; Graham et al, 1994; Higbee & Thomas, 2002; Muldoon, 2011; PeSymaco & Marcelo, 2003; Price et al., 2001). A training session using teams (Fiechtener & Michaelsen, 1984) was developed to impact adjunct nursing faculty perceptions on identifying and dealing with dishonest and unethical behaviors. It was rooted in Michaelsen et al.'s Team-Based Learning strategy (2008), and was found to be positively significant related to improving understanding as anticipated. It is understood that improved faculty agreement on what constitutes cheating and knowledge about what to do about cheating in itself does not necessarily guarantee that newly acquired behaviors will be performed by individuals (Rozycki, 2010; West & Schwenk, 1996), however implications of these important findings for teaching and learning in adjunct nursing faculty groups, and potentially also in nursing faculty groups are discussed, and recommendations for future study are offered.

Team Based Learning in Professional Development and Continuing Education

Typical collegiate educational courses have focused on the teacher-student relationship consisting of the educator organizing information and presenting huge amounts of data in a lecture format, students passively absorbing information and proving their understanding on periodic multiple-choice or true-false exams (Michaelsen et al., 1982; Michaelsen et al., 2008). Success of the team based group learning design in this study, which is based on learner-centered activities rather than instructor-centered lectures, can be explained by applying several of the concepts of andragogy that underpin Malcolm Knowles' theory of adult education. According to Knowles, adult learners have a need to know; adults resist when others impose their wills on them; adults have a lifetime of experiences that can be acknowledged; adults learn things that they can apply to their real-life situations; and adults are internally motived to learn (Merriam, 2001; Woodard, 2007). Dynamically engaging learners to actively participate in applying their knowledge to solve a significant, real-life problem is a defining attribute of Knowles' theory of

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adult education (Henschke, 2011). It is believed that the improved perceptions of faculty knowledge that were demonstrated in this study were probably due to providing team based learning activities founded in actual clinical cheating examples.

Michaelsen's TBL strategy has been implemented widely for decades and is reported to be a successful teaching and learning strategy in both non-nursing and nursing courses (Andersen et al., 2011; Clark et al., 2008; Feingold et al., 2008; Holleman et al., 2009; Michaelsen et al., 1982; Timmermans et al., 2012). Haidet and Facile (2006) describe applying TBL to continuing medical education settings, including workshops at specialty conferences and meetings for faculty and administrators; however there is no empirical evidence that has reported using brief TBL workshops or training sessions for adjunct nursing faculty to date. The TBL successes that have been reported in the literature focus on sixteen-week academic courses for a wide variety of contexts including business, medicine, nursing, dental and online students (Bastick, 1999; Michaelsen et al., 2004; Michaelsen et al., 2008; Sweet & Michaelsen, 2007) yet, positive results were also achieved during this three hour TBL adaptation, providing a platform for future applications and study.

The current study results have several practical implications for more effective student learning, teaching practice, and program administration. Michaelsen et al's. (2008) instructional strategy was applied in the development of a three hour training session for 41 adjunct nursing faculty members. Most nurses are accustomed to working together on teams or in small groups within their role as a registered nurse (Holleman et al., 2009). Using this carefully constructed team based training session resulted in a significant, positive impact on the perceptions of identification, preparedness and willingness of adjunct nursing faculty in dealing with dishonest or unethical nursing student behaviors.

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Each of the fifty United States has a professional licensing board that regulates how a student can become a registered nurse; the registered nurse's scope of practice; and requirements to maintain their state Registered Nurse (RN) license. These regulations include lifelong learning after licensure, known in nursing as continuing education (DeSilets, 1998; Stein, 1998). Many state requirements mandate that registered nurses seek a specific annual number of nursing continuing education units or hours as a condition to maintain current licensure and eligibility for employment as a registered nurse. Most hospitals offer continuing education and professional (staff) development to their employees to enhance their practice, either on a fee or non-fee basis. Using this and other team based learning successes as a guide, the team based group learning technique for professional development and continuing education can be applied to a facility's training, and potentially provide that facility with a positive return (i.e., employee learning that does not significantly decay over time) on their training investment of time, effort and money.

Improving Nursing Adjunct Faculty Perceptions of Managing Student Cheating

Nurses must practice ethically, or patients who are depending on them to perform nursing tasks can be seriously harmed by nurses who may have never actually learned the task, but unethically cheated their way through school. Part time adjunct faculty need to model ethical behavior as nursing professionals and demonstrate that they value veracity or truthfulness, and fidelity or trustworthiness and dependability (American Nurses Association Code of Ethics for Nurses, Standard 7, 2010). The results of this study indicate that a brief team based training session had a positive, significant impact on the perceptions of the convenience sample of adjunct nursing faculty participants, and could potentially be used to improve the perceptions of other nursing adjunct groups on faculty's dealings with ethical or honesty issues in the classroom and clinical areas.

The training session utilized the basic TBL tenets of backward designing the learning outcomes, based on an assessment of what learning needs were to be accomplished. New studies could also carefully construct team activities, utilizing the principles of andragogy which are incorporated to enable the adult learners to increase their understanding of how to apply their new knowledge to their own personal life, bring their considerable life-long learning experiences to the process of team learning, and self-direct their own intrinsic desire to increase their knowledge (Kroth, 2009; Merriam, 2001; Trotter, 2006; Woodard, 2007). Required in the team based group learning session design would be the following four S's that promote individual deep thinking and engaging, and content focused discussions as outlined in TBL (Haidet & Facile, 2006; Parmelee & Michaelsen, 2010):

1. A Significant problem: A problem that students would encounter in 'real life'.

2. The Same problem: The identical problem must be presented to each of the teams in order to make outcome comparisons when the exercise is completed.

3. A Specific choice: Teams will process specific decisions to answer the application activity, or determine the answers to the significant problem. Properly designed application activities will allow teams to make evaluations while processing their collective understanding, and through this process, will apply course or session concepts in order to explain and defend their answers to the significant problem.

4. A Simultaneous report: All teams will cease work on the problem simultaneously and report to the group in turn, focusing attention on each presentation.

These carefully constructed lesson plans and application activities are designed to take advantage of the interchange of experiences and collaboration between participants so that learners can build new knowledge, consistent with the assumptions of Vygotsky's constructivism

(Ally, 2004; Van Der Veer, 1986). This design could also be potentially used for full time nursing faculty in the training of identification, preparedness, and willingness to deal with unethical or dishonest nursing student behaviors.

Unlike huge classrooms or conferences where large numbers of participants have been traditionally lectured by an expert speaker and the learners passively listen, perhaps jotting down notes (Young, 2009), large numbers of adjunct faculty members can be broken into dynamic working teams whose members take an active role in learning. This study agrees with the literature that active, participative learning within teams results in the individual's deeper agreement and cognition (Fiechtner & Michaelsen, 1984; Parmalee & Michaelsen, 2010; Sweet & Michaelsen, 2007).

Adjunct Faculty Teams

Adjunct faculty members play a vital role in the education of students. Adjuncts are contracted by colleges to teach part time, supplementing the full time faculty, and are considered by full time faculty to be an invaluable asset for bringing a wealth of current knowledge and expertise to the online, classroom, clinical, and laboratory venues (Charlier & Williams, 2011; Gaillard-Kenny, 2006; Sweitzer, 2003). Adjunct faculty positions are seen as beneficial to the academic institution when their lower paid contracts can easily be terminated during economic downturns compared to the more expensive tenured, full time educators (Green, 2007; McLaughlin, 2005; Wallin, 2004). The numbers of online courses that are being offered has increased rapidly over recent years, opening teaching positions for adjunct faculty that cannot or will not be filled by full time faculty (Dedman & Pearch, 2004), and creating a new position for adjuncts who take several part-time adjunct positions, resulting in the adjunct working full time hours at combinations of institutions (Bedford, 2009).

Jacobson (2013) posits that in order to support a successful environment for adjunct faculty, a collaborative community of peers must be cultivated. This collaboration includes mentoring and training sessions that embraces prospects for active learning (Garet, Porter, Desimone, Birman, & Yoon, 2001), and takes advantage of networking opportunities with experienced peers (Baker, 2010; Fitzgerald & Theilheimer, 2012; Huston & Weaver, 2008; Woolforde, Lopez-Lang, & Lumley, 2012). The brief team based group learning format that was found to be successful for adjunct nursing faculty afforded participants the opportunity to not only attend the training session, but to work closely within the teams, networking and collaborating with their peers. This team based format should also be studied in other adjunct faculty groups for its generalizability to the larger adjunct faculty population and for its impact on learning, and could prove to be a valuable training tool to improve collegiality, collaboration, and understanding in this ever growing faculty group.

"Us versus Them"

Faculty fail to identify and act upon episodes of dishonest behavior for numerous reasons including the sense of a lack of administrative support (Coren, 2011; McCabe & Katz, 2009; Petress, 2003; Staats et al., 2009). Carefully constructed team based learning groups could be developed for faculty and administrators to engage in planned learning outcomes. In these learning teams participants reflect, interact, and collaborate on issues involving how unethical episodes are to be handled at the institution; how much the institution values the production of honest, ethical students; and how important the faculty's role in guiding students to behave ethically is held by the administration. Working on a diverse team made up of faculty and administrators in determining the proper steps to take in dealing with cheating behaviors would be more participative and interactive than simply taking a quiz on a Nursing Student or Faculty

Handbook policy or procedure to ascertain the facility's stance on student cheating, and could contribute to minimizing any "us versus them" attitudes.

Furthermore, combinations of faculty and student learning groups could apply the team based approach to the topic of cheating. Teams of faculty combined with students who work together to identify unethical or dishonest behaviors could anticipate an improved understanding when this topic is mutually defined and openly discussed between the two different types of participants, and the potentially different points of view. Coming to an improved consensus between faculty and student group participants about professional behaviors (or other topics) may potentially reduce any "us versus them" attitude that may underlie student/faculty relationships, conceivably culminating in improved understanding, collegiality, and professional expectations, and decrease any student perception of faculty who do not treat all students equally with veracity and fidelity. Professionalism and behaving ethically and honestly can then be arrived at in a communal manner, improving student and faculty "buy-in" rather than students strictly obeying rules mandated in a school handbook or policy just because they are there. Behaviors that are internalized are more likely to be carried into professional careers, resulting in registered nurses who practice honest, ethical nursing care.

<div align="center">**Limitations**</div>

Teaching Experiences

The sample included a number of instructors who had limited experience in both the clinical setting and in reporting unethical or dishonest behaviors. Most (68%) of the faculty respondents reported less than seven years of teaching in a clinical and/or skills lab class. Half (51%) of the respondents reported taking no action related to unethical or dishonest behavior within the last semester on the pre-intervention IRAT. It is unknown if the faculty did not

actually have an episode of unethical or dishonest nursing student behavior, or that the faculty member simply did not take action on unethical or dishonest behavior that had occurred.

Classroom Experiences

The reliability of the survey tool has been established in prior studies (Hilbert, 1985, 1988), and the use of Cronbach's alpha found the current tool to be a very reliable measurement tool with reliabilities ranging from .72-.97 for the pre-intervention IRAT, see Table 4-2. The classroom willingness reliability (.96) however was higher than the clinical willingness reliability (.72) perhaps due to the fact that this subject sample was entirely made up of clinical adjunct instructors who did not teach in a classroom per se, but taught in mainly the clinical or skills laboratory venues. Without experience in actual classroom unethical or dishonest events, these clinical experts may have been influenced by their imagining of what they think may happen, or how they might handle an unethical or dishonest incident of nursing student behavior in the classroom, rather than from an actual experience. Actual cheating incidents were not measured in the study.

Convenience Sample

This study took place at one large community college, with a convenience sample (Creswell, 2009) of 41 participants. The follow-up IRAT survey was collected from 31 of the possible remaining 38 faculty who were still available out of the original 41 participants, however only 27 were usable since four of the 31 were grossly incomplete. Threats to the study results include subject bias since there is no randomization of subjects within the sample. Although assumptions of normalcy were made, no guarantee can be implied that the group studied was representative of the population given that only the most convenient group of adjunct nursing faculty available was studied. This design resulted in limited external validity

and therefore generalizations to the population must be made with a full description of the study parameters.

Researcher Influence

In this study, the researcher also acted as the instructor during the training session. Researcher influence during the IRAT, GRAT, the case studies discussions, the team's best answer activity, and the final IRAT was possible since the researcher was present in the room when the data was being recorded by the participants. Research bias (2006) includes response bias where the participants may change their responses in order to please the interviewer, or where participants believe they know the expected findings and change responses and behaviors to what they perceive is a more socially acceptable response for the instructor's approval, and was a concern. The instructor's goal was carefully designed to inform and guide participants (Mehra, 2002), but these goals might have been confounded by the researcher's goals. The researcher could minimize influence by not interfering or interrupting the learning process (Panucci & Wilkins, 2010) during the team development sessions, which would conflict with the instructional goals and objectives. Being cognizant of the difference between the instructor role and researcher role may have helped minimize any anticipated influence (Sica, 2006), however this is unknown. It has already been noted that follow-up intervention results three months after the training session indicated no significant decline in identification, preparedness, or willingness compared to the post-intervention improvements. Since the follow-up results did not differ significantly, perhaps the concern that participants were influenced to respond in a manner intended to please the instructor/researcher can be minimized.

<center>**Recommendations for Further Research**</center>

Continuing Education and Professional Development

Professional development is an ongoing practice for registered nurses and nursing faculty to promote advanced technical skills and a deeper understanding within their specialties (DeSilets & Dickerson, 2008, 2011; Yoder-Wise & Esquibel, 2011). Methods that are proven to be effective in changing attitudes and behaviors can have positive results for both the faculty and the institution (Colbert et al., 2008; Desimone, 2011; Desimone et al., 2012; Fitzgerald & Theilheimer, 2012; Hadré, 2010), and eventually have a positive impact on students and the profession of nursing. This brief team based group learning intervention was successful for this small group, but in order to establish this method as effective in the larger population, the study should be replicated on a wider scale. The research recommends the use of a control group, multiple administration sites and randomized selection of sites and participants in addition to separating the role of instructor and researcher. Additional variables that could be explored include institutional demographics, participant experience levels, gender, type of nursing program (two, three, or four year degree programs), and even the number of actual episodes of dishonest or unethical behaviors that the participant has already addressed. Confounding variables could also be explored, including faculty members who have been involved in a student disciplinary action that resulted in a suspension or expulsion from the nursing program, since it has been reported in the literature (Coren, 2011; Petress, 2003 Staats et al., 2009) that faculty are reluctant to take action in the future if they have taken action in the past that was not supported or was reversed by administration. Additionally, a mixed method or qualitative study component could explore the details related to nursing faculty's perceptions of unethical or dishonest behavior. It would be valuable to understand if and how faculty members are projecting their

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own personal values onto nursing student behaviors and how their actions might be affected by individual preferences and biases.

Levels 3 and 4 Analyses

According to Kirkpatrick's evaluation model (Boyle & Crosby, 1997; DeSilets & Dickerson, 2009; Kirkpatrick, 1996), the third and fourth levels of evaluation (behavior and results) are where the most valuable information about the true impact of training sessions can be obtained. These levels are often omitted in the design and evaluation of training programs due to the expense and extended timeframe that this data takes to collect. A recommendation for future study would include the gathering of data to measure the actual changes in employee behaviors (Level 3), and the bottom line impact on the facility (Level 4).

In this study, an example of the impact of the training session on faculty perceptions of identifying dishonest or unethical behaviors, and being prepared and willing to deal with those unprofessional behaviors, the training could be replicated within a longitudinal study. Data would be gathered about the numbers of dishonest or unethical episodes before and after the training, and at periodic intervals to measure possible changes. Included in the study could be a determination of how the cheating episodes had been handled before the training, compared to after the training, i.e., whether the facility policy/procedures were followed correctly. A single situation where team based group training could be identified in this analysis as the basis for averting a sentinel event could contribute positively to the administration's understanding of a facility's financial return on its educational investment (Kirkpatrick's Level 4).

<div align="center">Concluding Remarks</div>

Part time adjunct faculty members who teach at the community college level benefit from the structured presentation of professional development, especially when the session includes small group work (Wallin, 2007). The team based group learning technique which facilitates

team and group work, peer interaction, and modeling which seems to have led to increased knowledge and understanding was a successful method for this group of community college adjunct nursing faculty members to improve their ability to identify unethical or dishonest nursing student behaviors, and be prepared and willing to take action when unethical or dishonest behaviors were seen.

This study has contributed to the body of research regarding the use of brief training sessions to influence adjunct nursing faculty perceptions of identification, preparedness and willingness to take action on unethical or dishonest nursing student behaviors. The results have found that there was a profound impact on adjunct nursing faculty perceptions after the training session in every tested area. This is an important finding that can potentially be applied to the training and professional development of any student group who typically is asked or mandated to participate in training sessions throughout their careers or in the academic setting. This short training session, using a brief team based learning approach, taking advantage of the experiences of seasoned faculty, and sharing that experience and knowledge with newer nursing faculty in a safe, collaborative setting that is appreciated by professionals is grounded in the principles of successful andragogy.

Although Team Based Learning has been used successfully to train students, to the best of the researcher's knowledge, there is no TBL training session data related to adjunct nursing faculty development on any subject at this time. This study provides a foundation for administrators and educators to broaden their understanding about improving adjunct nursing faculty agreement related to the identification of unethical or dishonest behavior, appropriate methods to address it, and faculty's potential willingness to take action to help train nursing students to develop honest and ethical practices. Future research may contribute to these

findings by exploring the generalizability of these results to the larger populations for studies in

unethical or dishonest nursing student behaviors and other unlimited topics.

INFORMED CONSENT

Protocol Title: Faculty Perception of Cheating and Unethical Behavior in the Classroom and Clinical Areas

Please read this consent document carefully before you decide to participate.

Purpose of the research study: The purpose of this study is to examine the responses of faculty about nursing student academic dishonesty and unethical behavior.

What you will be asked to do in the study: Fill in answers on a survey questionnaire individually and within a group that will be distributed and collected in class.

Time required: 3 hours

Risks and Benefits: None

Compensation: None

Confidentiality: Your identity will be kept confidential to the extent provided by law. Your name will not be collected or linked to your survey, or used in any report.

Voluntary participation: Your participation in this study is completely voluntary. There is no penalty for not participating.

Right to withdraw from the study: You have the right to withdraw from the study at any time without consequence.

Whom to contact if you have questions about the study:

Prof DJ Marshall, Palm Beach State College, Lake Worth, FL 33461
Erik W. Black, PhD 1701 SW 16th Ave Building A #2114 Gainesville, FL 32608

Whom to contact about your rights as a research participant in the study:

IRB02 Office, Box 112250, University of Florida, Gainesville, FL 32611-2250; phone 392-0433.

Agreement: I have read the procedure described above. I voluntarily agree to participate in the procedure and I have received a copy of this description.

Participant: _____ Date: _____

Principal Investigator: _____ Date: _____

APPENDIX B
IRAT

Unethical Classroom & Clinical Lab Nursing Student Behaviors IRAT

Demographics: Circle the item

1. Gender: Male   Female
2. Age (optional): 18-25   26-30   31-35   36-40   41-45   46-50   51-55   56+
3. Years of teaching in clinical and/or skills lab: 0-1   2-4   5-7   8-10   1-15   16+
4. Working status: Are you employed in nursing outside the college adjunct teaching role?   Yes   No
5. How often do you take action on unethical or dishonest student behaviors? Never Occasionally Sometimes Usually Always
6. Print the name of your Elementary School_____
7. How many times in the last semester did you take action on dishonest or unethical student behavior? 0   1   2   3   4 or more
8. Completed the reading assignment: ALL   PARTIALLY   NONE

A STUDENT IN THE CLASSROOM: Use the 1-5 Scale (upper right hand corner box) to describe if the behavior is unethical. or dishonest; and describe how prepared AND willing you are to take action. Complete each column before starting the next column	Unethical/ Dis-honest Behavior	How prepared are you to take action?	How willing are you to take action?
1. Getting electronic or hard copies of exams or exam questions from someone who has taken the exam			
2. Prior to taking the exam, discussing the exam or receiving answers from a student who has already taken the exam			
3. Allowing someone to copy from an exam or giving answers to another student during an exam			
4. Using unauthorized notes, books, or technology during a closed-book assignment or exam			
5. Taking an exam for another student			
6. Copying sentences or ideas from a reference source without referencing it in a paper			
7. Adding items to a bibliography (reference list) that were not used in writing the paper			
8. Turning in an assignment purchased from an online paper mill			
9. Turning in an assignment that was done entirely, or in part, by someone else (but not a paper mill)			
10. Helping a classmate complete an "Individual Work Only" assignment because that classmate has been falling behind			
11. Making completed (graded) assignments available for someone who has not yet had the assignment			
12. Working with another student on an assignment when the instructor did not allow it			
13. Not reporting when mistakes are discovered in the classroom area			

Unethical Classroom & Clinical Lab Nursing Student Behaviors IRAT

1-5 Scale:
1. Not at all
2. A little bit
3. Sometimes
4. Mostly
5. Extremely

A STUDENT IN THE <u>CLINICAL LAB</u>: Use the 1-5 Scale (upper right hand corner box) to describe if the behavior is unethical or dishonest; and describe how prepared AND willing you are to take action. Complete each column before starting the next column	Unethical/ Unethical/Dis honest Behavior	How <u>prepared</u> are you to take action?	How <u>willing</u> are you to take action?
1. Calling out sick for themself or a sick child when the student or child was not sick			
2. Coming to the clinical area while under the influence of drugs, alcohol, prescription medications, or over the counter agents			
3. Avoiding the delivery of nursing care to a disagreeable patient that no one likes			
4. Not reporting an incident involving a patient, even if no harm occurred			
5. Recording patient data without actually obtaining the data properly			
6. Using facility resources for personal use (internet surfing, printing copies, studying on duty)			
7. Taking medications from the hospital for personal use			
8. Recording that medications, treatments, or observations were done when they weren't			
9. Discussing patients in public or private places with those who do not have a "need to know"			
10. Failing to provide information to a patient about treatments, medications, or recommended health behaviors			
11. Not questioning an order when in doubt			
12. Not reporting when mistakes are discovered in the clinical lab area			

Adapted from Hilbert, G. (1985). Involvement of nursing students in unethical classroom and clinical behaviors. Journal of Professional Nursing, 1(4), 230-234.

RE: Request for Copyright Permission Form

Tammy D. Radford [tammy@styluspub.com]

Sent: Tuesday, October 02, 2012 10:34

To: Marshall, Deborah J

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Stylus Publishing

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Sincerely,

Deborah J. Marshall

APPENDIX D
THREE CASE STUDY SCENARIOS

Case Study 1

In reviewing the charting of a clinical student, the faculty member discovers that the vital signs for Mrs. Jones have not yet been charted. When the instructor questions the student about the lack of vital signs being documented in a timely fashion, the student says the vital signs will be attended to immediately and walks away. The instructor's attention is drawn to another student issue, but within two minutes after speaking with the first student, the clinical instructor returns to continue to review Mrs. Jones' chart, and finds the missing vital signs have now been charted by the student and are identical to the previous set of vital signs.

The team is to evaluate this scenario and recommend what action (if any) to take involving the student.

Case Study 2

A clinical student comes to you (the clinical instructor) to inform you that she has overheard two students discussing the unit lecture test that was given last week including specific questions and probable answers. The informing student is willing to come forward and gives you the names of the students who were discussing the test. You are aware that one of the students has been ill, and missed class last week, and therefore will probably be taking the make-up exam sometime this week. The make -up exam is in essay and short answer format, whereas the test that was given last week was computerized and multiple choice.

The teams will evaluate the scenario and recommend what action (if any) to take involving the nursing students.

Case Study 3

    A student has reported to class and seems to be slurring his words, seems sleepy, having a hard time focusing, is closing his eyes and putting his head on this desk. When he walked across the room, his gait was uneven, and he stumbled into the corner of the table instead of moving around the edge. He explains to you that he was up all night studying for his pharmacology exam, but does not make eye contact.

    The teams will evaluate the scenario and recommend what action (if any) to take involving the nursing student.

PRE-INTERVENTION INDIVIDUAL IRAT RESULTS

PRE-INTERVENTION IRAT CLASSROOM	N	Range	Minimum	Maximum	Mean	Standard Deviation	Variance
1. Getting electronic or hard copies of exams or exam questions from someone who has taken the exam							
Q1 Unethical Dishonest Class	40	4	1	5	4.83	.71	.50
Q1 Preparedness Class	38	4	1	5	4.58	.92	.85
Q1 Willingness Class	38	4	1	5	4.76	.75	.56
2. Prior to taking the exam, discussing the exam or receiving answers from a student who has already taken the exam							
Q2 Unethical Dishonest Class	40	4	1	5	4.63	.87	.75
Q2 Preparedness Class	38	3	2	5	4.39	.97	.95
Q2 Willingness Class	38	4	1	5	4.53	.92	.85
3. Allowing someone to copy from an exam or giving answers to another student during an exam							
Q3 Unethical Dishonest Class	40	4	1	5	4.85	.70	.49
Q3 Preparedness Class	38	3	2	5	4.66	.78	.61
Q3 Willingness Class	38	4	1	5	4.79	.74	.55
4. Using unauthorized notes, books, or technology during a closed-book assignment or exam							
Q4 Unethical Dishonest Class	39	2	3	5	4.90	.38	.15
Q4 Preparedness Class	38	4	1	5	4.61	.89	.79
Q4 Willingness Class	38	4	1	5	4.79	.74	.55
5. Taking an exam for another student							
Q5 Unethical Dishonest Class	40	4	1	5	4.90	.63	.40
Q5 Preparedness Class	38	4	1	5	4.68	.87	.76
Q5 Willingness Class	38	4	1	5	4.84	.72	.52
6. Copying sentences or ideas from a reference source without referencing it in a paper							
Q6 Unethical Dishonest Class	40	2	3	5	4.49	.64	.40
Q6 Preparedness Class	39	4	1	5	4.44	.97	.94
Q6 Willingness Class	39	4	1	5	4.51	.91	.84
7. Adding items to a bibliography (reference list) that were not used in writing the paper							
Q7 Unethical Dishonest Class	40	2	3	5	4.50	.75	.56
Q7 Preparedness Class	39	4	1	5	4.38	1.02	1.03
Q7 Willingness Class	39	4	1	5	4.44	.97	.94
8. Turning in an assignment purchased from an online paper mill							
Q8 Unethical Dishonest Class	40	3	2	5	4.85	.58	.34
Q8 Preparedness Class	39	3	2	5	4.69	.80	.64
Q8 Willingness Class	39	4	1	5	4.82	.72	.52
9. Turning in an assignment that was done entirely or in part, by someone else (but not a paper mill)							
Q9 Unethical Dishonest Class	40	4	1	5	4.80	.72	.52
Q9 Preparedness Class	38	3	2	5	4.61	.82	.68
Q9 Willingness Class	38	4	1	5	4.79	.74	.55
10. Helping a classmate complete an "Individual Work Only" assignment because that classmate has been falling behind							
Q10 Unethical Dishonest Class	40	4	1	5	4.33	1.02	1.05
Q10 Preparedness Class	38	3	2	5	4.16	1.15	1.33
Q10 Willingness Class	38	4	1	5	4.24	1.15	1.32
11. Making completed (graded) assignments available for someone who has not yet had the assignment							
Q11 Unethical Dishonest Class	40	4	1	5	4.70	.76	.57
Q11 Preparedness Class	38	3	2	5	4.58	.89	.79
Q11 Willingness Class	38	4	1	5	4.58	.92	.85
12. Working with another student on an assignment when the instructor did not allow it							
Q12 Unethical Dishonest Class	40	4	1	5	4.45	.99	.97
Q12 Preparedness Class	38	3	2	5	4.32	1.07	1.14
Q12 Willingness Class	38	4	1	5	4.39	1.08	1.16
13. Not reporting when mistakes are discovered in the classroom area							
Q13 Unethical Dishonest Class	39	4	1	5	4.21	.95	.90
Q13 Preparedness Class	37	3	2	5	4.24	.83	.69
Q13 Willingness Class	37	4	1	5	4.30	.91	.83

PRE-INTERVENTION IRAT CLINICAL	N	Range	Minimum	Maximum	Mean	Standard Deviation	Variance
1. Calling out sick for themselves or a sick child when the student or child was not sick							
Q1 Unethical Dishonest Clinical	39	4	1	5	4.05	1.07	1.16
Q1 Preparedness Clinical	37	4	1	5	3.95	1.31	1.72
Q1 Willingness Clinical	37	4	1	5	4.03	1.28	1.64
2. Coming to the clinical area while under the influence of drugs, alcohol, prescription medications or OTC agents							
Q2 Unethical Dishonest Clinical	39	4	1	5	4.82	.72	.52
Q2 Preparedness Clinical	37	4	1	5	4.73	.87	.76
Q2 Willingness Clinical	37	4	1	5	4.81	.74	.55
3. Avoiding the delivery of nursing care to a disagreeable patient that no one likes							
Q3 Unethical Dishonest Clinical	39	4	1	5	4.46	.85	.73
Q3 Preparedness Clinical	37	3	2	5	4.54	.77	.59
Q3 Willingness Clinical	37	2	3	5	4.65	.63	.40
4. Not reporting an incident involving a patient, even if no harm occurred							
Q4 Unethical Dishonest Clinical	39	4	1	5	4.64	.78	.61
Q4 Preparedness Clinical	37	3	2	5	4.65	.72	.51
Q4 Willingness Clinical	37	2	3	5	4.78	.48	.23
5. Recording patient data without actually obtaining the data properly							
Q5 Unethical Dishonest Clinical	39	4	1	5	4.82	.68	.47
Q5 Preparedness Clinical	37	3	2	5	4.86	.54	.29
Q5 Willingness Clinical	37	1	4	5	4.97	.16	.03
6. Using facility resources for personal use (internet surfing, printing copies, studying on duty)							
Q6 Unethical Dishonest Clinical	39	4	1	5	4.08	.96	.92
Q6 Preparedness Clinical	37	3	2	5	4.00	1.05	1.11
Q6 Willingness Clinical	37	3	2	5	4.16	.96	.92
7. Taking medications from the hospital for personal use							
Q7 Unethical Dishonest Clinical	39	4	1	5	4.74	.75	.56
Q7 Preparedness Clinical	37	3	2	5	4.76	.64	.41
Q7 Willingness Clinical	37	2	3	5	4.86	.42	.18
8. Recording that medications, treatments, or observations were done when they weren't							
Q8 Unethical Dishonest Clinical	39	4	1	5	4.79	.73	.54
Q8 Preparedness Clinical	37	3	2	5	4.89	.52	.27
Q8 Willingness Clinical	37	1	4	5	4.95	.23	.05
9. Discussing patients in public or private places with those who do not have a "need to know"							
Q9 Unethical Dishonest Clinical	39	4	1	5	4.79	.70	.48
Q9 Preparedness Clinical	37	4	1	5	4.70	.88	.77
Q9 Willingness Clinical	37	4	1	5	4.81	.70	.49
10. Failing to provide information to a patient about treatments, medications, or recommended health behaviors							
Q10 Unethical Dishonest Clinical	38	4	1	5	4.47	.86	.74
Q10 Preparedness Clinical	38	3	2	5	4.53	.76	.58
Q10 Willingness Clinical	37	2	3	5	4.65	.59	.35
11. No questioning an order when in doubt							
Q11 Unethical Dishonest Clinical	38	3	2	5	4.55	.76	.58
Q11 Preparedness Clinical	39	3	2	5	4.67	.70	.49
Q11 Willingness Clinical	38	2	3	5	4.76	.54	.29
12. Not reporting when mistakes are discovered in the clinical lab area							
Q12 Unethical Dishonest Clinical	39	4	1	5	4.59	.88	.77
Q12 Preparedness Clinical	37	3	2	5	4.78	.58	.34
Q12 Willingness Clinical	37	1	4	5	4.86	.35	.12

GRAT INTERVENTION CLASSROOM	N	Range	Minimum	Maximum	Mean	Standard Deviation	Variance
1. Getting electronic or hard copies of exams or exam questions from someone who has taken the exam							
Q1 Unethical Dishonest Class	6	0	5	5	5.00	0	0
Q1 Preparedness Class	6	0	5	5	5.00	0	0
Q1 Willingness Class	6	0	5	5	5.00	0	0
2. Prior to taking the exam, discussing the exam or receiving answers from a student who has already taken the exam							
Q2 Unethical Dishonest Class	6	1	4	5	4.83	.41	.17
Q2 Preparedness Class	6	1	4	5	4.83	.41	.17
Q2 Willingness Class	6	1	4	5	4.83	.41	.17
3. Allowing someone to copy from an exam or giving answers to another student during an exam							
Q3 Unethical Dishonest Class	6	0	5	5	5.00	0	0
Q3 Preparedness Class	6	0	5	5	5.00	0	0
Q3 Willingness Class	6	0	5	5	5.00	0	0
4. Using unauthorized notes, books, or technology during a closed-book assignment or exam							
Q4 Unethical Dishonest Class	6	0	5	5	5.00	0	0
Q4 Preparedness Class	6	0	5	5	5.00	0	0
Q4 Willingness Class	6	0	5	5	5.00	0	0
5. Taking an exam for another student							
Q5 Unethical Dishonest Class	6	0	5	5	5.00	0	0
Q5 Preparedness Class	6	0	5	5	5.00	0	0
Q5 Willingness Class	6	0	5	5	5.00	0	0
6. Copying sentences or ideas from a reference source without referencing it in a paper							
Q6 Unethical Dishonest Class	6	1	4	5	4.83	.41	.17
Q6 Preparedness Class	6	2	3	5	4.50	.84	.70
Q6 Willingness Class	6	2	3	5	4.50	.84	.70
7. Adding items to a bibliography (reference list) that were not used in writing the paper							
Q7 Unethical Dishonest Class	6	1	4	5	4.67	.52	.27
Q7 Preparedness Class	6	1	4	5	4.67	.52	.27
Q7 Willingness Class	6	1	4	5	4.67	.52	.27
8. Turning in an assignment purchased from an online paper mill							
Q8 Unethical Dishonest Class	6	0	5	5	5.00	0	0
Q8 Preparedness Class	6	0	5	5	5.00	0	0
Q8 Willingness Class	6	0	5	5	5.00	0	0
9. Turning in an assignment that was done entirely or in part, by someone else (but not a paper mill)							
Q9 Unethical Dishonest Class	6	0	5	5	5.00	0	0
Q9 Preparedness Class	6	0	5	5	5.00	0	0
Q9 Willingness Class	6	0	5	5	5.00	0	0
10. Helping a classmate complete an "Individual Work Only" assignment because that classmate has been falling behind							
Q10 Unethical Dishonest Class	6	1	4	5	4.67	.52	.27
Q10 Preparedness Class	6	1	4	5	4.67	.52	.27
Q10 Willingness Class	6	1	4	5	4.67	.52	.27
11. Making completed (graded) assignments available for someone who has not yet had the assignment							
Q11 Unethical Dishonest Class	6	1	4	5	4.83	.41	.17
Q11 Preparedness Class	6	1	4	5	4.83	.41	.17
Q11 Willingness Class	6	1	4	5	4.83	.41	.17
12. Working with another student on an assignment when the instructor did not allow it							
Q12 Unethical Dishonest Class	6	1	4	5	4.67	.52	.27
Q12 Preparedness Class	6	1	4	5	4.67	.52	.27
Q12 Willingness Class	6	1	4	5	4.67	.52	.27
13. Not reporting when mistakes are discovered in the classroom area							
Q13 Unethical Dishonest Class	6	1	4	5	4.50	.55	.3
Q13 Preparedness Class	6	1	4	5	4.50	.55	.3
Q13 Willingness Class	6	1	4	5	4.50	.55	.3

GRAT INTERVENTION CLINICAL	N	Range	Minimum	Maximum	Mean	Standard Deviation	Variance
1. Calling out sick for themselves or a sick child when the student or child was not sick							
Q1 Unethical Dishonest Clinical	6	1	4	5	4.83	.41	.17
Q1 Preparedness Clinical	6	1	4	5	4.83	.41	.17
Q1 Willingness Clinical	6	1	4	5	4.83	.41	.17
2. Coming to the clinical area while under the influence of drugs, alcohol, prescription medications or OTC agents							
Q2 Unethical Dishonest Clinical	6	0	5	5	5.00	0	0
Q2 Preparedness Clinical	6	0	5	5	5.00	0	0
Q2 Willingness Clinical	6	0	5	5	5.00	0	0
3. Avoiding the delivery of nursing care to a disagreeable patient that no one likes							
Q3 Unethical Dishonest Clinical	6	2	3	5	4.67	.82	.67
Q3 Preparedness Clinical	6	2	3	5	4.67	.82	.67
Q3 Willingness Clinical	6	2	3	5	4.67	.82	.67
4. Not reporting an incident involving a patient, even if no harm occurred							
Q4 Unethical Dishonest Clinical	6	0	5	5	5.00	0	0
Q4 Preparedness Clinical	6	0	5	5	5.00	0	0
Q4 Willingness Clinical	6	0	5	5	5.00	0	0
5. Recording patient data without actually obtaining the data properly							
Q5 Unethical Dishonest Clinical	6	0	5	5	5.00	0	0
Q5 Preparedness Clinical	6	0	5	5	5.00	0	0
Q5 Willingness Clinical	6	0	5	5	5.00	0	0
6. Using facility resources for personal use (internet surfing, printing copies, studying on duty)							
Q6 Unethical Dishonest Clinical	6	2	3	5	4.33	.82	.67
Q6 Preparedness Clinical	6	2	3	5	4.33	.82	.67
Q6 Willingness Clinical	6	2	3	5	4.33	.82	.67
7. Taking medications from the hospital for personal use							
Q7 Unethical Dishonest Clinical	6	0	5	5	5.00	0	0
Q7 Preparedness Clinical	6	0	5	5	5.00	0	0
Q7 Willingness Clinical	6	0	5	5	5.00	0	0
8. Recording that medications, treatments, or observations were done when they weren't							
Q8 Unethical Dishonest Clinical	6	0	5	5	5.00	0	0
Q8 Preparedness Clinical	6	0	5	5	5.00	0	0
Q8 Willingness Clinical	6	0	5	5	5.00	0	0
9. Discussing patients in public or private places with those who do not have a "need to know"							
Q9 Unethical Dishonest Clinical	6	0	5	5	5.00	0	0
Q9 Preparedness Clinical	6	0	5	5	5.00	0	0
Q9 Willingness Clinical	6	0	5	5	5.00	0	0
10. Failing to provide information to a patient about treatments, medications, or recommended health behaviors							
Q10 Unethical Dishonest Clinical	6	1	4	5	4.67	.52	.27
Q10 Preparedness Clinical	6	2	3	5	4.33	.82	.67
Q10 Willingness Clinical	6	2	3	5	4.33	.82	.67
11. No questioning an order when in doubt							
Q11 Unethical Dishonest Clinical	6	0	5	5	5.00	0	0
Q11 Preparedness Clinical	6	0	5	5	5.00	0	0
Q11 Willingness Clinical	6	0	5	5	5.00	0	0
12. Not reporting when mistakes are discovered in the clinical lab area							
Q12 Unethical Dishonest Clinical	6	1	4	5	4.83	.41	.17
Q12 Preparedness Clinical	6	1	4	5	4.83	.41	.17
Q12 Willingness Clinical	6	1	4	5	4.83	.41	.17

POST-INTEVENTION FINAL CLASSROOM	N	Range	Minimum	Maximum	Mean	Standard Deviation	Variance
1. Getting electronic or hard copies of exams or exam questions from someone who has taken the exam							
Q1 Unethical Dishonest Class	38	0	5	5	5.00	0	0
Q1 Preparedness Class	38	0	5	5	5.00	0	0
Q1 Willingness Class	38	0	5	5	5.00	0	0
2. Prior to taking the exam, discussing the exam or receiving answers from a student who has already taken the exam							
Q2 Unethical Dishonest Class	38	0	5	5	5.00	0	0
Q2 Preparedness Class	38	0	5	5	5.00	0	0
Q2 Willingness Class	38	0	5	5	5.00	0	0
3. Allowing someone to copy from an exam or giving answers to another student during an exam							
Q3 Unethical Dishonest Class	38	0	5	5	5.00	0	0
Q3 Preparedness Class	38	0	5	5	5.00	0	0
Q3 Willingness Class	38	0	5	5	5.00	0	0
4. Using unauthorized notes, books, or technology during a closed-book assignment or exam							
Q4 Unethical Dishonest Class	38	0	5	5	5.00	0	0
Q4 Preparedness Class	38	0	5	5	5.00	0	0
Q4 Willingness Class	38	0	5	5	5.00	0	0
5. Taking an exam for another student							
Q5 Unethical Dishonest Class	38	0	5	5	5.00	0	0
Q5 Preparedness Class	38	0	5	5	5.00	0	0
Q5 Willingness Class	38	0	5	5	5.00	0	0
6. Copying sentences or ideas from a reference source without referencing it in a paper							
Q6 Unethical Dishonest Class	38	1	4	5	4.84	.37	.14
Q6 Preparedness Class	38	1	4	5	4.84	.37	.14
Q6 Willingness Class	38	1	4	5	4.84	.37	.14
7. Adding items to a bibliography (reference list) that were not used in writing the paper							
Q7 Unethical Dishonest Class	38	1	4	5	4.82	.39	.16
Q7 Preparedness Class	38	1	4	5	4.84	.37	.14
Q7 Willingness Class	38	1	4	5	4.84	.37	.14
8. Turning in an assignment purchased from an online paper mill							
Q8 Unethical Dishonest Class	38	0	5	5	5.00	0	0
Q8 Preparedness Class	38	0	5	5	5.00	0	0
Q8 Willingness Class	38	0	5	5	5.00	0	0
9. Turning in an assignment that was done entirely or in part, by someone else (but not a paper mill)							
Q9 Unethical Dishonest Class	38	0	5	5	5.00	0	0
Q9 Preparedness Class	38	0	5	5	5.00	0	0
Q9 Willingness Class	38	0	5	5	5.00	0	0
10. Helping a classmate complete an "Individual Work Only" assignment because that classmate has been falling behind							
Q10 Unethical Dishonest Class	38	1	4	5	4.76	.43	.19
Q10 Preparedness Class	38	1	4	5	4.79	.41	.17
Q10 Willingness Class	38	1	4	5	4.79	.41	.17
11. Making completed (graded) assignments available for someone who has not yet had the assignment							
Q11 Unethical Dishonest Class	38	1	4	5	4.97	.16	.03
Q11 Preparedness Class	38	0	5	5	5.00	0	0
Q11 Willingness Class	38	0	5	5	5.00	0	0
12. Working with another student on an assignment when the instructor did not allow it							
Q12 Unethical Dishonest Class	38	1	4	5	4.92	.27	.08
Q12 Preparedness Class	38	1	4	5	4.95	.23	.05
Q12 Willingness Class	38	1	4	5	4.95	.23	.05
13. Not reporting when mistakes are discovered in the classroom area							
Q13 Unethical Dishonest Class	38	1	4	5	4.84	.37	.14
Q13 Preparedness Class	38	1	4	5	4.84	.37	.14
Q13 Willingness Class	38	1	4	5	4.84	.37	.14

POST INTEVENTION FINAL CLINICAL	N	Range	Minimum	Maximum	Mean	Standard Deviation	Variance
1. Calling out sick for themselves or a sick child when the student or child was not sick							
Q1 Unethical Dishonest Clinical	38	4	1	5	4.66	.75	.56
Q1 Preparedness Clinical	38	1	4	5	4.79	.41	.17
Q1 Willingness Clinical	38	1	4	5	4.79	.41	.17
2. Coming to the clinical area while under the influence of drugs, alcohol, prescription medications or OTC agents							
Q2 Unethical Dishonest Clinical	38	0	5	5	5.00	0	0
Q2 Preparedness Clinical	38	0	5	5	5.00	0	0
Q2 Willingness Clinical	38	0	5	5	5.00	0	0
3. Avoiding the delivery of nursing care to a disagreeable patient that no one likes							
Q3 Unethical Dishonest Clinical	38	1	4	5	4.89	.31	.10
Q3 Preparedness Clinical	38	1	4	5	4.89	.31	.10
Q3 Willingness Clinical	38	1	4	5	4.89	.31	.10
4. Not reporting an incident involving a patient, even if no harm occurred							
Q4 Unethical Dishonest Clinical	38	1	4	5	4.97	.16	.026
Q4 Preparedness Clinical	38	0	5	5	5.00	0	0
Q4 Willingness Clinical	38	0	5	5	5.00	0	0
5. Recording patient data without actually obtaining the data properly							
Q5 Unethical Dishonest Clinical	38	0	5	5	5.00	0	0
Q5 Preparedness Clinical	38	0	5	5	5.00	0	0
Q5 Willingness Clinical	38	0	5	5	5.00	0	0
6. Using facility resources for personal use (internet surfing, printing copies, studying on duty)							
Q6 Unethical Dishonest Clinical	38	3	2	5	4.79	.58	.33
Q6 Preparedness Clinical	38	3	2	5	4.79	.58	.33
Q6 Willingness Clinical	38	3	2	5	4.79	.58	.33
7. Taking medications from the hospital for personal use							
Q7 Unethical Dishonest Clinical	38	0	5	5	5.00	0	0
Q7 Preparedness Clinical	38	0	5	5	5.00	0	0
Q7 Willingness Clinical	38	0	5	5	5.00	0	0
8. Recording that medications, treatments, or observations were done when they weren't							
Q8 Unethical Dishonest Clinical	38	0	5	5	5.00	0	0
Q8 Preparedness Clinical	38	0	5	5	5.00	0	0
Q8 Willingness Clinical	38	0	5	5	5.00	0	0
9. Discussing patients in public or private places with those who do not have a "need to know"							
Q9 Unethical Dishonest Clinical	38	0	5	5	5.00	0	0
Q9 Preparedness Clinical	38	0	5	5	5.00	0	0
Q9 Willingness Clinical	38	0	5	5	5.00	0	0
10. Failing to provide information to a patient about treatments, medications, or recommended health behaviors							
Q10 Unethical Dishonest Clinical	38	1	4	5	4.82	.39	.15
Q10 Preparedness Clinical	38	2	3	5	4.74	.55	.31
Q10 Willingness Clinical	38	2	3	5	4.74	.55	.31
11. No questioning an order when in doubt							
Q11 Unethical Dishonest Clinical	38	1	4	5	4.95	.23	.05
Q11 Preparedness Clinical	38	1	4	5	4.98	.16	.03
Q11 Willingness Clinical	38	1	4	5	4.97	.16	.03
12. Not reporting when mistakes are discovered in the clinical lab area							
Q12 Unethical Dishonest Clinical	38	1	4	5	4.92	.27	.08
Q12 Preparedness Clinical	38	1	4	5	4.97	.16	.03
Q12 Willingness Clinical	38	1	4	5	4.97	.16	.03

THREE MONTH FOLLOW UP CLASSROOM	N	Range	Minimum	Maximum	Mean	Standard Deviation	Variance
1. Getting electronic or hard copies of exams or exam questions from someone who has taken the exam							
Q1 Unethical Dishonest Class	27	0	5	5	5.00	.19	0
Q1 Preparedness Class	27	0	5	5	4.90	.19	.03
Q1 Willingness Class	27	1	4	5	4.97	.18	.03
2. Prior to taking the exam, discussing the exam or receiving answers from a student who has already taken the exam							
Q2 Unethical Dishonest Class	27	2	3	5	4.87	.43	.19
Q2 Preparedness Class	27	1	4	5	4.90	.31	.10
Q2 Willingness Class	27	1	4	5	4.90	.31	.10
3. Allowing someone to copy from an exam or giving answers to another student during an exam							
Q3 Unethical Dishonest Class	27	0	5	5	5.00	0	0
Q3 Preparedness Class	27	0	5	5	4.97	.19	.03
Q3 Willingness Class	27	0	5	5	5.00	0	0
4. Using unauthorized notes, books, or technology during a closed-book assignment or exam							
Q4 Unethical Dishonest Class	27	2	3	5	4.93	.37	.13
Q4 Preparedness Class	27	1	4	5	4.93	.26	.07
Q4 Willingness Class	27	1	4	5	4.93	.25	.06
5. Taking an exam for another student							
Q5 Unethical Dishonest Class	27	0	5	5	5.00	0	0
Q5 Preparedness Class	27	0	5	5	4.97	.19	.03
Q5 Willingness Class	27	0	5	5	5.00	0	0
6. Copying sentences or ideas from a reference source without referencing it in a paper							
Q6 Unethical Dishonest Class	27	2	3	5	4.83	46	.21
Q6 Preparedness Class	27	2	3	5	4.76	.51	.26
Q6 Willingness Class	27	1	4	5	4.87	.35	.12
7. Adding items to a bibliography (reference list) that were not used in writing the paper							
Q7 Unethical Dishonest Class	27	1	4	5	4.83	.59	.35
Q7 Preparedness Class	27	1	4	5	4.79	.62	.38
Q7 Willingness Class	27	1	4	5	4.83	.59	.35
8. Turning in an assignment purchased from an online paper mill							
Q8 Unethical Dishonest Class	27	0	5	5	5.00	0	0
Q8 Preparedness Class	27	2	3	5	4.79	.41	.17
Q8 Willingness Class	27	1	4	5	4.97	.18	.03
9. Turning in an assignment that was done entirely or in part, by someone else (but not a paper mill)							
Q9 Unethical Dishonest Class	27	1	4	5	4.97	.18	.03
Q9 Preparedness Class	27	1	4	5	4.93	.26	.07
Q9 Willingness Class	27	1	4	5	4.97	.18	.03
10. Helping a classmate complete an "Individual Work Only" assignment because that classmate has been falling behind							
Q10 Unethical Dishonest Class	27	3	2	5	4.70	.65	.42
Q10 Preparedness Class	27	3	2	5	4.66	.72	.52
Q10 Willingness Class	27	3	2	5	4.70	.79	.63
11. Making completed (graded) assignments available for someone who has not yet had the assignment							
Q11 Unethical Dishonest Class	27	1	4	5	4.90	.40	.16
Q11 Preparedness Class	27	1	4	5	4.72	.65	.42
Q11 Willingness Class	27	1	4	5	4.83	.59	.35
12. Working with another student on an assignment when the instructor did not allow it							
Q12 Unethical Dishonest Class	27	1	4	5	4.83	.38	.14
Q12 Preparedness Class	27	2	3	5	4.69	.60	.37
Q12 Willingness Class	27	1	4	5	4.77	.63	.39
13. Not reporting when mistakes are discovered in the classroom area							
Q13 Unethical Dishonest Class	27	1	4	5	4.63	.49	.24
Q13 Preparedness Class	27	1	4	5	4.66	.48	.23
Q13 Willingness Class	27	1	4	5	4.33	.45	.20

THREE MONTH FOLLOW-UP CLINICAL	N	Range	Minimum	Maximum	Mean	Standard Deviation	Variance
1. Calling out sick for themselves or a sick child when the student or child was not sick							
Q1 Unethical Dishonest Clinical	27	2	3	5	4.56	.70	.49
Q1 Preparedness Clinical	27	2	3	5	4.59	.69	.48
Q1 Willingness Clinical	27	2	3	5	4.64	.68	.46
2. Coming to the clinical area while under the influence of drugs, alcohol, prescription medications or OTC agents							
Q2 Unethical Dishonest Clinical	27	0	5	5	5.00	0	0
Q2 Preparedness Clinical	27	0	5	5	5.00	0	0
Q2 Willingness Clinical	27	0	5	5	5.00	0	0
3. Avoiding the delivery of nursing care to a disagreeable patient that no one likes							
Q3 Unethical Dishonest Clinical	27	1	4	5	4.89	.32	.10
Q3 Preparedness Clinical	27	1	4	5	4.92	.27	.07
Q3 Willingness Clinical	27	2	3	5	4.89	.42	.42
4. Not reporting an incident involving a patient, even if no harm occurred							
Q4 Unethical Dishonest Clinical	27	1	4	5	4.93	.27	.07
Q4 Preparedness Clinical	27	1	4	5	4.85	.36	.13
Q4 Willingness Clinical	27	1	4	5	4.86	.36	.13
5. Recording patient data without actually obtaining the data properly							
Q5 Unethical Dishonest Clinical	27	0	5	5	5.00	0	0
Q5 Preparedness Clinical	27	0	5	5	5.00	0	0
Q5 Willingness Clinical	27	0	5	5	5.00	0	0
6. Using facility resources for personal use (internet surfing, printing copies, studying on duty)							
Q6 Unethical Dishonest Clinical	27	2	3	5	4.52	.70	.49
Q6 Preparedness Clinical	27	2	3	5	4.59	.69	.48
Q6 Willingness Clinical	27	2	3	5	4.60	.69	.47
7. Taking medications from the hospital for personal use							
Q7 Unethical Dishonest Clinical	27	0	5	5	5.00	0	0
Q7 Preparedness Clinical	27	0	5	5	5.00	0	0
Q7 Willingness Clinical	27	0	5	5	5.00	0	0
8. Recording that medications, treatments, or observations were done when they weren't							
Q8 Unethical Dishonest Clinical	27	0	5	5	5.00	0	0
Q8 Preparedness Clinical	27	0	5	5	5.00	0	0
Q8 Willingness Clinical	27	0	5	5	5.00	0	0
9. Discussing patients in public or private places with those who do not have a "need to know"							
Q9 Unethical Dishonest Clinical	27	1	4	5	4.92	.27	.07
Q9 Preparedness Clinical	27	1	4	5	4.89	.32	.10
Q9 Willingness Clinical	27	1	4	5	4.89	.31	.10
10. Failing to provide information to a patient about treatments, medications, or recommended health behaviors							
Q10 Unethical Dishonest Clinical	27	2	3	5	4.59	.69	.48
Q10 Preparedness Clinical	27	2	3	5	4.70	.61	.37
Q10 Willingness Clinical	27	2	3	5	4.71	.60	.36
11. No questioning an order when in doubt							
Q11 Unethical Dishonest Clinical	27	3	2	5	4.67	.68	.46
Q11 Preparedness Clinical	27	3	2	5	4.74	.66	.43
Q11 Willingness Clinical	27	3	2	5	4.75	65	.65
12. Not reporting when mistakes are discovered in the clinical lab area							
Q12 Unethical Dishonest Clinical	27	1	4	5	4.93	.27	.07
Q12 Preparedness Clinical	27	1	4	5	4.93	.27	.07
Q12 Willingness Clinical	27	1	4	5	4.93	.26	.26

APPENDIX I
PRE-INTERVENTION IRAT, GRAT, POST-INTERVENTION FINAL IRAT, AND FOLLOW-
UP IRAT MEANS STANDARD DEVIATIONS, AND VARIANCES

	Mean				Standard Deviation				Variance			
CLASSROOM **Identifying** **Unethical-Dishonest** **Behavior**	IRAT	GRAT	FINAL	FOLLOW UP	IRAT	GRAT	FINAL	FOLLOW UP	IRAT	GRAT	FINAL	FOLLOW UP
Q1 Identifying UD	4.83	5.00	5.00	5.00	.71	0	0	.19	.51	0	0	0
Q2 Identifying UD	4.63	4.83	5.00	4.87	.87	.41	0	.43	.66	.17	0	.19
Q3 Identifying UD	4.85	5.00	5.00	5.00	.70	0	0	0	.71	0	0	0
Q4 Identifying UD	4.78	5.00	5.00	4.93	.38	0	0	.37	.63	0	0	.13
Q5 Identifying UD	4.90	5.00	5.00	5.00	.63	0	0	0	.62	0	0	0
Q6 Identifying UD	4.49	4.83	4.84	4.83	.64	.41	.37	.46	.61	.17	.14	.21
Q7 Identifying UD	4.50	4.67	4.82	4.83	.75	.52	.39	.59	.64	.27	.15	.35
Q8 Identifying UD	4.85	5.00	5.00	5.00	.58	0	0	0	.66	0	0	0
Q9 Identifying UD	4.80	5.00	5.00	4.97	.72	0	0	.18	.65	0	0	.03
Q10 Identifying UD	4.33	4.67	4.76	4.70	1.02	.52	.43	.65	.67	.27	.19	.42
Q11 Identifying UD	4.70	4.83	4.97	4.90	.76	.41	.16	.40	.71	.17	.03	.16
Q12 Identifying UD	4.45	4.67	4.92	4.83	.99	.52	.27	.38	.73	.27	.08	.14
Q13 Identifying UD	4.10	4.50	4.84	4.63	.95	.55	.37	.49	.76	.30	.14	.24
Average	**4.63**	**4.85**	**4.94**	**4.88**	**0.75**	**0.26**	**0.15**	**.32**	**0.66**	**0.12**	**.06**	**.14**
CLASSROOM **Preparedness**	IRAT	GRAT	FINAL	FOLLOW UP	IRAT	GRAT	FINAL	FOLLOW UP	IRAT	GRAT	FINAL	FOLLOW UP
Q1 Preparedness	4.35	5.00	5.00	4.97	.92	0	0	.19	.68	0	0	.03
Q2 Preparedness	4.18	4.83	5.00	4.90	.97	.41	0	.31	.73	.17	0	.10
Q3 Preparedness	4.43	5.00	5.00	4.97	.78	0	0	.19	.70	0	0	.03
Q4 Preparedness	4.38	5.00	5.00	4.93	.89	0	0	.26	.65	0	0	.07
Q5 Preparedness	4.45	5.00	5.00	4.97	.87	0	0	.19	.63	0	0	.03
Q6 Preparedness	4.33	4.50	4.84	4.76	.97	.84	.37	.51	.63	.70	.14	.26
Q7 Preparedness	4.28	4.67	4.84	4.79	1.02	.52	.37	.62	.66	.27	.14	.38
Q8 Preparedness	4.58	5.00	5.00	4.90	.80	0	0	.41	.66	0	0	.17
Q9 Preparedness	4.38	5.00	5.00	4.9	.82	0	0	.26	.65	0	0	.07
Q10 Preparedness	3.95	4.67	4.79	4.66	1.15	.52	.41	.72	.69	.27	.17	.52
Q11 Preparedness	4.35	4.83	5.00	4.72	.89	.41	0	.65	.72	.17	0	.42
Q12 Preparedness	4.10	4.67	4.95	4.69	1.07	.52	.23	.60	.74	.27	.05	.37
Q13 Preparedness	3.93	4.50	4.84	4.66	.83	.55	.37	.48	.76	.30	.14	.23
Average	**4.28**	**4.82**	**4.94**	**4.83**	**0.92**	**0.29**	**0.13**	**.41**	**0.68**	**0.16**	**.05**	**.21**

CLASSROOM Willingness	Mean				Standard Deviation				Variance			
	IRAT	GRAT	FINAL	FOLLOW UP	IRAT	GRAT	FINAL	FOLLOW UP	IRAT	GRAT	FINAL	FOLLOW UP
Q1 Willingness	4.53	5.00	5.00	4.97	.75	0	0	.18	.64	0	0	.03
Q2 Willingness	4.30	4.83	5.00	4.9.	.92	.41	0	.31	.75	.17	0	.09
Q3 Willingness	4.55	5.00	5.00	5.00	.74	0	0	0	.68	0	0	0
Q4 Willingness	4.55	5.00	5.00	4.93	.74	0	0	.25	.64	0	0	.06
Q5 Willingness	4.60	5.00	5.00	5.00	.72	0	0	0	.62	0	0	0
Q6 Willingness	4.40	4.50	4.84	4.87	.91	.84	.37	.35	.64	.7	.14	.12
Q7 Willingness	4.33	4.67	4.84	4.83	.97	.52	.37	.59	.68	.27	.14	.35
Q8 Willingness	4.70	5.00	5.00	4.97	.72	0	0	.18	.66	0	0	.03
Q9 Willingness	4.55	5.00	5.00	4.97	.74	0	0	.18	.65	0	0	.03
Q10 Willingness	4.03	4.67	4.79	4.70	1.15	.52	.41	.79	.72	.27	.17	.63
Q11 Willingness	4.35	4.83	5.00	4.83	.92	.41	0	.59	.72	.17	0	.35
Q12 Willingness	4.18	4.67	4.95	4.77	1.08	.52	.23	.63	.75	.26	.05	.39
Q13 Willingness	3.98	4.50	4.84	4.33	.91	.55	.37	.45	.76	.30	.14	.20
Average	**4.39**	**4.82**	**4.94**	**4.85**	**0.87**	**0.29**	**0.13**	**.35**	**0.68**	**0.16**	**0.05**	**.18**

CLINICAL Identifying Unethical-Dishonest Behavior	Mean				Standard Deviation				Variance			
	IRAT	GRAT	FINAL	FOLLOW UP	IRAT	GRAT	FINAL	FOLLOW UP	IRAT	GRAT	FINAL	FOLLOW UP
Q1 Identifying UD	3.95	4.83	4.66	4.56	1.07	.41	.75	.70	.78	.17	.56	.49
Q2 Identifying UD	4.70	5.00	5.00	5.00	0.72	0	0	0	.83	0	0	0
Q3 Identifying UD	4.35	4.67	4.89	4.89	.85	.82	.31	.32	.82	.67	.10	.10
Q4 Identifying UD	4.53	5.00	4.97	4.93	.78	0	.16	.27	.80	0	.03	.01
Q5 Identifying UD	4.70	5.00	5.00	5.00	.68	0	0	0	.77	0	0	0
Q6 Identifying UD	3.98	4.33	4.79	4.52	.96	.82	.58	.70	.92	.67	.33	.49
Q7 Identifying UD	4.63	5.00	5.00	5.00	.75	0	0	0	.78	0	0	0
Q8 Identifying UD	4.68	5.00	5.00	5.00	.73	0	0	0	.76	0	0	0
Q9 Identifying UD	4.68	5.00	5.00	4.92	.70	0	0	.27	.75	0	0	.07
Q10 Identifying UD	4.25	4.67	4.82	4.59	.86	.5	.39	.69	.74	.27	.15	.48
Q11 Identifying UD	4.33	5.00	4.95	4.67	.76	0	.23	.68	.73	0	.05	.46
Q12 Identifying UD	4.48	4.83	4.92	4.93	.88	.41	.27	.27	.72	.17	.08	.07
Average	**4.57**	**4.86**	**4.92**	**4.83**	**0.81**	**0.25**	**0.22**	**.32**	**0.78**	**0.16**	**0.11**	**.19**

Item	Mean				Standard Deviation				Variance			
CLINICAL Preparedness	IRAT	GRAT	FINAL	FOLLOW UP	IRAT	GRAT	FINAL	FOLLOW UP	IRAT	GRAT	FINAL	FOLLOW UP
Q1 Preparedness	3.65	4.83	4.79	4.59	1.31	.41	.41	.69389	.81	.17	.17	.48
Q2 Preparedness	4.38	5.00	5.00	5.00	.87	0	0	0	.82	0	0	0
Q3 Preparedness	4.20	4.67	4.89	4.93	.77	.82	.31	.27	.83	.67	.10	.07
Q4 Preparedness	4.30	5.00	5.00	4.85	.72	0	0	.36	.80	0	0	.13
Q5 Preparedness	4.50	5.00	5.00	5.00	.54	0	0	0	.77	0	0	0
Q6 Preparedness	3.70	4.33	4.79	4.59	1.05	.8	.58	.69	.78	.67	.33	.48
Q7 Preparedness	4.40	5.00	5.00	5.00	.64	0	0	0	.78	0	0	0
Q8 Preparedness	4.53	5.00	5.00	5.00	.52	0	0	0	.76	0	0	0
Q9 Preparedness	4.35	5.00	5.00	4.89	.88	0	0	.32	.75	0	0	.10
Q10 Preparedness	4.30	4.33	4.74	4.70	.76	.82	.55	.61	.74	.67	.31	.37
Q11 Preparedness	4.55	5.00	4.98	4.74	.70	0	.16	.66	.73	0	.03	.43
Q12 Preparedness	4.43	4.83	4.97	4.93	.58	.41	.16	.27	.72	.17	.03	.07
Average	**4.27**	**4.83**	**4.93**	**4.85**	**0.78**	**0.27**	**0.18**	**.32**	**0.77**	**0.195**	**.08**	**.18**

	CLINICAL Willingness	IRAT	GRAT	FINAL	FOLLOW UP	IRAT	GRAT	FINAL	FOLLOW UP	IRAT	GRAT	FINAL	FOLLW UP
Q1	Willingness	3.78	4.83	4.79	4.64	1.28	.41	.41	.68	.83	.17	.17	.46
Q2	Willingness	4.45	5.00	5.00	5.00	.74	0	0	0	.82	0	0	0
Q3	Willingness	4.30	4.67	4.89	4.89	.63	.82	.31	.42	.81	.67	.10	.42
Q4	Willingness	4.43	5.00	5.00	4.86	.48	0	0	.36	.79	0	0	.13
Q5	Willingness	4.60	5.00	5.00	5.00	.16	0	0	0	.76	0	0	0
Q6	Willingness	3.85	4.33	4.79	4.61	.96	.82	.58	.69	.79	.67	.33	.47
Q7	Willingness	4.50	5.00	5.00	5.00	.42	0	0	0	.77	0	0	0
Q8	Willingness	4.58	5.00	5.00	5.00	.23	0	0	0	.75	0	0	0
Q9	Willingness	4.45	5.00	5.00	4.89	.70	0	0	.31	.74	0	0	.10
Q10	Willingness	4.30	4.33	4.74	4.71	.59	.82	.55	.60	.73	.67	.31	.36
Q11	Willingness	4.53	5.00	4.98	4.75	.54	0	.16	.65	.72	0	.03	.45
Q12	Willingness	4.50	4.83	4.97	4.93	.35	.41	.16	.26	.75	.17	.03	.22
Average		**4.35**	**4.83**	**4.93**	**4.86**	**0.59**	**0.27**	**0.18**	**.33**	**.77**	**0.20**	**.08**	**.24**

UFIRB 02 – Social & Behavioral Research
Protocol Submission Form

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Title of Protocol:	Perceptions of Unethical Classroom and Clinical Behavior Survey

Principal Investigator:	Deborah J Marshall		UFID #
Degree / Title:	MSN, MEd, Professor	**Mailing Address:** (If on campus include PO Box address): 4200 E Congress MS #31 Lake Worth, FL 33461	**Email:**
Department:	Nursing Palm Beach State College		**Telephone #:** 561.868.3440 FAX 561.868.3452

Co-Investigator(s):	None	**UFID#:**	**Email:**
Supervisor (*If PI is student*):	Dr Erik Black	**UFID#:**	
Degree / Title:	PhD, Educational Technology Assistant Professor	**Mailing Address:** (If on campus include PO Box address): 1701 SW 16th Ave, Bldg A, Rm 2113 Gainesville, FL	**Email :**
Department:	Education		**Telephone #:** 352.334.1357

Date of Proposed Research:	January 1, 2013 – December 31, 2013

Source of Funding (*A copy of the grant proposal must be submitted with this protocol if funding is involved*):	None

Scientific Purpose of the Study:
To individually and collectively survey clinical and skills lab nursing faculty about their perceptions of academically dishonest and unethical nursing student behaviors from a list of 25 questions, and to measure how the surveys compare.

Describe the Research Methodology in Non-Technical Language: (*Explain what will be done with or to the research participant.*) These 3 surveys are a continuation of a study (#2011-U-1209) conducted in Spring semester, 2012. Survey administration will be conducted by the researcher and will occur at Palm Beach State College, Lake Worth Florida. Individuals will be informed that participation is optional, have the study described to them and be administered an informed consent document. After obtaining informed consent, a 25 question anonymous and confidential survey will be administered (see attached) to individual faculty members. This first survey, including 7 demographic questions, will be followed by a group survey, and then a final individual survey during an orientation session in the spring semester of 2013. Surveys will be collected by the researcher.

The surveys are an adaptation of Hilbert's tool, used in 1985, and in the current study conducted in Spring 2012 by this researcher.

Hilbert, G. (1985). Involvement of nursing students in unethical classroom and clinical behaviors. *Journal of Professional Nursing, 1*(4), 230-234.

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Describe Potential Benefits: Determining differences in faculty perceptions of academic dishonest and unethical nursing student behaviors can help identify where steps can be taken to design curriculum to openly address the differences, and help faculty to guide students in their understanding of professional behaviors. It is believed that honest and ethical behaviors in school will facilitate professional, ethical behaviors in later practice. The long term benefits are that there will be more ethical, professional registered nurses caring for patients.

Describe Potential Risks: (*If risk of physical, psychological or economic harm may be involved, describe the steps taken to protect participant.*) None. Participation is voluntary and anonymous. Results will be collected and researchers will be unable to identify individual subjects, so participation will not yield an advantage and non-participation will not result in punishment. Identification of the participant's elementary school name on the first and third surveys will allow for a comparison of the two surveys, thereby allowing the researcher to measure differences, but not to specifically identify individual participants.

Describe How Participant(s) Will Be Recruited:

A convenience sample of Lake Worth campus adjunct faculty members will be attending a required orientation (synchronous) two hour orientation session, and will be asked if they would participate in the following survey session. Those who choose to participate will be issued the surveys. Those who choose not to participate will be dismissed and can leave the area.

Maximum Number of Participants (to be approached with consent)	60	**Age Range of Participants:**	25-70	**Amount of Compensation/ course credit:**	None

Describe the Informed Consent Process. (Attach a Copy of the Informed Consent Document. See http://irb.ufl.edu/irb02/samples.html for examples of consent.)

(SIGNATURE SECTION)		
Principal Investigator(s) Signature:	Deborah J Marshall	**Date:** Nov 19, 2012
Co-Investigator(s) Signature(s):		**Date:**
Supervisor's Signature (if PI is a student):		**Date:** Nov 20, 2012
Department Chair Signature:		**Date:**

APPENDIX K
PALM BEACH STATE COLLEGE RESEARCH STUDY APPROVAL

Palm Beach State
Personnel

Palm Beach State College
Research/Study Approval

Name: Deborah J Marshall   Date: 30 Jan 2012

Title: Professor 1, Dept Chair

Cluster/Department: Nursing

Title of research/study: Defining Unethical Classroom + Clinical Behavior

Purpose of study: To survey college online + face to face nursing students and nursing faculty about perceptions of academically dishonest behaviors

Level I Approval: (cluster/department administrator)

Name: JACQUELINE ROGERS   Title: DEAN, HEALTH SCIENCES and PUBLIC SAFETY

Signature: Jacqueline Rogers   Date: 2/7/12

Level II Approval: (provost)

Name: Maria M. Vallejo   Title: Provost

Signature: MMVallejo   Date: 2/9/12

Level III Approval: (Institutional Research & Effectiveness)

Name: Jennifer Campbell   Title: Dir, IRE

Signature: J Campbell   Date: 2/9/2012

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BIOGRAPHICAL SKETCH

Deborah J. Marshall has been a registered nurse since 1974, earning an associate's and baccalaureate, or two plus two degrees, in nursing from Purdue University. She used her nursing training to work in several emergency departments, and extended her experience as a Nurse Manager, hospital supervisor, and nurse educator. Moving into education, she completed her first master's in nursing with a functional minor in nursing education from the University of South Florida, after which she entered the United States Air Force as a Captain.

When the United States became engaged in the first Persian Gulf War, she was deployed to a medical/surgical hospital based in the United Arab Emirates. From there she was able to continue to train nurses in the field, and upon returning to the U.S., she successfully completed her certification in Nursing Staff Development through the American Nurse's Credentialing Center, becoming the second nurse in the Air Force to achieve this distinction. The next two Air Force assignments resulted in her being assigned as the Officer in Charge of the Nursing Staff Development department, first in America, and then in RAF Lakenheath, England where she was responsible for the staff development and continuing education for all medical personnel including physicians, nurses, Emergency Medical Technicians, and para-rescue jumpers.

After her honorable discharge from the Air Force, she focused on family matters until the attacks of 9/11, when she returned to nursing to again fulfill her passion for teaching, directing the nursing education department at Montgomery General Hospital, near Washington D.C. before coming to Florida to establish her teaching and Department Chair position at Palm Beach State College. It is at Palm Beach where she developed a desire to incorporate current technology and teaching strategies in and out of the classroom, and completed her second master's in education as a platform to achieve the degree of Doctor of Education from the University of Florida. She has worked passionately to improve her understanding of nursing

student cheating during her study entitled: *Adjunct Nursing Faculty Perceptions of and Reactions to Unethical or Dishonest Nursing Student Behaviors in the Classroom and Clinical Areas* in order to attempt to improve adjunct faculty perceptions of their role in dealing with student cheaters, and to lessen nursing student cheating.

Deborah is the daughter of Glenn and Jean Haller, who throughout their lifetimes, encouraged and supported her in her quest for education. Unfortunately, her mother passed away just a few months before the completion of her doctoral work, and never saw her graduate. She is also the mother of Christopher and Kevin Catron, who have always been a source of pride to her, in their lifetime achievements, their service to their country, and their thoughtful and steadfast support and encouragement.