Incivility Experiences of New Graduate Nurses

by

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Abstract

Background: New graduate nurses (NGNs) continue to experience co-worker incivility even when educational interventions, transition programs, and workplace policies and programs are provided. Incivility contributes to NGNs leaving the nursing profession at staggering rates contributing to an overall shortage of nurses.

Aim: What are the organizational structures, nurse leadership roles, and work conditions contributing to NGNs' co-worker incivility experiences?

Data Sources: Data from Starting Out National Survey, Time 1 data (November 2012-March 2013).

Methods: This dissertation is comprised of three studies, an integrative review (IR), theoretical approach to coworker incivility, and a quantitative secondary analysis. The IR of organizational antecedents, policy, and horizontal violence among nurses found that organizational situational factors sustain hierarchies and power inequalities oppressing registered nurses (RNs). The results of the IR showed that NGNs were only mentioned peripherally, and evidence showed that they were more vulnerable to incivility. Building on the core concepts of prior research on incivility among nurses the researcher draws from Ecological Systems Theory to propose an ecological model of NGNs' co-worker incivility experiences. A quantitative analysis using multiple linear regression was used to assess the relationships between independent variables (e.g., structural empowerment, trust in management, authentic leadership, and areas of worklife) to NGNs' co-worker incivility experiences.

Results: The IR findings indicated there were relationships between organizational hierarchies to nursing leaders' lack of job authority. The ecological approach allowed for the exploration of select variables related to NGNs' co-worker incivility experiences. The variables were placed

within a hypothesized model informed by the IR findings, and a literature review of NGNs' incivility experiences. Bronfenbrenner's Ecological Systems Theory (1978;1979), Laschinger et al.'s (2016) adaption of Scott et al.'s (2008) New Graduate Transition model were used to develop an ecological approach that considers the factors affecting NGNs. Through situating the variables within the model, relationships were hypothesized. The multiple linear regression found predictive relationships between NGNs' perceptions of workplace empowerment and areas of worklife to coworker incivility when controlling for important variables. Hypothesis 1 (H_1): There was a significant negative relationship between workplace empowerment and the perceptions of co-worker incivility by NGNs. Hypothesis 2 (H_2): There was a significant negative linear relationship between areas of worklife and the perceptions of NGNs' coworker incivility. Hypothesis 3 (H_3): There was a nonsignificant negative relationship between authentic leadership and NGNs' perceptions of coworker incivility.

Conclusion: NGNs' perceptions of workplace empowerment and areas of worklife drive co-worker incivility experiences. A workplace empowerment measure should include items reflecting NGNs' perceptions of nurse leadership control of workloads and access to human resources. New graduate nurses' perceptions of authentic leadership would benefit from workplace empowerment of the nurse leader in workplace environments to mitigate coworker incivility experiences. A new measure that captures the relationship between a nurse leader, formal authority within the job role as it relates to NGNs' workloads, resources, and perception of trust is discussed in relation to NGNs' co-worker incivility experiences is recommended.

Implications: Situating NGNs' coworker incivility experiences within an ecological approach, assists researchers, policy analysts, and nursing leaders to deepen the understanding of the problem of incivility. Second, understanding how workplace empowerment could be used to

support authentic nursing leaders within their job roles through provision of formal authority provides an opportunity for nurse leaders to improve NGNs' job control and access to resources. Third, this study contributes a new understanding of the interrelatedness of roles, and decision-making authority or lack thereof, to arm nursing students with knowledge to advocate for systemic change and to further understand nursing leaders' roles.

Future Research: Importantly, the nested impacts of organizational antecedents to NGNs' coworker incivility experiences within an ecological framework, and measures that capture nursing leader's job roles in relation to human resources and NGNs' workloads are needed. If nurse leaders have formal job authority within their job roles, then workload management systems could accurately reflect NGNs' and nurse leaders' nursing practice environments.

Key words: incivility, authentic leadership, areas of worklife, structural empowerment, theory.

Preface

The secondary analysis conducted in this thesis received ethics approval from the University of Alberta Research Ethics Board, (Incivility in Nursing, No. PRO0008774). Some of the research conducted for this thesis has been published. For example, the entire Chapter 2 of this thesis was published as S. Blackstock, B. Salami, & G. G. Cummings (2018), Organisational antecedents, policy, and horizontal violence among nurses: An integrative review. *Journal of Nursing Management*, 26(8), 972-991. I was the author of the integrative review as a part of my directed study supervised by Dr. B. Salami, and Dr. G. G. Cummings was the committee supervisory author involved in manuscript edits.

The remaining chapters are unpublished works. Chapter 3 of this thesis presents an ecological approach to NGNs' incivility experiences authored by S. Blackstock, with review by committee members G. G. Cummings, F. Glanfield, and O. Yonge (2020), "Proposed theoretical framework of incivility experiences of new graduate nurses." In Chapter 4 of this thesis, I was responsible for testing the assumption that NGNs' perceptions of nursing leadership, structural empowerment, and areas of worklife drive coworker incivility experiences. This chapter was reviewed by F. Glanfield, G. G. Cummings, and O. Yonge. In Chapter 5 of this thesis, I was responsible for the discussion of healthcare administrators' considerations of the study findings, and how the findings contribute knowledge to understanding the problem of coworker incivility, and to inform anti-incivility policy.

Dedication

This work is dedicated to practicing registered nurses and new graduate nurses. My intentions are to inform changes in the structure and administrative of healthcare organizations to support empowerment of nursing leaders and remediate incivility among nurses. In particular, empowering nurse leaders with formal decision-making authority at all levels of the health care organization to change the current nursing practice environments is needed. This will create a new normal wherein nurse-to-patient ratios and workloads are consistently safe, and job resources are available. Nurse leaders need formal authority within their job role to make and implement decisional changes to mitigate high job demands and lack of resources for new graduate nurses and registered nurses.

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Glossary

Areas of Worklife: Areas of worklife (Leiter & Maslach, 2004) relates to six key areas including: workload (job demands); control (able to influence management to obtain resources, autonomy); rewards (appreciation, recognition, or compensation); community (sense of belonging/cohesiveness with peers at work); fairness (perceived justice); and values congruence (e.g., match between employee and organization priorities and value).

Anti-incivility policy: workplace policy to target the mitigation of incivility behaviors of the employees.

Authentic Nursing Leadership: Authentic leaders' practice and value fairness, truthfulness, and integrity (Wong & Cummings, 2009). They build positive psychological capacity of their followers through strengthening confidence, optimism, and resilience in the shared vision of the team and each team member's contributions (Alilyyani et al., 2018).

Incivility: On a scale from one to ten, incivility ranges from one to three, workplace bullying ranges from four to nine (i.e., reflects mild to severe interference with accomplishment of legitimate organizational duties), and violence, battery and homicide are rated the highest score of ten (Namie, 2003). Incivility behaviours are at a low-intensity rating on a negative workplace behaviours ten-point scale of organizational disruption.

Bullying; On a scale from one to ten, incivility ranges from one to three, workplace bullying ranges from four to nine (i.e., reflects mild to severe interference with accomplishment of

legitimate organizational duties), and violence, battery and homicide are rated the highest score of ten.

Coworker Incivility: Negative interpersonal work experiences of incivility, bullying, and HV among nurses continue to rise (An & Kung, 2016; Giorgi et al., 2015; Hamblin et al., 2015; Purpora & Blegen, 2015; Yokoyama et al., 2016) impacting recruitment and retention within the nursing profession.

Ecological Approach: Bronfenbrenner's Ecological Systems Theory Model (1979) organizes contexts of development into five levels of external influence to capture how, from a child's perspective, they find themselves enmeshed in various nested ecosystems from the most intimate home environment/ecological system to the larger school system interactions with peers, teachers, and caregivers, school culture, and then the most expansive systems which include society

Psychological empowerment: Psychological empowerment results from socio-structural empowerment and contributes to improved outcomes such as satisfaction, positive workplace retention (Cicolini, et al., 2014), interprofessional collaboration (Reagan, et al., 2016) and low levels of incivility (Laschinger, et al., 2009; Lautizi, et al., 2009).

Workplace empowerment: Workplace empowerment consists of socio-structural empowerment and psychological empowerment (Spreitzer, 2007). Socio-structural empowerment perspective is about power sharing (e.g., formal authority or control over organizational resources) through delegation of responsibility through the organizational chain of command (Spreitzer, 2007).

Mobbing: Mobbing behaviours are negative workplace behaviours perpetrated by groups. Mobbing/psychological harassment/terror and aggression are more closely associated with

workplace violence behaviours and differ conceptually from workplace incivility and bullying behaviour.

New graduate nurse: new graduate nurse with less than three years' experience post graduation.

Oppression: Freire (2003) theorized that HV related to oppression results from a lack of recognition and value. Oppressed group behaviour theory (Freire, 1971) has been used to explain the etiology of HV, bullying, and incivility (Cortina et al., 2001; Roberts, 2015).

Trust: define trust as an individual's belief that another individual or group: a) makes good faith efforts to behave in accordance with explicit or implicit commitments, b) is honest in negotiations that preceded such commitments, and c) does not take excessive advantage of another even when the opportunity is available.

Horizontal violence: Horizontal violence includes bullying, and psychological violence among RNs in equal positions of authority. It includes mistreatment, harassment, bullying, and psychological violence among RNs in equal positions of authority.

Workplace Harassment: means any inappropriate conduct, comment, display, action or gesture or any bullying that the person responsible for the conduct, comment, display, action or gesture or the bullying knows, or ought reasonably to know, could have a harmful effect on a worker's psychological or physical health or safety.

Workplace violence: workplace violence, including, but not limited to, bullying, teasing, and abusive and other aggressive behaviours, and to prevent and protect against it

Workplace violence prevention policy: to develop a workplace violence prevention policy setting out, among other things, the obligations of the employer, which include: the dedication of sufficient attention, resources, and time to address factors that contribute to workplace violence,

including, but not limited to, bullying, teasing, and abusive and other aggressive behaviours, and to prevent and protect against it.

Chapter 1: An Overview of Studies Comprising This Thesis

Introduction

In Canada, many new graduate nurses are changing jobs or leaving the profession related to hostile work environments and incivility (Booth, 2011; Chachula et al., 2015; D'Ambra & Andrews, 2014; Read & Laschinger, 2013). This is of concern, given that by 2022 the profession will have a shortfall of 60,000 nurses (Canadian Nurses Association [CNA], 2018). Ultimately, nurses' incivility experiences lead to increased stress, communication barriers, and concentration difficulties (Yildirim, 2009), and the impacts to quality of patient care are notable (Purpora & Blegen, 2012; Vessey et al., 2010). Incivility is reported as witnessed or experienced at a rate of 77.6% (n=612) of new Canadian graduate nurses surveyed (D'Ambra & Andrews, 2014). This prevalence rate is significant given incivility and horizontal violence (HV) among registered nurses (RNs) are noted to be the most difficult forms of violence for victims to deal with (Farrell, 1999), yet incidences remain under reported (Becher & Visovsky, 2012; Vessey et al., 2010).

Incivility persists despite attempts to mitigate its occurrence through educational interventions in nursing schools (Gaffney et al., 2012), graduate transition programs (D'Ambra & Andrews, 2014; Evans et al., 2008), leadership (Laschinger & Fida, 2014), and anti-incivility policies (Blackstock et al., 2015; Blackstock et al., 2018). The CNA and the Canadian Federation of Nurses Unions' (CFNU) joint position statement on workplace violence and bullying outline the roles and responsibilities of several levels of stakeholders (i.e., health care organizations, nurses, and educators) in the prevention/mitigation of negative workplace behaviours (2015). Workplace legislation (Canada Occupational Health and Safety Regulations, 2014), labour laws (Canada Labour Code, 1985), professional ethical codes of conduct (CNA, 2017), and nursing professional bodies (CRNBC, 2008) target incivility through educational interventions and new

graduate transition programs. In Canada, organizations have a legal obligation through the Canadian Occupational Health and Safety Regulations (COH&SR, Section 20.3) to develop a workplace violence prevention policy setting out, among other things, the obligations of the employer, which include: the dedication of sufficient attention, resources, and time to address factors that contribute to workplace violence, including, but not limited to, bullying, teasing, and abusive and other aggressive behaviours, and to prevent and protect against it (2020, SOR/86-304). In spite of regulatory and professional legislation, the problem of incivility in nursing is ubiquitous (e.g., with the potential to escalate to HV, and reporting is deterred for fear of retaliation (Jackson et al., 2010; Peters et al., 2011; Schilpzand et al., 2016). New graduate nurses' incivility experiences can influence a decision to leave the job, and/or the nursing profession (Chachula et al., 2015; Lim et al., 2008; Schilpzand et al., 2016). When NGNs leave the nursing profession it contributes to a resource depleted scenario wherein new graduates are not replacing an aging workforce (Chachula et al., 2015; Lim et al., 2008; Schilpzand et al., 2016).

A step forward to addressing incivility is to deactivate the organizational hierarchical management that sustains nurses in an oppressed position and not feeling empowered (Blackstock et al., 2018; Wilson, 2016). Health care organizations are encouraged to pay attention to the impending nurse shortages and focus on retention and recruitment of NGNs to an environment where incivility does not thrive. Health care organizations have an opportunity to address incivility to mitigate escalation to bullying and violence in the workplace (Hoel et al., 2011).

The aim of this doctoral research was to identify and explore what organizational structures, nurse leadership roles and work conditions contribute to NGNs' co-worker incivility

experiences. I was intrigued by the systemic effects of organizational oppression related to nurse leaders' lack of formal authority to mitigate job demands/resources, new graduates' training, and the current realities of their nursing workplace environments. In this study, the work environment context is used to explore the relationship of a lack of workplace empowerment of authentic nurse leadership. A lack of workplace empowerment is demonstrated through a nurse leader's lack of formal authority within their job role, and it is suggested to influence NGNs' perceptions of their nurse leader. Secondly, NGNs' perceptions of the nurse leader may be a mediator to NGNs' perceptions of areas of worklife and trust of their immediate supervisor to coworker incivility experiences. The guiding research question for this work is: What are the organizational structures, nurse leadership roles, and work conditions contributing to NGNs capacity to deal with their own experiences of coworker incivility experiences?

Impetus for this Research

A doctoral nursing student's affinity for a theory and/or development of a theoretical model is grounded in their positionality and is evident in the commensurability with their research approach. This means a researcher may be drawn to another researcher's theory, perspective or research findings when informing their own research question, approach and, or analysis choices (Jafar, 2018). I share both with the reader before I move on to discuss how an ecological theory informed my theoretical approach to the phenomenon of coworker incivility experiences of NGNs.

Positionality

My positionality is a result of a northern Indigenous heritage rooted in good citizenship, mitigating the challenges and rewards of rural living, and a respect for land ethos. A holistic way of seeing the world becomes a part of you that mediates personal and collective conduct.

Individual and collective conduct by extension contributes to a sense of community to share responsibility, the duty to be good to one another, and the courage to challenge unjust situations with innovative solutions to sustain us collectively. My positionality, as a doctoral student with an advanced specialty in occupational health nursing, informs and grounds my organizational behavioural approach to the phenomenon of incivility experiences of NGNs. This means I view incivility not only as individual behaviour but also as a symptom of the collective, interrelated effects of the health care organization environmental conditions, sometimes referred to as using a work environment hypothesis (Notelaers et al., 2019) in this field of research. Incivility is a multidimensional phenomenon. This means that incivility cannot be accurately captured by theoretical models that discount the health care organizational management systems, structures, and administrative processes that impact nursing practice environments and patient care delivery.

My positionality has evolved due to my nursing experiences and advancing job roles to leadership and teaching. My personal, professional, and intellectual positionalities cohere with my upbringing, and guides my research inquiry approach. My personal beliefs, value systems, and moral stance are fundamentally present and inseparable from my professional and intellectual positionality as a nurse in the nursing research process. I continue to be influenced by nursing theorists' founding influences of the received view and post-positivist theorists (to approach incivility in nursing) in both a systematic and philosophical approach (Risjord, 2010). Positivists are realists, but as a post-positivist constructivist, I understand that we construct our view of the world based on our multiple perceptions of it and thus our observations may be theory-laden, yet we are inherently biased by our cultural experiences, worldviews, and other life experiences. Because our perceptions and observations are fallible with associated errors, our

constructions must be imperfect, and theory is revisable. Where earlier positivist researchers believed the goal was to uncover the truth, as a post-positivist constructivist, I believe the goal of nursing science and knowledge is to hold steadfastly to the goal of getting theory right about the realities of practice (e.g., incivility experiences of NGNs) within health care organizations, even though we may never fully achieve that goal. My hope is that my nursing standpoint influences my perspectives and drives me to critically view hierarchical systems in health care organizations. In the same manner prior nursing theorists have attempted to narrow the theory to practice gaps through values from a nursing perspective or standpoint (Risjord, 2010). A nursing standpoint reflects an epistemic standpoint acknowledging the interplay of the practice and discipline of nursing, beginning with the nurse. The nursing standpoint permits a nursing view to study the complex multidisciplinary systems and phenomena affecting their work (Risjord, 2010). I look to my positionality and professional values in my nursing standpoint to mediate the relationships between theory and the nursing practice environment.

My interest in the phenomenon of bullying among RNs and current incivility experiences of NGNs began as a student nurse watching, experiencing, and witnessing nurses being harassed, verbally assaulted (e.g., name calling), and their credibility questioned by nursing peers in the clinical environment of a regional teaching hospital. I continued to witness and experience bullying behaviours as my studies evolved, obtaining advanced certifications and degrees while changing nursing practice areas every 5–6 years and working in leadership positions. Although I eventually had excellent peer relationships after a month of working in new health care organizations, I was perplexed as to why nurses chose to bully each other. My master's thesis focused on an original research study exploring bullying among nurses in one hospital setting.

My research findings identified significant relationships of antecedents to bullying behaviours among acute care registered nurses within a hospital setting (Blackstock, 2012); however, I did not explore the relationships of predictor variables to horizontal bullying experiences of RNs. I am intrigued by the interface of organizational systems within the phenomenon of NGNs' coworker incivility and the relationships of other predictor variables. In my doctoral studies, I pulled back the research lens focus from the dyadic interaction of the perpetrator and victim of bullying behaviours explored previously in my master's studies (Blackstock, 2012) to include the health care organizational context and the associated relationships of predictor variables to NGNs' incivility experiences at the beginning of the negative workplace continuum (Namie, 2003).

Importantly, negative workplace experiences are on a trajectory, beginning with incivility and progressing to bullying, and ultimately workplace violence (Namie, 2003), yet the phenomenon of incivility among NGNs has yet to be situated within a multidimensional systems theory that is congruent with both the systematic organization of nursing and the organizations in which nursing is practised. Through my nursing experiences my positionality has been driven by a passion for quantifying scientific evidence that is generated from human behaviours and their interaction(s) with their environments and work contexts. My first study in my doctoral work was an integrative review (IR) (Blackstock et al., 2018) designed to explore the organizational antecedents related to HV among nurses and the extent to which policy initiatives reduce its incidence.

My intentions were to examine HV by conducting an IR of what is known about HV (e.g., predictor variables, concepts, theories); however, as I progressed, I noticed a significant trend of NGNs' incivility experiences being amplified (CNA, 2019; CASN, 2018; Zeller et al.,

2011). Interestingly, study findings did not consistently identify workplace causal factors contributing to the amplification of NGNs' incivility experiences, nor was a definition specific to new graduate nurse's incivility experiences offered. I decided to focus my study on the predictive variables and their relationships to NGNs' coworker incivility experiences. Study findings suggest well-meaning educational interventions, nursing transition programs, and mentorship were not effective in mitigating incivility experiences of NGNs (Zeller et al., 2011), and yet limited information was provided as to why these programs were found to be ineffective. I decided to narrow my focus to critically review research studies exploring incivility experiences of NGNs and the role of authentic leadership, combined with reflecting on my experiences of teaching and working in the clinical environment for over 30 years.

First, a gap in the literature exists in identifying and testing the relationships of predictive variables to incivility experiences specific to NGNs. An understanding of the relationships between predictive variables to coworker incivility experiences of NGNs is needed to curtail work absences, workplace stress, intention to leave the job, and in some cases—the nursing profession (Chachula et al., 2015; D'Ambra & Andrews, 2014; Laschinger, et al., 2015). Second, an important aspect of workplace behaviours are two interrelated factors of the work environment and the employee's behaviour per Lewin's Heuristic Theory (1936). Lewin (1936) acknowledged that human behaviour is a function of a person and their environment; thus, in terms of a resource depleted nursing environment, leadership and empowerment alone cannot account for a lack of sufficient number of nurses to provide care for high acuity patients. Given NGNs' responses to the transitioning nursing role are amplified by negative workplace behaviours (Zeller et al., 2011), I wondered which predictor variables might reflect or capture the phenomenon of their multidimensional work environmental experiences.

Third, I wondered why researchers were not embracing study findings of incivility experiences and nursing leadership's lack of formal authority within hierarchical organizational structures to mitigate job demands as a foundation to explore coworker incivility experiences of NGNs (Croft & Cash, 201; Kim et al., 2016). I purposely focused on the lack of structural empowerment support of the authentic leader in their job role (through a lack of formal decision-making authority) and attempted to show the effects on NGNs' workloads. The nurse leader's lack of formal authority may be a barrier to mitigate high patient to NGNs ratios and access additional nursing human resources. In this dissertation, work environment factors related to NGNs' workload is reflected in the variable areas of worklife and its relationship to coworker incivility. My intentions were to capture how decisions made at higher hospital administrative levels and bed managers impacting nursing and patient care are relayed by nursing leaders as mere minders of the system (Croft & Cash, 2012). Study findings indicated a reduction in perceptions of leadership by NGNs over time (Laschinger et al., 2015), but it may reflect a lack of formal decision-making authority within the nurse leader's job role. In addition, trust in management was also used as a control variable to determine whether trust is related to perceptions of authentic leadership in relation to NGNs' coworker incivility experiences. The factors noted in the IR and later my literature review seemed to be different from prior conceptualizations of authentic leadership when related to NGNs' perceptions of their leader and secondly, when related to a NGNs' workload fluctuations.

The inspiration for this research reflects a journey of coming to understand the situational organizational factors attributing to the occurrence of incivility among nurses. I explored the relationships of organizational antecedents to incidences of horizontal bullying among nurses to clarify the roles of organizational factors (i.e., structures, processes, and policies) to assist in

clarifying antecedent factors to incivility and bullying in my master's thesis. In my doctoral studies, I continue to be interested in the organizational context, antecedent concepts, and their strengths of effects in the causal world of incivility among NGNs. The findings and implications from this research will be published so that healthcare organizational leaders will act within their organizations to mitigate factors contributing to NGNs' coworker incivility experiences.

Definitions

Incivility, Bullying, and Horizontal Violence

Uncivil behaviour violates workplace norms of respect and exhibits lack of respect for others, discourteous behaviours, and ambiguous intent to harm; yet is measured as a low-intensity rating on a negative workplace behaviours ten-point scale of organizational disruption (Andersson & Pearson, 1999; Namie, 2003; Pearson et al., 2001). Scores for incivility range from one to three; workplace bullying scores range from four to nine (i.e., reflect mild to severe interference with accomplishment of legitimate organizational duties); and violence, battery and homicide are rated the highest score of ten (Namie, 2003). The distinction of incivility from other concepts such as aggression is the ambiguity of its intent to harm (Andersson & Pearson, 1999), as mentioned previously. Perpetrators could plead ignorance or deny any intentions of intent to harm, and thus confuse the resolution of the issue (Andersson & Pearson, 1999). Branch (2008) notes that intent is ambiguous in terms of workplace bullying; however, Keashly and Jagatic (2003) suggest that intent is not a defining element of workplace bullying, as there is no existing measure of intent in relation to workplace bullying. The attempt to clarify whether the perpetrator intended to bully a victim is circuitous—the bullying act(s) occur despite clarification of intent (Hickling, 2006), and thus intent is not an important component. An important point from this literature is that several authors argue there are minimal studies that focus on the

perpetrator perspective and outcomes of workplace incivility, thus missing key antecedents of incivility and an opportunity to reduce and prevent incivility at work (Jex et al., 2010; Meier & Semmer, 2013). Bullying behaviours rate higher in severity compared to incivility on the scale of organizational behaviour disruption by Namie (2003), including behaviours that obstruct job performance and advancement, and impede nursing team collaboration. In the context of negative workplace behaviours among RNs, incivility rates lower on the 10-point scale with potential to intensify strengths of effects and expand through social networks from individual to group perpetrators that can lead to bullying, HV, and aggression (Chips et al., 2013). Bloom has recently defined HV (2014) as "violence in the form of action, words, and other behaviours that is directed toward one's peers. It controls, humiliates, denigrates, or injures the dignity of another. Horizontal violence [action of the oppressor] reflects a lack of respect for the individual" (p. 4).

Horizontal violence includes mistreatment, harassment, bullying, and psychological violence among RNs in equal positions of authority. Horizontal violence here does not include physical or sexual forms of violence as they relate to different policies. Individuals rather than groups of coworkers typically perpetrate workplace aggression/violence (Buss, 1961). Workplace aggression/violence is defined along three dimensions of physical-verbal, active-passive, and direct-indirect behaviours (Buss, 1961), and in various combinations (e.g., direct, verbal, active aggression). Workplace aggression can also relate to a failure to respect personal privacy and/or confidentiality, with the potential to escalate from nonverbal innuendo to physical assault (Farrell, 2001). Andersson and Pearson (1999) conceptualize aggression as a form of workplace violence (high-end aggression) or incivility (low-end aggression). Workplace violence is any incident, behaviour, or action that is outside of reasonable conduct in which a person is

threatened, harmed, injured, or assaulted during, or as a direct result of, his or her work (Richards, 2003).

Mobbing behaviours are negative workplace behaviours perpetrated by groups. Mobbing/psychological harassment/terror and aggression are more closely associated with workplace violence behaviours and differ conceptually from workplace incivility and bullying behaviours (Andersson & Pearson; Branch, 2008; Namie, 2003). Increased frequency of behaviours experienced and/or combined with multiple kinds of negative workplace behaviours work through social networks to strengthen negative relationships (Chips et al., 2013). In addition, research findings show that organizational context and environmental factors, such as leadership style, oppressive working conditions, and low job control, contribute to the presence of incivility, bullying, and HV in health care organizations (Hutchinson et al., 2010; Purpora & Blegen, 2015; Rodwell & Demir, 2012).

Operational Definition of Incivility Informing This Study

A working definition of the developing theory is helpful to keep the researchers grounded in their reflection of what researchers assert as 'the causal world' of the phenomena of interest. The operational definition of incivility reflects the impacts of high job demands, low resources, and a lack of stability of patient care workloads for NGNs and creates frustration. Incivility is a behavioural tension of frustration often occurring when RNs respond to a workplace environment where they lack control over the increased job demands, fluctuation of patient assignments, and the pressure to do more nursing work without adequate resources. This behavioural tension of frustration response (e.g., a precursor to uncivil behaviour) is amplified by NGNs, given they are learning their roles (Mellor et al., 2017), and looking to nursing leaders to mitigate job demands, to respond, adjust and mitigate heavy patient assignments to allow for

stabilization of workloads in order to learn ward routines and policies, and balance patient care. Therefore, the working definition of incivility I developed is described as follows:

> Some behaviours of incivility include judgment of leaving work or incomplete nursing care for oncoming nursing staff; outward evaluation of quality of being a good nurse if all nursing tasks are completed on time (i.e., medications, new orders, admissions, bed transfers, discharges, transfer of patients, and ability to take breaks on time so other staff can take their breaks). Judgment also occurs in the form of negative verbal statements, accusations, degrading verbal comments, and nonverbal gestures to NGNs, calling into question the credibility of the NGN graduate with other staff, peers, patients, and/or their families, either while the NGN is present or behind their backs.

A gap in the research is a model that views the historical, organizational hierarchy of nurse leaders merely relaying upper management decisions and not having legitimate authority to positively impact job demands within nursing work environments. In this manner, the organizational hierarchy within hospitals has negative effects that diminish structural empowerment and authentic leadership as mediators to incivility experiences.

Chapters, Research Studies, and Questions

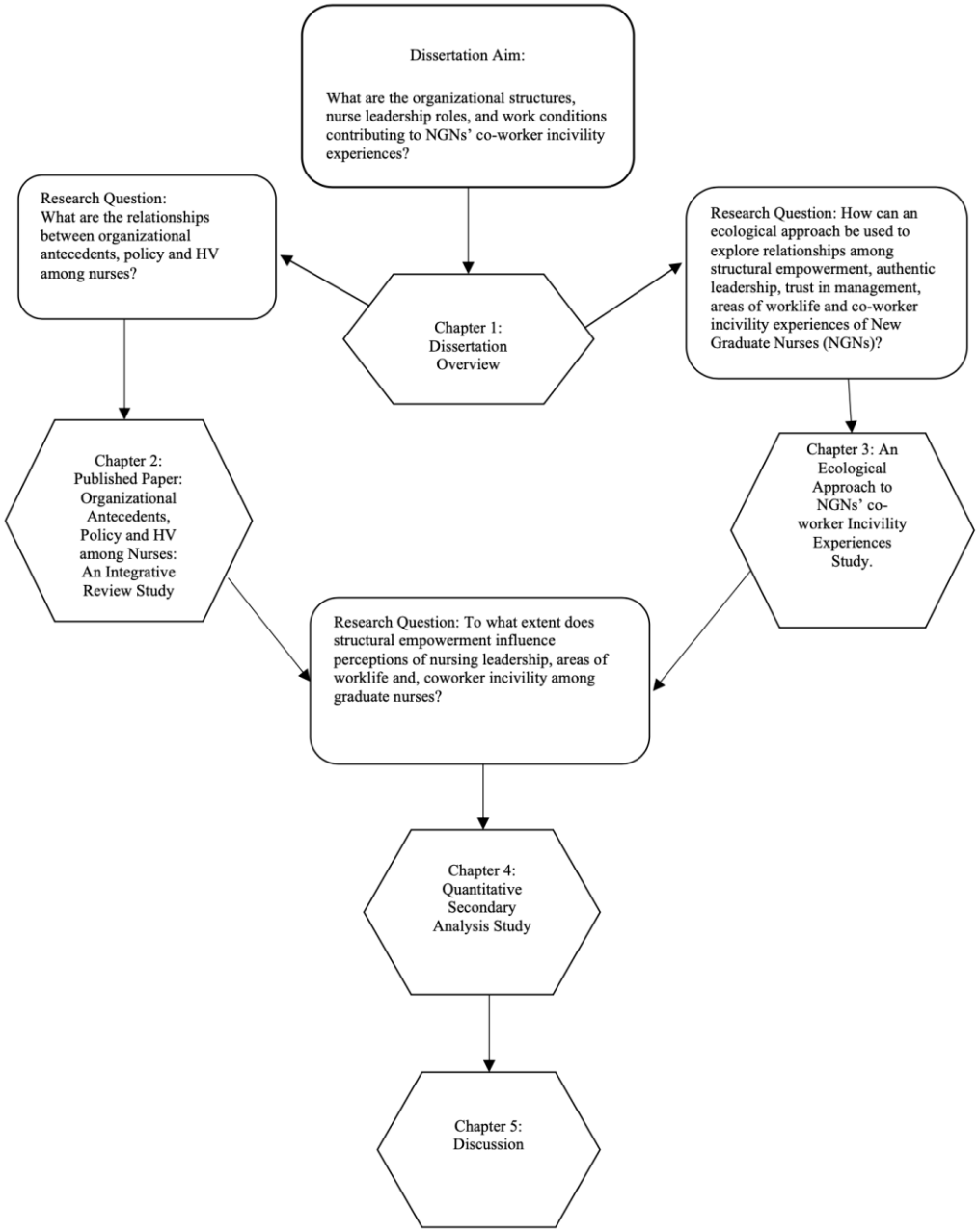
This dissertation consists of five chapters and three research studies. The aim of this dissertation was to answer the question: What are the organizational structures, nurse leadership roles, and work conditions contributing to NGNs' coworker incivility experiences?

This dissertation comprises five chapters. Chapter 1 is an overview of the entire dissertation; Chapter 2 is an IR study which was published in a peer reviewed journal; Chapter 3 is an ecological approach to NGNs' coworker incivility experiences; Chapter 4 is a quantitative

research study using secondary data analysis; and finally, Chapter 5 is a discussion of the dissertation findings. In total, three studies provided the foundation to guide my inquiry to explore the phenomenon of incivility experiences among NGNs, resulting in five chapters (see Figure 1). The aim of the dissertation leads to the next in a sequence, resulting in three research questions, three studies with an associated chapter, and one overview chapter. The plan is to submit papers for publication based on Chapters 3-5, targeting the following journals for each chapter respectively: Chapter 3 (Canadian Journal of Nursing Leadership), Chapter 4 (Nursing Research) and Chapter 5 (Journal of Organizational Behaviour). The format of this work allows for a comprehensive reference list at the end of this dissertation as per the Faculty of Graduate Research Studies at the University of Alberta dissertation format requirements.

Figure 1-1

Overview of Blackstock Research



Integrative Review: Organizational Antecedents, Policy, and Horizontal Violence

The aim of the IR was to explore the organizational antecedents related to HV among nurses and the extent to which policy initiatives reduce its incidence. I conducted an IR to determine how the causal relationships of analyzing antecedent factors related to HV assists in problem identification to clarify policy development, and to inform a hypothetical model of incivility. Further, the IR findings identify predictor variables and their relationships to coworker incivility experiences of NGNs and warrant further exploration. Additionally, I was interested in determining whether there are confounding issues clouding anti-HV policy, such as consistency in identifying HV behaviours; understanding of anti-HV policy; and decision-making authority of nurse leaders in applying anti-HV policy by nurse managers. Anti-HV policies are workplace policies targeted to mitigate the occurrence of HV (e.g., zero tolerance). The creation of effective anti-HV policies facilitates prevention and ensure appropriate actions in the reporting of incidents per relevant protocols. The following questions guided the IR search strategy:

1) What are the organizational antecedents related to HV among nurses?
2) What are the policy implications of these organizational antecedents?

IR Research Question #1: Which Organizational Antecedents Relate to HV?

In total, I identified 19 different organizational antecedents across the 22 studies. Organizational factors of labour environment (i.e., working conditions, tasks, and teamwork) and demographics (Ariza-Montes et al., 2013); workplace environmental factors (i.e., nursing role in quality of care/hospital affairs, staffing resources, and manager's ability); practice environment (Yokohama et al., 2016); and organizational culture (An & Kang, 2016; Yeun & Han, 2016) were important constructs for understanding incidences of HV. I categorized the most relevant constructs used to explore organizational antecedent factors as influential working conditions,

relational aspects of teams and leadership, organizational culture, climate, and the role of structural process. Two categories were: a) influential working conditions and relational aspects of teams and leadership; and b) organizational culture, climate, and the role of structural processes.

IR Research Question #2: Have Anti-HV Policy Initiatives Reduced the Incidence of Horizontal Workplace Violence Among Nurses?

Leadership roles, decision-making authority, and organizational structures' relationship with anti-HV policy were identified. Study results related to the second question were analyzed and synthesized, which provided two themes: leadership role and decision-making authority; and, organizational structures' relationship with anti-HV policy. Reconceptualizing HV by understanding the role of politics within health care organizational structures shows promise to reposition workplace policies and laws, beginning with addressing incivility within health care organizational structures to mitigate HV. The IR findings were themes of influence of working conditions; relational aspects of teams; leadership, organizational culture, climate; role of structural processes, leadership role and decision-making authority; and the relationship of organizational structures to anti-HV policy. The findings of the IR prompted a review of seminal and current theoretical frameworks and definitions of incivility reflecting NGNs' experiences and the role of their authentic leader. Organizational context provides a foundation to understand how NGNs perceive the effectiveness of nursing leadership to find resources and make changes because of structural hierarchies. Chapter 2 was published in the *Journal of Nursing Management*. (Refer to paper one, chapter two, for full manuscript details.)

Overall, an interesting finding was the relationships between reporting structures and how the position of nurses within the organization informs the anti-HV policy. In particular, the

hierarchical and horizontal axes of reporting and management structures are important to be articulated within anti-HV policies, and yet most of the included studies did not indicate the nature of the anti-HV policies and reporting structures. I explored NGNs' and coworker incivility experiences closely in Chapter 3 of this dissertation through the development of an ecological model of NGNs' coworker incivility experiences.

An Ecological Approach to NGNs' Coworker Incivility Experiences

The guiding research question for the third chapter was: How can an ecological approach be used to explore relationships among workplace, authentic leadership, trust in management, areas of worklife, and coworker incivility experiences of NGNs? The development of an ecological approach to NGNs' coworker incivility experiences was informed by the IR findings of Blackstock et al. (2018), a literature review of NGNs' incivility experiences, seminal works, and recent research studies (Croft & Cash, 2012; Kim el al., 2016; Laschinger et al., 2016; Laschinger & Read, 2016). The results of the IR by Blackstock et al. (2018) showed that NGNs were only mentioned peripherally, and evidence showed that they were more vulnerable to incivility. This prompted me to do a second more focused literature review on coworker incivility and its effects on NGNs. I took the key findings related to NGNs and incivility identified in the IR (Blackstock et al., 2018), and then refined the search criteria to focus a literature review on NGNs and incivility to review the literature to date.

The purpose of this chapter was to: a) use the constructs identified in the IR (Blackstock et al., 2018) to guide a literature review on predictive variables linked to NGN's coworker incivility experiences; b) demonstrate how the variables are situated differently in a Laschinger et al.'s (2016) New Graduate Successful Transition and Retention (NGSTR) model; and, c) demonstrate how an ecological model can capture the factors in an organizational context.

The aim was to better inform health care administrators to locate the source of incivility within complex health care settings and mitigate NGNs' coworker incivility experiences (Ditmer, 2010; Laschinger et al., 2012; Trepanier et al., 2016). An understanding of coworker incivility that does not only rely on personal behavioural reform also has direct benefits for the curricula in nursing schools (Gaffney et al., 2012), graduate transition programs (D'Ambra & Andrews, 2014; Evans et al., 2008), leadership programs (Laschinger & Fida, 2014), and policy interventions (Blackstock et al., 2015; Blackstock et al., 2018).

Laschinger et al.'s (2016) NGSTR model and Bronfenbrenner's Ecological Systems Theory (1979; 1978) were used as a framework to theorize the ecological approach to NGNs' coworker incivility experiences. Given that I was testing relationships versus trying to determine causality, I situated the select variables (e.g., structural empowerment, authentic leadership, areas of worklife and incivility) identified by Laschinger et al.'s (2016) study within Bronfenbrenner's Ecological Model (1979) to better understand how organizational factors in health care settings could influence NGNs' perceptions of coworker incivility. I proposed my model informed by Kanter's Structural Empowerment theory (1977; 1993), Avolio et al.'s Authentic Leadership theory (2006), The Organizational Trust Inventory Modified by Wong (2012), Leiter and Maslach's Person-Job Fit theory (2004), and Leiter and Day's Straightforward Workplace Coworker Incivility Subscale (2013).

Based on the ecological approach to NGNs' coworker Incivility Experiences Model, select predictor variables were chosen to examine the relationship to NGNs' coworker incivility experiences using regression models. The predictor variables relationships (e.g., structural empowerment, authentic leadership, trust in management, and areas of worklife) to NGNs' coworker incivility experiences were tested. Three regression models were used to test the

relationships between the independent variable of workplace empowerment, areas of worklife, and authentic leadership to the dependent variable of NGNs' coworker incivility experiences. It was predicted that there would be a significant negative linear relationship between workplace empowerment, areas of worklife, and authentic leadership to the perceptions of coworker incivility by NGNs.

Select concepts were based on my literature review findings; however, future research may explore the relationships of Laschinger et al.'s (2016) variables not included in this study, as well as variables situated in the macrosystem that influence the variables identified in the current study, and the effects over time (chronosystem) to NGN incivility experiences. This approach may assist health care administrators to focus on areas for organizational changes in NGNs' work environments and aid in secondary benefits of reducing coworker incivility experiences.

Situating the variables in Laschinger et al.'s (2016) adaptation of Scott et al.'s (2008) NGSTR model within the ecological model contributes to a multidimensional understanding of how variables operating at various levels in health care systems may influence NGN experiences of incivility. For my purposes, I used Laschinger et al.'s (2016) adaptation of the NGSTR model to situate NGN microsystem coworker incivility experiences within the mesosystem (nurse supervisor) and exosystem (workplace empowerment) to inform my hypothesis testing. In future this model could inform multi-level analysis of NGN incivility experiences using methods such as hierarchical linear modelling to better understand the level at which various factors have the most influence on incivility. The findings suggest there is more work to be done in understanding the role of lack of formal authority within nurse leadership roles. Future research should explore the other variables in Laschinger et al.'s (2016) framework not included in this study to understand their relationship(s) to coworker incivility experiences of NGNs.

In the fifth chapter, I discuss the results from all three studies and the implications. In each section of Chapter 3 (e.g., ecological approach to NGN's coworker incivility), I provided the context for each variable used and variables of interest for hypothesis testing, along with demographic variables of interest in Chapter 4, the quantitative study using secondary analysis.

Quantitative Study Using Secondary Analysis

An Ecological Model of NGNs' Coworker Incivility Experiences was conceptualized, and hypotheses based on the micro-, meso-, and exosystems, using select variables from Laschinger et al.'s (2016) adaptation of Scott et al.'s (2008) New Graduate Nurse Transition model. This study tested the assumption that NGN perceptions of nursing leaderships' control over workload contribute to coworker incivility experiences. In particular, the relationship between workplace empowerment, authentic leadership, and areas of work life (e.g., workload control and fair allocation of resources) to coworker incivility experiences were examined. The research question guiding the analysis was: To what extent are workplace empowerment, NGNs' perceptions of nurse leaders and trust in management, and areas of worklife experiences related to coworker incivility experiences of NGNs?

The analytic strategy chosen for the study needed to address how the variables were related to one another. Consistent with the ecological model, the research strategy for this study was to develop three models that tested the assumption that coworker incivility was predicted by workplace empowerment, areas of worklife, and authentic leadership while controlling for important variables (e.g., trust in management). Multiple linear regression was chosen as it allows for an iterative and simultaneous examination of multiple variables to better assess their interactive effects on the outcome variable (e.g., coworker incivility) (Frost, 2019). In the

methods and results chapter, I determined the items of the independent variables contributing the variability to the dependent variable.

Hypothesis 1(H_1): There will be a significant negative linear relationship between workplace empowerment and the perceptions of coworker incivility by NGNs; therefore, the slope will not equal zero. H_1: $B_1<0$, Null Hypothesis: H_0:$B_1=0$. The analysis shows that 8% (p=0.00) of the variability in NGNs' coworker incivility is explained by workplace empowerment, when controlling for authentic leadership and trust in management. For each one unit increase in workplace empowerment, coworker incivility decreases by .04 (B=-.04, p=.00), with a significance value of .00, CI [-.06, -.02]. For each one unit increase in perceptions of trust in management, coworker incivility experiences decrease by .07 (B=-.07, p=.01) and is significant at the 0.01 level, CI [-.12, -.01] when authentic leadership and workplace empowerment are held constant. Cook's distance (M=.001, SD =.004). Hypothesis 1 was accepted, and the null hypothesis was rejected.

Hypothesis 2 (H_2): There will be a significant negative linear relationship between areas of worklife and the perceptions of NGNs, coworker incivility; therefore, the slope will not equal zero. H_2: $B_2<0$; Null Hypothesis: H_0:$B_2=0$. The results revealed that 30% (p=0.00) variability in NGNs' coworker incivility experiences is accounted for by perceptions of areas of worklife, when controlling for authentic leadership, trust in management, and workplace empowerment. For each one unit increase in perceptions of areas of worklife, coworker incivility decreased by .60 (B= -.60, p=.00) with a significance value of .00, CI [-.69, -.50] when authentic leadership, trust in management, and structure empowerment are held constant. Cook's distance (M=.001, SD=.004). Hypothesis 2(H_2) was accepted, and the null hypothesis was rejected.

Hypothesis 3 (H_3): There will be a significant negative linear relationship between authentic leadership and NGNs' perceptions of coworker incivility; therefore, the slope will not equal zero. H_3: $B_3<0$. Null Hypothesis: H_0:$B_3=0$. The results revealed that 8% (p=0.00) variability in NGNs' coworker incivility experiences is accounted for by authentic leadership, when controlling for trust in management and workplace empowerment. For each one unit increase in authentic leadership, coworker incivility decreases by .03 (B=-.03, p=.26) with a significance level >0.01, CI [-.10, .02] when trust in management and workplace empowerment are held constant. Cook's distance (M=.001, SD =.009). Hypothesis 3(H_3) was rejected, and the null hypothesis was accepted.

The current study provides a perspective on predictive variables of authentic leadership, workplace empowerment, and perceptions of whether NGN's perceive a congruence between their work needs and the characteristics of their workplace (i.e., areas of work life) to NGN's coworker incivility experiences. Overall, NGNs' perceptions of trust in management and the degree of workplace empowerment in their workplace affects their perceptions of authentic leadership and coworker incivility.

Discussion

An overview of the organizational context and coworker incivility, an ecological approach to NGNs' coworker incivility experiences, the analytical approach chosen for the secondary analysis (e.g., data set, analytic approach), and the empirical findings from the current study were discussed. The study findings were compared and contrasted with the existing literature in this field. The ecological approach to NGNs' coworker incivility experiences adds to the body of literature on coworker incivility. Given my new understanding of NGNs' coworker incivility based on my findings, I share insights and recommendations into each of the areas,

including recommendations for policy in health care organizations. I discuss practice implications for health care administrators, the health care sector, anti-incivility policy makers, regulatory bodies, NGNs, and nursing leaders. In conclusion, I discuss the next steps for research into the organizational context of NGNs' coworker incivility experiences.

Overall, the results of this research reveal four main findings. First, NGNs' perceptions of workplace empowerment predict coworker incivility experiences when controlling for authentic leadership and trust in management. Second, NGNs' perceptions of areas of worklife predict coworker incivility experiences when controlling for authentic leadership, trust in management, and workplace empowerment. Third, NGNs' perceptions of authentic leadership do not predict coworker incivility experiences when controlling for workplace empowerment and trust in management. Finally, NGNs' perceptions of authentic leadership do predict coworker incivility experiences when trust in management and workplace empowerment are not controlled. The results indicate that hypotheses (H_1-H_2) are supported; however, H_3 was not supported.

Practice Implications

Implications to health care organization administration, workplace policy, practice and nursing leaders, and nursing education and teaching were discussed in detail in Chapter 5; however, some highlights are noted here. I discuss how health care administrators can advance their understanding of the role of workplace empowerment in supporting authentic leaders through assigning the nurse leader formal decision-making authority could lead to two important factors: first, broadening the NGNs' perspective of authentic leaders being congruent with their leadership philosophy and their ability to impact day-to-day changes to improve NGNs' job control and access to human resources. This will have secondary benefits of supporting trust of authentic leaders and nurse managers in general and mitigating NGNs' work stressors that lead

to judgment of work not being completed and coworker incivility. When NGNs' coworker incivility experiences are subsumed within my ecological approach, it can assist researchers, policy analysts, and nursing leaders to deepen the understanding of the problem of incivility. This process will also assist in expanding the understanding of the problem of coworker incivility to craft a relevant policy to mitigate the problem and assist in policy analysis evaluating the effectiveness of an anti-incivility policy. Second, the role of workplace empowerment in supporting authentic nursing leaders within their job roles through provision of formal authority will provide an opportunity for nurse leaders to improve NGNs' job control and access to resources. Third, this dissertation contributes new understanding of the interrelatedness of roles and decision-making authority, or lack thereof, to arm nursing students with knowledge to advocate for systemic change and to further understand nursing leaders' roles. In addition, nurse educators can use my ecological model of NGNs' coworker incivility experiences to teach nursing students the relationships of workplace empowerment to formal authority within nursing leadership job roles, areas of worklife, and trust in supervisors.

Conclusion

An ecological model of NGNs' incivility experiences is a step toward clarifying that incivility behaviours are not only individual behaviours observed by others but rather a symptom of work environment factors that influence individual behaviours. Regardless of authentic leadership in assuaging impacts of organizational decisions (i.e., patient workload fluctuation; nurse-to-patient ratios; and bed moves to accommodate patient admissions), resource depletion persists without the ability to stop factors contributing to its existence (Croft & Cash, 2012; Kim et al., 2016). Focusing on the effects of a lack of workplace empowerment of nurse managers' decisional authority and power affecting nursing work environments are important steps forward

to mitigate the indirect influences on NGNs' coworker incivility behaviours.

Chapter 2: Organizational Antecedents, Policy and Horizontal Violence Among Nurses: An Integrative Review[1]

Introduction

Bloom (2014) recently defined the problem of HV among RNs as "violence in the form of action, words, and other behaviors that is directed towards one's peers. It controls, humiliates, denigrates, or injures the dignity of another. HV reflects a lack of respect for the individual" (p. 4). Internationally reported incidences of HV are widespread among RNs (Hutchinson et al., 2008). This preponderance initially appears to be a paradox, given the historical under reporting of HV acts (Vessey et al., 2010). However, research findings indicate that 65% – 80% of the nurses surveyed reported to have witnessed or experienced HV (Vessey, et al., 2009; Wilson, et al., 2011). Horizontal violence causes nurses to experience increased stress, communication barriers, and concentration difficulties (Yildirim, 2009), and the potential impact on the quality of patient care is notable (Purpora & Blegen, 2012; Vessey, DeMarco & DiFazio, 2010).

Important contextual factors of nursing practice environments (i.e., organizational culture and climate) contributing to HV may be the very factors that are fueling HV and yet remain invisible due to being enculturated through hierarchical organizational processes within health care organizations. Organizational culture refers to the values, beliefs, customs, and norms shared by organizational members or a distinctive subculture within an organization (Pilsch & Turska, 2015). Organizational climate refers to the perceptions of organizational features like

[1] Blackstock, S., Salami, B., & Cummings, G. (2018). Organizational Antecedents, Policy and Horizontal Violence Among Nurses: An Integrative Review. *Journal of Nursing Management 26(8), 972-991,* 1-20.

decision-making, leadership and norms about work (Stone, Harrison, Feldman, Linzer, Peng et al., 2005). Researchers have sometimes used the terms ‘culture’ and ‘climate’ interchangeably.

Researchers have studied HV among nurses from the perspective of the precursors/antecedents in the workplace environment (i.e., organizational antecedents), and the contributing personality types of both the perpetrator(s) and victims (Hutchinson et al., 2010; Purpora & Blegen, 2012; Rodwell & Demir, 2012). Organizational antecedents refer to systems, processes, structure, anti-HV policy, and workplace which impact the working conditions of nurses (Oliveira, et al, 2016). Organizational antecedents related to work environments, structures, and processes lead to escalation in horizontal incivility to horizontal bullying and HV (Einarsen et al., 2003). Escalation of behaviours to HV makes it difficult for policy makers to decide which behaviours to target when identifying the problem of HV. Further, it is difficult to discern what HV is and is not due to competing terms and definitions. Moreover, organizational leaders continue to grapple with the etiology of HV and its impact on the nursing profession (Clarke et al., 2012). Multiple terms, definitions, and competing theoretical concepts (Cortina et al. 2001; Einarsen et al., 2003) make it difficult for the victims of HV to have their experiences validated and for researchers and policy makers to clearly understand and define the problem of HV (Griffin, 2004).

Horizontal violence is highly influenced by organizational policies (Coursey, Rodriguez, Dieckmann, & Austin, 2013). Policies must have internal consistency among three elements: problem definition, goals, and instruments (Pal, 2014; Stone, 2002). The focus of this IR is the problem definition of the policy statement, which is the first, central element; the problem must be recognizable and easily defined (Pal, 2014). “A problem definition is a statement of a goal and the discrepancy between it and that status quo; a substantial discrepancy between what is and

what should be" (Dery, 1984, p. 4). The irony of problem definition is that while it is central to understanding the policy, it is rarely articulated in great detail in a policy statement (Pal, 2014). Policy makers (Harlos & Axelrod, 2008) and researchers (Griffin, 2004) investigated HV to formulate anti-HV policies have to reconcile multiple definitions, terms, and theoretical conceptualizations of HV, which makes it difficult to target the contributing factors and mitigate HV. The purpose of this IR is to explore the organizational antecedents related to HV among nurses and the extent to which policy initiatives reduce its incidence. We suspect that the multiple terms used to define HV may be affecting the problem definition of HV and thus the internal consistency of anti-HV policy statements. If HV problem statements within anti-HV policies are not clear, then we question whether anti-HV policies are making a difference to mitigate HV.

Defining the Problem of Horizontal Violence

Freire (2003) theorized that HV related to oppression results from a lack of recognition and value. Oppressed group behaviour theory (Freire, 1971) has been used to explain the etiology of HV, bullying, and incivility (Cortina et al., 2001; Roberts, 2015). Horizontal violence includes bullying, and psychological violence among RNs in equal positions of authority. Horizontal violence is a term that is used in this IR to capture the associated terms for the literature search.

Horizontal incivility is known to be a low intensity behaviour that occurs along a continuum that can escalate to horizontal bullying and HV. Namie (2003) conceptualized that negative workplace behaviours of incivility, bullying and physical disruption lay on a 10-point scale of organizational disruption as follows: one to three is rated as incivility, bullying covers mild to severe interference with accomplishment of legitimate organizational duties, reflecting

scores of four to nine, and the highest score is reserved for battery and homicide. Incivility comprises of a long list of negative behaviours including name calling, making rude comments, eye-rolling, and attacking a person's integrity (Lachman, 2015). Workplace incivility theoretically overlaps with workplace bullying behaviours (Cortina et al., 2001). Namie (2003) rated horizontal bullying behaviours higher in severity, compared to incivility, on the scale of organizational behaviour disruption. Research findings show that environmental factors such as laissez-faire leadership style, oppressive working conditions, and low job control contribute to the presence of incivility, bullying and HV in health care organizations (Hutchinson et al., 2010; Purpora & Blegen, 2012; Rodwell & Demir, 2012). Historically, oppressive work environments have been enculturated into the nursing profession, and sustained, as evidenced today by nurse leaders, without any formal decision-making authority (Croft & Cash, 2012).

What Is Known About Incivility and Horizontal Violence

HV is linked to decreased work satisfaction, unsatisfactory team performance, high staff turnover, and absenteeism and has the potential to impact patient safety (Armmer & Ball, 2015; Chachula, Myrick, & Yonge, 2015; Purpora & Blegen, 2015; Purpora, Blegen, & Stotts, 2015). Incivility and HV among RNs are noted to be the most difficult form of violence to deal with (Budin, Brewer, Chao, & Kovner, 2013) yet incidences remain under reported (Becher & Visovsky, 2012). Incivility was initially thought to be different from bullying because bullying involved a clear power differential between the perpetrator and victim and was usually repetitive (Torkelson et al, 2016). However, researchers developed incivility scales related to incivility by supervisors and coworkers to clarify power differentials and ensure accuracy in measurement (Read & Laschinger 2013). The etiology of incivility and lack of reporting are further complicated by the presence of social peer networks, leading to further incidences of incivility

and negative effects on the career progression of victims who report the incidents (Chipps et al., 2013). Witnesses of HV are reluctant to report the incidences due to fear of potential backlash from peers and negative impact on their career progression (Chipps et al., 2013; Croft & Cash, 2012). Thus, there is a wealth of factors that contribute to incivility, bullying, and HV in spite of well-meaning anti-HV policies to mitigate their occurrences.

Anti-HV Workplace Policy

Regardless of the anti-HV workplace policy HV remains prevalent among nurses (Vessey, De Marco & Gaffney et al. 2009; Wilson et al., 2011). Therefore, understanding the role of anti-HV policies as an organizational antecedent within health care institutions presents an opportunity to address HV (Wang, Hayes, O'Brien-Pallas, 2008) and is the focus of this review. Anti-HV policies may play a role in the creation of power imbalances when it comes to rank structure (Johnson et al., 2015; Myers et al. 2016), leading to authoritarian leadership styles, and a strong emphasis on conformity of RNs to particular institutional processes and norms of behaviour (Croft & Cash, 2012). However, health care organizations can demonstrate that employee well-being is valued by integrating and acknowledging employee health and well-being in the vision of the organization to serve as a foundation for policy development (Shamian & El-Jardali, 2007). Anti-HV policy, for the purpose of this IR, has been defined as workplace policies meant to curtail incidences of HV; for example, policies such as anti-HV, zero tolerance, workplace respect, and code pink (ANA, 2014; 2017).

Aim

This review explores research literature to explore the organizational antecedents related to HV among nurses and the extent to which policy initiatives reduce its incidence. The creation of an effective anti-HV policy will facilitate prevention and ensure appropriate actions in the

reporting of incidences per relevant protocols. The following questions guided the research strategy:

1) Which organizational antecedents are related to HV among nurses?
2) What are the policy implications of these organizational antecedents?

Methods

Design

The first author selected an IR methodology that followed the steps outlined by Burns, Grove, and Gray (2011). The steps involved "identification, analysis and synthesis of research findings from independent studies to determine the current knowledge (what is known and not known) in a particular area" (Burns et al., 2011, p. 24). Thus, the review process included identification, analysis and synthesis of research findings from both qualitative and quantitative studies to determine current knowledge in relation to HV among RNs. Steps to achieve standards of clarity, rigor, and replication for primary research were documented throughout the IR. The rigor of the IR followed the integrative stages and methods outlines by Soares' et al. (2014). Once the aim of the study and associated questions as well as the inclusion criteria and key search terms were formulated, the next steps of the IR consisted of systematic literature search, review of results using inclusion criteria, screening, data assessment, quality review, data synthesis, and reporting of results.

Search Strategy

We began the review with a systematic search of all relevant literature using key terms and MeSH terms. Retrieved citations were screened against the inclusion criteria to identify relevant and original research. The search was conducted using 18 electronic data bases: CINAHL, Medline, Psych INFO, WEB OF SCIENCE, PubMed, EMBASE, Systematic

Reviews: Agency for Healthcare Research and Quality, Prospera, ARIF, DYNAMED, Clinical Key, Nursing Reference Center, Lexicomp, CATWalk, Cochrane Database, ProQuest; Scopus, and Google Scholar. The keywords used were "workplace violence," "nurs*," "organization," "antecedents," and "policy" to find the full text of peer reviewed studies in English language, published between 2006 and December 2016, which examined factors that contribute to HV among RNs. The term "workplace violence" was used to expand the literature search to ensure articles were not missed. We chose to use the keyword "workplace violence" as it is a MeSH heading that covers all forms of violence in the workplace including HV. The literature was reviewed by first viewing the titles and abstracts to narrow the search to articles focusing on "horizontal violence." In 2006, international professional associations and regulatory bodies enacted joint position statements against workplace violence in nursing (ICN, 2006) that support the authors' rationale for the publication inclusion timeframe criteria (i.e., 2006-December 2016). Articles included both qualitative and quantitative studies and grey literature. In addition, reference lists of selected articles were manually screened, following which, six more articles were found and included (ancestry searching).

Inclusion Criteria

Titles, abstracts, and manuscripts were included in the review if they met all of the following inclusion criteria: (1) published research; (2) investigated organizational factors that lead to HV. For the purpose of this review, physical, racial, and sexual aspects of workplace violence were not included as they are separate forms of negative workplace acts, which are covered under separate policies. We excluded studies involving nursing students only, visitor and patient violence, physicians, or unclear job titles that did not indicate a nursing population (i.e.,

public sector employees). We mainly reviewed primary studies from peer reviewed journals. We excluded literature reviews and systematic reviews.

Screening

We applied the inclusion criteria and recorded results on an Excel spread sheet, specifying the rationale for the respective article's exclusion. Abstracts were reviewed twice for inclusion. Only English language, full-text articles that included RNs and HV are included. The articles were reviewed using the inclusion criteria to ensure the focus was on antecedents to HV; interventions and outcome-only studies did not meet the inclusion criteria.

Data Extraction

The data elements extracted from the included studies were author(s), journal, research purpose/questions, theoretical framework, design, setting, subjects, sampling method, measurement instruments, with respective reported reliability and validity, threats to validity and reliability analyzed, in addition to major findings, strengths/weaknesses, and quality score. The search, inclusion, exclusion, and data extraction were reviewed by two external reviewers.

Quality Assessment

The data analysis was followed by a quality assessment of each study with respect to the following: aim, sample, method/theoretical framework/assessment of HV, organizational factors, reliability/validity, analysis, major findings, and strengths/limitations. The findings from each study were reviewed for clarity, rigor, and quality assessment score, and documented in the table into quantitative and qualitative studies.

Quantitative Studies

The first author reviewed the included studies (see Table 2-1) twice for methodological quality using quality assessment tools. Quantitative studies were reviewed using a modified

version of the Quality Assessment and Validity Tool, adapted from the works of Cummings and Estabrooks (2003) and Estabrooks et al. (2003). The first author consulted with two experts to ensure the tool is appropriate for survey research; the reviewed studies used varying analysis procedures such as correlation, SEM, regression and confidence intervals. The rationale is that a quality assessment focuses on the overall survey research quality in four areas of each study: research design, sampling, measurement, and statistical analysis, which are reviewed using the tool to assess scoring (i.e., including 13 criteria for a total of 14 points). Hence, it is appropriate for assessment of the quantitative studies selected for review. Based on the assessed points, each study was assigned into one of three categories: low (0-4), medium (5-9) and high (10-14). All 16 quantitative studies were assessed to meet the aims of the research questions.

Qualitative Studies

A critical appraisal of all reviewed qualitative studies was undertaken using 10 questions from the Critical Appraisal Skills Programme (CASP, 2006) evaluation tool. Three broad questions are considered when appraising the qualitative studies: Are the results of the review valid? What are the results? Will the results help locally? The ten questions within the appraisal tool address these broad questions systematically. The answer to the first two questions from the ten questions was required to be a "yes" before proceeding with the subsequent questions: Was there a clear statement of the aims of the research? Is the qualitative method appropriate? Qualitative studies were given a score out of 10.

Data Analysis and Synthesis

Accordingly, we followed the integrative review steps (these have been mentioned earlier under the design section) for identification, analysis, and synthesis of research findings across both qualitative and quantitative quality assessment findings (i.e., scores), and then for overall themes

in all included studies. In particular, the quality assessment tools previously outlined were reviewed and each study was given a score according to the parameters outlined in each respective tool (i.e., QAVT (Cummings, Estabrooks, 2003; Estabrooks et al., 2003) for quantitative studies and CASP (2006) for qualitative studies) to obtain an overall assessment of the rigor of the included studies. The total score for each respective study was added to the Excel tables for quantitative (see Table 2-3A) and qualitative studies (see Table 2-3B). Next, the tables (Table 2-3A & 2-3B) were reviewed to outline the relationships between organizational antecedents, anti-HV policy, and HV. The first author proceeded with a descriptive numerical summary describing the characteristics of the included studies. In particular, each study was reviewed for study design, year of publication, characteristics of the study population, and country where studies were conducted. Next, the studies were compared in general to the other included studies, then contrasted and compared for common or unusual patterns. The first author identified preliminary codes for qualitative research reports after multiple readings of articles and review of the patterns in the table. Numeric analysis further assisted in analyzing the results of quantitative studies. These codes, descriptive numerical summaries were synthesized and translated into themes and structured in line with our research questions. The final steps in the analysis included writing the results section of the paper while considering the points of convergence and divergence of included studies.

Results

The electronic data base search resulted in over 1,423 titles and abstracts. The final list included a total of 22 studies, featuring 16 quantitative studies and six qualitative studies, which met all the inclusion criteria.

Quality Assessment of Included Studies

Qualitative studies were given a score out of a maximum of ten points: four points (one study); six points (one study); eight points (three studies) and nine points (one study). Quantitative studies fell into one of the three categories: low (0-4) zero studies, medium (5-9) ten studies and high (10-14) six studies. A few of the reviewed studies contained minor weaknesses (i.e., lack of random or stratified sampling, self-report bias and researcher bias), theoretical weakness (i.e., the absence of theoretical frameworks), and a lack of validation through triangulation of data.

We reviewed the organizational antecedents across studies for themes related to the research questions. The following themes were found to be related to the first question: influential working conditions; relational aspects of teams and leadership; organizational culture; climate and role of structural processes. Further, the following themes were related to the second question: leadership role and decision-making authority; and organizational structure's relationship to anti-HV policy. Qualitative study designs mainly included critical discourse analysis, interpretive, and content analysis of an open-format textual response. The quantitative study designs were primarily cross-sectional, with one longitudinal study, one mixed method and one descriptive data analysis of human resource record documentation of reported workplace violence. Of the 22 studies, seven studies were conducted in Europe, six in the United States, four in Canada, two in Korea, one in Tokyo, and two in the United Kingdom (See Tables 2- 3A& 2-3B for characteristics of included studies).

Research Question 1: Which Organizational Antecedents are Related to Horizontal Violence?

In total, 19 different organizational antecedents were found across the 22 studies. Organizational factors such as labour environment (i.e., working conditions, tasks, and

teamwork) and demographics (Ariza-Montes et al., 2013); workplace environmental factors (i.e., nursing role in quality of care/hospital affairs, staffing resources, and manager's ability); practice environment (Yokohama et al, 2016); and organizational culture (An & Kang, 2016; Yeun, & Han, 2016) are important constructs for understanding incidences of HV. The most relevant constructs used to explore organizational antecedent factors were categorized as influential working conditions, relational aspects of teams and leadership, as well as organizational culture, climate and the role of structural process (see Table 2-4).

Influential Working Conditions, Relational Aspects of Teams, and Leadership

Various studies reported influential working conditions in health care organizations. Working conditions refer to job tasks, teamwork, stress, and expectations about career growth and motivation (see Table 4). Interestingly, job control was perceived primarily at the nurse-patient level rather than being considered at the decision-making hierarchical levels that control to a great degree the influx of new patients or discharges for nursing management, patient assignment to teams and RN roles (Camerino et al., 2007; Chipps et al., 2013; Rodwell &Demir, 2012). Further, the importance of humane behaviours is captured through concepts in collegial work teams (An & Kang, 2016; Yeun & Han, 2016). However, studies indicate that team behaviours are also being observed to help younger nurses adapt to organizational norms (i.e., bullying of younger nurses) and, at the same time, they are monitored by nurse managers for signs of HV behaviours (Boateng & Adams, 2016; Kvas & Seljak, 2014; Lewis, 2006; Leiter et al. 2010; Yokoyama et al., 2016). Purpora and Blegen (2015) used theoretical concepts to create a mediation model highlighting the importance of peer relationships and job satisfaction in relation to HV; a significant finding was a statistically negative relationship between peer relationship and HV ($r=-.641$; $p<.01$). A strong work team fosters compassion, support, and

creativity, aiding in career advancement, innovation, and enables quality patient care. Further, strong work teams coupled with management support and strong leadership abilities have a negative relationship to HV (Giorgi et al. 2016; Purpora & Blegen, 2015; Rodwell & Demir; 2012; Yeun & Han, 2016; Yokoyama et al. 2016). In contrast, conflict among work teams leads to higher incidences of HV, cynicism, burnout, and turnover intention.

Organizational Culture, Climate, and the Role of Structural Processes

The most relevant characteristics observed in the 22 papers, which studied organizational culture, climate, and role of structural processes, is that they used varying conceptualizations. The interaction between work processes, structures, and its influence on career advancement (Blackstock et al., 2015; Chipps et al., 2013; Croft & Cash, 2012; Hutchinson et al, 2010; Katrinli et al., 2010) was explored in relation to horizontal bullying and violence. Hutchinson et al. (2010) demonstrated how organizational factors are incrementally related to latent organizational antecedent factors. Organizational antecedents connect through peer alliances and networks to work processes, policies, and positions of authority. The hidden behaviours that are often difficult to detect, such as informal organizational alliances among staff and social networks wherein bullying intensifies and spreads, have strong correlations to HV. An and Kang (2016) reported that the highest prevalence of bullying (45.5%) was found in hierarchy-orientated culture (i.e., regard for authority, obedience, order, stability, and strictness). Decisions made at hierarchical levels to address economic funding shortfalls often impact nursing workloads. Economical decisions that result in staff mix changes, and workload discourse resulting from institutional processes, often embody colonization and sustain nurses in oppressed organizational positions (Croft & Cash, 2012).

Organizational culture (Han, 2010) is usually understood to encompass innovation-orientated aspects (i.e., cultural aspects such as changing environment, education and challenge), hierarchical-orientated culture (i.e., authority, obedience and order), and relation-orientated impulses (i.e., comfort, spirit, and humaneness) to broaden our understanding of organizational antecedents in nursing workplaces (An & Kang, 2016; Yeun & Han, 2016). Giorgi et al. (2016) proposed a Theoretical Model of Organizational Climate, informed by the theoretical concepts (i.e., work-related stress, organizational climate, negative acts and burnout), and examined five psychological aspects: communication, leadership, job involvement, team and autonomy in relation to workplace bullying, and relationships between bullying and burnout. One major finding of the model relevant to this review indicates that organizational workplace bullying prevention programs can create buffers for mental and physical problems and promote well-being rather than relying mainly on the organizational climate (Giorgi et al., 2016; Hutchinson et al., 2010).

Research Question #2: What are the Policy Implications of These Organizational Antecedents?

We analyzed and synthesized study results related to the second question, which provided two themes: 1) leadership role and decision-making authority; and, 2) organizational structures' relationship with anti-HV policy (see Table 2-4).

Leadership Role and Decision-Making Authority

A significant finding of the review included the identification of factors that contribute to antecedents and ultimately lead to HV, difficulties faced by nursing leaders in dealing with complaints of HV and illumination of contextual factors impacting HV policies; all these factors helped clarify the problem of HV for policy analysts, health care leaders, and nursing

professionals. A common finding across studies was that leaders did not have authority or autonomy in scheduling, organizational priorities, impacting nurse-to-patient workload, nursing roles (Rodwell & Demir, 2012; Blackstock et al., 2015; Yokoyama et al, 2016), and resolving reports of HV (Lewis, 2006; Leiter et al., 2010; Myers et al. 2016). Blackstock et al., (2015) found that the embedding of fair process tenets into the design and implementation of organizational procedures and into leadership reduces bullying acts and empowers nurse leaders to deal more effectively with bullying reports.

Further research is needed to explore Rodwell and Demirs' (2012) interesting finding that morning shift workers are more likely to experience bullying than other shift workers and to discover which other factors impact the morning work environment to inform management practice and policy makers. Armmer and Ball (2015) suggest the need for nursing leadership to mitigate and prevent workplace occurrences that impact younger nurses, given these nurses' demonstrated willingness to leave their position due to HV, compared to older nurses.

Johnson (2015) examined the presence, normalizing, and control of managers, as well as a sub-theme, *presence in absentia behavior,* through interviews and organizational documents to unveil how prevention strategies failed to recognize the systemic contributions to workplace bullying rather than its solely being rooted in individuals. Manager presence or presence in absentia (i.e., giving staff the perception of presence when managers are away, through others placed in provisional authority) to monitor behaviours, role model, and enforce anti-workplace violence/bullying policy (Johnson, 2015; Johnson et al., 2015) is another significant finding. Also, variance in the managers' interpretation and enforcement of anti-HV policies was found to be inconsistent. In some cases, managers disagreed on the definition of HV within the policies

(Johnson et al., 2015) and felt they were merely relaying administrative policies and doing a surveillance of nurses to monitor for signs of HV.

Managers often felt that they found the RNs' role overwhelmed by administrative changes yet lacked decision-making authority (Croft & Cash 2012) within the organization to advocate and make changes that ultimately improve both RNs' work roles and patient care. Further, they indicated that managers must be assigned leadership authority to reconcile their own roles as mere minders of the system and their health care organizations' colonizing processes (Croft & Cash, 2012).

Organizational Structures Relationship to Anti-HV Policy

Several studies (Croft & Cash, 2012; Johnson; 2015; Johnson et al., 2015) indicated that the management and administration need to understand the role of work structures and processes in relation to HV. Blackstock et al. (2015) found that bullying perpetrators are situated within nursing hierarchical networks [that inadvertently protect them from being reported]. These findings demonstrate that anti-bullying policies fail to capture the influences of work structures and social networks in nursing practice environments that cloak and protect perpetrators (Blackstock et al., 2015). If nurse managers were given authentic authority and decision-making abilities to break down hierarchies and power imbalances that sustain RNs in an oppressed position within organizations, then the problem of HV would become clearly defined. RNs are kept in oppressed positions (Croft & Cash, 2012; Rodwell & Demir, 2012; Myers et al. 2016) by health care organizations' boards of directors and administrative structures that blind policy makers to the oppression, and thus do not derive anti-HV policies congruent with the realities of everyday nursing practice roles. A lack of clear anti-HV policies and consistent direction to management to effectively communicate, address and prevent HV results in contradictory

interpretation and application of policies (Lewis, 2006). The positioning and role of politics, workplace policies, and laws in relation to understanding HV, however, shows promise for reconceptualizing HV within health care organizational structures.

Discussion: Organizational Antecedents, Policy, and Horizontal Violence

The studies included in this review explore organizational factors in relation to HV, offering important insights into its conceptualization. The relationship between reporting structures and the position of nurses within the organization informs the anti-HV policy. The hierarchical and horizontal axes of reporting and management structures are important to be articulated within anti-HV policies; however, most of the included studies did not indicate the nature of the anti-HV policies and the reporting structures. A political analysis of HV can offer insights into the problem by understanding organizational antecedents in relation to promotion/career advancement and the interplay within health care administrative structures. Politics has special meaning from a meta perspective as well as within groups and social networks; the interplay of relationships, influence, cooperation, and loyalty combine as powerful forces, shaping and molding the behaviours of individuals within the group (Stone, 2011). It has been argued that HV is rationalized by perpetrators to serve their self-interest (Katrinli et al. 2010). However, researchers have found several potential political reasons: the influence of promotion, assignments, recruitment, and dismissal, allocation of equipment, and organizational structure decisions, all of which may be related to rationalization of HV by nurse perpetrators (Katrinli et al. 2010). Some studies included in this review did not mention politics explicitly, however, measures and themes that examined social networks impacting promotion, allocation, and organization of RN work, were present in the research.

Research Implications

This IR indicates that further research is needed to explore anti-HV policies to be able to conclude whether anti-HV policies have been effective. Johnson (2015) recommends the discourses of anti-HV policies to be integrated with the workplace and system-level issues that contribute to the problem of HV. Exploring the role of administrative structures and giving authentic decision-making authority to nursing leaders is a first step in stopping oppression in nursing. Secondly, zero tolerance policies in the workplace are remiss in conceptualizing the problem of HV; an assumption persists that bullying occurs only at individual level rather than through alliances or at the group level, thereby ensuring reports are minimized if they are reported at all (Hutchinson et al., 2010). Future researchers should determine whether the implementation of policy initiatives has reduced the incidence of HV among nurses once nurse leaders are given the decisional authority to mitigate antecedents contributing to HV and to deal with HV incidents.

Implications for Nursing Management

The results of this IR signal those responsible for mandating and applying the policies to be consistent in their interpretation and application for witnessing or dealing with reports of HV behaviours. A goal for nursing management is to develop consistency in identification of HV behaviours and application of anti-HV policy. Once consistency in conceptualization of HV and application of anti-HV occurs, then the policy analyst can accurately assess their impact on mitigation of HV. When anti-HV policies are clear then nurse managers need to be given formal decision-making authority. Formal decision-making authority and training on identification of HV behaviours and how to implement the anti-HV policy will provide a solid foundation to mitigate HV occurrences.

The findings of this IR demonstrate that colonizing practices within health care organizations sustain oppression and power inequity (Croft & Cash, 2012; Giorgi et al. 2016), which is deeply enculturated and entrenched within RNs' everyday practice yet remains seemingly protected or guarded by health care organization executives and administrators. For example: a) nurses being placed lower within healthcare organizations' reporting hierarchy as employees (Hughes & Clancy, 2009), while other professionals with privileges to the hospital are placed higher; b) nurses having many authorities to which they report to and are accountable—nurse managers, administrators, patients, and physicians (Hughes & Clancy, 2009); and c) nurse managers are not being given a formal decision-making authority.

Further, nursing managers understand the complexities of an RN's job, its demands and work stressors, and thus, they should be at the board room table to address health care funding shortfalls or changes in staffing mix. Insights from nurse managers would avoid adding complexity and job stressors to the RNs' roles and, by extension, mitigate the possibility of providing a fertile environment for HV. The review's findings provide health care organizations with evidence to break down the colonial factors that disempower and oppress RNs, resulting in HV.

Internationally, the reality of RNs' work and roles within health care organizations confounds the ability to identify HV amidst its clouded conceptualizations. This IR is a step towards expanding on the in-depth understanding of the relationship between organizational antecedents and HV, and in clarifying the interrelationships of workplace culture (An & Kang, 2016) and climate (Hutchinson et al., 2010) to HV experiences. The recognition of nurse managers' discourses with administrators, nursing staff and policy makers as integral to improving anti-HV policies will reduce instances of HV and impact the attrition of RNs.

It is time to dismantle and unveil historical organizational hierarchies within health care organizations that inadvertently propagate oppressive nursing work conditions that may acts as organizational antecedents to HV. The findings of the IR are a step to expand the in-depth understanding of the relationship of organizational antecedents to incivility and clarify the interrelationships of workplace culture (An & Kang, 2016) and climate (Hutchinson et al., 2010) to incivility experiences. Mitigation of incivility stops the progression to HV and will impact the attrition of RNs and foster a healthy work climate for student nurses, new graduates, and clinical educators.

Strengths and Limitations

This IR expands the understanding of the role of organizational antecedents in relation to HV. It further assists in exploring how anti-HV policy is perceived and enacted by managers. The fact that the research term "violence" has other meanings unrelated to psychosocial violence (i.e., sexual and physical violence) called for careful screening in the search strategy. Our search strategy did not include some relevant search terms such as "workplace bullying" and "zero tolerance policy" as they are covered under the MeSH heading of workplace violence. Further, organization and antecedents were separated as search terms to broaden the search. This limited scope could have excluded some relevant studies and could be considered a limitation; however, an ancestry search was done to address this issue. Research findings not published in English were not included, and this selection too may have excluded some relevant studies. Studies included originated from different countries across four continents, and since, nurses training, competencies and designations vary from one system to another, it posed as a potential limitation for our review.

Conclusion

It is difficult to reconcile that HV exists among RNs, given that they are the most trusted professionals, globally known for the care and compassion they show towards patients, families, and communities. However, they do not seem to always extend this care and compassion toward each other. Organizational antecedents create fertile environments for HV among RNs, despite policies meant to ensure nursing practice environments are free of HV. Given the declining numbers of RNs internationally, understanding the organizational antecedents that contribute to HV will assist in creating an anti-HV policy that reflects the realities of RNs' roles in health care organizations.

Table 2-1

Summary of Quantitative Quality Assessment

Criteria	Studies (*n*)	
	No	Yes
Design	16	0
Prospective studies Probability sampling	11	5
Sample		
Appropriate/justified sample size	12	4
Sample drawn from more than one site	4	12
Anonymity protected	9	7
Response rate >60%	14	2
Measurement		
Reliable measure of organizational factors (s)	5	11
Valid measure of organizational factor(s)	5	11
HV effects		
Is HV observed rather than self-reported?	14	2
If scale was used for measuring effects, is internal consistency ≥.70?	6	10
Was a theoretical model/framework used for guidance?	10	6
Statistical Analysis		
Appropriate assumptions addressed/managed according to analysis	2	14
Management of outliers addressed	12	4

Note. Adapted from Cummings & Estabrooks, 2003; Estabrooks et al, 2003.

Table 2-2

Summary of Critical Appraisal of Qualitative Studies

Study	Q1 Aims	Q2 Method	Q 3 Design	Q4 Sampling	Q5 Data Collection	Q6 Researcher Relationships	Q7 Ethical Issues	Q8 Data Analysis	Q9 Findings	Q10 Value
Boateng & Adams, (2016)	√	√	√	√	√	√	√	Can't tell	Can't tell	√
Croft & Cash, (2012)	√	√	√	√	√	√	Can't tell	Can't tell	√	√
Johnson, (2015)	√	√	√	√	√	Minimal information	√	√	√	√
Johnson et al., (2015)	√	√	√	√	√	Can't tell	Minimal information	√	√	√
Lewis, (2006)	√	√	√	Can't tell	Minimal Information	Can't tell	Can't tell	Can't tell	Minimal Information	√
Myers et al., (2016)	√	√	Can't tell	√	Can't tell	Can't tell	√	Can't tell	√	√

Table 2-3A

Characteristics of Included Studies

A. Quantitative Studies

Study	Sample	Method/Theoretical Framework	Assessment of Violence	Organizational Factors	Reliability/Validity	Analysis	QA Score
Ariza-Montes, A., Muniz, N.M., José Montero-Simŏ, M., & Araque-Padilla, R.A. (2013)	n= 284 Health Professionals: Medical doctors (66.9%) Nursing/Midwife (21.5%) Other health professionals (11.6%). Public (67.6%) & private (32.4%).	Survey questionnaire. European Working Conditions Survey (2010). No theoretical framework noted.	One question for self-report based on individual experience past 12 months	Labour environment & individual factors: Individual characteristics. Working conditions: Tasks; team work, stress; Working conditions; Expectation of career growth and motivation. Organizational context.	None Reported (NR)	Binary logistic regression model (intended for dichotomous variables).	3 (0-14) = Low
An, Y, & Kang, J. (2016)	n= 297 participants-convenience sample of females. 269 Staff nurses 28 Charge nurses. 298 Hospitals	Descriptive correlational study. Survey questionnaire. No theoretical framework noted.	Negative Acts Questionnaire-Revised (NAQ-R), (Einarsen & Hoel, 2001)	Organizational Culture (Han, 2002) 20 items.	NAQ-R Cronbach's alpha = .93. This study Cronbach's alpha =.94. OC Cronbach's alpha = .88 Cronbach's alpha=.79	Workplace Bullying frequency; means, SD. Difference Multivariate logistical regression.	4 (0-4) =Low
Armmer, F., & Ball, C. (2015)	n= 108 RNs from Midwestern hospital mailed a survey with 108 returned. 104 usable surveys (36%).	Descriptive, correlational design. Survey questionnaire. No theoretical framework noted.	Briles' Sabotage Savvy Questionnaire (BSSQ) 20 items; "yes," "no," or "unsure"	Michigan Organizational Assessment Questionnaire (MOAQ) Intent to Turnover measure; three items Likert like 7-point scale. Demographic questionnaire.	BSSQ α=.86 MOQ α= .83	SPSS. Descriptive Statistics * Means, SD), and percentages Pearson's Product Moment Correlation.	7 (5-9) MED

Table 2-3A (*continued*)

Blackstock, S., Harlos, K., Macleod, M.L.P., & Hardy, C. (2015)	n= 103 Staff nurses in equal positions of authority.	Descriptive, Web based survey questionnaire. A New Model of Bullying in the Nursing Workplace Organizational Characteristics as Critical Antecedents (Hutchinson et al., 2008). Theoretical constructs: Australian model bullying (Hutchinson et al., 2010). Work environment hypothesis (Hoel & Salin, 2003).	Workplace Bullying (WB) Acts (Hutchinson, et al, 2010) WBA Cronbach's' alpha =.78 Workplace incivility (WBI), seven-item scale (Cortina et al., 2001).	Hutchinson et al., (2010) (MOP), (IOA) & (OT); Fairness of interpersonal treatment (PFIT, Donovan et al, 1998); Organizational Support OS (Lynch et a., 1999); Intention to leave (Ferris & Rowland, 2987); Organizational Tenure single item to assess number of years employed by organization.	MOP Cronbach's alpha=.85 IOA Cronbach's alpha= .92 OT Cronbach's alpha=.94	Correlation Regression & hierarchical regression in a three-step regression equation.	8 (5-9) MED
Kvas, A., & Seljak, J. (2014)	n= 692 nurses (18.2%) response rate from a National registry.	Descriptive, Survey questionnaire. No theoretical model noted.	Workplace violence (WPV): 426 (61.6%) exposed to one form of violence in the past year-Psychosocial, 416 (60.1%) violence most common.	Main reasons for not reporting are the belief nothing would change.	NR	SPSS 19.0 Software. Chi-square test and t-tests. Significance level ⟨= 0.05	2 (0-4) = LO

Table 2-3A (*continued*)

Camerino, D., Estryn-béhar, M., Conway, P.M., van Der Heijden, B.I.J.M., & Hasselhorn, H. (2007)	8 EU countries ;565 health care institutions (baseline & follow-up) Baseline October 2002 and June 2003 Longitudinal: 12 months later.	Cross-sectional & longitudinal survey designs. No theoretical framework noted.	NEXT study group measure 5- point rating scale. Cronbach's alpha = .57	Interpersonal relationships, (Kummerlig et al, 2003.) Nursing Stress Scale (Gray-Toft & Anderson, 1981). Role conflict/ ambiguity (NEXT study group, 2008). Time pressure (Copenhagen Psychosocial Questionnaire, Kristensen, 2000). Satisfaction with working time (NEXT study group, 2008). Measures of dependents: Organizational commitment (adapted from Allen and Meyer, 1990). Copenhagen Psychosocial Questionnaire (CPQ, Kristensen, 2000).	IR Cronbach's alpha = .72 NSS Cronbach's alpha = .73 RC Cronbach's alpha =.69 RA Cronbach's alpha =.70 Org commit Cronbach's alpha= .78. CPQ Cronbach's alpha =.75.	Cross-sectional; hierarchical linear regression analysis. Longitudinal analysis: hierarchical regression models.	6 (5-9) = MED
Chipps, E., Stelmaschuk, S., Albert, N.M., Bernhard, L., & Holloman, C. (2013)	n= 167). Two hospitals.	Cross-sectional design survey research. Theoretical Framework: A New Model of Bullying in the Nursing Workplace: Organizational Characteristics as Critical Antecedents (Hutchinson et al., 2008)	Negative Acts Questionnaire-Revised (NAQ-R, Einarsen, et al, 2009).	Emotional Exhaustion Subscale; Maslach Burnout Inventory (MBI).	NAQ-R; Cronbach's alpha =.81 to .92 MBI, Cronbach's alpha=.91	Descriptive statistics. Inferential statistics, correlational analysis, multiple regression & logistic regression.	7 (5-9) = MED

Table 2-3A (*continued*)

Giorgi, G., Mancuso, S., Perez, F.F., D'Antonio, A.C., Mucci, N., Cupellie, V., & Arcangeli, G. (2015)	n= 658 nurses working for the Local Health Authorities (LHA) in Lecce, Italy. Convenience sample Response rate 90%;	Survey research. Theoretical framework: Negative organizational climate (job involvement, leadership, communication, team and autonomy) relationship to bullying and burnout.	Negative Acts Questionnaire-Revised (NAQ-R, Einarsen, Mikkelson, 2001).	Health Scale (HS, Magnani, Mancini, & Majer, 2009). Burnout (BIT Tool, Mancini& Magnani, 2008) Organizational Climate Majer-D'Amato Organizational Questionnaire (MDOQ10, D'Amato, & Majer, 2005).	NASQ-R Cronbach's alpha =.88 HS Cronbach's alpha =.93 BIT Cronbach's alpha=.75 MDOQ10 Cronbach's alpha= .88	Structural Equation Modeling.	9 (5-9) = MED
Hamblin, L.E., Essenmacher, L., Ager, J., Upfal, M., Luborsky, M., Russell, J., & Arnetz, J. (2015)	15,000 employees and seven hospitals. 199 Type III workplace violence incidents 2010-2012.	Descriptive data analysis, within the hospital record system's office of occupational Health Services (OHS). No theoretical framework.	Dyads were formed by examining job categories listed in the human resource database for the perpetrator and target of each incident.	A zero tolerance policy is in place for acts of workplace violence.	NR	Descriptive statistics.	2= Lo (0-4)
Hutchinson, M., Wiles, L., Jackson, D. & Vickers, M.H., (2010)	Randomized sample N=370 selected from 145 000 members of a national nursing organization mailing list.	Mixed method study, data collected from a randomized survey of Australian nurses. Theoretical Framework: A New Model of Bullying in the Nursing Workplace: Organizational Characteristics as Critical Antecedents (Hutchinson et al., 2008).	Workplace Bullying Instrument (Hutchinson et al., 2006, 2008).	Features of organizational climate (FOC) (Hutchinson et al, 2006, 2008). Misuse of legitimate organizational processes & procedures (MLOP&P) Organizational Tolerance & Reward of bullying (OT &R) Informal organizational alliances (IOA).	WBI Cronbach's alpha= .92 FOC Cronbach's alpha =.90 MLOP &P Cronbach's alpha=.90 OT &R Cronbach's alpha=.91 IOA Cronbach's alpha= .92 NoB Cronbach's alpha =.91 Consequences of bullying Cronbach's alpha= .82 NHE Cronbach's alpha=.98 W &C Cronbach's alpha = .82 W &AW Cronbach's alpha =.82	Structural equation modeling & confirmatory factor analysis. <u>Outcomes of Bullying:</u> Normalization of bullying in nursing teams (NoB) Consequences of bullying (CoB); Negative Health Effects (NHE); Work and career interruption (W &CI), Withdrawal & avoidance at work (W &A W)	9 (5-9) = MED

Table 2-3A (*continued*)

Katrinli, A., Atabay, G., Gunay, G., & Cangarli, B.G. (2010)	One hospital in Turkey. 232 questionnaires (46.4%) response rate.	Descriptive, cross-sectional Survey research. No theoretical framework reported.	Leymann's (1996) classification of 5 specific bullying behaviours:	Organizational political reasons: 10 major organizational decision domains that are mostly connected with organizational politics and based on their relevancy to the organizational antecedents of bullying. Political: Individual:	NR	Descriptive statistics Sample t-test.	3(0-4) =LO
Leiter, M.P, Price, S.L., & Laschinger, H.K. (2010).	Canadian nurses (n= 533) in three district health authorities (5 hospitals) in Nova Scotia and two hospitals in Ontario completed a survey on dimensions of Worklife. LPNs (23, 4.3%) & RN (499, 95.7%). 729 completed surveys; response rate 45%.	Questionnaire survey of one organization by generation X (born between the years 1961 and 1981). Baby Boomers (born between 1943 and 1960). No theoretical framework reported.	Civility: CREW Civility Scale (Ozaukee et al, 2009); WIS (Cortina et al, 2001) Supervisor Incivility; 5 items. Coworker Incivility: 5 items; Team Incivility. Instigated Incivility; & items	Burnout; Emotional Exhaustion & Cynicism subscales of Maslach Burnout Inventory-General Survey (MBI_GS, 1996).	MBI_GS Cronbach's alpha=.91; Cynicism Cronbach's alpha = .82. Turnover Intentions (Kelowna et al, 1999); Cronbach's alpha = .92. Physical Symptoms;(Leiter, 2005). CREW Cronbach's alpha= .88 WIS Supervisor, Cronbach's alpha = .84 WIS Coworker, Cronbach's alpha = .85 Instigated Incivility Cronbach's alpha=.74	MANOVA	5(5-9) = MED
Pupora, C. & Blegen, M.A. (2015)	n= 175 Nurses working in hospitals in California 309,940 RNs.; response rate (13.8%).	Survey questionnaire. Cross-sectional mediational model testing. (Purpora et al 2014).	Horizontal Violence NAQ-R, (Einarsen et al, 2009). Peer Violence: Peer relations subscale for work environment (Blegen et al.'s, 2004).	Job satisfaction (Blegen et al, 2004); Brayfield & Rothe's Index of Job Satisfaction (BRIJS. Work characteristics	NAQ-R α=.90. This study α=.92. Peer Violence α= .75; this study α=.76. BRIJS α= .83; this study α=.87.	SPSS 2.0. Descriptive statistics Pearson's r Multiple regression Baron and Kenny's (1986) method of testing mediational models.	9 (5-9) =MED

Table 2-3A (*continued*)

Rodwell & Demir (2012).	*N*= 273 (37.1%) Nurses and midwives from one medium to large hospital site.	A cross-sectional design. Demand-Control-Support Model (Johnson and Hall, 1988).	Bullying (Hoel & Cooper, 2000) Violence (Hesketh et al, 2003) Sources of violence	Job Demands (Caplan et al. 1980). Job Control (Karasek, 1985). Social Support (Caplan et al, 1980); The Negative Affect Schedule (PANAS, Watson, et al., 1988). Demographic Variables: tenure and work schedule.	JD ⟨=.89 JC⟨=.73 The Cronbach's alphas for supervisor support, coworker support and outside work support in the study were .88, .80 and .81, respectively. Cronbach's alpha= .77.	SPSS, 2010. Ordinal regressions.	9 (5-9) = MED
Yokoyama, M., Suzuki, M., Y. Takai, A. Igarashi, Hoguchi-Watanabe, M., & Yamamoto-Mtiani, N. (2016)	*N*= 1,152 Nurses recruited at seminars or training courses outside of their workplaces in Tokyo.	A cross-sectional survey using a self-administered questionnaire. No theoretical framework.	Negative Acts Questionnaire-Revised (Einarsen et al. 2009).	Workplace environmental factors measured using Practice Environment Scale of the Nursing Work Index (PES-NWI, Ogata et al. 2008) used to measure Healthy Work Environment (HWE).	NAQ-R Cronbach's alpha = .93 this study. PES-NWI α in this study for subscales: 1)= .75; 2) = .79 3) = .84;	Logistical regression.	5 (5-9) = MED

Table 2-3A (*continued*)

Yeun, Y.R. & Han, J-W (2016).	Five general hospitals in South Korea.	Survey questionnaire. No theoretical framework reported.	Negative Acts Questionnaire-Revised (Einarsen et al, 2009).	Organizational culture (Han). Workplace burnout: Maslach Burnout Inventory (MBI, Maslach & Jackson 1981). Turnover Intention (TI); Four questions; 5-point Liker scale. (Lawler, 1981).	NAQ-R: not reported/not reported Organizational Culture α= .88 and .85 in this study. MBI ⟨=.76 this study ⟨= .75 TI ⟨=.84 this study ⟨=.8	Correlation. Multiple regression analysis.	6 (5-9) = MED

Table 2-3B

B. Quantitative Studies

Study	Sample	Method	Assessment of Violence	Organizational Factors	Reliability/Validity	Analysis	Q
Boateng, G.O., & Adams, (2016)	n= 66 nurses (6 males & 60 females; 28 white, 38 visible minorities). Purposive sampling was used to recruit direct care nurses working in two Ontario cities, further passive snow ball sampling.	Qualitative research design, Interpretive approach using in-depth interviews.	Minority nurses feared that white Canadian nurses would think that they had insufficient knowledge and might close ranks against them. Racial conflicts. Minority nurses experienced conflicts that their white colleagues did not. White nurses closed ranks against minority nurses, discounting expertise and marginalizing them. Conflicts by age.	Conflicts over work tasks and expertise: high workload /pressure to perform, often work left incomplete and transferred to next shift which fostered conflict. Lack of teamwork fostered conflict.	MAZQDA software; three staged process of coding themes. Self-reported bias. Investigator bias & preconceptions. Saturation of data was not indicated. Validation of results.	The transcription and analysis of the narratives followed a systematic approach using software (MAXQDA) to ensure rigor and to enable a rapid identification of major strands and patterns emerging from the interviews.	Critical Appraisal (CASP) Qualitative Checklist 8/10

Table 2-3B (*continued*)

Croft, R.K., & Cash, P.A. (2012).	Qualitative Sample: Series of mini focus group sessions with between 20-24 participants in total. Each session ran approx. 1.25 hours and videotaped during September 2009.	2009 British Columbia Nurses Union (BCNU) and Union of Psychiatric Nurses (UPN) qualitative study to explore the issue of bullying and lateral violence in nursing workplaces. Postcolonial feminist approach.	A combination of actions; colonizing practices;	Nurses, managers, and organizations need to interrupt and interrogate the embeddedness of bullying and lateral violence, to create a civil workplace. 'Economy and workload' discourse. 'Lack of interpersonal skills' discourse. Prisms of understanding: 'Lack of management skills' discourse.	Institutions not recorded. Investigator bias. Due to anonymous phone interviews researchers, unable to go back to participants to verify. No indication if saturation was achieved. Ethical issues were not discussed.	Adapted Phillips, Lawrence, & Hardy's (2004) framework to unpack discourses, actions, texts, and organizational practices	CASP 7/10
Johnson, S. (2015)	Hospital unit managers (n= 15) & organizational documents (n= 22).	Critical management theory (Alveson & Deetz, 2009) Critical discourse analysis and Foucault's (180) writings on governmentality. Data were collected between January-April 2012. Data from the managers were collected via semi-structures, audio-recorded interviews that ranged from 45 minutes to 2 hours.	Examples of question asked are: How can workplace bullying be prevented? Describe your efforts to prevent the occurrence of bullying on your unit. Who has primary responsibility for preventing bullying?	Presence, Normalizing & control; and one sub-theme, presence in absentia behavior.	Rigor: research experts critiqued the finding. Critical discourse analysis: self-report bias.	Interviews transcribed verbatim and checked by researcher for accuracy. Atlas t.i. 6.2, a qualitative software program. 1. Analysis process involved a careful reading of the interviews & organizational documents. 2. Passages were grouped to themes. Initially 10 themes were identified. 3. Foucault's concepts of governmentality & Panopticon	CASP 9/10

Table 2-3B (*continued*)

Johnson, S.L., Boutain, D.M., Tsai, J.H., & de Castro, A.B. (2015)	15 hospital nurse managers from 7 organizations. Purposeful and snowball samplings were used to recruit hospital nurse managers. .	Discourse analysis to analyze interview data and policy documents. Theoretical framework: Organizational discourse theory. The basic premise of this theory is that organizational discourse, or the language used by members of an organization to discuss an issue, influences behaviour.	To examine labels that were used to name bullying-type behaviours.	Roles and responsibilities of staff/managers. Anti-bullying policy.	NR	Audio taped interviews. Primary researcher checked transcripts for accuracy. 1. Comparison of results of separate analyses of documents & interview data to examine labels to name bullying-type behaviour. 2. Examination of roles and responsibilities of staff and managers. 3. Actions that managers said they could take in response to bullying were compared with the actions outlined in the policies of their organizations. 4. Results were then critiqued by experienced researcher familiar with discourse analysis.	CASP 8/10
Lewis, M.A. (2006)	Nursing Specialist from one large northern Trust. 20 participants: 10 nurse managers and 10 clinical nurses	Unstructured interviews.	Bullying behaviours identified through vignettes and unstructured interviews.	Complex, interactive events that create and maintain nursing bullying activities.	NR	Uniting theme of symbolic interactionism; with emphasis on the situational context; role of meaning; communicative process (via symbolization) located in interpretative acts.	CASP 4/10

Table 2-3B (*continued*)

Myers, G., Côté-Arsenault, D., Worrall, P/, Rolland, R., Deppoliti, D., Duxbury, E., Stoecker, M., & Sellers, K. (2016).	Voluntary participation in a piggyback to larger cross-sectional survey study. 126 Registered Nurses. 12.5% response rate of a total of n= 1,008 nurses.	Piggyback to a larger study conducted to identify the prevalence of HV in New York State (Sellers et al. 2012). Survey. An open-ended question to the end of the survey asking "is there anything you would like to tell us about your experiences with HV? Content analysis used to analyze open-format textual responses.	Experiences of HV were indicated and themed "the plot." 35 nurses declared incidences of bullying; 42 nurses (33.3%) identified consequences stemming from HV bullying.	The setting theme found that 'across the data, HV was described at all organizational levels (individual, group/unit, supervisory/administrative, institutional) and on all shifts, illustrating the pervasiveness of the phenomenon.' A prevalent theme in nurses' comments from all three study organizations is that HV is part of the workplace culture.	NR.	One research team member without institutional affiliation reviewed files. Data were de-identified to remove specific hospital affiliation information, merged into a single text document and distributed to team members. Data contained the elements of Who, What, When, Where and How; thus, a story structure was used to describe what the RNs conveyed through their comments.	CASP 6/10

Table 2-4

Research Questions

Research Question	Themes	No. of studies per theme	Sources
1. What organizational antecedents are related to HV?	1a) Influential working conditions, relational aspects of teams & leadership	12	Ariza-Montes et al., (2013); Armmer & Ball (2015); Boateng & Adams (2016); Giorgi et al., (2016); Hamblin et al., (2015); Kvas &Seljak (2014); Leiter et al., (2010); Lewis, (2006); Purpora & Blegen (2015); Rodwell & Demir, (2012); Yeun & Han (2016); Yokoyama et al., (2016).
	1b) Organizational culture, climate & role of structural processes	10	An & Kung (2016); Blackstock et al., (2015); Chipps et al., (2013); Croft & Cash (2012); Giorgi et al., (2015); Hutchinson et al., (2010); Katrinli et al., (2010); Myers et al., (2016); Yeun & Han, 2016); Yokoyama et al., (2016).
2. Have anti-HV policy initiatives reduced the incidence of HV among nurses?	2a) Leadership role & decision-making authority	11	Armmer & Ball (2015); Blackstock et al. (2015); Croft & Cash (2012); Hutchinson et al., (2010); Johnson, (2015); Johnson et al., (2015); Leiter et al., (2010); Lewis, (2006); Myers et al., (2016); Rodwell & Demir (2012); Yokoyama et al., (2016).
	2b) Organizational structures relationship to anti-HV policy	8	Blackstock et al. (2015); Croft & Cash, (2012); Hamblin et al., (2015); Johnson, (2015); Johnson et al., (2015); Lewis, (2006); Myers et al., (2016); Rodwell & Demir (2012).

Chapter 3: Ecological Model Approach to Coworker Incivility Experiences of New Graduate Nurses

Holistic and compassionate care is the foundation of nursing and yet ironically incivility among RNs is identified as a problem in the nursing profession (Broome & Williams-Evans, 2011; Sanner-Stier & Ward-Smith, 2017). Incivility is situated at the beginning of a continuum of problematic behaviour among nurses that can escalate to bullying or violence and is usually characterized by a series of negative behaviours including name calling, the making of rude comments, eye-rolling, and attacking a person's integrity (Lachman, 2015). According to Laschinger et al., (2016), 31% of NGNs report (n=406) experiencing coworker incivility. This is especially concerning given that Canadian NGNs report that they change jobs or leave the profession for reasons related to hostile work environments and/or incivility (Chachula, Myrick & Yonge, 2015; D'Ambra & Andrews, 2014), and researchers indicate that incivility is under reported (Becher & Visovsky, 2012). New graduate nurses leaving the profession due to incivility coupled with a retiring workforce contributes to the Canadian Nurses Association (CNA) estimating a shortfall of 60,000 nurses by 2022 (CNA, 2018).

Incivility experiences contribute to stress, erosion of communication efficacy and concentration, burnout, lack of job satisfaction, and intention to leave (Laschinger et al., 2009; Laschinger et al., 2015). Researchers have found that job satisfaction is influenced by the type of nursing practice, and personal factors such as education and gender (Kalisch et al, 2010). A substantial body of research literature has examined incivility and HV as an interpersonal interaction (Broome & Williams-Evans, 2011; Laschinger et al., 2016; Spector et al., 2014). Research studies have begun to examine the link between environmental conditions and workplace incivility (Einarsen et al., 2003; Hutchinson et al., 2010; Pearson, 2005; Purpora &

Blegen, 2012; Rodwell & Demir, 2012), which aligns with my interests in examining coworker incivility from an organizational context perspective. Factors such as leadership style, oppressive working conditions, and low job control over nursing practice have been shown to contribute to incivility, bullying, and HV among registered nurses (RNs) (Hutchinson et al., 2010; Purpora & Blegen, 2012; Rodwell & Demir, 2012). Addressing incivility requires understanding where these contributing factors are located within the health care environments where nurses work. For example, an NGN may feel low job control and feel their supervisor can and should address the issue, but the problem may be located outside the supervisor's sphere of influence. Designing effective interventions, therefore, requires knowing the contributing and protective factors relating to incivility and at which level(s) they operate.

Current literature has tended to explore incivility through the lens of the NGN or nurse supervisor's behavioural interactions, paying little attention to the hidden effects of structural or organizational factors (Blackstock et al., 2018; CNA & CFN, 2018; Hesketh et al., 2003). A growing body of literature shows that interventions targeting nursing and/or nursing supervisor education and behaviours such as anti-incivility policies, graduate transition programs and educational interventions have not sufficiently addressed the problem (Blackstock et al., 2015; Blackstock et al., 2018; D'Ambra & Andrews, 2014; Evans et al., 2008; Gaffney, et al., 2012). Additionally, the type of formal transition program (e.g., orientation and preceptorship, or preceptorship alone) and the duration of the NGN transition programs might not be as consistent and have variable impacts. For example, Rush et al. (2013) found that the bullying rate of 39% among nurses (n=142) who attended a formal transition program was the same as nurses (n=100) who did not attend the program. This is consistent with the suggestion of Budin et al., (2013) that

incivility among nurses has proven to be a very difficult problem to address. These findings suggest that organizational and structural factors contributing to incivility should be explored.

In this chapter, Bronfenbrenner's ecological theory (Bronfenbrenner, 1978;1979) is applied to Laschinger et al.'s (2016) adaptation of Scott et al.'s (2008) NGSTR model. Ecological theory helps to cast light on the structural and organizational factors of Laschinger et al.'s (2016) NGSTR model to explore the question: How can an ecological approach be used to explore relationships among workplace empowerment, authentic leadership, trust in management, areas of worklife, and coworker incivility experiences of NGNs?

Purpose

Paying particular attention to NGN self-reported experiences of incivility, the exploration of organizational factors of NGN perceptions of nursing leadership and worklife was done using a hybrid model of ecological theory and the NGSTR (Laschinger et al.'s 2016) model in this chapter. The findings of the IR review (Blackstock et al, 2018) of organizational antecedents related to HV among nurses, and the extent to which policy initiatives reduce its incidence were used to inform the development of a theoretical approach to the problem of NGNs coworker incivility experiences. The IR study (Blackstock et al., 2018) as described in Chapter 2 informs the literature review conducted in this chapter that explicitly focuses on the factors relating to NGN experiences of coworker incivility before moving on to describe Laschinger et al.'s (2016) adaptation of Scott et al.'s (2008) model. Purposefully, only some of the constructs of Laschinger et al.'s (2016) adaptation are selected to explore the relationships of workplace empowerment to NGNs' perceptions of authentic leadership, areas of worklife, and trust in management to coworker incivility experiences. Bronfenbrenner's Ecological Systems Theory

(1978; 1979) is reviewed next and each variable is situated within systems to explain my ecological approach to NGNs' coworker incivility experiences, and how the application of both models contributes to the examination of incivility, paying particular attention to the organizational factors of NGN perceptions of nursing leadership and worklife. The chapter concludes with suggestions for further theoretical examination and research on contributing organizational factors to coworker incivility operating at a structural level.

The purposes of this chapter are to: a) use the constructs identified in the IR (Blackstock et al., 2018) to guide a literature review on predictive variables linked to NGN's coworker incivility experiences; b) demonstrate how the variables are situated differently in a Laschinger et al.'s (2016) NGSTR model; and c) demonstrate how an ecological model can capture the factors in an organizational context. The aim is to better inform health care administrators to locate the source of incivility within complex health care settings and mitigate NGN coworker incivility experiences (Ditmer, 2010; Laschinger et al., 2012; Trepanier et al., 2016). An understanding of coworker incivility that does not only rely on personal behavioural reform also has direct benefits for the curricula in nursing schools (Gaffney, et al., 2012), graduate transition programs (D'Ambra & Andrews, 2014; Evans et al., 2008), leadership programs (Laschinger & Fida, 2014), and policy interventions (Blackstock et al., 2015; Blackstock et al., 2018).

Integrative Review Findings

Organizational antecedents refer to systems, processes, structure, anti-HV policy, work pressure, workload, and culture atmosphere which impact nursing working conditions (Oliveira, et al, 2016). Organizational antecedents related to work environments, structures, and processes

contribute to escalation of horizontal incivility to horizontal bullying and HV (Einarsen et al., 2003). The IR findings (Blackstock et al., 2018) included themes of influence of working conditions, relational aspects of teams; leadership, organizational culture, climate; role of structural processes, leadership role and decision-making authority; and the relationship of organizational structures to anti-HV policy.

The IR (Blackstock et al., 2018) focused on structural factors relating to bullying and violence among RNs; bullying and HV theoretically overlap with workplace incivility (Andersson & Pearson, 1999; Branch, 2008; Cortina et al., 2001). Moreover, studies show these constructs may be important in understanding incivility among NGNs (Alilyyani et al., 2018; Croft & Cash, 2012; Kim et al., 2016; Laschinger & Smith, 2013; Lautizi et al., 2009; Smith et al., 2017; Spreitzer, 2007; Wong & Cummings, 2009). On a scale from one to ten, incivility ranges from one to three, workplace bullying ranges from four to nine (i.e., reflects mild to severe interference with accomplishment of legitimate organizational duties), and violence, battery and homicide are rated the highest score of ten (Namie, 2003). Incivility behaviours are at a low-intensity rating on a negative workplace behaviours ten-point scale of organizational disruption (Andersson & Pearson, 1999; Namie, 2003; Pearson et al., 2001). Thus, by studying NGNs' coworker incivility experiences at the beginning of the negative workplace behaviours scale within the organizational context, it may curtail incivility progressing to HV and violence.

Based on the IR (Blackstock et al., 2018) findings of factors in the workplace being related to NGNs' coworker incivility experiences and the literature review of factors related to NGNs' coworker incivility experiences, a theoretical approach was developed. Although it

would have been preferable to include all the factors from the IR (Blackstock et al., 2018), select constructs were justified based on the literature review. The results of the IR showed that NGNs were only mentioned tangentially, and evidence showed that they were more vulnerable to incivility. That prompted a second more focused literature review on the constructs relating to incivility as it affects NGNs. The key findings related to NGNs and incivility identified in the IR were then refined in the literature search criteria, allowing for a literature review focused on NGNs and incivility experiences.

Literature Review of Constructs Related to NGNs' Incivility Experiences

A literature search was conducted using nine databases covering a 3-year time span (2016–2019) to capture recent research evidence, other model development in the literature, and the current reality of graduate nurses practice environments. The databases are: CINAHL, OVID, PSYCINFO, PUBMED, EBSCO, ERIC, SCOPUS, Cochrane Library; PROQUEST, and Google Scholar. The following keywords and phrases were used: workplace incivility, lateral, horizontal, NGNs, organization or workplace, workplace empowerment, and authentic leadership. Inclusion criteria: peer reviewed, English, and full text. Exclusion criteria: interventions, physical, intimate partner/sexual violence, patient, physician, university, and faculty. Further, when policy and job demands-resources were included, no results were found. Bullying, lateral violence, and aggression were excluded in order to yield literature more closely related to nursing coworker incivility.

The initial search yielded 95 full-text articles published from 2016–2019 in English. Seven duplicates were removed, resulting in 88 articles for title and abstract review. Following review of titles and abstracts, 82 articles that did not pertain to incivility and graduate nurses

were excluded, leaving six articles. Reference lists from these six articles were used to identify articles with job demand resources and workplace policies on incivility, resulting in an additional nine articles, seven of which were published outside the date range but met the other study criteria and the first author chose to include. In total, 15 resources were used in the literature review.

Approach to Synthesis

The included articles were then entered into a table using the following headings: study, aim, theory, sample, methods, situational factors, work experiences, reliability/validity, analysis, major findings, strengths, and limitations. This allowed for analysis across the literature to identify contributing factors to incivility and to see what theoretical models were applied and how these affected the recommendations for mitigation strategies. The literature review findings indicated that there was little attention to NGN's incivility experiences and yet they were at high risk for incivility experiences. There appeared to be an opportunity to explore other factors associated with NGN coworker incivility experiences compared to RNs.

To better understand the theoretical approaches in the literature, I then placed the literature into two thematic categories represented in Table 3-1. Themes were identified based on factors identified in the literature that relate to coworker incivility predictors/antecedents, and work experiences related to NGNs' coworker incivility experiences. The first theme includes predictive factors, structural, organizational, and cultural, and the second theme includes NGNs' work experiences of nursing leadership, trust, job resources, and access to resources.

Results

Table 3-1 reveals four important ideas. First, workplace empowerment may be closely related to organizational culture and climate with effects to situational factors (e.g., workplace dynamics), and NGNs' workplace experiences (Croft & Cash, 2012; Laschinger & Read, 2016; Smith et al., 2017). Second, a lack of structural support for authentic nurse leaders in their job role could be creating more workplace stressors related to high patient to nursing ratios, and ultimately NGNs' incivility experiences (Croft & Cash, 2012; Kim et al., 2016; Smith et al., 2017; Spreitzer, 2007). Third, the perception of the authenticity of a nurse leader may be related to exhibiting values of fairness and trustworthiness (Alilyyani et al., 2018; Laschinger & Smith, 2013; Wong & Cummings, 2009;) by controlling NGNs' workload and fair allocation of resources (Kim et al., 2016; Lautizi et al., 2009). Further, nurse leaders regardless of their leadership style (e.g., authentic, transformative) require structural and organizational support to be effective, and although all nurse leaders might exhibit behaviours that are inauthentic at times, authentic leaders explicitly strive to role model authenticity.

Authentic leadership, perceptions of fairness and trustworthiness (Alilyyani et al., 2018; Laschinger & Smith, 2013; Wong & Cummings, 2009) implicit in the authentic leadership style were chosen, given they may be influenced by structural factors beyond the nurse leader's domain of influence. Fourth, NGN trust in the manager may be closely related to determining the level of authenticity (Kim et al., 2016; Lautizi et al., 2009).

Table 3-1

Factors in the literature

Factors: Structural, Organizational & Cultural	**Supporting Literature**
Oppression within hierarchical health care organizations is enculturated in the nursing profession and is reflected through incivility.	Cortina, Magley, Williams, & Langhout, 2001; Croft & Cash, 2012; Hutchinson, Wilkes & Jackson, 2010; Purpora & Blegen, 2012; Roberts, 2015.
Workplace empowerment: Socio-structural and psychological	Croft & Cash, 2012; Laschinger & Read, 2016; Smith et al., 2017.
Socio-structural and psychological empowerment have a positive effect in specific oppressive work contexts.	Cheng et al., 2015; Laschinger & Read, 2016; Smith et al., 2017.
Focus on productivity amidst cutbacks/nursing shortages with empowerment interventions actually disempowers employees as decision power is at top of hierarchical structures.	Kanter, 1993; Spreitzer, 2007.
Confounding effects of hierarchical structures and lack of decision-making authority of nurse leaders needs to be examined.	Croft & Cash, 2012.
NGNs' Work Experiences: Nursing leadership, trust, job control & access to resources	**Supporting Literature**
High job demands and low nurses to complete nursing tasks.	Kim et al., 2016; Smith, Morin & Lake, 2017.
Lack of formal decision-making authority of nurse leaders to control job demands & resources leads to increased incivility.	Kim et al., 2016; Smith, Morin & Lake, 2017.
Reliance of leaders to 'coach' employees' job satisfaction negates the realities of a resource depleted work environment and heavy workloads leading to increased stressors.	Kim et al., 2016; Lautizi et al., 2009.
Absence of adequate resources, no way to control job demands leads to increased stress and incivility.	Kim et al., 2016.
Fostering trust and positive emotions are critical intervening variables that Authentic Leaders enhance in their followers.	Avolio et al., 2004.
Authentic Leaders value fairness, truthfulness, trustworthiness & integrity; building confidence, optimism & resilience in the team.	Alilyyani, Wong & Cummings, 2018; Laschinger & Smith, 2013; Wong, 2013; Wong & Cummings, 2009.
Authentic Leaders influence civility norms.	Bamford, Wong & Laschinger, 2013; Laschinger & Read, 2016; Wong & Giallonardo, 2013.
Nurse leaders' lack of decisional power to control workloads.	Kim et al., 2016; Lautizi et al., 2009

The findings from the IR (Blackstock et al., 2018) and the subsequent literature review on incivility and NGNs supported further exploration of the following factors and NGN incivility

experiences: lack of workplace empowerment of nurse leaders, authentic leadership, trust, and areas of worklife (e.g., control of workload and job resources) to incivility among NGNs. In their systematic review of authentic leadership in health care, Alilyyani et al., (2018) encourage further research on the associations between authentic leadership, expressing authenticity and positive emotions (e.g., trust); thus, the respective relationships to areas of worklife and NGN incivility experiences were explored. The literature was reviewed to identify a theoretical framework to inform the development of a hypothesized model of NGNs' coworker incivility experiences that were specific to their experiences during the first years of working in nursing practice as they transitioned to the RN role.

Review of Theoretical Frameworks

Hinshaw et al. (1987) were the first researchers to apply organizational theories to nursing (e.g., pre-work, actual work, and adjustment phases) to explore how individual and organizational factors influence job satisfaction and intention to leave. Scott et al.'s (2008) NGSTR model was developed based on a comprehensive review of organizational theoretical frameworks from relevant business (e.g., analysis of business students' transition from academic to business work) and informed in part by the work of Hinshaw et al. (1987). The NGSTR model (Scott et al., 2008) captures the influence of various personal and organizational conditions on NGNs through aspects of socialization into work (see Figure 3-1), specifically socialization factors of anticipatory socialization (e.g., what happens before work) as a student nurse, to organizational socialization (e.g., what happens when work begins) as a novice nurse, and ultimately socialization outcomes (e.g., outcomes of synergy and dissonance with work environments) as a competent practitioner along a trajectory within the first two years of practice (Scott et al., 2008). Laschinger et al. (2016) use situational, mediational, and outcomes that

provide a foundation for direct and indirect causal effects of new graduate incivility experiences (see Figure 3-2) informed in part by Scott et al.'s (2008) model. The conceptual framework includes factors related to the socialization of NGNs as they transition from a student to novice then competent practitioner over the first two years of nursing practice. The framework starts with anticipatory socialization (the factors intrinsic to the student nurse), then moves to organizational socialization factors influencing the novice nurse and ultimately socialization to a competent practitioner. Scott et al.'s (2008) NGSTR model and Laschinger et al.'s (2016) adaptation of the model, is of particular interest to me, given the model purposefully includes some aspects of the workplace environments (e.g., authentic leadership, workplace empowerment, and incivility). Laschinger (2003) broadened the understanding of workplace empowerment by maintaining that the organization and its administration are responsible for creating and ensuring workplace empowerment for its leaders and nurses. Workplace environments and the effects are not typically studied in formal NGN transition programs (Rush et al., 2013).

Researchers have used the NGSTR model (Scott et al., 2008) to advance the understanding of authentic leadership to organizational change (Bakari et al., 2017), occupational coping self-efficacy relationship to NGNs job turnover intentions (Fallatah et al., 2017), and exploration of the relationships between factors, work experiences, and job-related outcomes (Laschinger et al., 2016). The NGSTR model (Scott et al., 2008) was used to link the importance of orientation to successful transition yet it was limited in application given nurse leaders often recruit NGNs to understaffed units rather than being placed with experienced nurses (Scott et al., 2008; Whitehead & Holmes, 2011). In practice, these organizational shortcomings can mean that NGNs' learning experiences are governed by a "thrown into the deep end" approach versus

strategic mentorship. Understandably, NGNs in the "thrown into the deep end" approach often feel less control over their job and less confidence in their ability (Scott et al., 2008; Whitehead & Holmes, 2011). In addition, the success of transition programs depends on appropriate work allocation and a respectful workplace culture. Work allocations and patient acuity levels must match the emerging and developing critical reasoning skills of a beginning graduate nurse; otherwise, the socialization and engagement in the workplace is put at risk (Phillips et al., 2013; 2014 a, b). A workplace culture of respect and a sense of being a valued member of the team must be present for the NGN as they transition into nursing roles to reinforce a positive work environment (Phillips et al., 2015).

Based on the research from the IR (Blackstock et al., 2018), the factors starting with the organizational context (e.g., workplace empowerment) and authentic leadership not included in Scott et al.'s (2008) original model were of particular interest. Laschinger et al.'s (2016) adaptation of Scott et al.'s (2008) framework includes authentic leadership as an antecedent with workplace empowerment leading to work experiences where incivility is situated as a workplace relationship factor (see Figure 3-2). In Laschinger et al.'s (2016) framework, authentic leadership and workplace empowerment are independent variables to incivility as a mediator variable to job-related outcomes (e.g., job turnover and career satisfaction). Recent research findings point to workplace empowerment being the antecedent to nursing leadership (Croft & Cash, 2012; Kim et al., 2016). It seemed logical to place NGNs in the nested system of Bronfenbrenner's ecological systems model (1978;1979) to allow for varying degrees of distal relationships by separating all the factors which would have been situated in the mesosystem and moving some into the microsystem. Given research exploring incivility trends toward looking at domains of influence that lie beyond the NGNs and their spheres of influence, situating the variables within

an ecological model seemed to improve the understanding of the relationships between factors at different, but interconnected, levels of the complex health care environments. Therefore, Bronfenbrenner's Ecological Theory (1978; 1979) was overlayed onto the variables identified in Laschinger et al.'s (2016) NGSTR model to capture the fact that authentic nurse leaders are physically on the unit working closely, observing, and mentoring NGNs and are a driver of empowering workplaces (Laschinger et al., 2016; Laschinger & Fida, 2015).

The portrayal of these factors in Laschinger et al.'s (2016) NGSTR model assists by substantiating the factors to NGNs' perception of nursing leadership and ultimately incivility experiences in a linear process. However, health care organizational structures, systems, and cultures within the NGNs' work environment are not captured. Thus, Bronfenbrenner's Ecological Theory (1979) was overlayed to illuminate the cultural, structural, and organizational factors related to NGNs' incivility experiences.

Ecological Theory

Bronfenbrenner's Ecological Systems Theory (1979) posits that the inherent qualities of being human are a result of their interactions with the environment that influences them over time. Bronfenbrenner originally developed Ecological Systems Theory (1979) to explain how the inherent qualities of children and their multiple environments interact, influencing how they grow and develop (see Figure 3-3). It was originally developed to improve the understanding of the influences on an individual's development over time and has been applied to a variety of organizational contexts including nursing (Copeland, 2019; Johnson, 2011). Bronfenbrenner's Ecological Systems Theory Model (1979) organizes contexts of development into five levels of external influence to capture how, from a child's perspective, they find themselves enmeshed in various nested ecosystems from the most intimate home environment/ecological system to the

larger school system interactions with peers, teachers, and caregivers, school culture, and then the most expansive systems which include society. Interactions within the systems and how groups or individuals interact with the child affects how they grow and develop as human beings. Bronfenbrenner nested these systems to capture the concurrent influence of each on the child's life over their lifespan. Each of these ecological systems interacts with and influences each other in all aspects of the child's life. According to Bronfenbrenner's Ecological Systems Theory (1979), if a child's parents are actively involved in the friendships of their child then the child's development is affected positively through harmony and like-mindedness. If, however, the child's parents dislike their peers and openly criticize them, then the child experiences disequilibrium and conflicting emotions, which may likely lead to negative development (Bronfenbrenner, 1979). Bronfenbrenner's Ecological Systems Theory (1979) is portrayed within the Ecological Theory Model (Bronfenbrenner, 1979) to delineate system levels and show the interdependence of the child's environment. Bronfenbrenner's Ecological Systems Theory (1979) suggests that human experiences are a result of factors influencing them from various levels of their environment over time (e.g., chronosystem). Bronfenbrenner formulated the Ecological Systems Theory (1979) to explain how the inherent qualities of children, and their multiple environments interact as they grow and develop. More specifically, the child's development is situated within nested and interconnected ecosystem domains beginning with the intimate home environment (e.g., microsystem) expanding to the larger school system interactions with peers (e.g., mesosystem), teachers and caregivers (e.g., exosystem), school culture (e.g., macrosystem), over time (e.g., chronosystem), and then society at large. Given the interactional effects of the ecosystem domains, Bronfenbrenner's Systems Theory was applied to this study, to theorize that NGNs' experiences are shaped by their environmental working

conditions. Within the working conditions are the impacts of structural leadership processes, policies, and practices that situated nursing leaders in NGNs' work environment as mere minders of the organizational system without formal authority in their job roles noted previously. As shown in Figure 3-3, Bronfenbrenner's Ecological Systems Theory (1979) is portrayed within the Ecological Theory Model (Bronfenbrenner, 1979). The five levels of external influence are: microsystem (NGNs' immediate work environment); mesosystem (NGN's work relationships and connections); exosystem (indirect environment), macrosystem (health care organization social and cultural values); and the chronosystem (professional or organizational history).

Bronfenbrenner's Ecological Systems Theory (1979) has been used to address theoretical gaps in sociology, education, and nursing. For example, it has been used to frame a culturally relevant environmental education program to address gaps in environmental education and explore oppression of indigenous cultural groups and exploitation of nature to unearth racism and move toward ethical stewardship of the land (Sutherland & Swayze, 2012). Copeland (2019) developed a Model of Moral Ecology to bridge gaps between ethical theory and nursing practice. Johnson (2011) attempted to theoretically situate nursing bullying factors in four domains of Bronfenbrenner's (1979) model (microsystem, mesosystem, macrosystem and exosystem) along a three-stage continuum: a) bullying factors; b) the bullying event; and, c) bullying outcomes. Although Johnson's model (2011) was not applied in a research design, it explores the interconnectivity of the three stages within the four ecological domains; however, it excluded structural variables identified in the literature related to incivility such as characteristics of the nurse leader and workload fluctuations. In addition, Johnson's theoretical model (2011) infers Bronfenbrenner's chronosystem (measuring change over time) in the progression of bullying, to the bullying event, and ultimately the outcomes of bullying. Johnson's (2011) ecological theory

has been used to guide intervention research on workplace bullying (Blakey et al., 2009; Johnson, 2011; Merkel et al., 2020), identify organizational characteristics related to bullying behaviours in public health nursing (Sharma, 2019), identify risk factors for interpersonal violence (World Health Organization, 2020), and shows promise to explore gaps in theoretical models and predict linkages (Fulton et al., 2019). Predictive linkages between factors and NGNs' incivility experiences could guide short-term tactical decision-making (e.g., allocating decision-making authority to nurse leaders) and long-term strategies (e.g., analysis of anti-incivility policy). In fact, Bronfenbrenner's Ecological Systems Theory (1978;1979) has been hypothetically applied to the nursing context.

Johnson hypothesized a bullying in nursing ecological model which shows promise to frame my theoretical exploration of how structural factors beyond the individual (microsystem) domain affect incivility among NGNs. This theoretical framework/model showed promise to explore the organizational context and the related factors to NGNs' coworker incivility experiences. This is important as the focus on individual behaviour has contributed to a theoretical and empirical understanding of incivility that remains firmly situated at the level of the individuals and not understood as a systems issue.

Documenting predictive relationships between mesosystem, exosystem, and macrosystem factors and NGNs' incivility experiences could guide short-term tactical decision-making (e.g., allocating decision-making authority to nurse leaders) and long-term strategies (e.g., analysis of anti-incivility policy). Similarly, NGNs work within nested systems influencing their work on the date of hire and onward, dealing with role demands, stressors, and supports within their work environments. New graduate nurses' work environments are a result of nested influences of health care organizational structures and systems with nursing systems.

Bronfenbrenner's Ecological Systems Theory (1979) was chosen over other ecological theories given a systems theory approach is commensurable with nursing systems and health care organizational systems. Bronfenbrenner's Ecological Systems Theory (1979) acknowledges the interrelatedness of an individuals' evolution (e.g., at the core of the model) amidst demands, stressors, and supports influencing their environments. Similarly, NGNs work within nested systems influencing their work on the date of hire and onward dealing with role demands, stressors, and supports within their work environments. New graduate nurses' work environments are a result of nested influences of health care organizational structures and systems with nursing systems and seem to be experienced as effects directed toward NGNs at the core of the experiences. Accordingly, the variables from Laschinger et al.'s (2016) adaptation of Scott et al.'s model (2008) were situated within the ecological model in Figure 3-4. The diagram shows that many of the variables are either reasonably situated outside the NGN's microsystem sphere of control or are likely linked with factors outside that sphere. While there will be references to the macrosystem and chronosystem (change over time), these were not the primary domains of this chapter given that the data driving my theoretical exploration was point in time data that did not focus on macrosystem or chronosystem factors. New graduate nurses' self-reported perceptions of experiences with incivility (microsystem) are linked to perceptions of authority, job control, trust, and the concept of authentic leadership by their immediate nursing supervisor and their associated spheres of influence (mesosystem). The organization or exosystem also supports or hinders this relationship by broader public health policies such as legislation, government funding, and anti-bullying laws (macrosystem). The impact of the chronosystem or time also plays a role in understanding incivility (professional and organizational history).

Importantly, using an ecological approach to explore the organizational factors related to NGNs' incivility work experiences is rooted in research evidence demonstrating the link between organizations and employee bullying behaviours (Blakey et al., 2009; Johnson, 2011; Merkel et al., 2020). It may provide insights into factors contributing to the early onset of negative workplace behaviours in the form of incivility experiences, rather than waiting for bullying behaviours to surface. Information on these factors will expand our understanding of opportunities for health care administrators to re-orientate organizational structures to situate nurse leaders to control NGNs' workloads and be responsive through being able to provide appropriate resource allocation (e.g., human, financial, and material).

Ecological theory was used to explore the relationships between a nurse leader's control and a NGN's self-reported experiences of incivility among their peers and their evaluation of a supervisor's authentic leadership (Kelly & Abern, 2009). The judgment of the nurse supervisor leadership by the NGN is then related to the supervisor's lack of workplace empowerment support within their job role to control adverse organizational factors operating at an exosystem level. However, ecological theory on its own does not explain the factors and directionality of the relationships of the organizational factors (e.g., workplace empowerment) to mediator factors of NGNs' perceptions of leadership and the effects which are accounted for nicely in the adapted Laschinger et al.'s (2016) NGSTR model. This suggests that overlaying ecological theory onto Laschinger et al.'s (2016) model would be a useful approach.

Overlaying Ecological Theory onto Laschinger et al.'s (2016) NGSTR Model Variables

The ecological approach to NGNs' incivility experiences as shown in Figure 3-4 was adapted from Bronfenbrenner (1979) and consists of four concepts: a) microsystem worklife

work experiences (e.g., NGNs' experiences of coworker incivility); b) mesosystem behaviours of nurse leaders (e.g., trust, authentic leadership, and areas of worklife); c) exosystem (e.g., workplace empowerment); and, d) macrosystem (e.g., cultural norms of incivility in nursing and incivility theory). Although the macrosystem is important, for the purposes of this study, the microsystem, mesosystem, and exosystem were explored given there is little research in these areas. This is a limitation of the study and future researchers may want to consider this area. NGN's experiences (microsystem) are linked to the authentic leadership of their immediate nursing supervisor and their associated spheres of influence (mesosystem). The associated spheres of influence are affected by the organization (exosystem), and ultimately by broader public health policies such as legislation, government funding, and other variables such as anti-bullying laws (macrosystem). The element of time (chronosystem) in the historical development of the organization (hospital) was noted in the approach; however, I focused on the three aforementioned systems. I primarily explore the interconnections between factors within and among the micro-, meso-, and exosystem levels based on the findings from the IR (Blackstock et al., 2018) and literature review.

Ecological theory acknowledges that individual experience is influenced by factors in a nested layer of hierarchical systems, suggesting that microsystem incivility experiences for NGNs' is influenced by factors situated at other levels of the model. For example, NGNs' workload changes leading to job strain (e.g., change in patient assignments, increasing patient acuity without RNs to take on additional workload). Job strain occurs due to the disequilibrium between job demands and the resources employees have at their disposal (Bakker & Demerouti, 2007). High job demands and low job control are important predictors of psychological strain and illness (Karasek, 1979; Schnall et al., 1990). Increased stress and psychological strain are

fertile environments for negative emotions and conflict. Put in ecological theory terms, existing research on incivility among nurses has been limited to explorations of factors located within and between the micro- and mesosystem levels based on the findings from the IR (Blackstock et al., 2018) and the literature review (see Table 3-1). While useful, the lack of focused consideration of exosystem, macrosystem, and chronosystem factors may result in the codification of incivility as an individual versus a systemic issue. Workplace factors influence the risk of NGNs' incivility experiences through individual (i.e., character), social (i.e., formal and informal work team interactions), and organizational factors (i.e., job characteristics, leadership, and organizational structures and processes), positively and negatively (Howell, 2016). Inhibiting factors of incivility occur at individual (i.e., management of workload, control, and fairness), social (i.e., work cohesion, respect, and communication), and organizational (i.e., manageable workloads and career advancement opportunities) levels (Howell, 2016). Enabling factors of incivility occur through individual (i.e., stress, fatigue, and personal issues), social (i.e., organizational alliances and workgroup behaviours), and organizational levels (i.e., restructuring and organizational constraints). New graduate nurses' experiences of inhibiting and enabling factors are compounded by many feeling unprepared for practice given the time pressures, new roles, and responsibilities (Higgins et al., 2010). In the following section, I describe the importance of the Laschinger et al.'s (2016) variables within the domains that are a focus of my research (microsystem, mesosystem, and exosystem).

Microsystem

The microsystem level is composed of the perpetrator and the victim of incivility. At a microsystem level, new graduates initially struggle to get job tasks completed within their shift

and may have their work performance critiqued and subjected to unsupportive, uncivil behaviours by more experienced nurses (Zeller et al., 2011). These negative behaviours result from experienced nurses enculturating incivility as an accepted cultural norm; historically, enculturated hazing practices are modern day occupational hazards of nursing (Howerton et al., 2010). Hazing practices are meant to toughen up and test novice or newly hired nurses (i.e., regardless of experience) to see if they can demonstrate their competence. Specifically, on a micro level, NGNs are a high-risk group for experiencing incivility (Ditmer, 2010; Laschinger et al., 2012; Trepanier et al., 2016) because their inexperience is linked to increase stress, erosion of communication efficacy, and concentration, burnout, lack of job satisfaction, and intention to leave (Laschinger et al., 2015; Laschinger et al., 2009). However, Hawkins et al. (2019) suggest authentic leaders operating at the mesosystem level play an integral role in reducing NGNs' exposure to incivility and burnout.

Unfortunately, according to self-reporting surveys results, NGNs' perceptions of their supervisor's authentic leadership ability decrease as the NGNs' organizational tenure increases (Laschinger & Read, 2015). Moreover, exosystem (e.g., lack of workplace empowerment of nurse leaders) and macrosystem (e.g., workplace culture that condones coworker incivility) factors placed beyond the authentic leader's sphere of influence can also affect the nature and incidence of negative workplace environments (Einarsen et al., 2003; Hutchinson et al., 2010; Pearson, 2005; Purpora & Blegen, 2012; Rodwell & Demir, 2012). For example, environmental factors such as leadership style, oppressive working conditions, and low job control over nursing practice contribute to the presence of incivility, bullying, and HV (Hutchinson et al., 2010; Purpora & Blegen, 2012; Rodwell & Demir, 2012). However, nursing leaders operating at a mesosystem level lack formal authority within their job role; they are mere minders of the health

care organizational system (Croft & Cash, 2012), relaying decisions made by those in administrative positions (Johnson et al., 2015). Although challenging job demands can promote personal growth through problem-solving, and coping (Khan, 1990; Lazarus & Folkman, 1984), I suspect the higher levels of job demands means NGNs cannot respond effectively to each demand (Croft & Cash, 2012: Kim et al., 2016; Wilson, 2016). When job demands are high it leads to a sense of no control over their workload. New graduate nurses look to their authentic leader to mitigate job demands (Croft & Cash, 2012). Job demands, regardless of whether they challenge or hinder work, influence both relationships and can activate an energy depletion process building up tensions and strain potentially leading to burnout (Crawford et al., 2010).

Most new nurses have insight into the professional nursing standards shaping their recent academic training experiences and may become appropriately concerned when nursing workloads exceed registered nursing staff to patient ratios (Croft & Cash, 2012: Kim et al., 2016; Wilson, 2016), and the acuity of the patients exceeds nursing staffing (CNA & CFN, 2018). Perhaps NGNs are more prone to believing that workload matters fall within the exclusive domain of their authentic nurse leader without attenuating to exosystem and macrosystem factors that may be inhibiting the supervisor's efforts to mitigate the problem.

NGNs' responses to transitioning to nursing roles are amplified by negative workplace experiences (CASN, 2018; CNA, 2019; Zeller et al, 2001). I have not suggested workload factors, such as the number of patients or incivility experiences only occur with NGNs, nor are they more likely to suffer from incivility experiences. Rather, I wanted to explore the multidimensional factors contributing to NGNs' negative workplace experiences (CNA, 2019; CASN, 2018; Zeller et al., 2001). Past conceptualizations of incivility and conceptual differences (Hutchinson et al., 2010) do not capture the current "real world" realities of the nursing practice

environment for graduate nurses (Kring, et al., 2008). New graduate nurses' work was situated amidst fluctuating factors operating at different levels of the ecological model; for example, research on the impact of identification and control of workload factors such as the number of patients per nurse, the acuity of patients, and the stressors of transitioning from an NGN to more seasoned nursing roles (D'Ambra & Andrews, 2014).

Mesosystem: Authentic Leadership, Trust, and Areas of Work Life

The mesosystem level consists of the immediate workgroup of coworkers of the perpetrator and victim of incivility, the nurse leader, role stressors, low social support, low job control, high job demands, and leadership styles. An important aspect of workplace behaviours are the two interrelated factors of the work environment and the employees' behaviours (Lewin's Heuristic Theory, 1936). Importantly, Lewin's Heuristic Theory (1936) strongly influenced the development of Bronfenbrenner's theory (Bronfenbrenner, 1978). Bronfenbrenner attempted to provide psychological and sociological substance to Lewin's Heuristic Theory (1936) to capture the dynamic relation between person and situation (Bronfenbrenner, 1978). In the context of the theoretical approach used in this study, this means individuals through their job roles, actions and/or behaviours can mitigate or exacerbate incivility as a nurse leader or as a peer. For example, a nurse leader may mitigate or exacerbate coworker incivility through control over NGNs workload (e.g., acuity of patient assignments, fair allocation of resources) and ultimately work stressors. In addition, perceptions of trust of their immediate supervisor/nurse leader are based on a congruency between their authentic behaviours and actual management of NGNs workload assignment as noted below. On an individual level, an NGN can mitigate or exacerbate incivility passively through ignoring the behaviour or by actively contributing to incivility in support of the perpetrator or victim.

The approach to NGNs' incivility experiences, adapted from Bronfenbrenner's Ecological Systems Theory (1979), is shown in Figure 3-4. Below, each variable used in the hypotheses are reviewed through a discussion of the interrelated factors that contribute to workplace incivility experiences of NGNs.

Authentic Leadership. Authentic leaders' practice and value fairness, truthfulness, and integrity (Wong & Cummings, 2009). They build positive psychological capacity of their followers through strengthening confidence, optimism, and resilience in the shared vision of the team and each team member's contributions (Alilyyani et al., 2018). Authentic leaders exhibit a high level of relational transparency by being truthful and open to other's ideas, challenges, and opinions (Wong & Laschinger, 2012). Authentic leadership influences NGNs' perceptions of civility norms and mitigate job strain in the nursing practice areas in preventing early career burnout and coworker incivility (Laschinger & Read, 2016). Relationships between authentic leadership, trust, areas of worklife (e.g., workload, fair allocation of resources), and incivility experiences of NGNs were proposed.

A lack of workload control and perceptions of resource depletion related to unfair allocation of resources have been directly related to incivility experiences (Croft & Cash, 2012; Kim et al., 2016). These factors are located within the mesosystem level, given the direct relationship to behaviours of the nurse leader and NGNs' perceptions of the authentic leader in relation to their workloads and resource allocation. New graduate nurses are likely overwhelmed and stressed due to heavy workloads and inexperience (Hawkins et al., 2019), and therefore the relationship of perceptions of the nurse leader's control over NGNs' workload to incivility experiences needs to be examined. For example, an NGN may return from a dinner break and be assigned a whole new group of patients, have patients on stretchers in hallways or supply rooms,

and patients transferred across the ward from another team. These daily workload challenges mean NGNs' workload never seems to stabilize (Kring et al., 2008), and are exacerbated by low staffing levels (Ball et al., 2014; Francis, 2013). A sense of stabilization and manageability of workloads typically occurs once NGNs are familiar with patients, medications, and treatment times—typically when they are starting their first shift in a series of shifts. When patient assignments are in flux and job demands increase without a stabilizing period, this adds to the NGNs' job demands (Charette et al., 2019). When job demands are unstable or increase, it can lead to increased stressors and tensions among team members on the ward with the potential to contribute to incivility experiences among nurses. For NGNs, this stressor is magnified when combined with becoming familiar with their NGN roles and responsibilities (Zeller et al., 2011). Nurse leaders are left to mitigate the impacts of the admissions, sometimes assisting with, or navigating miscommunication to decrease the impact of transfers and reallocation of patients among teams without formal decisional authority to control the inflow and outflow of patients.

Trust in Immediate Supervisor. The Trust Inventory (Norman, 2006) was adapted by Cummings and Bromiley (1996) and further modified by Wong (Wong & Laschinger, 2012). The Modified Trust Inventory (Laschinger & Wong, 2012) reflects NGNs' perceptions of areas of trust of the immediate supervisor's competence, reliability, honesty, establishment and communication of expectations in a fair manner, truthfulness (e.g., in keeping their word, relaying true statements), and overall trustworthiness. Authentic nurse leader role model trustworthiness (Wong & Laschinger, 2012), and yet they lack formal authority to mitigate/control NGNs' workloads. Nurse leaders all lack formal authority within their job role regardless of the style of leadership (i.e., authentic/inauthentic, transformative, collaborative); thus, they do not have the ability to influence NGNs' workloads. Authentic leaders are the root

of positive leadership models such as transformative, ethical, and servant (Avolio & Gardner, 2005); thus, it makes sense to start with this leadership style. All nurse leaders might exhibit behaviours that are inauthentic at times; however, authentic leaders explicitly strive to role model authenticity. Authentic leaders role model core values of overall trustworthiness (Laschinger, Wong & Grau 2012), and NGNs may experience a breach of trust in the authentic leader, inauthentic, and other leadership styles (e.g., transformative), given the lack of workplace empowerment support of the nurse leader to mitigate high job demands, and provide additional human resources even when nursing workloads exceed registered nursing staff to patient ratios (Croft & Cash, 2012: Kim et al., 2016; Wilson, 2016). This means the combination of the high numbers of patients beyond ward capacities and higher acuity levels of patients exceeds the ability and capacity of nurses to complete nursing tasks and patient care duties (CFN & CAN, 2018)

Areas of Work Life. Authentic leaders positively influence civility norms through the optimization and perception of areas of worklife match as graduates begin their nursing career (Bamford et al., 2013; Laschinger et al., 2015; Laschinger & Read, 2016; Wong & Giallonardo, 2013), and areas of work life match (e.g., person-job fit) mediate the effect of authentic leadership on nurse engagement (Laschinger et al., 2015). Areas of worklife (Leiter & Maslach, 2004) relates to six key areas including: workload (job demands); control (able to influence management to obtain resources, autonomy); rewards (appreciation, recognition, or compensation); community (sense of belonging/cohesiveness with peers at work); fairness (perceived justice); and values congruence (e.g., match between employee and organization priorities and value). When areas of worklife are poor, burnout is likely to develop (Laschinger & Read, 2016). I argue a similar importance of the areas of worklife (Leiter & Maslach, 2004) in

relation to negative work experiences of incivility among NGNs given high job demands and a lack of adequate resources leads to incivility (Kanter, 1984). This process occurs when employees experience an absence of adequate resources (i.e., sufficient number of nurses), a lower perception of resource effectiveness of authentic leaders, and no way to control the job demands which leads to a sense of being stretched or succumbing to resource depletion (Ball et al., 2014; Francis, 2013; Kim et al., 2016). The inability to control job demands is of interest as I examine the role of areas of worklife (e.g., control of work, fair allocation of resources). A resource depletion scenario has potential to progress to increased stress, psychological strain, and ultimately incivility (Kim et al., 2016).

New Graduates Nurses' Perceptions

When new graduates perceive job demands as low then perception of job control increases (Croft & Cash, 2012; Kim et al, 2016; Laschinger et al., 2016). It is logical to propose there will be a significant linear relationship between NGNs' areas of worklife and coworker incivility experiences. Job strain occurs as a result of the disequilibrium between job demands and the resources employees have at their disposal (Bakker & Demerouti, 2007). In addition, there may be a significant linear relationship between areas of work life experiences and NGNs' perceptions of trust of their authentic nurse leader. New graduate nurses' perceptions of the ability of the authentic leader to find resources and make changes because of organizational hierarchies has been rated as lower as new graduates become familiar with the authentic leader's role and the decisional authority. The lower rating of resource effectiveness will mean a lower rating in relation to NGNs' perceptions of an empowering environment.

New graduate nurses working in resource-depleted environments (Ball et al., 2014; Francis, 2013) may experience increased stress and psychological strain, thereby creating fertile

environments for negative emotions and conflict. Currently, most nursing leaders lack formal authority within their job role to stop admissions or patients being moved from room to room on wards and encounter the impacts of lack of human resources. Regardless of the nurse leader's leadership style (i.e., authentic, transformative, collaborative), they may lack formal authority to control job demands of NGNs (Duncan et al., 2014). When NGNs perceive a sense of futility to meet job demands combined with a decrease in competence and no self-control (Kim et al., 2016), energy may be expended on frustration and anxiety (Harter et al., 2002). The frustration and anxiety could result from incomplete work and judgment from peers—leading to incivility experiences.

Subsequently, when NGNs do not have adequate resources to complete job demands during their shifts, they may leave work undone for the oncoming shift. Judgment of prior shifts' work being incomplete may occurs and result in nursing staff starting their shift feeling overwhelmed with job tasks and striving to provide adequate patient care (Kim et al., 2016). Thus, it follows that resource depletion (i.e., not enough RNs per patient workload) could be positively related to perceptions of the degree of authenticity of authentic leadership behaviour being diminished by a lack of workplace empowerment (Croft & Cash, 2012). Furthermore, all elements described in this section could be explained by factors outside of these spheres, so it is important to consider the influence of factors situated within the exosystem.

Exosystem

The exosystem includes the health care organization as a whole, inclusive of organizational and administrative structures, unions, and organizational policies. In Canada, there has been gradual and varying incremental changes in laws to address negative workplace behaviours such as workplace violence, bullying, and harassment, according to provincial and

territorial laws that precipitate mandated organizational workplace policies. At the organizational level, information on workplace violence, harassment, and bullying policies would be included in this system. For example, nurse leader's awareness of the policy, and their understanding of their role in enforcement.

In addition, NGNs need to be aware of the workplace violence, harassment and/or bullying policies, reporting mechanisms, and supports in the event of time off from work. A key aspect of my model are the conditions of the exosystem having inward effects to incivility experiences of NGNs such as workplace empowerment. I focused on the lack of workplace empowerment (e.g., socio-structural and psychological empowerment) of nurse leaders within this system to critically review the relationship to NGNs' perceptions of authentic leadership and incivility.

Workplace Empowerment. Workplace empowerment consists of socio-structural empowerment and psychological empowerment (Spreitzer, 2007). Socio-structural empowerment perspective is about power sharing (e.g., formal authority or control over organizational resources) through delegation of responsibility through the organizational chain of command (Spreitzer, 2007). This means the power of having formal authority or control over organizational resources, and the ability to make decisions relevant to a person's job or role (Lawler, 1986). A key element of socio-structural empowerment is relevance; in the nursing context this means empowered nurses and nurse leaders should have the power to make decisions that fit within the scope and domain of their work (e.g., nurse leadership delegation of workload and allocation of resources), and ultimately mitigate NGNs being overwhelmed and stressed.

Psychological empowerment is a mediator between socio-structural empowerment and

individual or organizational outcomes (Both-Nwabuwe et al., 2020; Oswick & Oswick, 2020; Spreitzer, 2007). Critical and post-modern theorists argue the roots of empowerment are seen as shared power between organizations and employees and is dominated by an organizational focus on employee productivity (Bartunek & Spreitzer, 2006). The focus on organizational productivity in an era of organizational fiscal cutbacks (and nursing shortages) can lead to empowerment interventions and union involvement that disempowers employees, as decisional power of nurse leaders varies, and is constrained at the top of hierarchical organizational structures (Both-Nwabuwe et al., 2020; Oswick & Oswick, 2020; Spreitzer, 2007).

Psychological empowerment results from socio-structural empowerment and contributes to improved outcomes such as satisfaction, positive workplace retention (Cicolini, et al., 2014), interprofessional collaboration (Reagan, et al., 2016) and low levels of incivility (Laschinger, et al., 2009; Lautizi, et al., 2009). Psychological empowerment is related to the exosystem, given it is reflected by actualizing administrative policies and procedures to support NGNs (e.g., hospital orientations, buddy shifts with staff members, and opportunities for career advancement). In my approach, I anticipated a relationship from a lack of workplace empowerment without support of authentic leaders who displayed a lack of formal authority within their job role. Laschinger et al.'s (2016) Starting Out Study explored personal (e.g., demographics, psychological capital, occupational coping self-efficacy) and situational (e.g., authentic leadership, workplace empowerment, support for professional practice, person-job fit and new graduate nurse support) factors that they hypothesized to influence NGNs' early career retention. They situated the personal and situational factors within a linear transition to practice conceptual model they derived from Scott et al.'s (2008) New Graduate Successful Transition and Retention Model. In addition, work experiences were added as a mediating factor (e.g., work relationships of

incivility and work stressors (e.g., burnout and work/life interference). They used hierarchical linear modelling to test whether authentic leadership positively related to NGNs' job and career satisfaction, while having a negative effect on their job and career turnover intentions. The researchers looked at the positive influence of workplace empowerment on job and career satisfaction (Laschinger et al., 2016). This study differs from Laschinger et al.'s (2016) Starting Out Study, given : a) select variables from Laschinger et al.'s (2016) New Graduate Transition Model were used; b) the variables were situated within an ecological model of NGNs' co-worker incivility experiences; c) multiple linear regression to test whether there was a negative relationship of workplace empowerment, to NGNs co-worker incivility experiences while controlling for the effects of areas of worklife and authentic leadership. This study was informed in part by literature indicating workplace empowerment and authentic leadership were shown to positively influence NGNs' responses to their work settings (Laschinger et al., 2016) and promote civility (Laschinger & Read, 2016). Laschinger and Read (2016) used structural equation modelling to examine how authentic leadership and person-job fit influence civility norms and how they, in turn affect co-worker incivility, and emotional exhaustion. NGNs' perceptions of their managers' authentic leadership behaviors were positively related to person job fit, leading to higher perceptions of civility norms and thus less frequent co-worker incivility (Laschinger and Read, 2016). This was a key factor in my ecological approach to a model of incivility experiences of NGNs and reflects a lack of workplace empowerment of authentic nursing leaders to key aspects of NGNs' areas of worklife (e.g., control of work, fair allocation of resources).

A great deal of research has focused on how to empower workers in human resource depleted environments by relying on leadership skills of managers to increase employees'

personal and professional work satisfaction (Lautizi et al., 2009). The reliance of leaders to coach employees' job satisfaction negates the realities (Kring et al., 2008) of the resource-depleted work environment, and heavy workloads that lead to job stressors (Kim et al., 2016; Lautizi et al., 2009). In fact, a resource-depleted environment and a lack of control over nursing workloads may contribute to a lack of workplace empowerment; thus, workplace empowerment was included in the model given the relationship of positive organizational contexts to authentic leadership-performance link (Gardner et al., 2005; Luthans & Avolio, 2003). Organizational hierarchy within the conceptual model was located at the beginning with core variables, shaping, and affecting the multidimensional workplace (i.e., authentic leadership, lack of workplace empowerment of authentic leaders to mitigate NGNs' workload). Relationships between authentic leaders, trust, worklife control, and authentic leaders' lack of workplace empowerment support as evidenced by a lack of formal authority in their job role were added to the model. Authentic leaders can be effective in obtaining resources; however, the effectiveness is based on the availability of job resources, and ultimately impacts the NGNs' job demands. Further exploration of the impacts of NGNs' workload indicated will be explored in future studies. For example, the impact of patient assignment changes, high acuity patient, and over safe patient-to-nurse ratios (e.g., high census of patients and not enough RNs to safely provide care) are indicated as these factors may mediate the authentic nurse leader's resource effectiveness and subsequent NGNs' emotional exhaustion.

Interplay Between Micro-, Meso-, and Exosystems

In this theoretical chapter, the development of coworker incivility experiences of NGNs, was informed by the role of organizational hierarchies in sustaining oppressive nursing practice environments (Croft & Cash, 2012; Kelly & Ahern, 2009). I situated the constructs in Laschinger

et al.'s (2016) adaptation of Scott et al.'s (2008) NGSTR model to expand the concepts identified in the literature to contribute to knowledge development of incivility experiences of NGNs using Bronfenbrenner's Systems Theory (1979). The seminal incivility concepts and other behavioural theories were reviewed to show how this approach focuses on unique aspects of the multidimensional workplace environment, the role of authentic leaders, trust, and areas of work life to augment the understanding of incivility experiences of NGNs. In each section, the context for each variable used and variables of interest for the hypothesis testing are provided, along with demographic variables of interest in the methodology chapter.

Hypothesis

Informed by the literature and by situating the variables in Laschinger et al.'s (2016) adaptation of Scott's model in Bronfenbrenner's model, my research hypotheses focusing on variables in the micro-, meso-, and exosystems are:

1. Hypothesis 1(H_1): There will be a significant negative linear relationship between workplace empowerment and the perceptions of coworker incivility by NGNs; therefore, the slope will not equal zero. H_1: $B_1 < 0$. Null Hypothesis H_0: $B_1 = 0$

2. Hypothesis 2 (H_2): There will be a significant negative linear relationship between areas of worklife and the perceptions of coworker incivility by NGNs; therefore, the slope will not equal zero. H_2: $B_2 < 0$. Null Hypothesis H_0: $B_2 = 0$

3. Hypothesis 3 (H_3): There will be a significant negative linear relationship between authentic leadership and NGNs' perceptions of coworker incivility; therefore, the slope will not equal zero. H_3: $B_3 < 0$. Null Hypothesis H_0: $B_3 = 0$

Future research may explore the relationships of Laschinger et al.'s (2016) variables not included in this study, as well as variables situated in the macrosystem which influence the

variables identified in my study and the effects over time (chronosystem) to NGNs' incivility experiences. This approach may assist health care administrators to focus on areas for organizational changes in NGNs' work environments and aid in secondary benefits of reducing coworker incivility experiences.

Conclusion

Situating the variables in Laschinger et al.'s (2016) adaptation of Scott et al.'s (2008) NGSTR model within the ecological model contributes to a multidimensional understanding of how variables operating at various levels in health care systems may influence NGNs' experiences of incivility. For my purposes, it situates the NGN microsystem coworker incivility experiences within the mesosystem (nurse supervisor) and exosystem (workplace empowerment) to inform my hypothesis testing. In future, this model could inform multi-level analysis of NGN incivility experiences using methods such as hierarchical linear modelling to better understand the level at which various factors have the most influence on incivility. Additionally, NGN coworker incivility research designed to measure change across time and across system domains could also be informed by this ecological approach. While Scott et al.'s (2008) model is an important framework, the ongoing nature of incivility among NGNs suggests other approaches such as the one discussed in this paper can shape new ways of thinking about how to prevent and mitigate workplace incivility for NGNs and thereby reduce workforce shortages.

Figure 3-1

Conceptual model of the transition of new graduates into the workplace

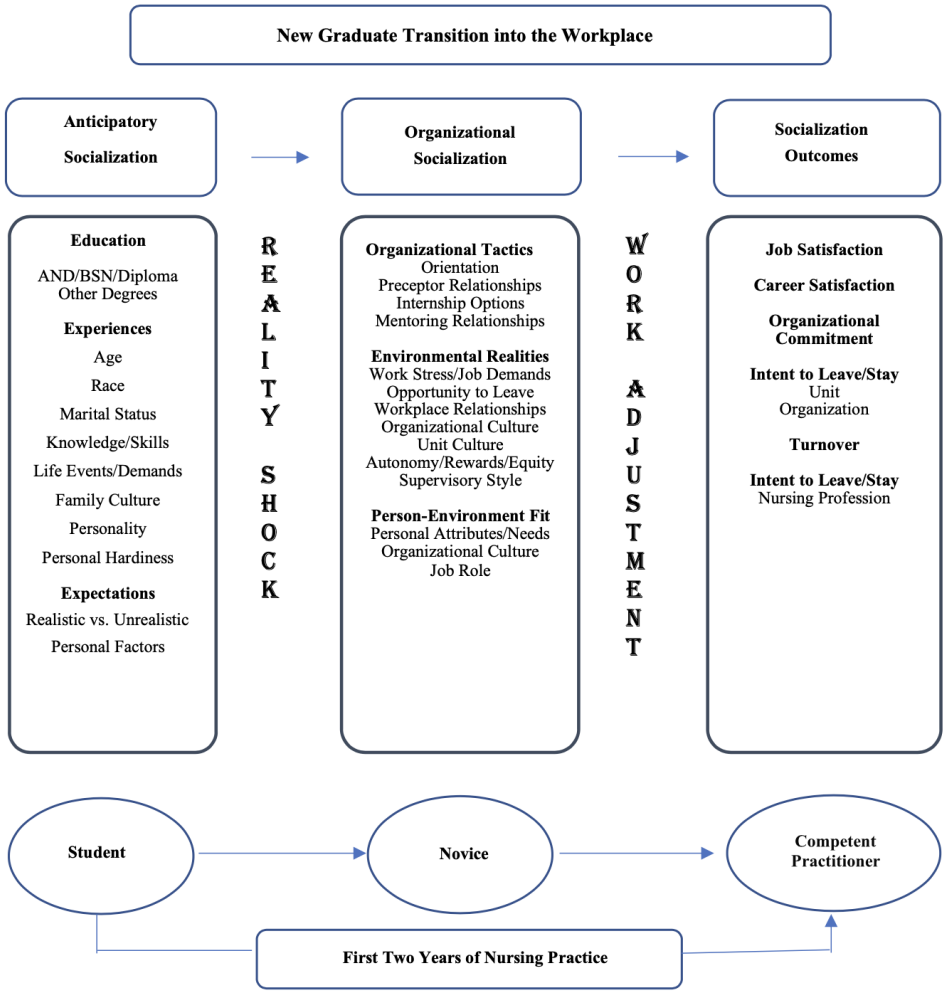


Figure 1: Conceptual model of the transition of new graduate nurses into the workplace Scott et al. (2008).

Figure 3-2

Laschinger et al. (2016) New Graduate Successful Transition Model derived from Scott et al. (2008)

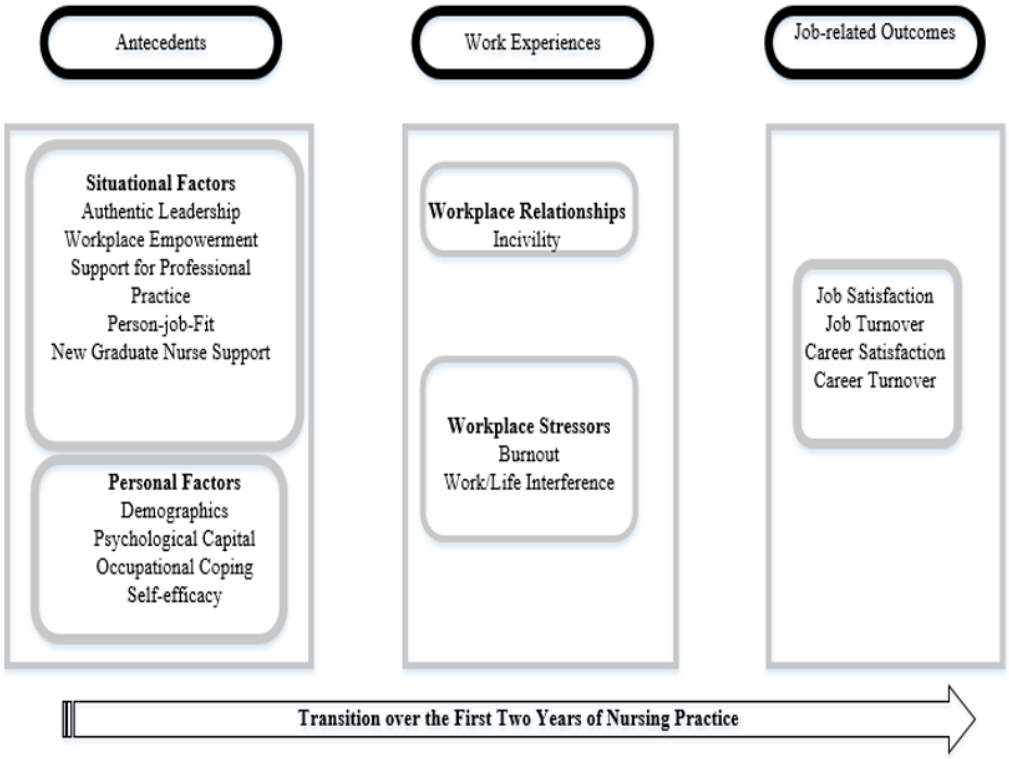


Figure 3-3

Bronfenbrenner's Ecological Systems Theory

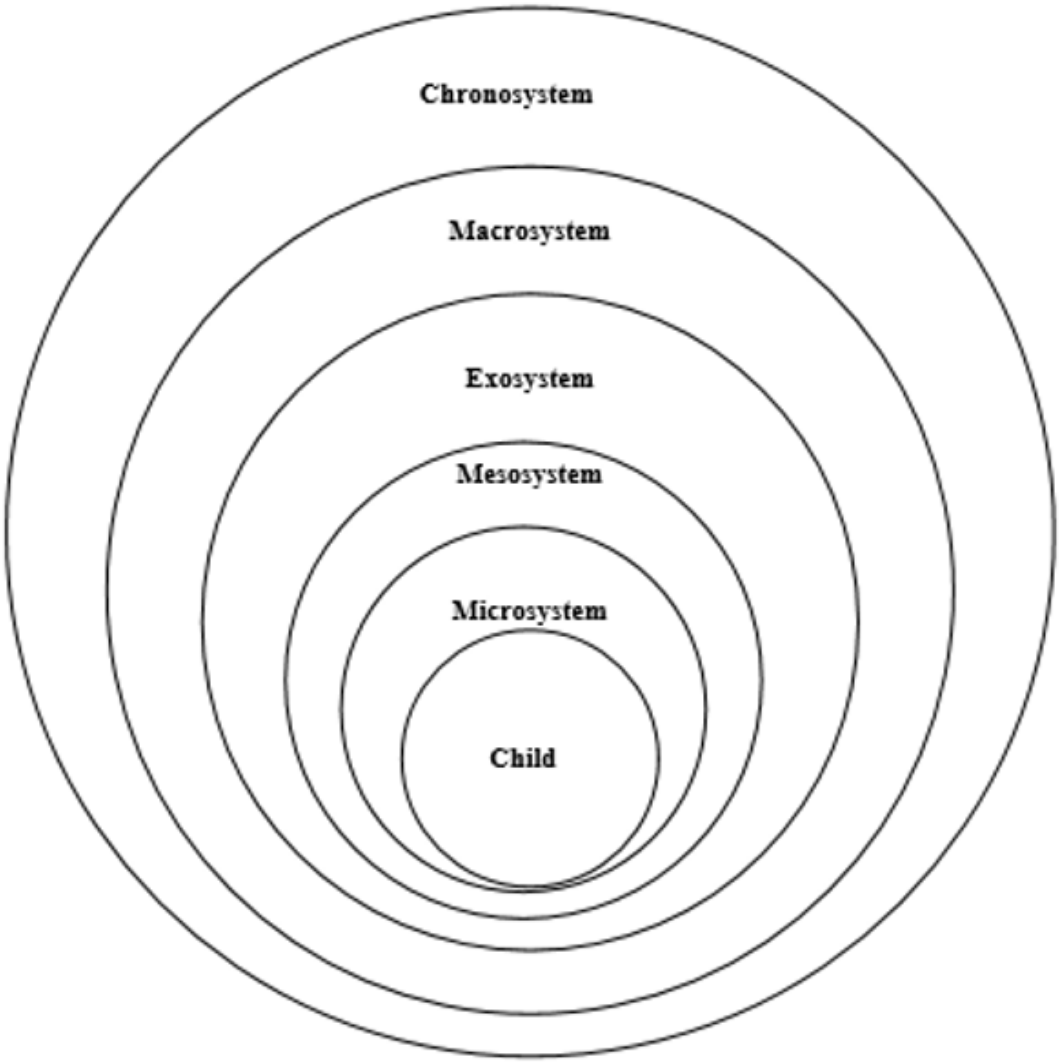
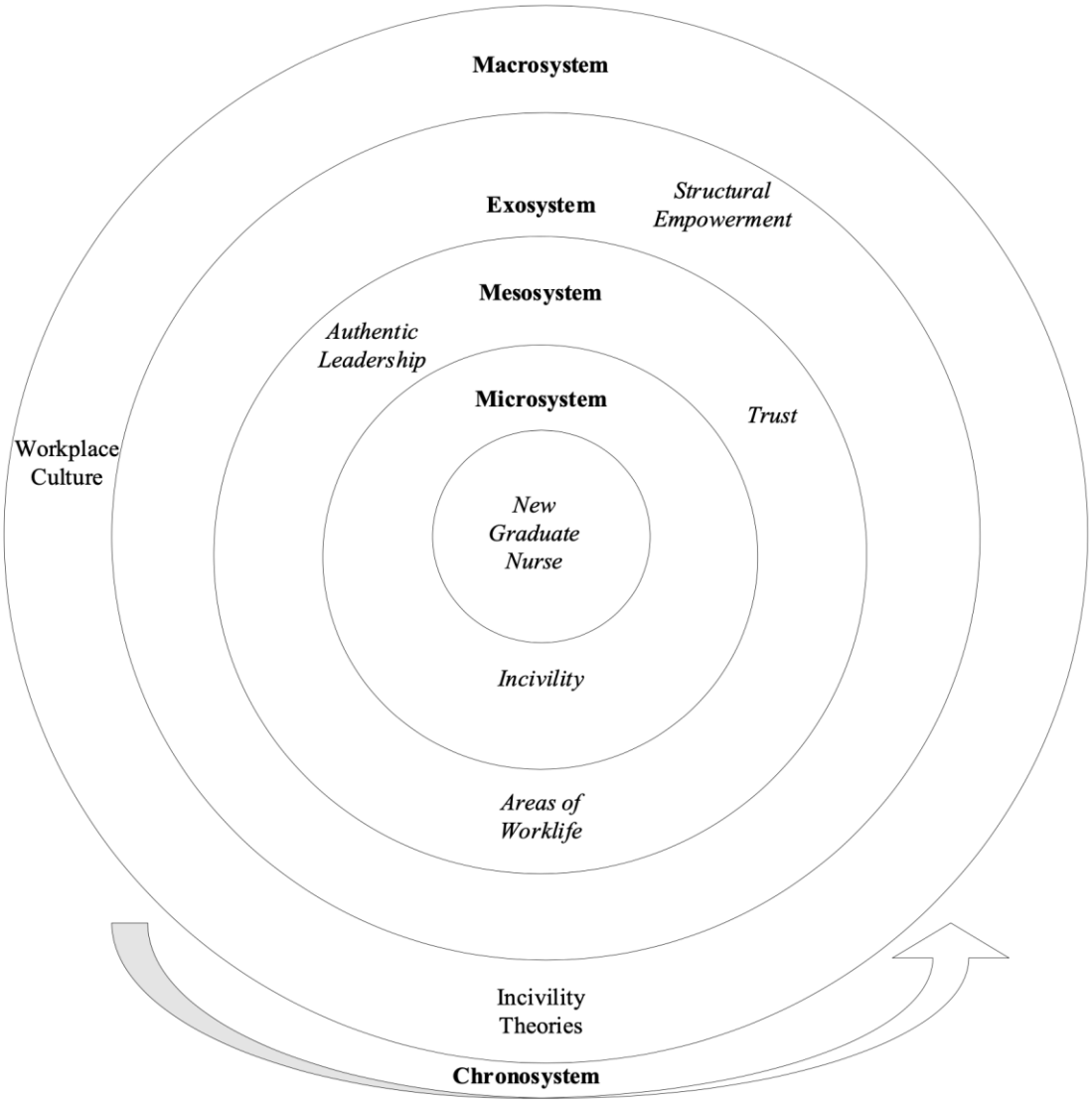


Figure 3-4

Ecological Model Approach to New Graduate Nurse's Incivility



Chapter 4: Quantitative Secondary Analysis

Research Design and Methodology

This study tested the assumption that NGNs' perceptions of nursing leaderships' control over workload contribute to coworker incivility experiences. In particular, the relationship between workplace empowerment, authentic leadership, and areas of work life (e.g., workload control and fair allocation of resources) to coworker incivility experiences were examined. This was a secondary analysis of Starting Out (Laschinger et al., 2012-2014), national survey, Time 1 dataset (Laschinger et al., 2012-2013). The research question guiding the analysis was: To what extent are workplace empowerment, NGNs' perceptions of nurse leaders, trust in management, and areas of worklife related to coworker incivility experiences? The hypotheses are based on the IR findings (Blackstock et al., 2018), a literature review of incivility and NGNs (Alilyyani, et al., 2018; Croft & Cash, 2012; Kim et al., 2016; Laschinger & Read, 2016; Smith et al., 2017), and my experiences working in leadership roles and teaching in nursing.

Hypotheses

This study explores the following three hypotheses:

Hypothesis 1(H_1): There will be a significant negative linear relationship between workplace empowerment and the perceptions of NGNs' coworker incivility; therefore, the slope will not equal zero. H_1: $B_1 < 0$. Null Hypothesis H_0: $B_1 = 0$.

Hypothesis 2 (H_2): There will be a significant negative linear relationship between areas of worklife and the perceptions of NGNs' coworker incivility; therefore, the slope will not equal zero. H_2: $B_2 < 0$. Null Hypothesis H_0: $B_2 = 0$.

Hypothesis 3 (H_3): There will be a significant negative linear relationship between authentic leadership and NGNs' perceptions of coworker incivility; therefore, the slope will not equal zero. H_3: $B_3 < 0$. Null Hypothesis H_0: $B_3 = 0$.

Secondary Analysis

Secondary analysis of the Time 1 dataset (Laschinger et al., 2012-2013) from the Starting Out Study (Laschinger et al., 2012-2014) was conducted. This dataset is derived from a national survey of NGNs with less than three years' experience and contains information about key antecedents (e.g., situational and personal factors), work experience (e.g., workplace relationships and work stressors) and job-related outcomes (e.g., job and career satisfaction, and job and career turnover). Laschinger et al.'s (2016) study findings showed both situational and personal factors explained significant amounts of variance in NGNs' job and career satisfaction, and turnover intentions over their first year of practice. A secondary finding was that NGNs reported high levels of burnout and incidences of bullying and incivility at work. This study differs from Laschinger et al.'s (2016) Starting Out Study in three ways. First, Bronfenbrenner's Ecological Theory (1978;1979) theory informed the conceptualization of an ecological approach to NGNs' co-worker incivility experiences. Second, select factors of workplace empowerment, authentic leadership, areas of worklife, trust in management and NGNs' co-worker incivility experiences were situated within the ecological approach. Third, multiple linear regression was used to test whether there was a negative relationship of workplace empowerment, areas of worklife and authentic leadership to NGNs co-worker incivility experiences.

In secondary analyses, it is important for the researcher to review the study description, sampling, characteristics of demographics of the sample, and data collection procedures to evaluate the relevance of the data, and assess the credibility of the data (Goodwin, 2012). Thus, I

begin this chapter by presenting the Starting Out (Laschinger et al., 2012-2014) main study description, sampling, and data collection procedures before moving on to discuss the variables of interest for the current study, analytic strategy, statistical analysis, and results.

Data Source: Starting Out (Laschinger et al., 2012-2013) Time 1 Dataset

Study Description

This study is based on a secondary analysis of data collected in the Starting Out national two wave self-reported survey (see Table 4-1 in the Appendix) of 3,743 nurses located across Canada (Laschinger et al., 2016) to examine the factors influencing NGNs' transition to practice and determine predictors of job and career satisfaction and turnover intentions in an effort to better understand why nurses were leaving the profession. The primary objective of the Starting Out Study (Laschinger et al., 2012-2014) was to conduct a national study, creating a national database of NGNs to identify factors that support or hinder Canadian NGNs' successful transition over the first two years of practice (Laschinger et al., 2013). Time 1 data were collected in 2012-13 and Time 2 in 2013-14. At the time of the study, there was a predicted nursing shortage in Canada of almost 60,000 full-time equivalent positions by 2022 (Tomblin Murphy et al., 2009). In addition, the outflow of nurses to the United States was a growing concern given, in the past, the equivalent of a quarter of 3,000 new Canadian graduates (CNA, 2007) migrated to the United States (US). The US National Center for Health Workforce Analysis (2002) predicted the shortage of RNs would grow from 12% in 2012 to 20% in 2015.

Sampling Procedures

Data collection procedures in the Starting Out survey (Laschinger et al., 2016) conformed to those specified by Dillman et al., (2004). A list of RNs with less than three years of experience was obtained by provincial registries. The study was conducted using a disproportionate

stratified sampling method to ensure that nurses from each province were adequately represented in the sample. The researchers requested a sample from each of the provincial registries, targeting 400 NGNs from each province, with a targeted 50% response rate. The researchers stratified regions in Canada based on ten provincial regulatory nursing geographical boundaries. Of note—territorial regions were not specified in this study (e.g., Northwest Territories and Nunavut); nor were their associated regulatory nursing bodies. The Northwest Territories Registered Nurses Association (e.g., established in 1975) changed its name to the Registered Nurses Association of Northwest Territories and Nunavut (RNANT/NU) effective in 2004, following new legislation (RNANR/NU, 2020). Yukon registered nurses were a part of the British Columbia Registered Nurses Association until 1992 (BNNP, 2020). Alberta, Manitoba, and Quebec each provided a sample of 400 nurses, while Ontario provided a sample of 878 and British Columbia provided a sample of 555 nurses. The remaining provinces—New Brunswick, Newfoundland, Nova Scotia, Prince Edward Island, and Saskatchewan—had less than 400 NGNS practising as RNs with 379, 191, 292, 130, and 280 respectively (Laschinger et al., 2013). A random sample of 3,906 RNs from the provincial registry databases across Canada was obtained.

Sample Description

The supply of RNs at the time of the survey in 2012 across Canada was 289,597, whereas RNs in the workforce were 268,655, compared to 11,777 NGNs from entry-to-practice programs (CNA, CASN, 2013). The study was meant to address a top priority theme identified by the Listening for Direction III (2007-2010) workforce and the work environment report by focusing on the factors influencing NGNs' successful transition to their full professional role (Laschinger et al., 2013). In order to determine whether the random sample from the study represented the

available NGNs in Canada at the time of the study, I sought out information from the Canadian Institute for Health Information (CIHI) and created a table of the available NGNs in the workforce.

The characteristics of NGNs in 2012 (e.g., new graduate demographics identifying gender, age, areas of nursing practice for hiring data) were not available; however, I was able to find the number of NGNs in Canada are noted by province and territory (CIHI, 2012) (see Table 4-2). The majority of Canadian graduate nurses work in the jurisdiction they graduated and the majority of the NGNs in the sample benefited from an orientation/preceptorship program ranging from 3.5 to 7 weeks. The details of the orientation and preceptorship program are not known. Nearly nine out of ten regulated nurses who graduated from a Canadian nursing program continuing to reside in Canada in 2012 either did not move after graduation, or eventually returned to their jurisdiction of graduation (CIHI, 2012).

Table 4-2

New Graduate Nurse Workforce in Canada 2012

	Graduates from Nursing Program	Graduates Employed Within the Province		% Migrated to Another Province						
Province/ Territory		%	#	Ont.	Alta.	N.S.	N.B.	Que.	B.C.	SK.
Newfoundland and Labrador (N.L./T)	10,120	76.0	7,691	6.8	6.2	5.3				
Prince Edward Island (P.E.I.)	2,086	78.9	1,627	3.4	3.8	7.3				
Nova Scotia (N.S.)	12,834	80.7	10,267	5.8	3.9		3.1			
New Brunswick (N.B.)	11,699	83.2	9,710	4.3		4.3		2.2		
Quebec (Que.)	90,928	95.5	86,381	2.9						
Ontario (Ont.)	115,287	93.6	10,721						2.2	
Manitoba (Man.)	17,035	80.0	13,628	3.6	6.5				6.0	

Saskatchewan (SK)	13,103	75.5	9,827	1.9	13.9				6.1	
Alberta (Alta.)	34, 117	84.3	28,658	2.0					8.0	3.6
British Columbia (B.C.)	30,031	91.7	27,328	1.5	4.7					.5
Yukon (Y.T.)	67	71.6	47	3.0					17.9	4.5
Northwest Territories and Nunavut (N.W.T. & Nvt.)	240	65.0	156	5.4	12.5	5.0				
Total				40.6	54.5	21.9	3.1	2.2	40.2	8.6

Note. CIHI, Regulated Nurses, 2012 Summary Report

In 2012, the available information on NGNs indicates those who moved after graduation; British Columbia, Alberta, and Ontario were the destination of choice (CIHI, 2012). Quebec had the highest proportion of provincial nursing graduates to amount employed in the province at (95.5%); Saskatchewan had the lowest proportion among the provinces (75.5%); and the Northwest Territories and Nunavut had the lowest proportion among provinces and territories (65.0%) (CIHI, 2012).

Characteristics of the Sample

Table 4-3 provides descriptive statistics of the T1 sample of 1,015 NGNs for my study. Results reveal 1,012 NGNs worked in direct patient care (8 missing designated area of care). New graduate nurses' age was (M=27.44, SD=6.34), and total years working as an RN (M=1.21 years; SD=.56). The majority of the respondents were from Ontario 21.1% (n= 215), British Columbia 15% (n=153), Alberta 13.3% (n=136) and Manitoba 12.1% (n=123).

The NGN workforce in Canada in 2012 is shown in Table 4-5. Of nursing program graduates who remained in the same province for employment— Ontario had 93.6 %; British Columbia; 91.7 %; Alberta 84.3 %; and Manitoba 80.0%. In addition, a percentage of other nursing graduates migrating from other provinces are noted under each province or territory, for

example: Ontario, 40.6%; British Columbia, 40.2%; Alberta, 54.5%; and Manitoba 0%. The sample proportion of NGNs compared to the national proportions does not represent the population of NGNs available in the ten provinces included in the study. In particular, as noted previously, Quebec, Nova Scotia, Manitoba, Northwest Territories, and Nunavut were under-represented and contributed to a biased sample. The T1 sample is a representative sample of British Columbia, Alberta, and Ontario. However, the T1 sample is not representative of the provincial NGNs available at the time of the survey in other provinces given the following comparisons between provincial NGNs compared to T1 provincial responses: Quebec available NGNs (86,381), respondents to survey (n=65), Nova Scotia (10, 267), respondents (n=77), Manitoba (13,628), respondents to survey (n=122). Almost 91% of respondents (n=925) were English speaking. The majority of respondents had a bachelors' degree in nursing (92.4% [n= 942]). Over half of respondents worked full-time (50.6% [n=618]); whereas 28.2% (n=288) worked part-time, and almost 75% of NGNs sampled had one to three preceptors during their transition to practice (Laschinger et al., 2013). Reported nursing practice specialty areas of respondents were mainly medical-surgical, at 49.9 % (n=509) and community health, at 4.4 % (n=59). New graduate nurses reported working in one specialty area represented 92% (n=938) of the sample, whereas 7.3 % reported working in multiple areas (n=74) or acting in a float pool capacity, at 2.6% (n=27).

Data Collection Procedures

Recruitment to the T1 (November 2012-March 2013) study employed several strategies. Participants received an information letter, study questionnaire, pre-paid return envelope, and a $2 gift card mailed to their home. To encourage a high response rate, a reminder letter was sent four weeks after the initial package, and a second questionnaire package was mailed to non-

responders four weeks after the reminder letter. French-speaking participants received a French version of the survey questionnaire package. Time 1 of Starting Out dataset (Laschinger et al., 2012-2013) contains 356 variables with information on NGNs. The RNs included in the sample were mailed a questionnaire and the total response rate for the study was 30% (n=1,175). Of the 1,175 questionnaires returned, 1,021 were usable, six were missing information, 141 were returned by the sender, and 13 were ineligible. As a result, 1,015 questionnaires were deemed eligible for analysis, yielding a 27.1% response rate. Surveys were ineligible if they were completed by an RN with greater than three years nursing experience.

Starting Out (Laschinger et al., 2012-2014) Data Collection Instrument. The Laschinger et al.'s (2012-2014) survey instrument was not pilot tested prior to use for the main study. Data were collected using a 213-item data collection instrument (Starting Out, Laschinger et al., 2012-2014). The self-report survey instrument used standardized questions with acceptable psychometric properties to obtain information about NGNs' professional practice, conditions of work, workplace experiences (e.g., bullying, incivility, civility), health, and work outcomes. In addition, there were qualitative questions asking respondents to reflect on their post-graduation practice as an RN relative to workplace integration/transition supports; identification of missing supports; and anything the respondent wanted to share regarding their transition/adjustment to their professional nurse role.

Table 4-3

Descriptive Results of Participant Characteristics

Data Element	M	(SD)		
Age	27.44	(6.34)		
Years of experience as an RN	1.211	(.564)		
	Category		**n**	**%**
Gender	Female		934	91.6
	Male		76	7.5
Province	British Columbia		153	15.0
	Alberta		136	13.3
	Saskatchewan		83	8.1
	Manitoba		123	12.1
	Ontario		215	21.1
	New Brunswick		55	5.4
	Newfoundland		77	7.6
	Nova Scotia		78	7.6
	Prince Edward Island		31	3.0
Language	English		925	90.7
	French		83	8.1
Education	BScN		942	92.4
	Master's degree in nursing		3	0.3
	College diploma in nursing		71	7.0
Preceptorship helped transition to RN role	Definitely		530	52.0
	Somewhat		378	37.1
	Not at all		59	5.8
Employment Status	Full-time		618	60.6
	Part-time		288	28.2
	Casual		108	10.6
Specialty Area	Med-Surg		509	49.9
	Critical Care		183	17.9
	Mat-child		104	10.3
	Mental Health		61	6.0
	Float pool or nursing resource unit		39	3.8
	Community Health		59	5.8
	Long Term Care		45	4.4
	Geriatric/Rehab		12	1.2
	One Specialty Area		938	92.0

Note. Format for table from Laschinger et al., 2016 Technical Report

Laschinger et al. (2016) used a variety of Likert scale measures in the Starting Out Time 1 (November 2012-March 2013). Relevant to the focus of this doctoral work are the following

measures: Authentic Leadership Questionnaire (Walumbwa et al., 2008) uses a 4-point Likert scale (0= not at all to 4= frequently if not always), whereas structural empowerment-Conditions for Work Effectiveness Questionnaire-II (Laschinger et al., 2001) uses a 5-point Likert scale (1=None to 5=A lot), with the total score being a sum of four subscales (range: 4-20); and the Straightforward Workplace Incivility Scale (Leiter & Day, 2013) uses a 5-point Likert scale (0=Never to 6=Daily). Descriptive statistics, correlations and hierarchical linear regression analyses were conducted on the data (Laschinger et al., 2016).

Ethical Considerations

The original study (Starting Out Study, Laschinger et al., 2012-2014) is reviewed to provide information on ethical processes such as free and informed consent to participate in the study, use of data for secondary analysis, anonymity, and confidentiality of participants. Approval for the Starting Out Study (Laschinger et al., 2012-2014) was granted by the University of Western Ontario Ethics Board for Health Sciences in Research in June 2012 and from all of the other ten provincial nursing regulatory bodies. Participants were supplied with the study information indicating the risks and benefits, to allow them to decide whether to participate based on free and informed consent, and the use of information gathered for future studies. Participants were given the opportunity to withdraw anytime during the study. In the original study, precautions were taken to protect the participants' anonymity and privacy. For example, each participant was assigned a PIN used for the survey and in the database. The information letter attached to the survey outlined the study procedures, the voluntary nature of taking part in the study, and return of the completed survey signified consent to participate in the study.

Based on the substantive review of the study description, sampling, characteristics of demographics of the sample, and the data collection procedures of the Starting Out Study

(Laschinger et al., 2012-2014), the T1 dataset (November 2012-March 2013) was determined to be of substantive quality and relevant to the research question of this study.

Current Study

Ethics

The current study was granted ethics approval from the University of Alberta Research Ethics Board, Pro00087747 to access the T1 dataset (November 2012-March 2013). The University of Alberta received approval from the University of Western Ontario Ethics Board to house the dataset in the Health Research Data Repository (HRDR) at the University of Alberta.

Selection and Description of Predictor Variables

Consistent with the ecological model and my hypotheses, workplace empowerment factors are the focus of my secondary analysis because the literature suggests they are related to authentic leadership, trust in management, and areas of worklife to incivility experiences. Descriptions of the theoretical basis for each predictor and outcome variables contained in this study are summarized in Table 4-4 (see Appendix). The direction of relationships between variables and their respective theoretical basis informed the direction of the hypotheses in my study.

Variable Measures Used in the Analysis

Starting Out (Laschinger et al., 2012-2014) demographic survey and five standardized self-report instruments were used to measure the four variables of interest: workplace empowerment, authentic leadership, trust in managers, areas of work life, and coworker incivility experiences of NGNs (see Table 4-5).

Table 4-5

Study Instruments

Scale/subscales	Items	Scale range	Cronbach's α	Validity
Organizational				
Structural empowerment-Conditions for Work Effectiveness Questionnaire-II (Laschinger et al., 2001)	12	1=none to 5=A lot Total score=sum of 4 subscales (range: 4-20).	.87	Construct validity was established by Laschinger et al. (2001) using CFA.
Opportunity			.80	
Information			.81	
Support			.78	
Resources			.81	
Perceptions of Leadership Behaviour and Effects				
Authentic Leadership Questionnaire (Walumbwa et al., 2008)	16	0=Not at all to 4=Frequently, if not always.	.66-.93	Construct validity was established by Walumbwa et al. (2009) using CFA on data from two samples.
Transparency			.87	
Self-Awareness			.92	
Moral/Ethical			.76	
Balanced Processing			.81	
Areas of worklife-Short form (Leiter and Maslach, 2004).	20	1=Strongly disagree to 5=Strongly agree	.81	Construct validity was established by Leiter and Maslach (2004) using both EFA* and CFA*.
Workload Control Reward Community Fairness Values			.80-.89	
Trust in immediate supervisor/manager (Norman, 2006). The Organizational Trust Inventory-Adapted (Cummings et al., 1996).	12	1=Strongly disagree to 5= Strongly agree	.93	Construct validity was established by Cummings et al., (1996) using CFA. Modified version used in survey, Wong, (2013).

Scale/subscales	Items	Scale range	Cronbach's α	Validity
NGNs' Work Experiences				
Straightforward Workplace Incivility Scale (Leiter and Day, 2013)				Construct validity established by Leiter and Day (2013) using EFA
Coworker Incivility	5	0=Never to 6=Daily	.95	

*EFA exploratory factor analysis
*CFA confirmatory factor analysis

The theoretical definition of each variable is reviewed before moving on to explain the operational definition (measure) for each variable used in my study. The measures reflect NGNs' perceptions of workplace empowerment, authentic leadership (e.g., immediate supervisor), trust in management (e.g., immediate supervisor/manager), area of worklife, and coworker incivility experiences. Variables on awareness of workplace violence, harassment, and bullying policies would have been preferrable to include in the analysis; however, these data were not available in the dataset. In addition, I would have liked to include measures that capture everyday managerial processes such as giving negative feedback on job performance or feedback on unsuccessful attempts at in-house training or education that could be interpreted by an NGN as unfair actions (Cortina et al., 2001). Depending on the personality trait of an affective disposition, choosing negative legitimate feedback or have pessimistic views may lead the NGNs to perceive that they have been mistreated by the organization which may bias their responses when asked about the organization in which they practise. Measures such as Donovan et al.'s (1998) Perceptions of Fair Interpersonal Treatment (PFIT) Scale would have been beneficial to include; however, it was not available in the dataset and will be noted as limitations in the results. All scores below were calculated at the individual nurse level.

Workplace Empowerment Theoretical Definition. Workplace empowerment is a situational factor that provides new graduates with resources, information, support, and professional development, and varies according to the age of the nurse (Laschinger, 2009;

Spreitzer, 2007). Laschinger et al. (2003) argue that administrative level managers must create empowering structures that facilitate healthy work environments and working conditions to be in place which enable nurses to accomplish their work in a meaningful way and feel psychologically empowered. When most new graduates feel empowered, they are compelled to accomplish their work in meaningful ways to complete job tasks and advance in their career growth, which leads to job satisfaction and autonomy (Cheng, et al., 2015; Laschinger, et al., 2009; Wagner, et al., 2010). Structural determinants of individual behaviours create a cause-and-effect interaction through feedback loops, rather than a static manner (Kanter, 1993). The feedback loops between structure and behaviour can provide momentum for upward cycles of advantage or downward cycles of disadvantage (Kanter, 1993). Spreitzer's (2007) empowerment at work review provides two perspectives that have evolved in the literature and informs this work—the social-structural contextual conditions (i.e., organizational centrix) and the psychological (i.e., individual centrix) experience of empowerment. The social-structural contextual conditions focus on empowering structures, policies, and practices while the psychological is reflective of an individual's perception of empowerment in reaction to structures, policies, and practices within nursing practice environments.

Structural Empowerment Operational Definition. The Conditions of Work Effectiveness–II (CWEQ-II), is a 12-item, 5-point Likert scale (1= none to 5= a lot). The CWEQ-II is a reliable and valid tool used in nursing research (Laschinger et al., 2001) to measure NGNs' perceptions of being empowered to accomplish their work in meaningful ways, reflected in the following four subscales: a) access to resources (e.g., equipment and supplies for their job); b) access to support (e.g., performance feedback and assistance from one's coworker and supervisor); c) opportunities to learn and grow (e.g., development training and professional

development); and, d) access to information (e.g., access to organizational goals, policies, and procedures). The structural empowerment total score is the sum of all 12 items, which includes the four subscales (range 4-20), (Laschinger et al., 2016; Laschinger et al., 2013). Cronbach's alpha: Information α=.81; Opportunity α=.80; Support α=.78; Resources α=.81 and overall alpha α=.87.

Authentic Leadership Theoretical Definition. Authentic leadership style focuses on transparency, behavioural integrity, consistency, and congruency between behaviour and words, honesty, and relational transparency (Avolio et al., 2004). Avolio et al.'s (2004) conceptualization of authentic leadership is chosen for the purpose of this study given that consideration of the leader's values and convictions are taken into account authentic leaders enact their values to build credibility in the concept. A leader's enactment of their values and convictions are related to higher levels of ethical morals and development to display authentic behaviours that are consistent with their values, beliefs, statements, and actions. Authentic leadership is the foundational conceptualization of other forms of positive leadership such as transformational and ethical leadership (Avolio, et al., 2004). Authentic leaders enact their values to build credibility and develop trust and respect over time, through their followers' acknowledgement of the leader being authentic. A challenge to nurses enacting authentic leadership positions is the reconciliation of a resource depletion scenario to nursing staff; the realities of not having enough nurses to do the job leaves staff feeling overwhelmed with job demands and calls into question the leader's authenticity of empowering nursing staff with positivity and motivation.

Authentic Leadership Operational Definition. New graduate nurses' perceptions of their immediate supervisor's authentic leadership were measured one year after their

commencement of employment using the Authentic Leadership Questionnaire (Avolio et al., 2007; Walumbwa et al., 2008), used to measure nurses' ratings of manager authentic leadership, a 16-item, 5-point Likert scale (0= not at all to 4= frequently, if not always). The Authentic Leadership Questionnaire (Avolio et al., 2007; Walumbwa et al., 2008) consists of the following four subscales: self-awareness (e.g., understanding own strengths, weaknesses, and limitations and how their actions affect others); relational transparency (e.g., being open with others, and promoting an environment where opinion, and sharing ideas and challenges are encouraged); internalized moral/ethical perspective (e.g., defining and modelling a high standard of moral and ethical integrity and making decisions consistent with these values); and balanced processing (e.g., soliciting feedback and opinions from others prior to resolving important decisions). The values for each subscale are averaged to produce a total authentic leadership score between 0 and 4, with higher scores representing higher levels of authentic leadership (Avolio et al., 2007; Walumbwa et al., 2008). Cronbach's alpha: Self-awareness α=.92; Relational Transparency α=.87; Moral/Ethical α=.76; Balanced Processing α=.81 and overall alpha α=.66-.93.

Trust in Manager Theoretical Definition. Cummings and Bromiley (1996, p. 303) define trust as an individual's belief that another individual or group: a) makes good faith efforts to behave in accordance with explicit or implicit commitments, b) is honest in negotiations that preceded such commitments, and c) does not take excessive advantage of another even when the opportunity is available. The definition of trust has evolved from an expectancy held by NGNs that the word, promise, and verbal or written statement of their supervisors can be relied upon (Rotter, 1967). Trust within an organization is a choice and is a judgment based on evidence and yet the trustor makes a leap of faith out of care for the relationship (Solomon & Flores, 2001).

Trust in Manager Operational Definition. This instrument reflects the NGNs' beliefs of their immediate supervisor/manager. Trust in the manager (Norman, 2006) was adapted by Cummings and Bromiley (1996) and further modified by Wong (2015). Cummings and Bromiley's (1996) 12-item organizational trust inventory scale assesses cognitive (six items) and affective trust (six items). Cognitive-based trust is defined as beliefs about reliability and competence, and affective-based trust is described as mutual interpersonal concern or emotional connections with others (McAllister, 1995). The overall 12-item scale had a Cronbach's alpha = .93; the 6-item affective component scaled has α=.82 and the 6-item cognitive component had a reliability of α=.88. Wong's Modified Trust Inventory (2015) is used in the Starting Out Study (Laschinger et al., 2013). The stem wording, "I believe that my immediate supervisor/manager […]" was used with five items from the Norman et al. (2010) scale and rated using 5 points with the following scale: 1= strongly disagree, 2= disagree, 3= hard to decide, 4= agree, 5= strongly agree. An example item for affective trust is "[…] will keep his/her word" and an example of cognitive trust is "[…] tells me the truth." Two additional items were added: "[…] is competent in his/her job" and "Overall, I trust my immediate supervisor/manager." All items are averaged to achieve a score out of five for each nurse participant. The Modified Trust Inventory (Wong, 2015) reflects perceptions of areas of trust of the immediate supervisor's competence, reliability, honesty, establishment, and communication of expectations in a fair manner, truthfulness (e.g., in keeping their word, relaying true statements), and overall trustworthiness.

Areas of Worklife Theoretical Definition. Maslach and Leiter's (1997) found having a match between an employee's work needs and workplace characteristics is important for an employee's relationships with their work. The relationship between person-job fit and six areas of worklife have been significantly related to burnout (Leiter & Maslach, 2004), job satisfaction

(Laschinger, 2012), structural empowerment (Laschinger et al., 2006) and authentic leadership (Laschinger et al., 2015). There is imprecise information in review of the literature on Michael Leiter's Area of Worklife Survey (Leiter & Maslach, 2004; 2009) on whether the measure is capturing the concept of person-job fit (Laschinger et al., 2016) or areas of worklife (Wong et al., 2020). Although I did reach out to Michael Leiter for clarification, he did not respond to my inquiry. I chose to use area of worklife name of the scale as recent literature indicated (Wong et al., 2020) and that it reflects the concept within my ecological model. In addition, given the organizational context was used in this study, occupational health is noted to depend on the perceived fit between the employee's abilities and workplace demand factors (Brom et al., 2015). The Areas of Worklife Scale (Leiter & Maslach, 2004; 2009) reflects six areas of worklife that had been significantly related to work-related areas of occupational health (Brom et al., 2015), and thus the concept of areas of worklife are used in this study. The six key aspects of areas of worklife described by Maslach and Leiter (1997) include the following: workload (the amount of time and resources available to employees in order to accomplish their job); control (the amount of self-determination and decision-making capacity afforded to the employee in the job); reward (acknowledgement, either financially or otherwise, of work contributions); community (the quality of working relationships with colleagues); fairness (degree of transparency and justice in the decision-making process); and, value congruence (the extent to which organizational values coincide with those of the employee).

Areas of Worklife Operational Definition. The areas of worklife (Leiter & Maslach, 2004; 2009) short instrument was used to measure nurses' person job match in the following six key areas of worklife: workload (e.g., job demands); control (e.g., able to influence management to obtain resources, autonomy); rewards (e.g., appreciation, recognition, or compensation);

community (e.g., sense of belonging/cohesiveness with peers at work); fairness (e.g., perceived justice); and, a values congruence (e.g., match between employee and organization priorities and value).

The areas of worklife scale (Leiter & Maslach, 2004: 2009) shortened version was used to measure nurses' person job match in the six areas of worklife. The areas of worklife measure is a 5-item Likert scale (1= strongly disagree to 5= strongly agree). Item scores are averaged to form one overall score (range 1-5), and subscale items are averaged for each subscale score. Person job match is reflected in a score of $\geq$ 3.0 and a low score of <3.0 indicates a mismatch (Leiter & Maslach, 2004). The Cronbach's alpha = .80-.89 for the areas of worklife scale (Leiter & Maslach, 2009).

Coworker Incivility Theoretical Definition. Negative interpersonal work experiences of incivility, bullying, and HV among nurses continue to rise (An & Kung, 2016; Giorgi et al., 2015; Hamblin et al., 2015; Purpora & Blegen, 2015; Yokoyama et al., 2016) impacting recruitment and retention within the nursing profession. Incivility is explained as a low intensity behaviour that is rude or disrespectful toward another (Anderson & Pearson, 1999). Compelling research findings suggest that new graduates are often targets of incivility due to their lower ranking among power-related hierarchies associated with ward cultures (McKenna et al., 2003; Stanley et al., 2007;). I chose the best variable available in the dataset (Starting Out, Laschinger et al., 2012-2013), which I hoped would capture the relationships of workplace empowerment, authentic leadership, and trust in management to coworker incivility experiences of NGNs.

Coworker Incivility Operational Definition. Straightforward Workplace Incivility Scale (Leiter & Day, 2013) is a 15-item, 7-point Likert scale (0= never to 6= daily). The scale includes three subscales: supervisor, coworker, and instigated incivility. The coworker incivility, five-item scale question asks, "Over the past month, how often have your coworkers behaved in the following ways?" The following items are included in the scale: "ignored you," "excluded you," "spoke rudely to you," "behaved rudely to you," and "behaved without consideration for you." Item scores are summed and averaged to form one overall score for coworker incivility. A higher score indicated a higher frequency of incivility experiences from coworkers in the previous month. Subscale scores can be calculated by summing and averaging subscale items. The Cronbach's alpha=.95 for the coworker incivility scale.

Data Management Procedures

The Time 1 dataset (Starting Out, Laschinger et al., 2012–2013) was contained within the HRDR. The researcher and her supervisor had access to the dataset. The dataset was cleaned, coded, and added to a Statistical Package for Social Sciences (SPSS) file at the University of Western Ontario Ethics Board by the researchers of the Starting Out (Laschinger et al., 2012–2014) study. Upon transfer to the HRDR at the University of Alberta, a code book and technical report was provided to the supervisor and primary researcher of this study. Only my supervisor and I had access to the dataset. The primary researchers were contacted to confirm that data transformations were not conducted on the data.

Analytic Strategy

A strength of the Starting Out (Laschinger et al., 2013–2014) dataset is that it included data about NGNs' experiences of coworker incivility along with important predictor variables (e.g., structural empowerment), authentic leadership, and work experience variables (e.g.,

person-job fit, trust in management) in a variety of nursing practice specialty areas. The analytic strategy chosen for the study needed to address how the independent variables (IV) (e.g., structural empowerment, authentic leadership, trust in management, person-job fit), interacted with one another and the dependent variable (DV) (e.g., coworker incivility). Consistent with an ecological approach to NGNs' coworker incivility, the research strategy for this study was to use regression analysis to test the assumption that coworker incivility was predicted by workplace empowerment, areas of worklife, and authentic leadership while controlling for important variables (e.g., trust in management). Multiple linear regression was chosen as it allows for an iterative and simultaneous examination of multiple variables to better assess their interactive effects on the outcome variable (e.g., coworker incivility) (Frost, 2019).

Linear regressions require a continuous dependent outcome variable (Frost, 2019). The dependent variables used in this study are interval scaled data (i.e., Likert scale); however, they are treated as equidistant. After meeting assumptions for skewness and the number of categories (Glass et al., 1972; Lubke & Mauthen, 2004), interval scale data were analyzed as continuous variables. These types of measures are usually used in non-experimental, descriptive cross-sectional survey studies investigating participants' perceptions of incivility experiences in the nursing profession (Keller et al., 2020).

Multiple linear regression provides an estimate of each variable's relationship to coworker incivility experiences, as well as the effects of workplace empowerment and trust on incivility experiences. Centered variables were used in the regression models to reduce structural multicollinearity of independent variables. Centering the variables involved calculating the mean for each independent variable and then subtracting the mean from all the observed values of that variable (Frost, 2019).

Statistical Analyses

All data analyses were conducted using the SPSS version 25 (SPSS Inc. 2018). Bivariate analysis was conducted to determine the relationships between each outcome variable and theoretically relevant predictor variable. For continuous variables, independent sample t-tests were performed. Pearson's correlations were conducted for predictor and outcome variable(s).

Power Analysis

A power analysis was conducted using G* Power (Erdfelder et al., 1996) software program. I selected the following parameters: Test family, F tests; statistical test, linear multiple regression: fixed model, R^2 increase; type of power analysis, *a priori*: compute required sample size-given, power, and effect size. I selected the following input parameters: alpha of 0.01, four predictors, and a power level of .95. The regression effect size is Cohen's f^2 values are as follows: 0.02, small effect, 0.15, medium, and 0.35 large effect (Aron et al., 2009). I used the effect drawer to input partial R^2 values to determine effect size f^2 to calculate the sample size for each of small, medium, and large effects. I calculated the following sample sizes: 1,224 participants were needed for a small effect; 169 participants were needed for a medium effect; and 77 participants for a large effect. Therefore, the sample size of 1,015 participants was sufficient for the current study; however, it did result in the study being overpowered for a medium effect. To address overpowering, I did a Bonferroni correction resulting in a conservative significance level and used a two-tailed level of significance.

Missing Data

There are no best practice guidelines to deal with missing data for multivariate analysis (Frost, 2019). In this analysis, less than 5% of the data were missing. Missing data were managed using pairwise deletion, resulting in a sample size of 1,005 cases from the sample. To reduce

bias, a pairwise deletion (e.g., resulting in ten missing cases) was used that allows for the most usable values to be included in the bivariate or multivariate analysis. To test the assumption for using pairwise deletion for missing data, missing completely at random (MCAR), missing values were computed for each variable of interest. The missing values were as follows for each variable: authentic leadership – 7 missing; structural empowerment – 5 missing values; coworker incivility – 5 were missing; trust in management – 3 were missing; and area of worklife – 4 were missing. On review of the missing values, it was determined the values were MCAR.

Bivariate Analyses

In order to determine the relationship between the outcome variable and each theoretically relevant predictor variable, bivariate analyses were conducted. Scatterplots were also used to check for linearity, whether there were positive or negative relationships, and strength of the relationship between pairs of variables by visualizing how data points fall to the line that defines the relationships (Frost, 2019). Each bivariate analysis served as a foundation for interpreting the multivariate analysis that followed it as the second step.

For categorical variables, Pearson Chi-squares were calculated. The Chi-square test and Fisher's test of independence determines whether there is a statistically significant relationship between categorical variables. The T-test, Chi-square, and Fisher's test were used to review descriptive data to identify patterns and trends.

For continuous variables, independent sample t-tests were performed. Differences in scores between genders on key variables (e.g., coworker incivility) were tested using two sample t-tests. The scores of men and women are independent of each other, so the t-test for independent means focuses on the difference between the means on scores of the two groups. Given Kalisch et al. (2010) found a relationship between education, gender, age, and job satisfaction, I

wondered if similar relationships would be found between education, gender, and coworker incivility experiences. Careful attention was given to independent variables to ensure that they were measuring different constructs to minimize multicollinearity. The correlation coefficients were reviewed to ensure they accurately reflected the strength of the relationships between pairs of variables as studies of human behavioural relationships tend to have correlations weaker than +/- 0.6 (Frost, 2019). In addition, correlations were reviewed for values of independent variables that may indicate there is too much overlap or similarity in what the variables are measuring leading to multicollinearity (Tabachnick & Fidell, 2019). Correlation tables were reviewed for correlation values between important independent variables to assess for correlations ($r > 0.70$), that could contribute to multicollinearity (Frost, 2019). To be considered for inclusion in the regression analysis, correlations of ($r > .0.30$) are considered optimal (Frost, 2019). Each bivariate analysis served as a foundation for interpreting the multivariate analysis that followed it as a second step.

Tests for Normality

After retesting for assumptions, transformation of the coworker incivility variable to reduce skewness, reduce the number of outliers, and improve the normality, linearity, and homoscedasticity of the residuals was performed. Scatterplots were used to determine whether relationships between variables were positive or negative and if they were linear or curvilinear. With the exception of the coworker incivility measure (kurtosis Z value of 23.96) the variable data were normally distributed, and linear relationships existed between the variables. As per Tabachnick and Fiddel (2019), a square root transformation was conducted resulting in a kurtosis of coworker incivility measure to -3.72 closer to the Z value span of -1.96 to +1.96. Cronbach's alpha reliability estimates were calculated for each scale and subscales.

Bonferroni Correction

Multiple testing increases the likelihood that significance levels will result from chance and the probability for making a Type I error increases with more tests (Maxwell & Delaney, 1990). The simplest corrective procedure is the Bonferroni correction (1936) using a conservative <.01 alpha level for identifying a significant effect between coworker incivility and the independent variable(s). I chose to keep the alpha at a <.01 level conservatively, and a two-tailed significance level which results in reduced power (Aron et al., 2009).

Regression Analysis

The effects of workplace empowerment, trust in immediate supervisor to authentic leadership, areas of worklife, and coworker incivility experience variables were evaluated initially using total scores of measures according to each hypothesis. Based on my findings, I was curious about the independent variables and the respective individual items' contributions to the variability of the dependent variable, and thus I conducted further analyses. Then, I used these centered variables in my model. Initial regression analysis results were reviewed for significance of the effects of the centered variable(s). Given the Bonferroni correction was done (1936), all of the variables of interest were kept in the model even if they were not significant (e.g., <.01) as multiple hypotheses were tested using multiple regression.

Assumptions of model testing were verified in the following categories: normality of errors, homoscedasticity of errors, and the absence of outlying or influential observations (Denis, 2020). Normality of errors were assessed by reviewing the residuals from each model and verifying that they were approximately normally distributed using a Q-Q plot and histograms. Homoscedasticity of errors specifies the distribution of errors should be approximately the same for each conditional distribution of the predictors using plots of residuals against predicted or

fitted values from the regression. If the assumption is satisfied, then residuals should more or less be distributed relatively evenly across the plot. The absence of outlying or influential conditions was assessed through review of each model's scatter plots and Cook's distance. Cook's distance was used to assess whether there were influential observations; a value of less than 1.0 is optimal. A value that exceeds 1 is considered an influential outlier and the associated case is removed from the analysis and run again without the case. In this study, the largest Cook's distance for cases and all the variables of interest was one case at 0.03. If there is not a substantial change or difference, then the outlier remains. For all variables of interest, the largest Cook's distance was 0.03 for one case.

The Variance Inflation Factor (VIF) was measured to determine if there was an indication of which variables were affected by multicollinearity and the strength of the correlation. The VIF is computed for each predictor; relatively large values for VIF are indicative that the predictor might be collinear with other predictors in the model (Denis, 2020). They are a measure of how much the variance of a predictor (e.g., with respect to its variance or standard error) is inflated due to being correlated with other predictors in the model (Denis, 2020). The minimum VIF is 1 and signifies no correlation between this independent variable and any others. VIF between 1 and 5 suggest a moderate correlation, but not severe enough to warrant corrective measures (Frost, 2019). Variance Inflation Factor values larger than 5-10 represent critical levels of multicollinearity where the coefficients are poorly estimated, and the p-values are questionable (Frost, 2019). Variance Inflation Factor values larger than 5-10 should signal to the researcher it might be worth dropping one or more of the predictors in the model (Denis, 2020).

Control of Independent Variables

Consistent with the literature and hypotheses, structural empowerment and trust in

immediate supervisor were included in the regression analysis as control variables. In SPSS standard multiple regression, the dependent variable is specified, METHOD=Enter, followed by the list of independent variables, is the instruction that specifies standard multiple regression (Tabachnick & Fidel, 2019). In this step the control variables are entered at the same time as the independent variables (Tabachnick & Fidel, 2019; Frost, 2019). In a regression analysis including independent variables as controls in the analysis allows for estimation of the effect one independent variable has on the dependent variable while holding all the other independent variables constant (Frost, 2019). This allows for each independent variable to be assessed by accounting for the effects of other variables in the model (Frost, 2019).

Results

Descriptive Results

Coworker Incivility and Civility Norms

Respondents (n=1015, 6 missing) reported the following coworker incivility experience ratings of coworker incivility total scale (α = .90, M=.98 out of 6, SD= 1.11) compared to civility norms (n=1018, 2 missing) total scale, (α =.89, M=5.03 out of 7, SD=1.44) as noted in Table 4.6. Of note item scores are summed and averaged to form one overall core (Cronbach's alpha: .78 - .87) for Civility Norms Questionnaire-Brief (Walsh et al, 2011).

Table 4-6

Coworker Incivility and Civility Norms Item Statistics

Coworker Incivility	Item	M	SD	α
	Ignored you	.92	1.25	.94
	Excluded you	.90	1.28	.95
	Spoke rudely to you	1.04	1.22	.94
	Behaved rudely to you	.95	1.21	.94
	Behaved without consideration for you	1.12	1.32	.94
Total Score		.98 out of 6	1.1	.98
Civility Norms				
	Rude behaviour is not accepted by your coworkers	4.9	1.7	.92
	Angry outbursts are not tolerated by anyone on your unit	5.0	1.7	.93
	Respectful treatment is the norm on your unit	5.2	1.5	.92
	Your coworkers make sure everyone on your unit is treated with respect	4.8	1.6	.91
Total Score		5.03 out of 6	1.44	.88

Study Variable Statistics

The means, standard deviations, and Cronbach's alphas for the independent study variables are depicted in Table 4-7. The Cronbach's alphas ranged from .56 to .78. Means, standard deviations and independent one sample t-test results were conducted comparing female and male NGNs' perceptions of authentic leadership, structural empowerment, trust in management, person-job fit-areas of worklife, and coworker incivility experiences. Two sample t-test analyses were used to determine whether female and male NGNs had statistically significantly different perceptions of authentic leadership, structural empowerment, trust in management, and coworker incivility experiences.

Table 4-7

Study Independent Variable Statistics (N=1005)

Variable	M	Range	SD	α
Structural Empowerment	13.64	4-20	2.50	.78
Authentic Leadership	2.60	0-4	.87	.56
Trust in immediate supervisor	3.76	1-5	.96	.57
Areas of Worklife	3.26	1-5	.46	.62
*Nursing Worklife	2.8	1-4	.53	.64

* Added in post-hoc analysis

Review of the t-test results indicated no significant differences in male and female perceptions of structural empowerment, trust in management, authentic leadership, areas of work life, and coworker incivility experiences based on a two-tailed level of significance.

Pearson Chi-square tests were conducted to determine whether there was a significant difference between the sexes in their education level. Fisher's Exact Test value of 18.56, and a 2-sided p=.000. Males had 11.8% (n=9) college level training compared to females with 6.6 % (n=62). A Chi-square test was conducted to determine whether there was an association between sex and coworker incivility experiences. Coworker incivility experiences were recoded (incivility =0 and incivility >0). Results show that 76.3% (n=328) of females reported coworker incivility experiences compared to 5.9 % (n=25) of males. There was a nonsignificant association between sex and incivility rates (X^2 Likelihood Ratio =.98, 2 df, and a 2-sided p=.614 which exceeds the significance level of 0.01). Bivariate analyses were conducted between variables to determine which variables could partially explain the relationships between independent and dependent variables before they were used in multiple regression models.

Importantly, Tabachnick and Fidell (2019) caution researchers that in all types of regression models (multiple, sequential, or statistical) the researcher must compare the total relationship of the IV with the DV (correlation), the unique relationship of the IV with the DV and the correlation of the IV with each other (correlation matrix) in order to get a complete picture of the function of an IV in regression.

Correlates of Variables

The correlations between the independent variables (e.g., structural empowerment, NGN's perceptions of leadership behaviours, trust of immediate supervisor, areas of worklife-areas of work life, nursing worklife), and coworker incivility experiences were significant ($p<0.01$, 2-tailed) as shown in Table 4-8. The correlation between authentic leadership and trust in management ($r= .735$), were significant at a two-tailed level.

Table 4-8

Correlations for Study Variables

Variable	M	SD	1	2	3	4	5	6
1. Structural Empowerment	13.65	2.49	–					
2. Authentic Leadership	2.60	0.86	.498**	–				
3. Trust in Management	3.76	0.96	.405**	.735**	–			
4. Areas of Worklife	3.27	0.46	.566**	.505**	.503**	–		
5. Coworker Incivility	0.79	0.60	-.250**	-.226**	-.225**	-.455**	–	
6. Nursing Worklife	2.89	0.53	.444**	.342**	.376**	.571**	-.255**	–

**Correlation is significant at the $p<0.01$ level (2-tailed).

Regression Results

Hypothesis 1(H_1): There will be a significant negative linear relationship between workplace empowerment and the perceptions of coworker incivility by NGNs; therefore, the slope will not equal zero. H_1: $B_1<0$; Null Hypothesis: H_0:$B_1 =0$.

Table 4-9a

Regression Coefficients[a] and Model Summary H1

Variable	B	Beta	SE	Sig.	VIF
(Constant)	1.76		.11	.00	
*Authentic Leadership (AL)	-.03	-.05	.03	.28	2.52
*Trust in Management (TIM)	-.07	-.11	.02	.01	2.24
Structural Empowerment (SE)	-.04	-.18	.00	.00	1.36
AL_TIM Centered	.00	.00	.02	.92	1.93
TIM_SE Centered	-.01	-.08	.01	.08	2.42
AL_SE Centered	.00	.03	.01	.44	2.30
Adjusted R^2	.079			.00	

[a] Dependent Variable: coworker incivility
*Control Variables

The analysis shows that 8% (p=0.00) of the variability in NGNs' coworker incivility is explained by structural empowerment, when controlling for authentic leadership and trust in management (See Table 4-9a). For each one unit increase in structural empowerment, coworker incivility decreases by .04 (B=-.04, p=.00), with a significance value of .00, CI [-.06, -.02]. For every one unit increase in perceptions of trust in management, coworker incivility experiences decrease by .07 (B=-.07, p=.01) and is significant at the 0.01 level, CI [-.12, -.01] when authentic leadership and structural empowerment are held constant. Cook's distance (M=.001, SD =.004). VIF were between 1-5 indicating moderate correlation between IVs. Hypothesis 1 is accepted, and the null hypothesis is rejected. In order to determine what "a one unit increase in

structural empowerment" means I ran the regression model again using each of the four subscales (e.g., opportunity, information, support and resources), items to determine the respective contribution of each to the variability in coworker incivility. I removed the centered variables given they were not significant; however, left in the control variables of authentic leadership and each subscale item for trust in management given the significance level noted in the prior analysis (B=-.073, p=.01). I wanted to see which items contribute to variability in coworker incivility (see Table 4-9b). Structural empowerment subscale of support, item "please rate the extent to which the following is present in your current job: specific information on the things you do well" (B=-.074, p=.00) was significant with an alpha level of <.01.

Table 4-9b

Regression Coefficients[a] and Model Summary H_1 Subscales and Items of IV included.

Variable and Subscale(s)	Subscale item	B	Beta	SE	Sig.	VIF
	(Constant)	1.53		.12	.000	
*Authentic Leadership	Total Scale	-.01	-.02	.03	.67	2.58
Structural Empowerment: Opportunity, Information, Support & Resources.	Opp1-Challenging work	.03	.04	.03	.276	2.19
Opportunity (Opp)	Opp2-Gain new skills & knowledge	.01	.01	.03	.77	2.69
	Opp3-tasks using skills & knowledge	-.02	-.03	.02	.46	1.69
Information (Inf))	Inf1-current state of hospital	.00	.01	.02	.73	1.69
	Inf2-management values	-.08	-.13	.03	.03	4.43

Table 4-9b
(*continued*)

Variable and Subscale(s)	Subscale item	B	Beta	SE	Sig.	VIF
	Inf3-management goals	.05	.09	.03	.14	4.27
Support (Sup)	Sup1-info on things you do well	-.07	-.14	.02	.00	2.49
	Sup2-comments on things to improve	.02	. 03	.02	.43	2.29
	Sup3-hints or advice	-.04	-.08	.02	.04	2.03
Resources (Resc)	Resc1-time for paperwork	.02	.04	.02	.40	2.74
	Resc2-time to accomplish job	-.04	-.07	.03	.14	2.81
	Resc3-temporary help when needed	-.02	-.05	.02	.19	1.59
*Trust in immediate supervisor/manager (Tim)	Tim1-will keep his/her word	.04	.07	.03	.14	4.62
	Tim2 -is reliable	.04	.07	.04	.31	6.11
	Tim3 -deals with me honestly	-.01	-.02	.04	.70	5.40
	Tim4-establishes and communicates expectations fairly	-.02	-.04	.03	.48	3.97
	Tim5-tells me the truth	-.07	-.13	.03	.04	4.84
	Tim6- is competent in his/her job	.00	.01	.03	.85	4.15
	Tim7-overall, I trust my immediate supervisor/manager	-.04	-.07	.04	.30	6.62
	Adjusted R^2	.079			.000	

[a] Dependent Variable: coworker incivility
*Control Variables

Hypothesis 2 (H_2): There will be a significant negative linear relationship between areas of worklife and the perceptions of NGNs, coworker incivility; therefore, the slope will not equal zero. H_2: $B_2<0$; Null Hypothesis: H_0:$B_2=0$.

Table 4-10a

Regression Coefficients[a] and Model Summary H_2

Variable	B	Beta	SE	Sig.	VIF
(Constant)	2.69		.12	.00	
*Authentic Leadership (AL)	-.00	-.00	.03	.91	2.57
*Trust in Management (TIM)	.00	.00	.02	.83	2.41
*Structural Empowerment (SE)	.00	.01	.00	.71	1.64
Area of Work life(AWS) Total Scale	-.60	-.46	.04	.00	1.74
AWS_SE Centered	.01	-.04	.01	.26	1.96
TIM_AWS_Centered	7.81	.00	.01	.99	2.17
AL_AWS_Centered	.13	.10	.06	.05	3.68
AL_TIM_Centered	-.00	-.00	.02	.83	2.17
Adjusted R^2	.29			.00	

[a] Dependent Variable: coworker incivility
*Control Variables

The results revealed that 30% (p=0.00) variability in NGNs' coworker incivility experiences is accounted by perceptions of areas of worklife, when controlling for authentic leadership trust in management, and structural empowerment (See Table 4-10a). In the initial analysis I used centered variables for each independent variable; however, none of them had a significance level of <.01. For each one unit increase in perceptions of areas of worklife, coworker incivility decreased by .60 (B= -.60, p=.00) with a significance value of .00, CI [-.69, -.50] when authentic leadership, trust in management, and structure empowerment are held constant. Cook's distance (M=.001, SD =.003). Variance Inflation Factor values were between 1-

5, indicating moderate correlation of significant IVs, and some between 5-10 indicating multicollinearity between IVs. Hypothesis 2 is accepted, and the null hypothesis is rejected.

I ran a second analysis to determine which areas of worklife subscale(s) (e.g., workload, control, reward, community, fairness, and values) and items were significantly contributing to the variability to decrease in coworker incivility (see Table 4-10b). Areas of worklife subscale item of (workload) "[p]lease rate the extent to which you agree with": "I work intensely for prolonged periods of time," coworker incivility decreases (B=-.08, p=.00); (community) item "I do not feel close to my colleagues," coworker incivility decreased (B=-.12, p=.00); and the (community) item "members of my work group co-operate with one another," coworker incivility decreases (B=-.14, p=.00). These items were followed by items that were the close to a significance alpha level of <.01 such as (community) item "I am a member of a supportive work group" (B=-.05, p=.01). Given, for some respondents working intensely for long periods of time may be a positive experience, the item does not accurately capture the construct of feeling overworked and/or stretched. I looked for a measure and items that may come closer to reflecting the sense of a lack of control over workload and a lack of nursing resources for NGNs to do their job.

Table 4-10b

Regression Coefficients[a] and Model Summary H_2 Subscales and Items of IV included

Variable & Subscale(s)	Subscale Item	B	Beta	SE	Sig.	VIF
(Constant)		2.77		.13	.00	
*Authentic Leadership (AL)		-.00	-.00	.02	.93	2.48
*Trust in Management (TIM)		-.01	-.01	.02	.69	2.38
*Structural Empowerment (SE)		-.00	-.02	.00	.49	1.72

Variable & Subscale(s)	Subscale Item	B	Beta	SE	Sig.	VIF
Area of Work Life: Workload, Control, Reward, Community, Fairness, and Values	Wkld1R-I work intensely for prolonged periods of time	-.08	-.13	.02	.00	1.35
	Wkld2R-I have so much work to do on the job that it takes me away from my personal interests	-.02	-.05	.01	.12	1.5
	Wkld-3R- I do not have time to do the work that must be done.	.02	.01	.74	.74	1.3
Community (cmty)	Cmty3R-I do not feel close to my colleagues	-.12	-.23	.01	.00	1.37
	Cmty1- I am a member of a supportive work group	-.05	-.08	.02	.01	1.87
	Cmty2-Members of my workgroup co-operate with one another	-.14	-.20	.02	.00	1.73
Control (Ctl)	CTL1-I have control over how I do my work.	-.01	-.01	.02	.59	1.31
	Ctl2-I can influence management to obtain the equipment and space I need for my work.	.09	.01	.01	.61	1.40
	Ctl3-I have professional autonomy/independence in my work.	.01	.01	.02	.66	1.42
Reward (Res)	Rew1-I receive recognition from others for my work.	-.02	-.04	.02	.23	2.21
	Rew2-My work is appreciated.	-.01	-.02	.03	.62	2.61
	Rew3R-My efforts usually go unnoticed.	-.03	-.05	.02	.10	1.75
Fair	Fair1-Resources are allocated fairly here.	-.03	-.05	.02	.09	1.36
	Fair2-Opportunities are decided solely on merit.	-.01	-.02	.01	.43	1.08
	Fair3-There are effective appeal procedures available when I question the fairness of a decision.	.09	.01	.02	.67	1.3

Variable & Subscale(s)	Subscale Item	B	Beta	SE	Sig.	VIF
Values (Val)	Val1-My values and the organization values are alike.	-.00	-.00	.02	.85	1.83
	Val2-The organization goals influence my day-to-day work activities.	-9.2	.00	.02	.99	1.47
	Val3-My personal career goals are consistent with the organization stated goals.	-.00	-.00	.02	.79	1.89
Adjusted R^2		.28			.00	

[a] Dependent Variable: coworker incivility
*Control Variables

I looked for an alternative measure to capture the concept of areas of worklife (e.g., job control and human resources). The Nursing Worklife Index (Lake, 2002) is an alternative measure for the concept I was seeking. The Nursing Worklife Index subscale item of supportive professional practice (Lake, 2002) "[o]n my unit:" "nurses control their own practice," and "there are enough nurses to provide quality patient care," were used as independent variables with centered variables of authentic leadership, trust in management, and structural empowerment in the regression model to determine if the items contribute significantly to the variability in NGNs' coworker incivility. The centered variables were nonsignificant and therefore removed from the analysis. The distribution of Nursing Worklife Index subscale (Lake, 2002) was normally distributed. I ran the regression model using the subscale items and controls of structural empowerment, trust in management, and structural empowerment (see Table 4-10c).

Table 4-10c

Regression Coefficients[a] and Model Summary using Nursing Worklife Subscales

Variable & Subscale(s)	Subscale Item	B	Beta	SE	Sig.	VIF
(Constant)		1.83		.11	.00	
*Authentic Leadership		-.04	-.05	.03	.21	2.43
*Trust in Management		-.05	-.08	.02	.07	2.24
*Structural Empowerment		-.03	-.13	.00	.00	1.46
Nursing Worklife	NWI1-Nurses control their own practice	-.04	-.05	.02	.11	1.15
	NWI4-There are enough nurses to provide quality patient care.	-.07	-.10	.02	.00	1.21
Adjusted R^2		.09			.00	

[a] Dependent Variable: coworker incivility
*Control Variable

The results revealed that 9% (p=0.00), CI [1.6, 2.0] variability in NGNs' coworker incivility experiences is accounted for by nursing worklife, when controlling for authentic leadership , trust in management, and structural empowerment. A significant finding for every one unit increase in "there are enough nurses to provide quality patient care" (B=-.07, p=0.00) coworker incivility decreases by .07. An interesting finding is for each unit increase in structural empowerment (B=-.03, p=0.00), coworker incivility decreased by .03, and had a significant variability (p=0.00). Cook's distance (M=.001, SD =.002). When trust in management and structural empowerment are removed as controls, 8% (p=0.00), CI [1.31, 1.71] variability in NGNs coworker incivility experiences is accounted for by the nursing worklife items, when controlling for authentic leadership. The Nursing Worklife Index, subscale item of supportive

professional practice (Lake, 2002) “there are enough nurses to provide quality patient care,” (B=-.09, p=.00) and authentic leadership (B=-.11, p=.00) were both significant. It could be that the item “nurses control their own practice” does not capture the effects of control over the change of patient assignments, the acuity of patients, and whether requests for additional resources to control their workload are being met.

Hypothesis 3 (H_3): There will be a significant negative linear relationship between authentic leadership and NGNs’ perceptions of coworker incivility; therefore, the slope will not equal zero. H_3: $B_3 < 0$. Null Hypothesis: H_0:$B_3=0$.

The results revealed that 8% (p=0.00) variability in NGNs’ coworker incivility experiences is accounted for by authentic leadership, when controlling for trust in management and structural empowerment (See Table 4-11a). For each one unit increase in authentic leadership, coworker incivility decreases by .03 (B=-.03, p=.265) with a significance level >0.01, CI [-.10, .02] when trust in management and structural empowerment are held constant. Cook’s distance (M=.001, SD =.005). VIF were between 1-5 indicating moderate correlation of IVs. Hypothesis 3 is rejected, and the null hypothesis is accepted.

An insignificant finding in a research study could be a result of having a high power on first review, but it is also a fairly strong argument against the research hypothesis (Aron et al., 2009). In the first regression analysis I used the four subscales of authentic leadership. Although the VIF indicated moderate collinearity (e.g., 1-5), I ran a second analysis using individual items of authentic leadership from each of the subscales of transparency, moral/ethical, balance processing, and self-awareness (see Table 4-11b).

Table 4-11a

Regression Coefficients[a] and Model Summary H_3

Variable	B	Beta	SE	Sig.	VIF
(Constant)	1.77		.11	.00	
Authentic Leadership (AL)	-.03	-.05	.03	.26	2.46
Trust in Management (TIM)	-.07	-.11	.02	.00	2.22
Structural Empowerment (SE)	-.04	-.18	.00	.00	1.37
TIM_SE Centered	-.01	-.07	.01	.09	2.30
AWS_SE Centered	.01	.02	.01	.53	1.64
AL_SE Centered_	.00	.02	.01	.54	2.39
Adjusted R^2	.08			.00	

[a]Dependent Variable: coworker incivility
*Control Variables

The authentic leadership subscale self-awareness item "please rate the extent to which your leader (immediate supervisor) knows when it is time to re-evaluate his or her positions on important issues" (B=.09, p=.00) was the only significant item in the subscale contributing to variability in coworker incivility when controlling for structural empowerment and trust I management. However, it is possible that there is less of an effect than predicted for the population (Aron et al., 2009).

Table 4-11b

Regression Coefficients[a] and Model Summary H_3 Subscales and Items of IV included

Variable	Subscale Item	B	Beta	SE	Sig.	VIF
(Constant)		1.72		.11	.00	
Authentic Leadership (AL): Transparency, Moral/Ethical, Balanced Processing and Self-awareness						
Transparency (TRI)	Tri1-Says exactly what he or she means.	-.02	-.04	.03	.39	2.59
	Tri2-Admits mistakes.	-.03	-.06	.02	.21	2.96
	Tri3-Encourages everyone to speak their mind.	.11	.05	.02	.03	2.81
	Tri4-Tells you the hard truth.	.04	.07	.02	.11	2.17
	Tri5-Displays emotions in line with feelings.	.00	.00	.02	.88	2.32
Moral/Ethical	Mor1-Demonstrates beliefs consistent with actions.	.01	.03	.03	.54	3.20
	Mor2-Makes decisions based on core values.	-.01	-.02	.03	.64	2.45
	Mor3-Asks you to take positions consistent with core values.	-.05	-.10	.02	.02	3.14
	Mor4-Make decisions based on high ethical standards.	.00	.00	.03	.98	2.8
Balanced Processing (Bal)	Bal1-solicits views that challenge his or her positions.	-.01	-.02	.02	.65	2.13
	Bal2-Analyzes relevant data before coming to a decision.	-.00	-.01	.03	.83	2.83
	Bal3-Listens carefully to different points of view before coming to conclusions.	-.04	-.09	.02	.09	3.40
Self-awareness (Sa)	Sa1-Seeks feedback to improve interactions with others.	.00	.01	.02	.78	3.0
	Sa2-Accurately describes how others view his or her capabilities.	-.07	-.14	.03	.02	3.97
	Sa3-knows when it is time to re-evaluate his or her positions on important issues.	.09	.17	.03	.00	4.18
	Sa4-Shows he or she understands how specific actions impact others.	.00	.01	.03	.77	3.92
*Trust in Management (TIM)		-.07	-.11	.03	.00	2.22

Table 4-11b (*continued*)

Variable	Subscale Item	B	Beta	SE	Sig.	VIF
*Structural Empowerment (SE)		-.04	-.18	.00	.00	1.37
Adjusted R^2		.08			.00	

[a] Dependent Variable: coworker incivility
*Control Variable

I was curious about the relationship of age, orientation length, and total years respondents worked as an RN in their organization given the literature review findings indicating these were significant factors. I ran an analysis using the aforementioned demographic variables, including structural empowerment, authentic leadership, trust in management, and NGN's experiences of coworker incivility. In review of the analysis, I decided to run a model with all the variables of interest, and to include additional controls (e.g., gender, length of orientation program, total years working as an RN with the organization) to see if it would provide more insight into the relationships of the IV to coworker incivility experiences, as shown in Table 4-12.

Table 4-11c

Regression Coefficients[a] and Model Summary of all IV and Demographics

Variable	B	Beta	SE	Sig.	VIF
(Constant)	2.48		.15	.00	
Authentic Leadership (AL)	-.00	-.00	.03	.93	2.45
Trust in Management (TIM)	.00	.00	.02	.88	2.33
Structural Empowerment (SE)	.00	.00	.02	.95	1.64
Area of Worklife	-.59	-.46	.04	.00	1.72
*Orientation length	.00	.06	.00	.02	1.02
*Total years worked	-.01	-.01	.03	.72	1.02
*As an RN in your Organization	.00	.08	.00	.00	1.00
*Age					

[a]Dependent Variable: coworker incivility
*Control Variable

The results reveal that 22% of the variability in coworker incivility is accounted for by AL, trust in management, structural empowerment, and areas of worklife, when controlling for orientation length, total years worked as an RN in your organization, and age. Age was a significant finding; for every year increase in age, coworker incivility increased by .008 (B=.008, p=.00). VIF were between 1-5 indicating moderate correlation of IVs. A significant finding was area of worklife, for each unit increase in area of worklife, coworker incivility decreases by .59 (B= -.59, p=.00) with a significance level of <.01, CI [-.692, -.498]. Cook's distance (M=.00, SD=.00). The finding that organizational tenure was nonsignificant (B=.01, p=.72) could offer some insights into whether seniority of NGNs and RNs within an organization or nursing practice area plays a role in mitigating NGN coworker incivility and mentoring NGNs to role model and support a work environment wherein coworker incivility is not the norm.

Limitations

Secondary data analysis is a key limitation of this study given the data are: a) self-report; b) not independently verified; c) not triangulated; and, d) the variables exist in the dataset so I could not define and construct them in the manner I would have liked in my study; and e) post-hoc analysis and associated errors when statistical regression is used as an exploratory took, inferential procedures may be inappropriate and contribute to a Type I error rate (Tabachnick & Fidel, 2019). In Chapter 5, I critically review the strengths and limitations of this study.

Conclusion

The results of the current study provide a perspective on predictive variables of authentic leadership, workplace empowerment, and perceptions of whether NGNs perceive a congruence

between their work needs and the characteristics of their workplace (i.e., areas of work life) to NGNs' coworker incivility experiences. Overall, NGNs' perceptions of trust in management and the degree of workplace empowerment in their workplace affects their perceptions of authentic leadership and coworker incivility. The results add to the evidence that can assist health care administrators to create supportive linkages between the workplace empowerment to authentic leadership related to NGNs' perceptions of a congruence between their work needs and the characteristics of their workplace (i.e., areas of work life) to address coworker incivility experiences.

Chapter 5: Discussion

Discussion

Given the findings of the IR by Blackstock et al., (2018) and the literature review on NGNs' incivility experiences, Laschinger et al.'s (2016) adaptation of NGSTR model (see Figure 3-2) was explored to inform an ecological model of NGNs' coworker incivility experiences. Select constructs (e.g., workplace empowerment, authentic leadership, areas of worklife, and coworker incivility) were chosen from Laschinger et al.'s (2016) NGSTR model, and then situated in Bronfenbrenner's model in order to reflect the ecological importance evidenced from the literature review (see Figure 3-4). Key variables from Laschinger et al.'s (2016) adaptation of NGSTR were selected to explore relationships between coworker areas of worklife, authentic nursing leadership, workplace empowerment, trust in management, and coworker incivility. Descriptive statistics and regression models were used to analyze self-report survey data collected from 1,005 NGNs within a random proportional stratified sample of (N= 3,906) RNs across ten Canadian provinces for the Starting Out (Laschinger et al., 2012-2014) study Time 1 sample from the year 2012-2013. The overall aim of this dissertation was: What are the organizational structures, nurse leadership roles, and work conditions contributing to NGNs' coworker incivility experiences?

The aim was important to explore given the nursing profession assumes that coworker incivility behaviours are enculturated primarily through behaviours originating from individual personality traits, a lack of an ability to identify and prevent coworker incivility behaviours, a lack of support of RNs, and NGNs transitioning to their RN role (Croft & Cash, 2012); Kelly & Ahern, 2009). This study prompts nursing regulators, educators, and administrators to consider factors originating within health care organizational structures beyond NGNs and nursing

leadership domains. The study was designed to explore NGNs' perceptions of the following: workplace empowerment, authentic leadership, trust in management, and areas of worklife, to coworker incivility experiences. This study also attempted to identify relationship patterns between the IVs (e.g., workplace empowerment, authentic leadership, trust in management and areas of worklife) and the DV (e.g., coworker incivility). These relationships were hypothesized based on a review of the literature, and conceptually located within an ecological approach to NGNs' coworker incivility experiences.

In this chapter, the following implications of the study findings are discussed: a) secondary analysis and empirical findings; b) the organizational context, NGNs, nursing leaders, and coworker incivility; c) findings and an ecological approach to NGNs' coworker incivility experiences; d) contribution to existing literature on NGNs coworker incivility experiences; e) policy, health care organizations, and nursing education recommendations; f) knowledge contribution; and, g) future program of research. The findings of the IR (Blackstock et al., 2018), literature review, and the ecological approach to NGNs' coworker incivility experiences reviewed in Chapter 3, and the results of the quantitative, secondary analysis findings in Chapter 4, all culminate to contribute knowledge to the organizational context, NGNs, nursing leaders, and NGNs' coworker incivility experiences. The results add to the research evidence of the role of organizational structures and nursing leaders NGNs' coworker incivility experiences. This knowledge contribution can assist health care administrators to create supportive linkages between the workplace empowerment to authentic leadership related to NGN's perceptions of a congruence between their work needs and the characteristics of their workplace (i.e., areas of work life) to address coworker incivility experiences.

Secondary Analysis and Empirical Findings

Analytic Approach

Consistent with the ecological model, the research strategy for this study was to develop three models that tested the assumption that coworker incivility was predicted by workplace empowerment, areas of worklife, and authentic leadership while controlling for important variables (e.g., trust in management). Multiple linear regression was chosen as it allows for an iterative and simultaneous examination of multiple variables to better assess their interactive effects on the outcome variable (e.g., coworker incivility) (Frost, 2019). In multiple linear regression, it is possible for an IV to appear unimportant to a solution when it actually is highly correlated with the DV (Tabachnick & Fiddel, 2019). For this reason, the full correlation and the unique contribution of the IVs are considered in the interpretation of the results through the use of separate items for each of the measures. Although linear regression was used for the analysis, it could be argued that hierarchical regression modelling might have captured the effect of each of the systems (e.g., exosystem, mesosystem, and microsystem) used in the ecological approach. In this approach, IVs are entered into the equation with an order specified as it relates to a higher theoretical or logical importance of each variable. Conversely, the variables could be entered in an order of lesser importance. The problem with both these approaches is that the measures and items used from the available Time 1 dataset (Laschinger et al., 2012-2013) did not come close enough to the conceptualization of each construct. Secondly, this approach would not reflect the manner in which an NGN experiences the concepts within the nursing practice environment as an interrelated phenomenon(s), having the combined effects of each system in the ecological model.

Findings and the Organizational Context, NGNs, Nursing Leaders, and Coworker Incivility

Freire contends oppression within hierarchical institutions is enculturated in the nursing profession by the internalization of the views of the dominant group (2003). The internalization creates angst and feelings of rejection in the oppressed group; these internalized emotions cannot be enacted against a more powerful group, so they are enacted against members of the same group (Freire, 2003). The use of unequal power in oppression seeks to marginalize and silence a group so they [nurses] cannot control their own environments (Freire, 2003) and they are viewed by the medical hierarchy as an accessory to the physician (Brooten et al., 2012). Although the nursing profession has progressed, hierarchical organizational structures within medical practice and nursing roles, on the whole these continue to be unsupported by management (Clark & Springer, 2012; Huntington et al., 2011). The marginalization of nurses begins at entrance to nursing practice and continues throughout a nurse's career (Duchscher & Cowing, 2004). Horizontal negative workplace acts such as coworker incivility are the final part of oppression wherein the oppressed group expresses through dominant behaviours and appears through oppressive group behaviour within work environments, reflected in part through incivility (Cortina et al., 2001; Freire, 2000; Purpora & Blegen, 2012; Roberts, 2015; Rodwell & Demir, 2012). As noted previously, the characteristics of oppressive hierarchical environments were determined to originate from historical medical hierarchies where nurses were taught to honour physicians as the final decision-making authority, and as a result, nurses adapt their work behaviours and perceptions of self (Purpora & Blegen, 2012). The nursing profession's adaptation of work behaviours and perceptions of being in lower authority within the health care system are often viewed by researchers as common behaviours but, they may be embedded or as

a result of administrative structures, policies, and procedures within health care organizations. For example, administrative structures, roles, systems, and policies may perpetuate oppression through a lack of workplace empowerment of nurse leaders as evidenced by a lack of formal authority within their job roles (Croft & Cash, 2012; Kim et al., 2016; Laschinger et al., 2016).

In my experiences of teaching nursing students in clinical, precepting nursing students, and being a nurse leader, I witnessed NGNs in the nursing workforce were supported by participation in new graduate transition programs, RN preceptors, and additional buddy shifts with a senior RN. New graduate nurses are keen to learn the role of the RN and work hard to demonstrate their competence to their new employer during their probationary period (e.g., typically three months from hire date), and beyond. New graduate nurses' demonstrating competency has relevance to my study findings given the NGNs in the data set (Laschinger et al., 2012-2013) were in a transition or preceptor program as a part of their employment ranging from 3.5 to 7 weeks. Although the details of each preceptor and or transition program are not known, 37.1 % (n= 378) NGNs in this study were supported in their transition to RN roles. Some researchers might argue if NGNs are experiencing oppression and ultimately coworker incivility experiences, then it makes sense they would retreat from the work situation. Systemic oppression occurs through health care structures and policies that impact NGNs' workloads, and at times resulting in coworker incivility experiences. Although NGNs may experience incivility experiences, their responses may be delayed. A delay in the retreat from the work environment which is likely due to NGNs' support through transition programs, preceptorships, and the desire to make it through their probationary period, in spite of coworker incivility experiences.

When NGNs are working on their own, beyond the probationary period, they usually begin to experience and understand respective job roles of interdisciplinary team members (e.g.,

respiratory technicians, practical nurses), and administrator's roles in managing patient flow (e.g., admissions to wards, discharges) through the health care organization (Federal /Provincial/Territorial, Committee on Health Workforce, 2020). It seems logical that they are more focused on learning ward routines and managing a full patient load during the first few months of their hire. Once they begin to feel confident in managing a full patient load and the ward routines and receive feedback on their performance then their immediate focus broadens to how organizational systems and authority roles impact their workload and patient assignment. New graduate nurses need feedback on their performance to implement corrective measures as necessary and advance their confidence and competence as a registered nurse. This notion is supported by the results from Hypothesis 1, structural empowerment subscale of "please rate the extent to which the following is present in your current job: specific information on the things you do well" (B=-.07, p=.00), the only significant indicator with an alpha level of <.01. For example, NGNs begin to understand the administrative roles of the people making decisions on the inflow and outflow of patients to the wards (e.g., bed managers), and can initiate a domino effect impacting a change in patient assignment, additional patients, and increased nursing workloads. Nurse leaders do not have any formal authority within their job roles to stop patient admissions to the ward when the wards are full to capacity, and/or, if patients are at a higher acuity level (e.g., requiring one-to-one nursing care). Often within health care organizations there is a system wide situation where patients cannot move out of the emergency department to a bed on a ward, as all the beds are full. This results in patients located in the hallways on stretchers or transferred up to nursing wards that are already full. This scenario is referred to as a "code grid lock" situation and has become a new normal for health care organizations (Wait Time Alliance Report Card, 2015). This means nurse leaders are left to make decisions to transfer patients

around the ward between teams, disrupting NGNs' and RNs' patient assignments while putting patients in storage rooms, patient lounges, and hallways on the ward. For NGNs working in community health, a similar process occurs given they learn their new roles in the clinic environment over time and they begin to broaden their responsibilities as a community health nurse to community agencies and become responsive to disease outbreaks, suicides, and addictions.

Perhaps a lack of workplace empowerment of authentic nurse leaders in relation to NGNs' job demands is not noticeable by NGNs until later in their tenure with the health care organization, although it could be the measures and items selected for Hypothesis 2 that did not accurately capture the concept. It was interesting that areas of worklife subscale item of (workload) "[p]lease rate the extent to which you agree with: "I work intensely for long periods of time," coworker incivility decreases (B=-.08, p=.00). It is reasonable that some NGNs enjoy working intensely for long periods of time; however, the item did not capture the sense of being overworked or stressed in the conceptualization of the relationships of being stressed by high workloads. For example, an item could be worded as "work intensely for too long," "too much," or "the work gets in the way of completing all my job duties" or, "I work intensely for long periods and it is causing me stress or a sense of lack of control over my nursing tasks." Nor is there an item that indicates that they can take time off to deal with being overworked and or stressed. Upon review of the measures and items in the available data set that may come closer to reflecting the sense of a lack of control over workload and a lack of nursing resources for NGNs to do their job, the Nursing Worklife Index (Lake, 2002) items came closer to reflecting the sense of workload and control. The Nursing Worklife Index (Lake, 2002), a 4-point Likert scale (1= strongly disagree to 4= strongly agree) consists of six items. A total score is obtained by

averaging the item responses. A significant finding for each one unit increase in “there are enough nurses to provide quality patient care” (B=-.07, p=0.00) is that coworker incivility decreases by .07. I would have liked to use a measure that captured “Please indicate the degree to which you agree with the following: The amount of patients I am assigned” stem with the following items “puts patient safety at risk,” “is determined by patient acuity,” “allows me to complete all nursing care required in my x hr. shift,” “is directly determined by the nurse leader,” “is offset as we can ask the nurse leader for more staffing to complete all nursing care within my shift,” and “is manageable given all the RNs work as a team to make sure all nursing care is complete.” Similarly, the use of a measure that accurately captures NGNs’ perceptions of nurse leaders as having a lack of formal authority within their role to impact NGNs’ workloads and provide more staffing resources may have resulted in a significant finding in my results for the third hypothesis, rather than nonsignificant findings.

It would have been preferable to find a measure that captured the relationship between a nurse leader, formal authority within the job role as it relates to NGNs’ workloads, resources, and perceptions of trust, such as “Please rate the degree to which you agree with the following: The nurse leader/supervisor on my ward” stem with the following items: “can control my patient assignment to ensure patient safety,” “ has the ability to stop new patient admissions and transfer of patients on the ward,” “is supported by administration to have formal authority in their job role to positively impact job demands and resources,” “ can advocate and make decisions to ensure safe nurse-to-patient ratios,” “I trust them based on a congruency between what they say and what they do,” “do their utmost to create a supportive work environment,” and “have a voice at the administrative level to support positive work environments for me.” These types of items in a measure would more accurately reflect authentic leadership theory stressing the idea of

leading by example through honesty and integrity (Avolio et al., 2004) as it relates to fostering a work environment that is responsive to mitigating NGNs' job demands. To understand the results of my study further, the ecological approach is used to gain some insights into understanding the phenomenon within the health care organizational system.

Findings and the Ecological Approach to NGNs' Coworker Incivility Experiences

This study used a framework informed by Laschinger et al.'s (2016) adaptation of Scott et al.'s (2008) NGSTR model and Bronfenbrenner's Ecological Systems Theory (1978;1979) to guide the exploration of the factors contributing to NGNs' coworker incivility experiences. The research question was situated within an ecological model of NGNs' coworker incivility experiences noted in Chapter 3, focusing on the organizational context of the exosystem working inward to the microsystem and ultimately the NGN. When an NGN becomes employed, their nursing work experiences are considered as a part of the health care organizational system(s)' interdisciplinary team and are influenced by each level of the ecosystem. Although the macrosystem (e.g., organizational culture) influences NGNs, I focused on the effects that impact the NGN's day-to-day-work life experience of patient care workloads and the availability of human resources. The influence of workplace empowerment has been associated with resources and support of nursing leaders and NGNs. Workplace empowerment is within the exosystem of a health care system, with the understanding that its effects work inwards to the levels of the ecosystem. Thus, as the research lens focus is moved inwards toward the levels of authentic leadership and trust in immediate supervisor in the mesosystems, a relationship is implied to the microsystem of the NGNs' work environment, coworker incivility, and ultimately the individual NGNs.

Exosystem: Workplace Empowerment

Workplace empowerment was situated within the exosystem based on two premises. First, it may be closely related to organizational culture (e.g., located in the macrosystem) with effects to perceptions of authentic nursing leadership and trust (e.g., located in the mesosystem) to NGNs' coworker incivility experiences (e.g., located in the microsystem) (Croft & Cash, 2012; Laschinger & Read, 2016; Smith et al., 2017). Second, a lack of workplace empowerment support of formal decision-making authority (e.g., control over patients being admitted to the ward, and inability to obtain additional human resources as needed) within the authentic leadership role may be creating more workplace stressors related to high patient to nursing ratios, and ultimately NGNs' incivility experiences (Croft & Cash, 2012; Morin & Lake, 2017; Smith, et al., 2016; Spreitzer, 2008).

Workplace empowerment is comprised of the two constructs—socio-structural empowerment and psychological empowerment (Spreitzer, 2008). Through the health care organization's chain of command, power is shared through delegation of responsibility (Spreitzer, 2008). Socio-structural empowerment is perceived as power related to formal authority or control over organizational resources, and the ability to make decisions relevant to the nurse leader's and the NGN's job role. Psychological empowerment results from socio-structural empowerment and contributes to improved outcomes such as satisfaction, positive workplace retention (Cicolini et al., 2014), interprofessional collaboration (Reagan et al., 2016), and low levels of incivility (Laschinger, et al., 2009; Lautizi et al., 2009). Psychological empowerment is related to the exosystem, given it is reflected by actualizing administrative policies and procedures to support NGNs (e.g., hospital orientations, buddy shifts with staff members, and opportunities for career advancement). The findings from the regression analysis in this study support workplace empowerment having effects to trust in management located

within the mesosystem, and ultimately to coworker incivility experiences located within the microsystem.

Although health care organizations are legally obligated to develop and enforce policies against workplace incivility, bullying, and violence (COH& SR, 2020), there are likely variations in timelines of the laws garnering royal ascent and thus resulting policies, this means there is an opportunity for health care administrators to promptly enact policy changes according to provincial and territorial amendments to workplace violence legislation. In Canada, there has been gradual and varying incremental changes in laws to address negative workplace behaviours such as workplace violence, bullying, and harassment according to provincial and territorial laws. In 2004, Quebec was the first province to pass legislation addressing workplace bullying with its Act Respecting Labour Standards (§ Chapter N-1.1). In 2007, Saskatchewan expanded the definition of harassment under its Occupational Health and Safety Act to include bullying (§ Bill 66-2006-07). Ontario expanded its definition of workplace harassment under the Occupational Health and Safety Act in 2009 (§ Bill 168). In 2011, Manitoba made changes to its Workplace Health and Safety Act to include protection from workplace bullying (§ C.C.S.M. c.W210). In 2012, British Columbia was the fifth province to pass legislation addressing workplace bullying (§ Bill M212-2012).

Mesosystem: Authentic Leadership, Areas of Worklife, and Trust in Management

Authentic leadership is closely related to areas of worklife (r=.569, p=0.00 two tailed) and trust in management (r=.735, p=0.00, two tailed). It could be that authentic leadership was too highly correlated to trust in management in the regression model to pick up authentic leadership significance and/or there is something confounding the construct, such as structural empowerment (r=.494, p=0.000, two tailed). Perceptions of the authenticity of the authentic

leader may hinge on whether the leader can be congruent with exhibiting values of fairness and trustworthiness (Alilyyani et al., 2018; Laschinger & Smith, 2013; Wong & Cummings, 2009) through control of NGNs' workload and fair allocation of resources (Kim et al., 2016; Lautizi et al., 2009). In the ecological model, authentic leadership, trust in management, and areas of worklife are situated between workplace empowerment and NGNs' workplace experiences (e.g., incivility). I was interested in exploring what factor(s) impacts increased nurse leader control over meso level factors, such as workplace dynamics and workload, on NGNs' self-reported coworker incivility at a microlevel. Further, I looked at whether downward trends of NGNs' evaluation of their supervisors' authentic leadership (Kelly & Abern, 2009) were related to the supervisor's lack of control over adverse organizational factors operating at an exosystem level.

Predictor and Outcome Variable Relationships

Bivariate analysis was used in the methods to assess relationships between predictor variables and the outcome variable. Authentic leadership is strongly correlated to trust in management ($r=.73$, $p=.00$, two tailed). Centered interaction variables were used to decrease multicollinearity between trust in management and authentic leadership. The regression model used to determine if authentic leadership predicted coworker incivility included structural empowerment and trust in management as controls**,** along with their associated centered interaction terms. The centered interaction terms were nonsignificant. In results of the regression model (e.g., H_3), NGNs' perceptions of authentic leadership did not predict NGNs' coworker incivility experiences when controlling for structural empowerment and trust in management. These findings make sense given what I have experienced and witnessed in nursing practice as a leader, nurse**,** and educator working with NGNs. New graduate nurses are aware that the authentic leader is not controlling their workload in terms of patient admissions, discharges, and

acuity levels of patients admitted to the area. Bed managers are often on the wards and contacting staff to manage patient inflow and outflow. New graduate nurses understand that although a nurse leader might be able to request extra staff, those in higher administrative levels are controlling staffing and patient levels (e.g., admissions, referrals, transfers among wards, discharges). Given the structural empowerment item "specific information on the things you do well" contributed a significant degree of variability to NGNs' coworker incivility experiences when controlling for authentic leadership and trust in management (H_1), this means there is an opportunity for health care administrators to support authentic leaders through workplace empowerment— the allocation of formal authority within the job role of the authentic leader. In addition, trust in management contributes more variability to coworker incivility experiences than authentic leadership when regressed in the third model; thus, NGNs' trust in management perceptions are more significant than authentic leadership . This means that NGNs' perceptions of trust in management item are coming closer to connecting to their perceptions of the nurse leader and factors contributing to their experience of coworker incivility in the clinical environment, in addition to the notion of value congruence of the nursing leader's behaviour aligning with their actions. Trust in management is closely tied to some of the items in the areas of worklife measure to coworker incivility experiences of NGNs.

NGNs' Coworker Incivility Experiences

This study contributed knowledge to coworker incivility experiences of NGNs through providing an organizational context using an ecological approach to examine the relationships of select variables of interest to coworker incivility experiences. Incivility is closely tied to perceptions of areas of worklife noted above, and to the literal aspects of day-to-day nursing practice workload (e.g., job demands); control (able to influence management to obtain

resources, autonomy); community (e.g., sense of belonging/cohesiveness with peers at work); fairness (e.g., perceived justice); and values congruence (e.g., match between employee and organization priorities and values). Howell's (2016) research finding focused on organizational factors, such as job characteristics, leadership, and organizational structures that can positively or negatively influence NGNs' incivility experiences. Yet NGNs' experiences of enabling and inhibiting factors are compounded by many feeling unprepared for practice due to time pressures, new roles, and responsibilities (Higgins et al., 2010). Inhibiting factors of incivility occur at individual (i.e., management of workload, control, and fairness), social (i.e., work cohesion, respect, and communication), and organizational (i.e., manageable workloads and career advancement opportunities) levels (Howell, 2016). The inhibiting factors of incivility occur at individual levels (i.e., management of workload, control, and fairness) are quite similar to items of the areas of worklife scale items (e.g., workload-job demands, control-able to influence management to obtain resources, autonomy), trust in management scale items "establishes and communicates expectations fairly." The connections of the measures of authentic leadership items are more general rather than specific to factors that may directly impact NGNs' workload-job demands, control, and fairness. For example, the addition of authentic leadership moral/ethical items "makes difficult decisions based on high standards of ethical conduct," and balance "analyzes relevant data before coming to a decision," and "demonstrates beliefs that are consistent with actions." Howell's (2016) organizational level (i.e., manageable workloads and career advancement opportunities) seems to align more closely with items from the authentic leadership measure. These organizational level factors reflect the mediational role of authentic leadership between NGNs' and relaying decisions of organizational level administrators.

Authentic leadership alone does not account for a reduction in coworker incivility when used as a predictor variable to NGNs' coworker incivility in a regression model, although it is highly negatively correlated with coworker incivility experiences of NGNs. As nurse educators and researchers, we need to be aware of how workplace empowerment may be perceived by NGNs and the relationship of authentic leadership to their perceptions.

First, workplace empowerment is meant to counter the role of colonizing practices through providing support and resources to NGNs and nurse leaders. My personal experiences of working in nursing leadership and education roles gave me the sense that a lack of workplace empowerment may be contributing to sustaining colonization of nurses. There is a lack of workplace empowerment of nurse leaders, as such they are mere minders of the system lacking formal decision-making authority within their role. Workplace empowerment is an important predictor of NGNs' coworker incivility; thus, nurse leaders should be empowered by health care organizations given they have a greater influence over NGNs. The greater level of influence of authentic nurse leaders is reflected in the ecological framework as situating authentic leaders within the mesosystem next to the microsystem and NGNs.

Second, a lack of structural support of authentic nurse leaders in their job role may be creating more workplace stressors related to high patient to nursing ratios, and ultimately NGNs' incivility experiences (Croft & Cash, 2012; Kim et al., 2016; Smith et al., 2017; Spreitzer, 2008). Third, the perception of the authenticity of a nurse leader who adopts a leadership style of being an authentic leader may hinge on whether the leader can be congruent with exhibiting values of fairness and trustworthiness (Alilyyani et al., 2018; Laschinger & Smith, 2013; Wong & Cummings, 2009;) through control of NGNs' workload and fair allocation of resources (Kim et al., 2016; Lautizi et al., 2009). In fact, nurse leaders regardless of their leadership style (e.g.,

authentic, transformative) lack structural support.

Limitations

Secondary data analysis is a key limitation of this study given the dataset (Laschinger et al., 2012-2014) was self-report contributing to selection bias, not independently verified or triangulated and the variables exist in the dataset (Laschinger et al., 2012-2013) so I could not define and construct them in the manner I would have liked in my study.

The sample proportion of NGNs compared to the national proportions of available NGNs working in Canada in 2012 did not represent the population of NGNs available in the ten provinces included in the study. As noted in Chapter 3, Quebec, Nova Scotia, Manitoba, Northwest Territories, and Nunavut were under-represented and contribute to a biased sample. Ethnicity, first language (e.g., other than French versus English speaking), country of origin, and country of origin for nursing training or ethno-racial identification was not obtained from respondents in the dataset. It is possible that these excluded variables could have influenced the results of the analysis undertaken in this study. It is possible that the demographic factors such as ethno-racial identity, first language, gender, and disability may affect incivility experiences.

The main effects of variables were explored in this study. The main effects are the portion of the IVs (e.g., structural empowerment, trust in management, AL, areas of worklife) on the DV (e.g., NGN coworker incivility experiences) when controlling for important variables that do not depend on the values of other important variables in the models (Frost 2019). Variables explicit to the exosystem (e.g., organizational culture), and chronosystem (e.g., time) were not included in this study. This is a key limitation of my study given I did not explore the predictor relationships of variables from the exosystem and chronosystem to coworker incivility as an outcome variable as explained in Chapter 4.

Threats to Internal Validity

Selection Bias

Selection bias in those who chose to respond to the survey is reported as a limitation for this study. The data were collected using self-report by nurses; therefore, response bias may be a limitation. In the current study the response rate was 30% (n= 1,175); thus, NGNs who are not represented in the sample and their experiences and/or opinions are not reflected. In addition, nurses from territories not included in the sample may have different experiences based on factors such as geographic areas, rurality, and variances in nursing practice settings and nursing services to marginalized populations.

Additive and Interactive Effects

Several validity threats can operate simultaneously and if they do, the net bias is dependent on the direction and magnitude of each individual bias plus whether they combine additively or interactively (Shadish et al., 2002). Although centered variables were used to identify interaction effects of multiple IVs there may have been other effects. For example, multiple items were used in the current study, and most were positively scored measures and thus combined could have created a net bias. Interaction effects are the portion of an IV's effect that does depend on the value of at least one other IV in the model (Frost, 2019). For example, through the use of interaction terms to explore the theoretical interconnection of variables (e.g., trust in management and authentic leadership) respective relationships and contributions to the variability of NGNs' coworker incivility experiences are identified.

Historical Effects

The NGNs included in the study worked in a range of nursing practice areas (Laschinger et al., 2012-2013 Time 1 Dataset). At the organizational level, 3.8% of NGNs migrate to

different wards, while 7.3% of NGNs work in multiple specialty areas (Laschinger et al., 2012-2013 Time 1 Dataset) and may experience varying nurse leadership approaches, variances in team nursing, and responses to coworker incivility reports and resolution of complaints. In addition, each group experiences a unique local history associated with variations of timelines in the implementation of provincial occupational health and safety laws developing on workplace violence, harassment, and bullying as noted previously in Chapter 3. Close to the time of the data gathering (November 2012-March 2013), Manitoba made changes to its Workplace Health and Safety Act *(*§ C.C.S.M. c.W210, 2011) to include protection from workplace bullying. Meanwhile during the time of data gathering, British Columbia introduced the Workplace Bullying Prevention Act (§ Bill M212-2012, 2012) that health care organizations were mandated to implement. Variance in coworker incivility policies and perhaps varying approaches to coworker incivility reporting and ways of dealing with reports by nursing leaders and administrators may have been a factor. Although a heterogeneity of units is represented, there is also the effect resulting in non-equivalent groups of nurses based on variances in practice location and health care organizations in which they work.

Threats to Construct Validity

Threats to construct validity are reasons why inferences about the constructs that characterize study operations may be incorrect (Shadish et al., 2002).

Construct Confounding

Given that all predictor variables from my hypothesized ecological model of NGNs coworker incivility experiences were not included in this study (e.g., chronosystem, time, a measure for perceptions of fair treatment) construct confounding is indicated as an issue. In addition, the knowledge and experience with workplace violence, harassment, bullying policy,

personal factors of psychological state, and a person's self-appraisal of their ability to cope with environmental demands may have contributed to incorrect inferences about the relationships between the predictor variables to the outcome variable.

Confounding Constructs with Levels of Constructs

The intensity and range of the construct used in my study may have failed to describe the limited levels of the construct that only recognized some levels of each facet (e.g., territories not included in the sample). However, there was a good range of NGNs age and areas of practice.

Inadequate Explication of Constructs

Inadequate explication of constructs was a limitation, given some of the variables did not adequately reflect the constructs I hypothesized in the ecological approach to NGNs' coworker incivility experiences. In addition, confounding constructs with levels of constructs were limited by not including explicit variables measuring organizational culture in the macrosystem of my ecological model of NGNs' coworker incivility experiences.

Mono-Method Bias

Mono-method bias is a limitation given the same self-report method was used as the means of recording responses. In the original study (Laschinger et al., 2016), qualitative data was collected; however, not used in the current study were questions pertaining to NGNs reflecting on their practice as a registered nurse since graduation, such as: what aspects of the practice environment have supported them, what supports were needed but not available, and specifically, a question reflecting on the NGN's experiences transitioning to practice. i.e., "Is there anything else you would like to share about your transition/adjustment to your role as a professional nurse?" This information could have added clarity to some of the quantitative findings related to areas of worklife, authentic nurse leadership, and workplace empowerment.

Threats to Statistical Conclusion Validity

Statistical conclusion validity threats are the reason(s) why inferences about covariation between two variables may be incorrect (Shadish et al., 2002).

Inaccurate Effect Size Estimation

For this study, the threat of inaccurate effect size estimation and heterogeneity of units are of concern. I chose a medium effect size estimation which may have been an overestimate or underestimate of the actual effect of predictor variables (e.g., structural empowerment, trust in management, authentic leadership, and areas of worklife) to the outcome variable (e.g., coworker incivility).

Heterogeneity of Units

Heterogeneity of nursing practice units increased the variability on the outcome variable within conditions increasing error variance, making detection of a relationship more difficult. New graduate nurses included in this study were from different several specialty areas of nursing practice (e.g., medical/surgical, community health, geriatric, and mental health nursing). These variances in job roles and characteristics of practice settings interact with a cause-and-effect relationship between differences in organizational administrative structures of managements, nursing leadership, nursing ward/unit routines, and policies and procedures. In addition, a threat to external validity are reasons why inferences about how study results would hold over variations in persons, settings, and outcomes may be incorrect (Shadish et al., 2002).

Restriction of Range

The regression models tested the variability of the IV on the DV for each hypothesis. Although the variability range was quite low (e.g., 8 to 20%), an assumption of regression analysis is that IVs are measured without error, a clear impossibility in most social and

behavioural science research (Tabachnick & Fiddel, 2019). Studies for human behaviour have R^2 values less than 50% (Frost, 2019). The best a researcher can do is to choose the most reliable IVs possible. Even though I have low R^2 values, the IVs were statistically significant for H_1 and H_2; thus, important conclusions about the relationships between variables can still be drawn. Statistically significant coefficients continue to represent the mean change in the DV given a one unit change in the IV (Frost, 2019). The findings for my third hypothesis (H_3) did not have a significant unit change for the IV; for each one unit increase in authentic leadership, coworker incivility decreased by .03 (B=-.03, p=.265) with a significance level >0.01, CI [-.10, .02] when trust in management and structural empowerment are held constant. A 95% CI means that 95 times out of 100 when samples are collected and analyzed in the same manner the CI contains the true value. The true value within the range is -.10 to .02 for NGNs' perceptions of authentic leadership being negatively related to coworker incivility experiences. Alternately, the distribution of means could be narrow because the population of individuals may have a small standard deviation relating to a larger effect size. The effect is the difference between the true population parameter and the null hypothesis values. The bigger the effect size is, the greater the power. The effect size, however, is also affected by the population standard deviation. The smaller the standard deviation is, the bigger the effects size (Aron et al., 2009).

Fishing and the Error Rate Problem

I chose a very conservative Bonferroni correction (1936) for all tests of hypothesis; however, this was not adjusted when I did post-hoc analysis to determine which items of each construct was contributing the most significant variability to the DV. When further inferential statistics were done in the regression models using items and then other scales as in H_3, all the IVs were included, and their assumptions tested. However, additional inferential procedures of

any kind without an associated hypothesis (e.g., the use of the Nursing Worklife Index measure (Lake, 2000) may be viewed as taking an exploratory approach to look for preferred outcomes (Tabachnick & Fidel, 2019). This could have contributed to a Type 1 error in review of analyses.

Contributions to the Existing Literature on NGN's Experiences of Coworker Incivility

The findings from both the IR (Blackstock et al., 2018), and literature review supported exploring the predictor variables of structural empowerment, authentic leadership , areas of worklife, and trust in management to incivility among NGNs. Specifically, I sought to determine if workplace empowerment situated within the exosystem had predictive effects inwards toward NGNs' coworker incivility experiences. Understanding the relationship(s) of workplace empowerment and other variables of interest to coworker incivility assists to clarify the systems and factors contributing to its existence, thereby adding to the body of knowledge of NGNs coworker incivility. This expansion of knowledge assists to identify the problem of coworker incivility, and subsequently, the contributing factors so that policy makers can develop relevant anti-incivility policies. Problem definition is critical in policy development and implementation to ensure appropriate identification, reporting, and procedures (Pal, 2010) in dealing with reports of coworker incivility. When clear policies are developed there are domino effects and impacts to health care administrators and management insights into how coworker incivility can be mitigated through organizational structural change in administrative processes and job roles. My research findings support workplace empowerment and areas of worklife as being significant predictors of coworker incivility experiences.

Workplace Empowerment, Areas of Worklife, and Nursing Worklife

The use of workplace empowerment measures are intended to capture the empowerment of nurses through workplace processes, policies, culture, and career advancement. Although I

used workplace empowerment in this study, I would have liked to use a measure that captures a lack of workplace empowerment through lack of decisional authority of nurse leaders to mitigate NGNs' job demands and access to human resources. Further, as I conducted the analysis in Chapter 3, I wondered if the workplace empowerment measure of workload accurately captures the role of nurse leaders being linked to workloads, given NGNs look to their nurse leader to mitigate high job demands through additional resources (Croft & Cash 2012; Smith et al., 2017). The measure of structural empowerment (CWEQ-II, Laschinger et al., 2001) are contrasted against this study findings to determine whether aspects of the measure were not being captured among the relationships of NGNs' perceptions of workplace empowerment to their authentic nurse leader, and areas of worklife.

The structural empowerment measure (CWEQ-II, Laschinger et al., 2001) in this study reflects the following for NGNs: a) access to resources (e.g., equipment and supplies for their job); b) access to support (e.g., performance feedback and assistance from one's coworker and supervisor); c) opportunities to learn and grow (e.g., development training and professional development); and, d) access to information (e.g., access to organizational goals, policies, and procedures).

Areas of worklife measure (Leiter & Maslach, 2004:2009) is comprised of six key areas: workload (e.g., job demands); control (e.g., able to influence management to obtain resources, autonomy); rewards (e.g., appreciation, recognition, or compensation); community (e.g., sense of belonging/cohesiveness with peers at work); fairness (e.g., perceived justice); and values congruence (e.g., match between employee and organization priorities and value). Areas of worklife had a stronger predictive effect to coworker incivility (B= -.60, p=.00) when authentic leadership, trust in management, and structure empowerment were held constant. However,

structural empowerment had a smaller effect (B=-.04, p=.00) when authentic leadership and trust in management are held constant. It may be that the areas of worklife measure comes closer to capturing the NGNs' workload/job demands and control (e.g., human resources) than the structural empowerment measure, given it reflects support in material resources, performance feedback from a supervisor, access to information, professional development, and career advancement. I looked for a measure and items that may come closer to reflecting the sense of a lack of control over workload and a lack of nursing resources for NGNs to do their job. A regression model was run using the Nursing Worklife Index, subscale item of supportive professional practice (Lake, 2002) "[o]n my unit:" "nurses control their own practice," and "there are enough nurses to provide quality patient care," were used as independent variable with centered variables of authentic leadership, trust in management, and structural empowerment in the regression model to determine if the items contribute significantly to the variability in NGNs' coworker incivility. The results revealed that 9% (p=0.00), CI [1.6, 2.0] variability in NGNs' coworker incivility experiences is accounted for by nursing worklife, when controlling for authentic leadership , trust in management, and structural empowerment. A significant finding for each one unit increase in "there are enough nurses to provide quality patient care" (B=-.07, p=0.00) coworker incivility decreases by .07. This item comes close to reflecting the relationship of NGNs' workloads and staffing resources. The finding aligns with the ecological model identifying the relationship of Nursing Worklife Index (Lake, 2002) subscale items to NGNs; however, I was looking for a measure that captures the NGNs' workload and whether there are enough staffing resources to ensure that NGNs' nursing care and job duties are manageable within their shift work.

In addition, the majority of the NGNs in the sample benefited from an

orientation/preceptorship program ranging from 3.5 to 7 weeks; thus, some of the measures of workplace empowerment used in this study (e.g., information on policies, procedures, organizational goals) were addressed early on in their employment tenure as NGNs in the health care organization. Given this may have been the case, perhaps these measures of workplace empowerment would have been captured well before the one-year timeline of this Time 1 (November 2012-March 2013) sample. For example, information on policies and procedures, organizational goals, career advancement, and awareness of location of equipment and supplies for their jobs in the nursing practice area are typically learned during orientation seminars and subsequent preceptor shifts with an RN from the ward reviewing ward routines, nursing policies, and procedures. Probation periods for NGNs are typically a three-month period from date of hire; thus, performance feedback has to be provided prior to this time and in a formative manner. This reinforces the premise that NGNs are focusing on demonstrating their competence to their employer, other RNs, and NGN peers, as well as working hard at being valued team members, perhaps at times in spite of experiencing or witnessing coworker incivility experiences.

Importantly, positive aspects of social networking at work and a sense of team cohesiveness are known to support civility behaviours among nurses (Howell, 2016). The sense of comradery and team support related to the sense of community in the areas of worklife may be capturing more of the variability in the measure given NGNs were working mainly in one specialty area 96.6 % (n= 985). This means that NGNs could become familiar with their coworkers and ward routines, and develop a sense of comradery in working together to deal with high acuity patients, over ward capacity of patients, and a lack of human resources. The issue of comradery in working together resonates with the findings from the H_2. The areas of worklife being negatively related to coworker incivility finding of the item “members of my workgroup

co-operate with one another." If NGNs have a clear expectation of the importance of teamwork and expectation to work together then it shows promise to mitigate the pressure of feeling overwhelmed with workload and, ultimately, NGNs' coworker incivility experiences. New graduate nurses work with the nurse leader through their work interactions on the ward and begin to develop a relationship, along with perceptions of trust and the leadership style of the nursing leader. Through these relationships and development of NGNs' perceptions, they begin to develop an understanding of the role of the authentic leader and how they are supported by the health care organization to enact their role. In addition, NGNs begin to understand the impacts of the nurse leader's lack of formal authority within their job role to mitigate NGNs' workloads.

Authentic Leadership, Workplace Empowerment and Trust

Authentic leadership restores optimism, promotes transparent relationships, and fosters trust (Laschinger & Smith, 2013). Evidence of a leader's trustworthiness and authenticity is demonstrated through their modelling of fairness, execution of justice for others, and reliability (Laschinger & Smith, 2013). Fostering trust and positive emotions are critical intervening variables that authentic leaders enhance in their followers (Avolio et al., 2004). Authentic leadership was strongly correlated to trust in management ($r=.73$, $p=.00$ two tailed). Thus, it seems plausible that when NGNs experience the reality of high job demands on the wards and a lack of appropriate job resources, it may be judged as a breach of trust of the authentic leader resulting in a reduced perception of authenticity of their leader.

In this study, NGNs' perceptions of authentic leadership were measured using Walumbwa et al.'s (2008) Authentic Leadership measure, consisting of the following four subscales: self-awareness (e.g., understanding own strengths, weaknesses, and limitations and how their actions affect others); relational transparency (e.g., being open with others, and

promoting an environment where opinion, and sharing ideas and challenges are encouraged); internalized moral/ethical perspective (e.g., defining and modelling a high standard of moral and ethical integrity and making decisions consistent with these values); and balanced processing (e.g., soliciting feedback and opinions from others prior to resolving important decisions). I wondered whether NGNs judge the degree of their nursing leader's authenticity based on the leader's control of job demands on the ward and access to resources. Authentic leaders differ from inauthentic leaders given they are known to build credibility, and win the respect and trust of followers, thereby leading in a manner that followers recognize as authentic (Avolio et al., 2004). Authentic leadership was not a significant predictor of coworker incivility rates when controlling for trust in management and workplace empowerment in this study. When I ran the analysis again using separate items for each measure, the authentic leadership subscale self-awareness item "please rate the extent to which your leader (immediate supervisor) knows when it is time to re-evaluate his or her positions on important issues" (B=.09, p=.00) was the only significant item in the subscale contributing to variability in coworker incivility when controlling for trust in management and workplace empowerment. It is possible that NGNs may perceive this related to what they witness in practice when their leader is up against an issue, yet the indicator does not allow for determination as to whether the issue is urgent as it relates to NGNs' experiences of the nursing practice environment. It may mean that there is a measure missing that would capture the disconnect between the nurse leader's position and the NGNs' perception of their nurse leader's impact/control over nurse-patient ratios and staffing resources. It was an interesting finding given research to date support authentic leadership as a key role in mitigating incivility rates. When NGNs struggle to meet the job demands due to high acuity patients, over ward capacity scenarios, and a lack of human resources in spite of other team members pitching

in, they may look to the authentic leader. They may initially believe early in their work employment tenure within the health care organization that the authentic leader has the authority within their job role to respond with additional human resources and make decisions to control and/or manage patient inflow and outflow from their specialty areas. As NGNs gain more work experiences, they understand their authentic leader does not have control over the factors such as human resources and mitigating patient inflow/outflow from the practice areas. This premise is supported by Laschinger and Read's (2016) findings that authentic leadership perceptions decreases as the NGN's tenure in an organization increases. New graduate nurses may be making the connection of perceived control over workloads as an effect from workplace empowerment. Structural empowerment has a higher significance level (B=-.04, p=.00) to coworker incivility compared to trust in management (B=-.07, p=.00). Workplace empowerment may be perceived/interpreted differently by the NGN as tied to a nurse leader who controls aspects of areas of worklife related to job control and human resources, rather than connecting workplace empowerment directly to the nursing staff through material support and access to information. In future research, I will explore current mentorship and new graduate transition programs to determine the following: "What is the relationship of organizational tenure in supporting NGNs and coworker incivility?"

Healthcare Organization, Policy, Nurse Leaders, and Practice

Organizational influence through workplace empowerment has been researched related to allocation of resources, career advancement, information about the values/goals of top management, and support (i.e., time to do paperwork and accomplish job requirements) to RNs within the health care system. New graduate nurses benefit from aspects of workplace empowerment, but limited studies look at the combined impacts of a lack of workplace

empowerment and nursing leadership on NGNs. Combined impacts include a lack of workplace empowerment of nurse leaders within their role and the impacts to NGNs' perceptions of authenticity of leaders, trust of immediate supervisors, and the relationship to NGNs' areas of worklife. Understanding NGNs' coworker incivility experiences included within the ecological framework assists researchers in deepening the understanding of the problem of incivility. Key information related to NGNs' coworker incivility experiences such as whether participants attended educational interventions on bullying or incivility prevention prior to or during their employment, their knowledge of anti-incivility policies and procedures, and authentic leader's experiences dealing with coworker incivility reports were not available in the dataset.

However, the role of workplace empowerment in supporting authentic leaders through assigning the nurse leader formal decision-making authority will lead to two important factors: first, broadening the NGNs' perspective of authentic leaders being congruent with their leadership philosophy and their ability to impact day-to-day changes to improve NGNs' job control and access to human resources, and second, supporting trust of authentic leaders and nurse managers in general in mitigating NGNs' work stressors that in the past have led to judgment of work not being completed and coworker incivility. This process will also assist in expanding the understanding of the problem of coworker incivility to craft a relevant policy to mitigate the problem and assist in policy analysis in evaluating the effectiveness of an anti-incivility policy. This process is important given the historical lack of clarity in defining coworker incivility in policy statements (Griffin, 2004). A lack of a clear definition is further complicated by a lack of training of those responsible to be able to accurately identify coworker incivility, and to effectively deal with reports of coworker incivility has consistently been identified as a limitation in prior studies (Leiter et al., 2010; Lewis, 2006; Myers et al., 2016).

Secondary gains of identifying the problem of coworker incivility experiences of NGNs will be developing nursing curriculum and relevant educational workplace sessions.

Nursing Education and Teaching

Regulatory and accrediting nursing bodies and schools of nursing are positioned to advocate for nursing leaders to have formal authority within their job roles. Regulatory nursing bodies are positioned to advance the narrative wherein nurse leaders are given formal authority within health care organizations to control NGNs' workloads to develop relevant indicators and metrics to measure NGNs' workloads, resources, and aspects of areas of worklife. For example, the Registered Nurses Association of Ontario (RNAO) discussion paper (2005) explored workload management systems in order to understand and manage the organization of work (functions) and the costs of nursing care and the impact of nursing resources (on patient outcomes) to benefit hospital administrators. In addition, the workload management system was anticipated to have positive impacts on the work environment and nursing practice, and nurses to be given "a voice to the practice of nursing" (RNAO, 2005). If the workload management system included the importance of nurse leaders being given formal authority then the ability of nurse leaders to control NGNs' workloads (e.g., management of patient inflow/outflow and control of human resources) would be a normal part of practice and the workload management system would potentially have the ability to improve nursing care and patient outcomes.

Nursing educators and regulatory and accreditation nursing bodies could use the ecological model of NGNs' coworker incivility experiences to lobby for formal decision-making authority of nursing leaders. Nurse educators will be able to use the ecological model of NGNs' coworker incivility experiences to teach nursing students the relationships of workplace empowerment to formal authority within nursing leadership job roles, areas of worklife, and trust

in management. This new understanding of the interrelatedness of roles, and decision-making authority, or lack thereof, will arm nursing students with knowledge to advocate for systemic change and understand nurse leaders' roles. If nursing students understand nursing leaders lack formal authority in their job roles, then they will be able to target appropriate authority to mitigate disproportionate and unsafe RN-to-patient care ratios. Ensuring nurse educators are using a curriculum that is congruent with current nursing practice workloads prepares nursing students for higher acuity patients and variations in delivery of nursing care on wards and in community. Although this is the goal of nursing schools, there is a disconnect between control over workloads by those in nursing leadership positions and perceptions/expectations of NGNs. This means that NGNs may be expecting nurse leaders to mitigate nurse-to-patient workloads and obtain more RNs as necessary all to support and ensure NGNs and RNs can complete nursing care duties. In addition, the expectation is likely that patient safety is maintained. Secondary impacts are supporting NGNs to deal with competing priorities and patient load variations with secondary benefits of enhancing nursing care delivery and contributing to nursing knowledge.

Knowledge Contribution to Nursing

New graduate nurses are a valued resource to succession planning of RNs in Canada. Given the incidence and prevalence rates of coworker incivility experiences are often under reported, it is important to identify and mitigate the sources of coworker incivility. Most new graduate nurses look to their nurse leaders, RN coworkers, preceptors, and NGN peers for knowledge, collaboration in nursing care of patients, and guidance. In nursing practice, NGNs try to build trust with nurse leaders, RNs, interdisciplinary team members, and NGNs' peers as they progress in their employment. My findings of this study shed light on the importance of area

of worklife, trust in management, and workplace empowerment to NGNs' coworker incivility experiences. New graduate nurses need to learn about the job role(s), and the lack of authority of the nurse leader within their role. If NGNs gain clarity on the nursing leader's roles, authority, or lack thereof, then they will understand the nurse leader's limited ability to control nurse-to-patient ratios and acquire additional human resources. Further, NGNs can look at the effects of systemic structures, administrative roles, and policies that impact patient flow through the health care organization within institutions and the community. Importantly, future research to determine which items of the measure has the most variability to decreased NGNs' coworker incivility experiences will assist health care administrators and nurse leaders in supporting NGNs. In addition, this information can assist nurse educators in training nurses in the theoretical and practical importance to mitigate coworker incivility experiences.

This dissertation marks the beginning of my research area, using an organizational context to explore NGNs' experiences of coworker incivility. My research plans are as mentioned previously, in addition to using all of Laschinger et al.'s (2016) antecedents within an ecological model to explore relationships of all the systems. In the next section, I share some more insights into my future program of research on NGNs' incivility experiences.

Future Program of Research

The organizational context of NGNs' practice has remained constrained amidst a colonial administrative hierarchy on the one hand, and on the other hand, patient acuity on general nursing wards has increased to the extent wherein NGNs do not experience a stabilization of patient assignments/workload and thus the associated nursing tasks and patient care. My program of research on NGNs' coworker incivility experiences will focus on four key areas, as follows: a) identification and creation of measures that accurately reflect the conceptualization of workplace

empowerment, authentic nurse leadership, NGN's work experiences, and NGN's coworker incivility in my ecological model; b) the role of employment probation and perceptions of NGNs' coworker incivility experiences; c) nurse leadership, formal authority in their job role, NGNs' workload, and NGNs' incivility experiences; and, d) policy and NGNs' coworker incivility experiences.

Nurse Leader, Formal Authority, and NGN's Coworker Incivility Measures

The current measures available in the literature are not specific to NGNs and their nursing practice environments nor are they able to capture the lack of formal authority of nursing leaders as reflected in the ecological model of NGNs coworker incivility experiences as noted earlier. For example, items in a scale that capture whether they are currently in a mentorship/preceptorship, probationary period, their perceptions of workload, the nurse-to-patient ratios, and perceptions of how much control they have over their workload, and a sense of whether they experience workload help through teamwork. In addition, items are needed that could link the role of the nurse leader in mitigating their workload through additional staffing resources and/or patient admissions, and transfers during their shift or work rotation. There is an opportunity to devise measures that reflect the old patriarchy and the current NGNs' and RNs' nursing practice environments, wherein a lack of formal authority in nurse leaders' job roles is the norm. My hope is that these findings will provide the evidence needed to dismantle the systemic oppression in health care organizations and empower nurse leaders, RNs, and NGNs so that manageable workloads and the ability to have input into patient admissions/discharges and transfers about the ward is the new normal.

I believe that the ecological approach to NGNs' coworker incivility shows promise to understand the relationships of each concept if measures accurately capture the constructs

indicated in both the IR (Blackstock et al., 2018) and literature review I conducted. Although using a linear regression approach was helpful, once I have measures that accurately reflect the constructs specific to NGNs, further multiple linear regression analyses might capture the layered systems within the ecological approach to NGNs' coworker incivility experience to answer the question "What is the impact of a lack of workplace empowerment to nursing leaders and NGN's coworker incivility experiences?".

The Role of Employment Probation, Preceptorships/Residency Duration, and Perceptions of NGNs' Coworker Incivility Experiences

The role of employment probation in relation to NGNs' experiences of coworker incivility is an intriguing area of research that could have secondary benefits of informing NGNs preceptorships. It may be that NGNs endure incivility in the workplace differently during their probationary period compared to when they have completed the probationary period. It could be that NGNs 'turn a blind eye' to coworker incivility to avoid conflict with the hope that it will successfully contribute to passing the probationary period. Although the chronosystem was not explored in this study, the notion that a competent practitioner occurs within the first two years of practice, as demonstrated within Laschinger et al.'s (2016) model, is of interest. Researchers recommend that nurse leaders designate part of the education budget to provide education for preceptors and those being orientated to the wards in addition to a nurse residency program that covers the new graduate nurse's first year instead of the traditional six to 12 weeks (Hussein et al., 2017; Theisen & Sandau, 2013). This particular focus would be of interest to explore in future research.

Nurse Leadership, Formal Authority in Their Job Role, NGNs' Workload, and NGNs' Incivility

In keeping with the ecological approach, I am interested in which coworkers with informal (NGN peers, RNs, Licensed Practical Nurses) or formal leadership (e.g., nurse leaders or senior nurses) job roles and abilities play more of a role in supporting, mentoring, and advocating for NGNs. In turn, the findings would also lead to insights into NGNs' transition programs, preceptorships, and mentorship program design, duration, and policies related to NGNs' onboarding, support, and career advancement.

Policy and NGNs' Incivility Experiences

The importance of gaining clarity to identify the problem of NGNs' coworker incivility experiences is an important first step as noted previously. New graduate nurses' incivility experiences have been measured through instruments that are geared to RNs. So, although problem clarity may be coming clearer with this study, more work is needed to correctly specify NGNs' incivility experiences as unique to them. Through identification of NGNs' incivility experiences, the problem becomes clearer, and thus policy makers have an opportunity to craft policies that are inclusive of NGNs' work experiences.

Conclusion

Researchers who study incivility focus on general nursing populations, yet NGNs are identified as a high-risk group of victims (Laschinger, & Grau, 2012; Trepanier et al., 2016). The researchers' findings highlight the detrimental effects of unmanageable workloads (Russell, 2016), lack of manager support, and hospital administrators' accountability (Reuter, 2014), yet less is known about the factors specific to new graduates and what contributes to a lack of support of nurse leaders and NGNs' unmanageable workloads. Clarification of factors

contributing to a lack of workplace empowerment of nurse leaders and NGNs' unmanageable workloads is timely, given the vision of the future of nursing (Federal/Provincial/Territorial [FPT] Committee on Health Workforce, 2020) calls for optimizing autonomy of nurses, and to enable nurses to play an enhanced change in leadership roles in supporting nurses to provide high-quality, cost-effective care through authorizing enhanced nursing scope of practice, and improving unity among nurses.

The ecological model of NGNs' coworker incivility experiences uses an organizational context linking the lack of formal decision-making authority of authentic leadership to job demands. I highlight the impacts of a resource depleted environment as a proxy for considering impacts of a lack of workplace empowerment of nurse leaders with the intent to unveil oppression in nursing. Organizational context provides a foundation to understand how NGNs perceive the effectiveness of nursing leadership to control their job demands, obtain more human resources, and make changes because of structural hierarchies. I suspect when NGNs rate 'job resource effectiveness' of the leader as low, that it leads to a decrease in perceptions of an 'empowering environment' and negatively affects perceptions of trust and authenticity of the 'authentic leader.'

In particular, the ecological model of NGNs' coworker incivility experiences is a step to clarify that incivility behaviours are not only individual behaviours observed by others but rather a symptom of work environment factors that influence individual behaviours. Regardless of authentic leadership in assuaging impacts of organizational decisions (i.e., patient workload fluctuation; nurse-to-patient ratios; and bed moves to accommodate patient admissions), resource depletion persists without the ability to stop factors contributing to its existence (Croft & Cash, 2012; Kim et al., 2016). Focusing on the effects of a lack of workplace empowerment of nurse

managers' decisional authority and power affecting nursing work environments are important steps forward to mitigate the indirect influences on NGNs' coworker incivility behaviours.

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Appendix

Table 4-1

Starting Out Study Instruments

Scale/subscales	Items	Scale range	α	Validity
Situational Variables				
Authentic Leadership Questionnaire (Walumbwa et al., 2008)	16	0=Not at all to 4=Frequently, if not always	.96	Construct validity was established by Walumbwa et al., (2009) using CFA on data from two samples.
Structural empowerment-Conditions for Work Effectiveness Questionnaire-II (Laschinger et al., 2001)	12	1=none to 5=A lot Total score=sum of 4 subscales (range: 4-20)	.85	Construct validity was established by Laschinger et al. (2001) using CFA.
Support for professional practice-Nursing worklife index (modified) (Aiken and Patrician, 2000)	6	1=Strongly disagree to 4=Strongly agree	.76	Construct and criterion validity (Aiken and Patrician, 2000).
Areas of Worklife Scale (Leiter and Maslach, 2004)	20	1=Strongly disagree to 5=Strongly agree	.86	Construct validity was established by Leiter and Maslach (2004) using both EFA and CFA.
Graduate nurse support (Casey et al., 2004)	9	1=strongly disagree to 4=Strongly agree	.86	Construct validity was supported by studies linking new graduate nurse support to nurses' transition experiences (Casey et al., 2004) and nurse residency program (e.g., Krugman et al., 2006).
Personal Variables				
Occupational coping self-efficacy (Pisanti et al., 2008)	9	1=Strongly disagree to 5=Strongly agree	.84	Construct validity established by Pisanti et al. (2008) using EFA and CFA.
Psychological capital (Luthans et al., 2007)	12	1= Strongly disagree to 6=Strongly agree	.88	Construct validity established by Luthans et al. (2007) using CFA with data from two US samples.
Immediate Outcomes				
Work interference with personal life (Hayman, 2005)	7	1=Not at all to 7= All the time	.92	Construct validity established by using EFA (Hayman, 2005).

Scale/subscales	Items	Scale range	α	Validity
Immediate Outcomes				
Straightforward Workplace Incivility Scale (Leiter and Day, 2013)				Construct validity established by Leiter and Day (2013) using EFA.
Supervisor Incivility	5	0=Never to 6=Daily	.90	
Coworker Incivility	5	0=Never to 6=Daily	.91	
Physician Incivility	5	0=Never to 6=Daily	.91	
Negative Acts Questionnaire (NAQ) Einarsen & Hoel, 2001	3	1= never to 5=daily	.92	
Bullying and Harassment Einarsen et al., 1994	2	1=Yes, 2=No	.92	
Bergen Bullying Index (Einarsen et al., 1994)	5	1=Disagree strongly to 4=Agree strongly	.86	
Civility Norms-Brief (Walsh et al., 2011)	5	1= Strongly disagree to 7=Strongly agree	.78 .87	
Interpersonal Strain at Work Scale (ISW) (Borgogni et al, 2011)	6	0=Never to 6=Daily	.81	
Affect Transfer (Sluss et al., 2012)	3	1 item :1=Not at all to 5=Very much, items 2,3: 1=Strongly disagree to 7=Strongly agree.	.92	
Trust in immediate supervisor/manager (Norman, 2006) The Organizational Trust Inventory-Adapted (Cummings et al., 1996)	12	1=Strongly disagree to 5= Strongly agree.	.93	Construct validity was established by Cummings et al (1996) using CFA.
Nursing Worklife Index (Aiken & Patrician, 2000).	6	1=Strongly disagree to 5=Strongly agree.	.84	Construct validity was established by Aiken & Patrician, 2000 using CFA.
Maslach Burnout Inventory (MBI) (Schaufeli and Leiter, 1996)				Construct validity for the MBNI was established using CFA across numerous occupational groups including nurses.
Emotional exhaustion	5	0=Never to 6=Daily	.93	
Cynicism	5	0=Never to 6=Daily	.91	
Health Outcomes				
PTSD (Prins et al., 2004)	6	1= Yes to 2= No		
General Health Questionnaire (Goldberg & Williams, 1988)	12	1= Not at all to 4= Much more than usual.	.78 .95	

Table 4-1 (*continued*)

Scale/subscales	Items	Scale range	α	Validity
Outcomes				
Job satisfaction (Cammann et al., 1983)	3	1=Strongly disagree to 5=Strongly agree	.88	Construct validity has been demonstrated across a wide range of studies (Bowling and Hammond 20008).
Job turnover intentions (Kelloway et al., 1999)	3	1=Strongly disagree to 5=Strongly agree	.88	Construct validity demonstrated in a number of past studies (e.g., Kelloway et al., 1999; Laschinger, 2012).
Career Satisfaction (Shaver and Lacey, 2003)	2	1=Strongly disagree to 5=Strongly agree	.77	Construct validity supported (Shaver and Lacey, 2003).
Career turnover intentions (Kelloway et al., 1999)	2	1=Strongly disagree to 5=Strongly agree	.75	Construct validity demonstrated in a number of past studies (e.g., Kelloway et al., 1999; Laschinger, 2012).
Pittsburgh Sleep Quality Index (Smyth, 2012)	9	Questions 1 to 4 are single answer questions. Questions 5a to 8 are measured from 0= Not during the last month to 3= three or more times during last week. Question 9 measured from 0=very good to 3= very bad	.83	
Relational Identification (Sluss et al., 2012)	4	1=Strongly disagree to 7=Strongly agree	.85	
Frequency of Staffing Inadequacy (Scott et al., 2008)	1	1=Never to 5=Daily		

Table 4-4

Theoretical Importance and Effects of Variables

Laschinger et al. (2015)	SEM to test AL, person-job fit, areas of work life, OSCE, burnout, and mental health of new graduate nurses
Causal Claims	**Direct Effects**
AL to AOW	Positive effect
AOW to OSCE	Positive effect
Laschinger & Read (2016)	SEM to test AL, areas of worklife, civility norms, and coworker incivility
Causal Claims	**Direct Effects**
AL to AOW	Positive effect
AOW to Civility Norms	Positive effect
Civility Norms to Coworker Incivility	Negative effect
Coworker Incivility to EE	Positive effect
Kim et al. (2016)	Qualitive study identifying individual, interpersonal and organizational factors contributing to interprofessional conflicts
Causal Claims	**Direct Effects**
High job demands to low job [human]resources	Negative effect
Low job[human] resources to decreased abilities for self- control	Positive effect
Low self-control to conflict	Negative effect
Low job resources to perceptions of lack of competence	Positive effect
Perceived lack of competence leads to conflicts	Positive effect
Low job resources to feeling stretched	Positive effect
Lack of role clarity to feeling stretched	Positive effect
Croft & Cash (2012)	Understanding antecedent factors to bullying and lateral violence in nursing
Causal Claims	**Direct Effects**
Lack of leadership authority within their role to increase [human] job resources	Positive effect
Lack of [human] job resources to nurses feeling no control over workload	Positive effect
No control over workload to bullying/violence	Positive effect

Note: SEM: Structural Equation Modelling
AOW: Person-job fit, areas of worklife
AL: Authentic Leadership
OSCE: Occupational coping self-efficacy
ISW: Interpersonal Strain