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THE INFLUENCE OF EMPOWERMENT AND INCIVILITY ON THE MENTAL HEALTH OF NEW GRADUATE NURSES

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THE INFLUENCE OF EMPOWERMENT AND INCIVILITY ON THE MENTAL HEALTH OF NEW GRADUATE NURSES

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Abstract

In this secondary analysis, Kanter's (1977) theory of structural empowerment was tested using a predictive, non-experimental design in a sample of new graduate nurses working in hospital settings in Ontario (n=394). The two hypothesized models predicted that high levels of structural empowerment would be associated with lower mental health symptoms, which would be mediated by high levels of coworker and supervisor incivility, respectively. The *Conditions for Work Effectiveness Questionnaire-II* (Laschinger, Finegan, Shamian, & Wilk, 2001), the *Workplace Incivility Scale* (Cortina, Magley, Williams, & Langhout, 2001), and the *State of Mind* subscale of the *Pressure Management Indicator* (Williams & Cooper, 2001) were used to measure study variables. Both hypothesized models revealed coworker and supervisor incivility partially mediated the relationship between empowerment and mental health symptoms. The findings suggest that empowering workplaces contribute to lower mental health symptoms in new graduate nurses, an effect that is diminished by incivility.

Keywords: structural empowerment, workplace incivility, mental health, new graduate nurses, Kanter.

Co-Authorship Statement

Travis Wing completed the following work under the supervision of Dr. Sandra Regan and Dr. Heather Laschinger.

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Table of Contents

List of Tables

PAGE

List of Figures

PAGE

List of Appendices

PAGE

Part One

Introduction

With a projected need for an additional 60,000 full time-equivalent [FTE] nurses by the year 2022 (Canadian Nurses Association, 2009), creating a positive work environment to recruit and retain new graduate nurses can help alleviate the burden of a nursing shortage on the health care system by supporting current and future nurses. Despite being relatively new to the profession, 66% of new graduate nurses reported severe symptoms of burnout (Cho, Laschinger, & Wong, 2006). Laschinger, Grau, Finegan, and Wilk (2010) found that workplace bullying was significantly associated with lower symptoms of burnout in new graduate nurses. Smith, Andrusyszyn, and Laschinger (2010) found that incivility, along with structural and psychological empowerment, significantly predicts greater commitment in new graduate nurses.

The nature of the work environment in which new graduate nurses practice can have a significant influence on the transition experience of new graduates. Thomas (2010) suggests that many new nurses experience negative behaviours, such as incivility, but view these behaviours as a 'rite of passage' they must endure as new members of the profession. Laschinger, Finegan, and Wilk (2009) reported professional practice environments, civil relationships, and empowering work conditions contributed to lower levels of burnout in new graduate nurses. Workplace incivility has been found to negatively affect the mental health of individuals in the workplace (Lim, Cortina, & Magley, 2008). Rowe and Sherlock (2005) found that 75% of nurses had been a target of verbal abuse from other nurses at work. When the well-being of nurses is threatened by

their work environments, the ability to recruit and retain new graduate nurses is jeopardized as young nurses seek out healthy workplaces and opportunities (Lavoie-Tremblay et al., 2008).

New graduate nurses appear unlikely to remain in negative work environments. According to Griffin (2004), an estimated 60% of new graduate nurses leave their first jobs as a result of being targeted by negative behaviours in the workplace. Hostile work conditions can also negatively impact the mental health of new graduate nurses. When employees lack resources and positional power, they become particularly vulnerable to having power exerted upon them through uncivil behaviors in the workplace (Cortina, Magley, Williams, & Langhout, 2001). New graduate nurses may inherently possess little power as new members to the nursing profession and their workplaces, making them potential targets for aggressive and uncivil behavior.

Structural Empowerment

Kanter's (1977) theory of structural empowerment offers a useful framework to study new graduate nurses in the workplace. Previous research has shown empowerment to lead to positive outcomes for new graduate nurses, such as increased work engagement, organizational commitment, and lower turnover intentions (Cho et al., 2006; Laschinger et al., 2010; Smith et al., 2010). Kanter asserts that when employees have access to empowering structures in the workplace, they will be motivated and able to perform their jobs well. According to Kanter, individuals must exercise power through formal and informal avenues in order to accomplish organizational goals and perform their jobs. Formal power is achieved by individuals who hold positions that are flexible,

visible, and central to organizational success, while informal power is gained through interpersonal relationships within and outside of the organization (Kanter, 1977).

Individuals are able to realize power when they have access to the opportunities, information, resources, and support necessary to perform their jobs in a meaningful way. Access to opportunities to learn and advance within the organization leads to employees that are more motivated in and committed to their jobs (Kanter, 1977). Access to information involves tacit, expert and professional knowledge needed to perform one's job (Kanter, 1977). Access to resources means that individuals have the physical and human resources needed to do their job well (Kanter, 1977). Finally, access to support involves feedback and guidance from coworkers and superiors, as well as social and emotional support in the workplace (Kanter, 1977).

Workplace Incivility

Workplace incivility is defined as "low-intensity deviant behavior with ambiguous intent to harm the target in violation of workplace norms for mutual respect. Uncivil behaviors are characteristically rude and discourteous, displaying a lack of regard for others" (Andersson & Pearson, 1999, p. 457). The effect of incivility on individuals is primarily psychological (Felblinger, 2009). Cortina et al. (2001) found that as individuals encountered more frequent uncivil behaviours, their experiences of psychological distress significantly increased. Lim et al. (2008) reported that incivility was significantly associated with anxiety and depressive symptoms, work satisfaction, and turnover intentions.

Although anecdotal literature cites incivility as an issue in nursing workplaces and for new graduate nurses, few studies have been conducted to date. Incivility in the workplace creates a psychological burden for nurses that negatively influence patient, nurse, and organizational outcomes (Rogers-Clark, Pearce, & Cameron, 2009). Workplace incivility has been shown to negatively affect the mental health of individuals targeted by the behaviour (Lim et al., 2008). Cortina et al. (2001) found that increased frequency of incivility was associated with increases in feelings of general psychological distress. The authors suggest that employees who lack resources and hierarchical power are particularly vulnerable to workplace incivility.

Incivility experienced from supervisors and coworkers may increase psychological distress in new graduate nurses as they transition into their new role of professional nurse. Cortina and Magley (2009) found that uncivil encounters were perceived as significantly more negative when the behaviours were varied, more frequent, and instigated by someone holding greater organizational power. Pearson and Porath (2005) contend that individuals who hold hierarchical power within organizations are likely to engage in uncivil behaviour with little or no consequence for their behaviour as a result of their status within the organization. As new members to the nursing profession and their workplaces, new graduate nurses may be susceptible to marginalization and uncivil behaviour (Boychuk Duchscher & Cowin, 2004).

New Graduate Nurses' Mental Health

The initial months of practice can be particularly difficult for new graduate nurses (Duchscher, 2008). New graduate nurses face a potentially challenging adjustment period upon entering practice that can contribute to adverse outcomes. In a recent

Canadian survey, high levels of psychological distress were found in 43.4% of new graduate nurses (Lavoie-Tremblay et al., 2008). Ferguson and Day (2007) suggest that when new graduate nurses are unable to perform up to their own expectations they can lose self-confidence, which leads to greater anxiety and progresses in a cyclical manner. Erikson and Grove (2008) found that young nurses (those less than 30 years old) experienced more intense negative feelings when compared to their older colleagues. McKenna et al. (2003) found that 34% of new graduate nurses were exposed to verbal abuse in their first year of practice. New graduate nurses that practice in hostile workplaces may be socialized into uncivil behaviours that sustain unhealthy work environments.

While it is understood that negative psychological and emotional stressors will arise during the transition process of new graduate nurses, the influence of workplace conditions and interpersonal relationships on new graduate mental health symptoms is not well understood. In this study, new graduate nurses' mental health is operationalized in assessing the frequency new graduate nurses experience symptoms of anxiety and depression. Lavoie-Tremblay et al. (2008) propose that healthy workplaces for new graduate nurses need to provide social support and decision latitude. Cho et al. (2006) concluded that empowering work conditions promote work engagement for new graduate nurses. Laschinger et al. (2010) found that empowering work conditions contributed to low levels of incivility and lower levels of burnout in new graduate nurses. The nature of nursing work environments and relationships may influence mental health symptoms in new graduate nurses. The relationships among empowerment, incivility, and mental health have not been examined in new graduate nurses.

Conclusion

Kanter's (1977) theory of structural empowerment provides an appropriate framework to examine the relationships among workplace empowerment, incivility and mental health symptoms experienced by new graduate nurses. Empowering structures have a substantial influence on the attitudes and behaviours of employees (Kanter, 1977). The presence of empowering structures promotes individual control over and satisfaction with one's work and can reduce the chance of incivility infiltrating nursing work environments (Laschinger et al., 2009). Empowered employees are motivated in their jobs and are able to complete their work in a meaningful way (Kanter, 1977). As a result, empowering workplaces may promote positive mental health for new graduate nurses. The purpose of this study is to test two models based on Kanter's (1977) theory of structural empowerment that examines the relationships between new graduate nurses' perceptions of structural empowerment, workplace incivility, and mental health symptoms. The results of this study may provide evidence that supports the importance of empowering structures into nursing work environments in reducing workplace incivility and negative mental health symptoms experienced by new graduate nurses.

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Part Two

Manuscript

Background and Significance

An aging population, increasingly complex health care needs, and health human resource shortages have made recruitment and retention of nurses a priority to ensure quality health care delivery (O'Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010). The future of the nursing profession is dependent upon the incoming generations of nursing graduates to replace those nurses retiring from the profession. New graduate nurses already make up a significant proportion of the nursing workforce. In 2009, 11.6% of registered nurses working in Canada were less than thirty years old (Canadian Institute of Health Information [CIHI], 2010). These nurses are entering a health care system that features an expanding knowledge base and an increasingly acute and complex patient population. Health care organizations require that new graduates be capable, competent, and able to contribute in the delivery of quality patient care (Hayes et al., 2006). However, recent research has shown that new graduate nurses' transitions have been stressful due to negative or uncivil interactions in their work environments (Smith, Andrusyszyn, & Laschinger, 2010; Laschinger, Grau, Finegan, & Wilk, 2010).

Workplace incivility threatens the sustainability of the nursing workforce by creating hostile work environments that foster disruptive and discourteous behaviour resulting in attrition of nurses (Felblinger, 2009). Incivility in the workplace is significantly related to increased job stress, turnover intentions, and mental health symptoms (Lim, Cortina, & Magley, 2008). Uncivil behaviour can jeopardize the

professional and personal relationships that new graduate nurses value and seek in their initial nursing positions. Such work environments impede recruitment and retention of new graduate nurses who are seeking collegial work environments in which their contributions to professional nursing practice are valued. The nature of work environments can contribute to negative mental health symptoms experienced by nurses (Way & MacNeil, 2006). In one study, one third of new graduate nurses had considered leaving the profession within their first year of practice as a result of interpersonal conflict in the workplace (McKenna, Smith, Poole, & Coverdale, 2003). Laschinger et al. (2010) reported one-third of new graduate nurses were exposed to bullying behaviours at least twice per week, which were significantly related to burnout. Smith et al. (2010) found a significant negative association between supervisor and coworker initiated incivility and organizational commitment in new graduate nurses. Griffin (2004) suggests that 60% of new graduate nurses leave their first jobs because of hostile working conditions. The potential loss of an important resource requires attention be paid to the environments in which new graduates work and the quality of the relationships that exist in these work environments.

New graduate nurses may be particularly vulnerable to uncivil behaviour as new members of their profession and within their work environment. Pearson and Porath (2005) reported that while differences in age and tenure between targets and instigators of incivility are minimal, employees of lower status within the organization are more likely to be targets of uncivil behaviour. An inherent lack of experiential and unit-specific knowledge can leave new graduate nurses feeling reliant on more seasoned nursing staff for direction and expertise as their own professional experience and autonomy grows. A

recent study of nursing turnover in Canada found that role conflict and ambiguity, along with low job satisfaction were directly related to turnover (O'Brien-Pallas et al., 2010). Workplaces that are perceived as unsupportive and unhealthy will have difficulty recruiting and retaining new graduate nurses who seek environments that value professional nursing practice and supportive, collegial work relationships (Lavoie-Tremblay, Wright, et al., 2008). Nurses who feel their workplace supports their health and safety report lower turnover intentions and better perceived emotional health (Palumbo, Rambur, McIntosh, & Naud, 2010).

Creating healthy workplaces to recruit and retain members of the health care workforce has been identified as an international priority by the World Health Organization [WHO] (2006). Shamian and El-Jardali (2007) define healthy workplaces as policies, programs, practices and actions in place to provide health care providers with physical, mental, psychosocial, and organizational conditions needed to improve employee well-being and contribute to quality patient care and safety, organizational performance, and greater societal outcomes. Healthy work environments increase patient satisfaction, job satisfaction and retention, and reduce turnover, job stress, and burnout (Kramer & Schmalenberg, 2008). Empowering work environments have been shown to be associated with positive individual health outcomes (Laschinger, Almost, Purdy, & Kim, 2004; Laschinger, Finegan, & Shamian, 2001a). Kanter's (1977) theory of structural empowerment offers a framework to explore the influence of empowering workplace environments, along with workplace incivility, on the mental health symptoms experienced by new graduate nurses.

Theoretical Framework

Kanter's (1977) theory of structural empowerment serves as the theoretical framework for this study. Kanter (1977) describes empowering workplace structures as those that support employees to accomplish their work in a meaningful way. According to Kanter (1977), power is the ability to mobilize the human and material capital needed to achieve organizational goals and is realized through access to information, resources, support, and opportunities to learn and advance. Work environments that ensure access to empowering structures influence employee attitudes and behaviours, which results in increased organizational effectiveness.

Kanter (1977) argues power is attained through organizational hierarchy and interpersonal networks within the workplace. Employees are able to exercise power through formal and informal avenues. Formal power is generated when employees' jobs are flexible, visible, and central to achieving organizational goals. Informal power is derived from interpersonal networks and allegiances with peers, superiors, and subordinates within and outside the organization.

According to Kanter (1977), power is realized through access to various structures that exist in the workplace. Access to information involves having knowledge of organizational decisions, policies, and goals. It also encompasses the technical knowledge and expertise employees need to perform competently in their jobs. Access to support means employees receive timely feedback and guidance from peers, supervisors, and subordinates. Support also includes social and emotional support, hands-on assistance, and advice provided by others. Access to resources includes the ability to access material, equipment, money, time, and supplies needed to meet organizational

goals. Access to opportunities to learn and advance involves professional development through challenges, rewards, and recognition by participating on committees, work groups, or task-forces. Kanter (1977) contends that job satisfaction, productivity, motivation, and commitment are enhanced when opportunity is present in the workplace.

Kanter (1977) explains that when individuals do not have access to structures of empowerment they are rendered powerless. According to Kanter (1977), disempowered employees lack control over their work and are held accountable to those above them within the organization, which can result in feelings of frustration and failure. When employees are able to access structures of empowerment, they feel greater motivation in their jobs and are able to achieve organizational and personal goals and empower others around them, ultimately increasing effectiveness within the organization (Kanter, 1977).

Kanter's (1977) theory of structural empowerment was expanded to include psychological empowerment as a direct outcome of empowering workplace structures (Laschinger, Finegan, Shamian, &Wilk, 2001). According to Spreitzer (1995), psychological empowerment is a psychological state that employees must experience to consider the implementation of empowerment structures successful. Psychological empowerment consists of four components: meaning, competence, self-determination, and impact (Spreitzer, 1995). When employees have access to empowering structures in the workplace, they have higher feelings of empowerment which results in positive individual and organizational outcomes (Laschinger, Finegan, Shamian, &Wilk, 2001).

Related Research

Within the nursing population, Kanter's (1977) theory of structural empowerment has been shown to be a significant predictor of key organizational outcomes such as job satisfaction, organizational commitment (Laschinger, Finegan, & Shamian, 2001b), job strain (Laschinger, Finegan, & Shamian, 2001a; Laschinger, Finegan, Shamian, & Wilk, 2001), and turnover intentions (Nedd, 2006; Laschinger, Leiter, Day, & Gilin, 2009). Structural empowerment was shown to be significantly related to group cohesion, which also improved patient outcomes in a study of nurses in Canadian hospitals (Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010). In one study of Canadian staff nurses, Laschinger, Leiter, et al. (2009) found empowerment, along with low levels of burnout and incivility, to positively influence organizational commitment, job satisfaction, and reduce turnover intentions.

In the new graduate nurse population, Cho, Laschinger, and Wong (2006) found structural empowerment to have a direct, positive influence on areas of work life and work engagement, which then led to greater organizational commitment. New graduate nurses with access to empowering workplace structures were found to be more engaged in their work and as a result experienced less burnout, and were ultimately more committed to the organization. Laschinger, Finegan, and Wilk (2009) concluded that structurally empowering workplaces, in combination with supportive nursing practice environments and civil working relationships, led to lower levels of emotional exhaustion in new graduate nurses. Smith et al. (2010) found that structural empowerment and coworker incivility to be significant predictors of affective commitment in new graduate nurses.

Workplace Incivility

The concept of incivility is garnering increased attention in nursing, occupational health, and management literature. Incivility is defined as "low-intensity deviant behavior with ambiguous intent to harm the target in violation of workplace norms for mutual respect. Uncivil behaviours are characteristically rude and discourteous, displaying a lack of regard for others" (Andersson & Pearson, 1999, p. 457). Andersson and Pearson (1999) further explain that incivility consists of three characteristics: violation of norms, ambiguous intention, and low intensity behaviour. First, norms exist within every organization with regard to what is considered acceptable and expected interactional conduct for employees. Uncivil behaviour violates this shared understanding and threatens the well-being of the organization and its members (Andersson & Pearson, 1999). Second, targets and witnesses of incivility may be unsure whether the instigator had malicious intention. The third characteristic of incivility, low intensity, is understood to be a negative act with less force than compared with more overt forms of aggression such as verbal abuse or violence (Andersson & Pearson, 1999).

While acts of incivility are perceived as mildly disruptive behaviours within the workplace, the intent of the behaviour is not an obvious attempt to harm the victim. Such behaviour may be attributable to oversight, ignorance, personality conflict, or simply be accidental. Examples of incivility include: rude comments, disrespectful verbal attacks, condescending language, lack of collaboration, disregard for interdisciplinary input, public criticism, subtle/covert aggression, name calling, slurs/jokes, sexual comments, yelling/screaming, attacking a person's integrity/reputation, withholding information, blaming others in front of patients, and superficial listening (Felblinger, 2009).

Individuals faced with deciphering the ambiguous intentions of their peers in the workplace may find the situation to be particularly distressing as they decide how they should respond to the behaviour.

Cortina, Magley, Williams, and Langhout (2001) suggest that incivility may occur in the workplace as an assertion of power. In their large study of federal court system employees, Cortina et al. (2001) found that more frequent exposure to acts of incivility was associated with increased psychological distress, turnover intentions, and decreased job satisfaction. Approximately one-third of the uncivil acts reported in this study were instigated by individuals holding powerful positions in the organization.

Pearson and Porath (2005) suggest some instigators of incivility may have their behaviour excused or ignored because of a certain expertise they possess or the position they hold within the organization. Individuals in high ranking positions may become habitual instigators of incivility as individuals with less hierarchical power may not feel able to resolve the behaviour without reprimand or detriment to their work life. In this context, individuals lacking hierarchical power may be at risk to have another's power asserted against them. Pearson and Porath (2005) explain that the status instigators hold within an organization may offer a sense of immunity from the consequences of uncivil and disruptive behaviour that employees of less power likely do not possess. Uncivil behaviour instigated by individuals holding hierarchically powerful positions in the workplace may lessen an employee's ability to feel empowered by accessing the opportunities, information, support, and resources needed to effectively complete their work.

As uncivil behaviour becomes increasingly frequent in the workplace, there is increased potential for these behaviours to escalate into more overt forms of aggression. Despite uncivil behaviour being of low intensity and ambiguous intent, Andersson and Pearson (1999) suggest that as acts of incivility become increasingly frequent, the work environment has the potential to become hostile and result in an 'incivility spiral'. In this spiral, targets of incivility have a tendency to respond to uncivil acts with uncivil acts of their own, yet are mindful of the power held by the perpetrator (Pearson & Porath, 2005). Kane and Montgomery (1998) argued that workplace incivility can produce a negative response which harms an individual's occupational well-being, stripping them of the motivation needed to be empowered at work over time. Acts of incivility that go unnoticed or unaddressed can escalate into overt, aggressive behaviours such as bullying or harassment (Andersson & Pearson, 1999). Workplace bullying is characterized as deliberate, detrimental behaviours that involve a perceived power imbalance in which one individual asserts power over another in a coercive and aggressive manner, creating a hostile work environment (Felblinger, 2008). Bullying and harassment in the workplace have been shown to have a significant effect on nurses' well-being (McKenna et al., 2003; Hoel, Faragher, & Cooper, 2004) and organizational outcomes (Pearson & Porath, 2005). High levels of structural empowerment have been found to be negatively related to exposure to bullying and subsequently experience of burnout in new graduate nurses (Laschinger et al., 2010).

Lim et al. (2008) suggest that as individuals become dissatisfied with their work they experience symptoms of psychological distress resulting from workplace incivility. The authors further assert that mental health symptoms such as depression and anxiety

are acute reactions to incivility that may produce physical strain on the body over time. In examining the effects of incivility on individual and organizational outcomes, Lim et al. (2008) found personal incivility – an individual directly targeted by incivility – to have a direct effect on mental health and turnover intentions. Personal incivility was also significantly associated with job satisfaction which in turn, had a significant influence on mental health symptoms. The effects of uncivil behavior were shared within the work environment by coworkers, as Lim et al (2008) found workgroup incivility - incivility witnessed by or directed at peers and coworkers - to be significantly related to decreased job satisfaction, worsening mental health, and higher turnover intentions.

Caza and Cortina (2007) examined the frequency and impact of incivility experienced by university students. The authors found that incivility instigated by peers and by superiors resulted in increased psychological distress and decreased academic performance. Furthermore, the authors found that incivility was directly related to perceptions of injustice and social ostracism, although only social ostracism significantly impacted psychological distress. New graduate nurses value and desire social and professional acceptance from their colleague (Duchscher, 2009) and as a result may experience increased mental health symptoms if targeted by uncivil behaviour.

Leiter, Price, and Laschinger (2010) proposed that uncivil behaviour in nursing workplaces may be attributed to generational differences within the health care workforce. Leiter et al. (2010) found that Generation X nurses - those born between 1961 and 1981 - experienced greater incivility from supervisors and coworkers than did Baby Boomer nurses – those born between 1943 and 1960. Generation X nurses were also found to be experiencing greater distress than Baby Boomer nurses, reporting more

emotional exhaustion, cynicism, turnover intentions, and physical health symptoms. The results from this study suggest that younger generations may have different expectations and socialization experiences than older nurses which may contribute to uncivil work environments, higher turnover intentions, and greater negative mental and physical health symptoms for young nurses.

While studies involving structural empowerment with new graduate nurses provide great insight into organizational outcomes, the relationship between structural empowerment, incivility, and mental health has not been empirically tested in the new graduate nurse population. Recently, studies have linked high levels of structural empowerment to low levels of incivility in the nursing population (Smith et al., 2010; Laschinger et al., 2009). Structural empowerment has been shown to be significantly related to mental health symptoms such as stress, frustration, anxiety, depression, and burnout within the general nursing population (Laschinger & Finegan, 2005; Laschinger, Almost, Purdy, & Kim, 2004; Spence Laschinger & Havens, 1997).

New Graduate Nurses and Mental Health

New graduate nurses represent the future of the nursing profession and much of the literature regarding new graduates to date has focused on examining factors related to recruiting and retaining this valuable health human resource. An aging workforce has cast doubt on the ability of the current nursing workforce to sustain itself as a disproportionate number of experienced nurses approach retirement compared to the number of new nurses that are entering the workforce (CIHI, 2010). Issues affecting nurses' physical and mental health may further jeopardize the sustainability of the nursing workforce. The CIHI (2010) found that nurses rated their physical and mental

health as lower in comparison to employees in other professions, which was associated with greater sickness related absenteeism. Job stress, perceived support from supervisors and coworkers, high physical demand, role overload, autonomy, and nurse-physician relationship were found to significantly influence the physical, mental, and general health of Canadian nurses. New and inexperienced nurses describe issues with practice as being primarily psychologically and emotionally challenging (Rella, Winwood, & Lushington, 2009). In a recent study of nursing turnover in Canadian hospitals, O'Brien-Pallas et al. (2010) found that 44.4% of nurses reported poor mental health when compared to standardized population norms, which was associated with higher patient acuity, higher turnover, and increased role conflict.

New graduate nurses must adjust to professional roles and responsibilities, which may create feelings of emotional exhaustion and burnout, low job satisfaction, apathy, and high anxiety when new graduate nurses do not feel adequately supported (Duchscher, 2008). Stressors for new graduate nurses can include lack of confidence, lack of experience, large patient loads, interactions with members of the health care team, frequent interruptions, unfamiliar environments, reliance on others, and perceived lack of support (Morrow, 2009; Halfer & Graf, 2006). Few studies have examined the structural and interpersonal workplace conditions that influence mental health in new graduate nurses.

In a survey of Canadian new graduate nurses, Lavoie-Tremblay, Wright et al. (2008) found that new graduate nurses experiencing high levels of psychological distress were significantly more likely to perceive an imbalance in the effort they exuded and the rewards received from their work. High levels of psychological distress were also

significantly related to low decisional latitude, high psychological demands, high job strain, and low social support from peers and supervisors. It is important to consider how workplace structures influence the mental health symptoms in this population and whether uncivil behaviour from peers and supervisors contribute to mental health symptoms.

Kramer (1974) used the term 'reality shock' to describe the feelings of anxiety and distress experienced by new graduate nurses when values and practices learned throughout their education clash with realities and difficult situations encountered in the workplace. Duchscher (2009) extended Kramer's work in describing the initial stage of role adaptation by new graduate nurses as a 'transition shock'. Duchscher (2008) noted that after beginning their professional nursing career, new graduates experience moral distress, disillusionment, discouragement, and role stress and proposed that new graduate nurses' transition experience from student to professional nurse is a non-linear transformation encompassing personal and professional, intellectual and emotive, and skill development. In their initial months of practice, new graduate nurses tend to be task-focused as they engage in an intense process of discovering, learning, performing, concealing, adjusting, and accommodating in their practice (Duchscher, 2008).

In order to provide formal, structured support for new graduates during their transition into professional nursing practice, some organizations have implemented extended mentorship and orientation programs that have resulted in positive individual and organizational outcomes (Beecroft, Kunzman, & Krozek, 2001). Mentorship programs, and other structured orientation programs, are consistent with Kanter's (1977) theory of structural empowerment as they promote access to information, support,

resources, and opportunities to new graduate nurses by partnering them with experienced nurses who can offer guidance and expertise during the transition into the workplace. The effectiveness of mentorship programs at retaining new graduate nurses is jeopardized when there are inconsistent preceptors due to illness or scheduling conflicts as this has be reported to fragment the learning of new graduate nurses and as a result can be counterproductive (Beecroft, Hernandez, & Reid, 2008). Delaney (2003) described new graduates' feelings of frustration when relationships with mentors were fragmented or inconsistent as creating unnecessary stress and confusion during orientation in their first nursing position. Despite their inconsistent length and scope, orientation programs for new graduate nurses have been shown to reduce work anxiety, create realistic job expectations, and increase organizational commitment, but run the risk of being cut short or eliminated completely due to current economic constraints (Scott, Engelke, & Swanson, 2008).

In a study examining emotional labour, the task of managing the emotions involved in doing one's job effectively, Erickson and Grove (2008) reported that younger nurses (those less than 30 years old) experienced significantly more intense emotions at work, specifically negative emotions, than did older nurses. Along with experiencing more intense emotions, younger nurses were found to have significantly higher levels of burnout than older nurses, prompting the authors to suggest that how young nurses manage emotions at work is as important as the emotions themselves. Cho et al. (2006) found that 66% of new graduate nurses experienced severe levels of emotional exhaustion, a primary component of burnout. Emotional exhaustion is associated with unhealthy mental and physical symptoms (Laschinger, Almost, Purdy, &

Kim, 2004). Additionally, emotional exhaustion was found to be directly related to organizational commitment, and lack of fit in workload, fairness, and community in new graduates' perceived areas of work life (Cho et al., 2006).

In their study, McKenna et al. (2003) found that new graduate nurses in New Zealand commonly experience covert interpersonal conflict in their workplace. Specifically, new graduate nurses reported experiences where they felt undervalued, had learning opportunities blocked, felt neglected, had been distressed by others' conflict, and were given too much responsibility without adequate support. New graduate nurses also cited experiences of overt interpersonal conflict that included verbal statements characterized as rude, abusive, and humiliating, as well as verbal sexual harassment and verbal threats. New graduate nurses commonly identified individuals they were directly accountable to as perpetrators of their most distressing experiences of interpersonal workplace conflict. Such incidents resulted in new graduate nurses taking time off work, leave their positions, and, in some cases, leaving the profession entirely. Research has not examined whether these experiences are similar for Canadian new graduate nurses.

New graduate nurses may be particularly vulnerable to verbal aggression in the workplace as these nurses tend to rely on the expertise and knowledge of more experienced colleagues. Rowe and Sherlock (2005) found 75% of registered nurses reported having been verbally abused by other nurses in their workplace. The outcome of verbal abuse experienced by nurses varied from adaptation and positive coping mechanisms to negative coping strategies, absenteeism, silence and passivity, lower job satisfaction, and decreased sense of well-being in the workplace. It is unclear how work

environment characteristics influence the prevalence and intensity of verbal abuse in the nursing environment.

In this review of the literature, it has been shown that the characteristics of work environments and the nature of interpersonal relationships within the work environment can negatively impact individual and organizational outcomes in new graduate nurses. Structurally empowering work environments enable employees to perform their jobs in a meaningful way while meeting organizational goals (Kanter, 1977). Previous research indicates new graduate nurses experience incivility in the workplace from coworkers and supervisors (Laschinger, Finegan et al., 2009; Smith et al., 2010). Workplace incivility has been shown to negatively impact the mental health of those targeted by these behaviours (Lim et al., 2008), although this relationship has not been empirically tested in the new graduate population. In this study, mental health is operationalized to include the experience of symptoms of anxiety and depression that reflect a negative state of mind. It is vital that work environments are perceived as healthy and supportive for all nurses, particularly new graduates who represent the future of the profession.

The purpose of this study is to test a model based on Kanter's (1977) theory of structural empowerment that examines the relationships among new graduate nurses' perceptions of structural empowerment, workplace incivility, and mental health symptoms.

Hypotheses and Rationale

Based on Kanter's (1977) theory of structural empowerment, along with a review of the literature, the following hypotheses were developed.

- New graduate nurses' perceptions of structural empowerment will have a direct negative relationship with mental health symptoms.
- New graduate nurses' perceptions of coworker incivility will mediate the effect of structural empowerment on mental health symptoms in new graduate nurses (Model 1).
- New graduate nurses' perceptions of supervisor incivility will mediate the effect of structural empowerment on mental health symptoms in new graduate nurses (Model 2).

This study tested two mediation models for the effect of structural empowerment and workplace incivility (supervisor and coworker) on the mental health of new graduate nurses. The hypothesized models tested can be seen in Figure 1. Kanter's (1977) theory of structural empowerment asserts that empowered employees are able to accomplish their work effectively and in a meaningful way. Employees that are empowered have access to the resources, information, support, and opportunities needed to do their jobs. Empowered employees will engage in positive, collegial working relationships leading to fewer incidents of uncivil behaviour (Laschinger, Finegan et al., 2009) while disempowered employees may engage in more frequent acts of incivility as they compete with other employees for greater power within the organization (Kanter, 1977). Empowered employees should also feel low levels of distress and anxiety as a result of access to these structures in their work environments. The presence of incivility in the workplace is known to increase mental health symptoms of targeted employees (Lim et al., 2008). New graduate nurses must rely on more experienced colleagues for

professional and social support early in their careers. When uncivil behaviour is present, new graduate nurses may not perceive their workplace to be empowering, resulting in increased mental health symptoms for new graduates and mediating the relationship between empowerment and mental health symptoms.

Figure 1. Hypothesized Model 1: Coworker Incivility

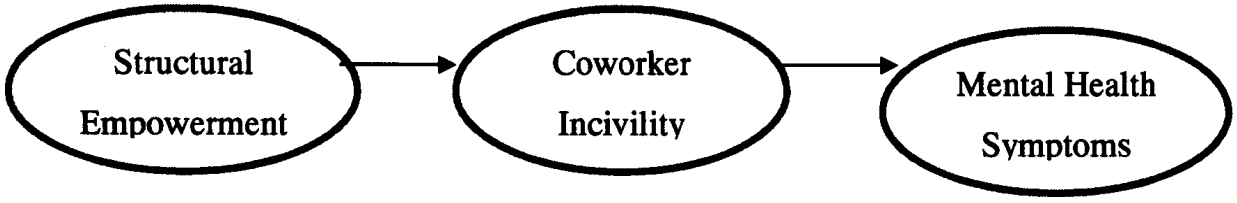
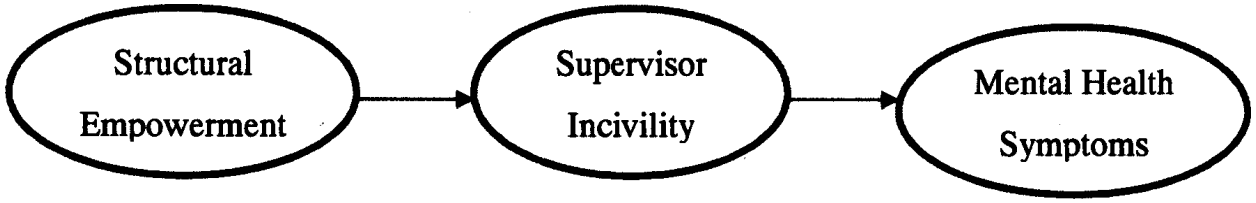


Figure 2. Hypothesized Model 2: Supervisor Incivility



Methods

Design and Sample

This study is a secondary analysis of a larger study that sampled 1,400 new graduate registered nurses currently practicing in Ontario with less than three years of work experience (Laschinger et al., 2010). In the larger study, a list of nurses who had been practicing as a registered nurse for less than three years was generated from the provincial college registry. There were 546 surveys returned completed for a response rate of 39%. Surveys were excluded for participants with greater than three years of experience in nursing or if missing data were present for study variables. A subset of the larger data set was used to test the hypothesized models in this study. As this study

focuses on new graduate nurses working in hospital settings, respondents were included only if they identified their primary work setting as a medical-surgical, critical care, or maternal-child unit. A final sample of 394 new graduate nurses was included in this study. To ensure that the study was sufficiently powered for a regression analysis with two independent variables, the Horatio software package (Lee, 2004) was used to calculate the sample size. Based on an alpha of 0.05, a power of 0.80 and a moderate effect size (0.15), a minimum sample size of 66 participants is required.

Instruments

The Conditions for Work Effectiveness Questionnaire [CWEQ-II] was used to measure structural empowerment. This instrument operationalizes the six sub-concepts (formal power, informal power, access to information, resources, information, and opportunity) of Kanter's (1977) theory of structural empowerment. The CWEQ-II has been psychometrically validated by Laschinger et al. (2001). Previous studies have reported acceptable internal consistencies, with Cronbach's alphas ranging from 0.78 to 0.94 (Laschinger, 2011). The instrument is composed of 19 items scored on a five-point Likert scale and includes a 2-item global empowerment scale that is used for construct validation. Scores of each sub-concept are summed and averaged to provide a score for each component of structural empowerment. Each component score is then summed to provide a total empowerment score ranging from 6-30, with higher scores representing higher perceptions of empowerment.

The Workplace Incivility Scale [WIS] (Cortina et al., 2001) was used to assess incivility experienced by new graduates from their supervisors and their coworkers. The WIS consists of seven items and uses a five-point Likert scale to measure the frequency

of uncivil behaviors in the past month in the workplace where high scores represent high levels of incivility. Psychometric properties of the WIS have shown the instrument to be valid and reliable (Cortina et al. 2001; Lim et al., 2008). In a recent study of new graduate nurses, acceptable internal consistency was reported for coworker incivility (α = 0.89) and supervisor incivility (α = 0.85) (Smith et al., 2010). There has been some inconsistency with rating scales used with the WIS in the nursing literature making comparisons of results between studies difficult. This instrument was used by Laschinger, Leiter, et al. (2009) in a study that examined the relationships between empowerment, incivility, and burnout in recruitment and retention of staff nurses, and used a seven-point Likert scale (0-6), where high scores indicated high levels of incivility. The authors reported mean scores of 0.66 for supervisor incivility and 0.81 for coworker incivility.

The State of Mind subscale from the Pressure Management Indicator [PMI] (Williams & Cooper, 1998) was used to measure depressive and anxious symptoms experienced by respondents. The instrument uses a five-item, six-point Likert scale to identify the frequency of mental health symptoms over the previous four weeks. Scale development and validation found this subscale to be significantly related to other mental health measure such as resilience and energy level in diverse populations, and significant group differences between psychiatric outpatients and the general population (Williams & Cooper, 1998). Internal reliability for this scale has ranged from 0.82 to 0.85, and has been found to be a reliable tool in the studies of Canadian staff nurses (Laschinger, 2004). While the State of Mind subscale is a useful instrument to assess the presence of negative mental health symptoms, it is not inclusive of a broad spectrum of negative

mental health symptomology or diagnoses. The scale was coded so that higher scores represented greater frequency of mental health symptoms.

In order to describe the sample, 14 demographic survey questions developed by the researcher were included in the analysis. Demographic questions included age, sex, education, employment status, preferred employment status, unit specialty, length of employment as a registered nurse, length of employment at their current organization and on their current unit, as well as their unit size, patient assignment size, hours worked per week, overtime worked, immediate supervisor, number of missed work days, and most common reason for missing work.

Data Collection Procedures

A subset of data from the larger study of new graduate nurses was used in this study. In the larger study, nurses included in the sample were mailed a survey package, including a letter of information explaining the study, a questionnaire, a stamped and addressed envelope to return the questionnaire, and a voucher for a popular coffee restaurant as a token of appreciation for their time. In an effort to increase response rate, a modified version of the Total Design Method recommended by Dillman (2000) were used. Two weeks after the initial mailing, a reminder letter was mailed to all potential participants. After six weeks, all non-respondents were mailed a replacement questionnaire package (Laschinger et al., 2010). The final sample included respondents that work in hospital settings and completion of questionnaires with no missing data for the major study variables.

Data Analysis

Statistical analyses were performed using the Statistical Package for Social Sciences [SPSS] program, version 18.0 (SPSS Inc., 2009). Descriptive statistics and reliability analysis were conducted for all study variables and scales. Mean differences for categorical demographic variables with major study variables were examined using one-way ANOVA. The hypothesized models were tested using mediated regression analysis in a four-step process, as described by Baron and Kenny (1986). In mediation regression analysis, the first step is to show that there is a relationship between the independent variable and the dependent variable. The second step is to show that the independent variable is correlated with the mediator. The third step in the analysis tests whether the mediator affects the dependent variable. The final step tests whether the mediator fully mediates the relationship between the initial variable and the outcome variable. In order for full mediation to occur, the effect of the initial variable on the outcome variable must no longer be significant when the mediator is added to the model. If the relationship between the independent and dependent variable is lower after the mediator variable is added to the model, but remains significant, then a partial mediation exists.

Results

Sample Description

Full demographic statistics can be seen in Table 1. The final sample of new graduate nurses were primarily female (94.7%) with an average age of 27.3 years. New graduates were registered nurses for an average of 2.3 years and worked 2.1 years at their current organization with 1.9 years on their current unit. The majority of respondents

held baccalaureate degrees (96.4%) and reported a registered nurse as their immediate supervisor (95.7%). Most new graduate nurses worked full-time (82%), while 15.5% worked part-time and 2.5% worked in a casual position. New graduate nurses also indicated a preference to work in a full time position most of the time (81.5%), while 14% preferred part-time positions, and 4.1% preferred casual positions. Most respondents worked between 20 and 39 hours per week (62.9%) while 30.7% worked more than 39 hours per week and 4.1% worked less than 20 hours per week.

Table 1.

Description of Demographic Characteristics of New Graduate Nurses

		M	SD
Age		27.28	4.5
Patients on unit		30.57	28.40
Patients assigned		5.22	9.13
Years as a Registered Nurse (RN)		2.31	0.39
Years at current organization		2.10	0.59
Years on unit		1.88	0.7
Missed shifts in past year		4.38	10.51
		N	%
Gender	Female	373	94.7
	Male	21	5.3
Education	RN diploma	5	1.3
	BScN	380	96.4
	MScN	4	1.0
	Other	4	1.0
Unit specialty	Medical-surgical	202	51.3
	Critical care	131	33.2
	Maternal-child	50	12.7
Current employment status	Full-time	323	82
	Part-time	61	15.5
	Casual	10	2.5
Preferred employment status	Full-time	321	81.5
	Part-time	55	14.0
	Casual	16	4.1
Immediate supervisor	Registered Nurse	377	95.7
	Other	13	3.3
Hours worked per week	<20	16	4.1
	20-39	248	62.9
	>39	121	30.7
Overtime	Increased	96	24.4
	Remained the same	166	42.1
	Decreased	74	18.8
	Not applicable	52	13.2
Reason for missing work	Physical illness	282	71.6
	Injury (work-related)	16	4.1
	Family situation	20	5.1
	Mental health day	41	10.4

Note. M = mean; SD = standard deviation

The most frequent unit specialty identified was medical-surgical (51.3%), followed by critical care (33.2%) and, lastly, maternal-child (12.7%). The average number of patients assigned to new graduate nurses was 5.2 with an average of 30.6 patients on their units. Participants had missed an average of 4.4 shifts during the past year. The most common reason for missing work was due to physical illness (71.6%) followed by mental health day (10.4%), family situation (5.1%) and work-related injury (4.1%). Group mean differences were tested for the demographic variables current employment status, preferred employment status, unit specialty, overtime, and reason for missing work with major study variables. No significant mean differences were found among selected demographic variables.

Study Variables

Descriptive statistics and correlations of study variables can be seen in Table 2. New graduate nurses reported moderate levels of structural empowerment. Access to opportunity (M=4.28, SD=0.71) was perceived as highest by the participants followed by informal power (M=3.55, SD=0.71), access to information (M=3.19, SD=0.92), access to resources (M=3.05, SD=0.78), and access to support (M=2.99, SD=0.90), while formal power (M=2.75, SD=0.79) was rated lowest. These findings are similar to previous studies involving new graduate nurses (Cho et al., 2006; Smith et al., 2010).

New graduate nurses reported experiencing incivility in their workplaces from coworkers (M=1.29, SD=0.50) and from supervisors (M=1.51, SD=0.65). There has been some inconsistency with rating anchors used with the WIS in the nursing literature, making comparisons with previous studies challenging. The WIS, as developed by Cortina et al. (2001) uses a 5-point Likert scale, with 0 representing 'never' experienced

the behaviour and 4 representing 'most of the time'. Smith et al. (2010) and Laschinger, Leiter, et al. (2009) found comparable rates of incivility experienced by nurses from co-workers and from supervisors. Smith et al., (2010) used a 4-point Likert scale with anchors ranging from 1 to 4, with 1 representing 'never' and 4 representing 'most of the time' and reported mean scores of 1.5 and 1.69 for supervisor incivility and coworker incivility respectively. Laschinger, Leiter, et al. (2009) used a 7-point Likert scale, using 0 through 6 as anchors, with high scores indicating higher rates of incivility and reported mean scores of 0.66 and 0.81 for supervisor incivility and coworker incivility respectively. In comparison to the mean incivility scores in this study, Smith et al. (2010) and Laschinger, Leiter, et al. (2009) reported slightly higher rates of both supervisor and coworker incivility after converting reported scores into a 5-point rating scale.

Table 2.

Reliability Analysis, Means, Standard Deviations and Correlations between Variable Scales for Structural Empowerment, Coworker Incivility, Supervisor Incivility, and Mental Health

	Variable	Alpha	Mean	SD	1	2	3	4
1	Empowerment	0.89	19.78	3.38	1			
2	Coworker Incivility	0.86	1.29	0.50	-0.25**	1		
3	Supervisor Incivility	0.89	1.51	0.65	-0.23**	0.49**	1	
4	Mental Health Symptoms	0.83	2.41	0.86	-0.29**	0.31**	0.31**	1

Note. Empowerment, Coworker Incivility, and Supervisor Incivility were measured using response options ranging from 1-5; Mental Health Symptoms were measured using response options ranging from 1-6; SD = Standard Deviation.

$^{**}p < 0.01$

New graduate nurses reported having recently experiencing mental health symptoms (M=2.41, SD=0.86). These results are lower than those reported by Laschinger (2004) in a study of nurse managers in Canadian hospitals. The reported mental health symptoms in this study were positively correlated with coworker incivility (r=0.312, p<0.001) and supervisor incivility (r= 0.307, p<0.001). These results are similar to those reported by Lim et al. (2008) in their study of university students.

As predicted in the first hypothesis, structural empowerment had a significant, negative relationship with mental health symptoms (r=-0.29, p<0.001). This relationship indicates that access to information, support, resources, and opportunities contributes to lower levels of adverse mental health symptoms, such as anxiety and depressive symptoms, for new graduate nurses.

Mediated Regression Analysis

The results of the mediation analysis can be seen in Table 3. In the first step of the mediation, a significant relationship was found between empowerment and mental health symptoms (β= -0.286, p <0.001). The second step of the mediation showed a significant relationship with empowerment and coworker incivility (β=-0.232, p<0.001). In the third step, coworker incivility was found to significantly impact mental health symptoms (β=0.307, p<0.001). In the fourth step, structural empowerment continued to have an effect on mental health symptoms after coworker incivility was added to the regression equation (β=-0.227, p<=0.001), indicating a partial mediation (see Figure 3). As recommended by Baron and Kenny (1986), the indirect effect of empowerment on mental health symptoms carried by the mediator, incivility, was assessed using the Sobel

test. Coworker incivility (Sobel test statistic = -3.68, p<0.001) carried the effect of structural empowerment onto mental health symptoms.

The second hypothesized model predicted that supervisor incivility would mediate the relationship between structural empowerment and mental health symptoms. The first step, empowerment was significantly correlated with mental health symptoms, was confirmed in the first model. The next step in the mediation found a significant relationship with empowerment and supervisor incivility (β=-0.250, p<0.001). The third step showed that supervisor incivility had a significant effect on mental health symptoms (β=0.312, p<0.001). In the final step, as in the first model, the relationship between structural empowerment and mental health symptoms remained significant with the addition of the mediator, supervisor incivility, into the model (β=-0.221, p<0.001), indicating a partial mediation (see Figure 4). A Sobol test confirmed supervisor incivility (Sobel test statistic = -4.09, p<0.001) carried the indirect effect of empowerment onto mental health symptoms in the hypothesized model.

Table 3. *Summary of Mediation Regression Analysis of Hypothesized Models*

Variable	B	SE B	β	R^2
Model 1				
Coworker Incivility				
Step 1: Empowerment predicts mental health				
Empowerment	-0.072	0.012	-0.286**	0.082
DV: Mental health				
Step 2: Empowerment predicts coworker incivility				
Empowerment	-0.045	0.010	-0.232**	0.054
DV: Coworker incivility				
Step 3: Coworker incivility predicts mental health				
Coworker incivility	0.402	0.063	0.307**	0.094
DV: Mental Health				
Step 4: Empowerment predicts coworker incivility, which in turn predicts mental health				
Step 4a				
Empowerment	-0.072	0.012	-0.286**	0.082
Step 4b				
Empowerment	-0.057	0.012	-0.227**	
Coworker incivility	0.333	0.063	0.255**	0.143
DV: Mental health				
Model 2				
Supervisor Incivility				
Step 1: Empowerment predicts mental health				
Empowerment	-0.072	0.012	-0.286**	0.082
DV: Mental Health				
Step 2: Empowerment predicts supervisor incivility				
Empowerment	-0.037	0.007	-0.250**	0.063
DV: Supervisor incivility				
Step 3: Supervisor incivility predicts mental health				
Supervisor incivility	0.531	0.082	0.312**	0.097
DV: Mental health				
Step 4: Empowerment predicts supervisor incivility, which in turn predicts mental health				
Step 4a				
Empowerment	-0.072	0.012	-0.286**	0.082
Step 4b				
Empowerment	-0.056	0.012	-0.221**	
Supervisor incivility	0.437	0.082	0.256**	0.143
DV: Mental health				

** $p < 0.001$

Figure 3. Model 1. Mediated Regression Analysis: Coworker Incivility

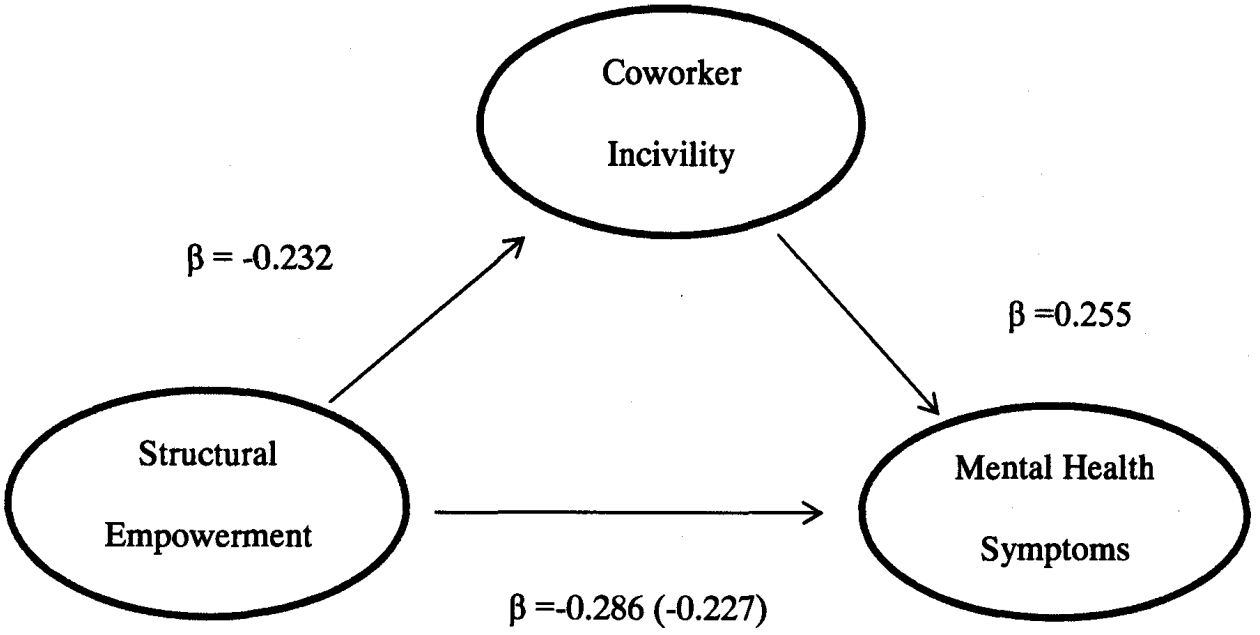
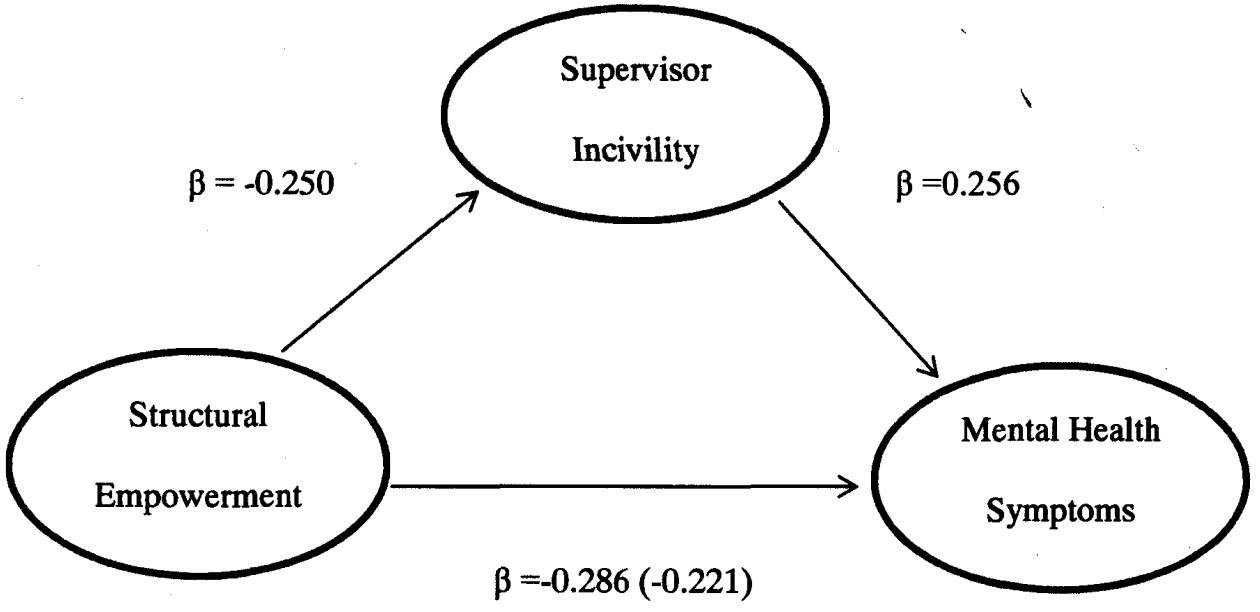


Figure 4. Model 2. Mediated Regression Analysis: Supervisor Incivility



Discussion

New graduate nurses in this study reported moderate levels of structural empowerment, and perceived access to opportunities to learn and advance as the most empowering structure in their workplace. New graduate nurses encounter a myriad of new experiences early in their careers so it is not surprising that these new graduate nurses felt empowered by opportunities to gain new skills and experiences. Gaining knowledge and experience through new opportunities encountered in the workplace allows new graduate nurses to build clinical competence and confidence in their professional practice (Hayes et al., 2006). Halfer and Graf (2006) found that job satisfaction improved when new graduate nurses were able to effectively organize and complete work-related tasks.

New graduate nurses reported formal power and access to support as the least empowering structures in their workplace. Low levels of formal power may reflect their inexperience in both their current position within their organization and within the profession. New graduate nurses value support through regular feedback and clinical guidance from experienced nurses, as well as through social and emotional support from peers (Lavoie-Tremblay, O'Brien-Pallas et al., 2008). Low social support has been found to be related to turnover intentions (Lavoie-Tremblay, O'Brien-Pallas et al., 2008) and high levels of psychological distress in new graduate nurses (Lavoie-Tremblay, Wright et al., 2008). New graduate nurses may rely on experienced nurses for support in acclimating and socializing to their unit and organization, as well as support in clinical decision making as they encounter new situations in their professional careers. Ferguson and Day (2007) found that new graduate nurses tend to rely on the experience of other

nurses in the workplace when encountering new or difficult situations. Without this support new graduates may feel isolated or inept (Duchscher, 2008), which could further contribute to mental health symptoms experienced by the new graduate nurse.

There was a negative relationship between structural empowerment and mental health symptoms in new graduate nurses. This finding suggests that empowering workplaces contribute to lower levels of mental health symptoms for new graduate nurses. This is consistent with findings reported by Way and MacNeil (2006) in their review of organizational characteristics that influence the health of nurses. Along with structural empowerment, Way and MacNeil found that job demand and social support also influence nurses' health outcomes. Laschinger, Finegan, and Shamian (2001a) found that empowering work conditions to be negatively associated with job strain in a study of Canadian nurses. New graduate nurses that perceive their work environments to be empowering, that is have access to opportunities, support, resources, and information necessary to perform their work, should experience fewer mental health symptoms than those working in disempowering environments. By emphasizing the importance of empowering workplace structures, nursing leadership can promote healthy work environments for new graduate nurses during a particularly stressful and difficult period in their professional careers.

Structural empowerment had a significant negative relationship with both supervisor incivility and coworker incivility. This finding suggests that empowering work conditions are associated with fewer acts of incivility initiated by new graduate nurses' coworkers and supervisors. Empowering workplaces provide employees with access to the resources, support, opportunity, and information needed to perform their job

effectively (Kanter, 1977). When employees perceive their workplace to be empowering, they are more likely to engage in cooperative, less critical behaviour (Kanter, 1977), which should reduce the prevalence of uncivil behaviour present in the workplace. The presence of these structures may decrease perceived competition between employees for the resources necessary to complete their work. Empowering structures may also promote collegial relationships between employees by ensuring individuals can complete their work effectively. Purdy et al. (2010) found that structural empowerment significantly influenced group processes, the ability to function as a team, which reduced patient-risk outcomes. Nursing work environments that are perceived as empowering may benefit from positive team functioning and low incidence of uncivil behaviour which can contribute to positive new graduate nurse and patient outcomes.

Workplace incivility, instigated by co-workers and by supervisors, was significantly associated with mental health symptoms. As the frequency of uncivil behaviour increases, so too does the prevalence of mental health symptoms in new graduate nurses. This result is consistent with previous studies examining the individual outcomes of workplace incivility (Lim et al., 2008). Although uncivil behaviour is characteristically of lower intensity than overt aggression, its impact on mental health symptoms highlights its negative impact in nursing workplaces. Workplace incivility has also been linked to lower organizational commitment (Smith et al., 2010), decreased job satisfaction, and increased turnover intentions in nurses (Laschinger, Finegan et al., 2009).

Although incivility scores were relatively low, new graduates in this study reported more frequent uncivil behaviours from supervisors than from coworkers. This

finding differs from previous studies of new graduate nurses that reported slightly higher rates of incivility instigated by coworkers (Smith et al., 2010; Laschinger, Leiter, et al., 2009) This could possibly be explained by temporal factors associated with economic constraints or the introduction of an extended orientation program for new graduate nurses. There was a significant relationship between workplace incivility and increased mental health symptoms in this study. This relationship suggests that uncivil behaviour contributes to anxiety and depressive symptoms for new graduate nurses, though new graduates perceived levels of incivility to be low. Caza and Cortina (2007) found incivility that was instigated from top-down and lateral sources predicted perceived ostracism, which then predicted symptoms of psychological distress New graduate nurses that encounter discourteous behaviour from their colleagues and supervisors likely will not feel as though they fit in at work. Lavoie-Tremblay, O'Brien-Pallas et al. (2008) state the today's generation of new graduate nurses expect to be valued members in their workplaces and hold jobs that provide recognition, advancement, and social support. The presence of workplace incivility diminishes the impact of positive work conditions to reduce mental health symptoms experienced by new graduate nurses.

Empowering work environments were associated with decreased mental health symptoms of new graduate nurses in this study, although this benefit was partially mediated by the presence of incivility from both coworkers and supervisors. The impact of workplace incivility can also extend beyond the direct target of the behaviour and negatively impact other members of the organization as witnesses to disruptive behaviour and mistreatment empathize with the target (Lim et al., 2008). Lim et al (2008) found

that incivility experienced by coworkers, workgroup incivility, was significantly related to lower job satisfaction and greater mental health symptoms.

The results from this study partially support the hypothesized relationships between structural empowerment, workplace incivility, and mental health symptoms in new graduate nurses. Kanter's (1977) theory of structural empowerment was supported as high levels of structural empowerment were significantly associated with low rates of mental health symptoms. Coworker incivility and supervisor incivility partially mediated the effect of structural empowerment on new graduate nurses' mental health symptoms. This suggests that while structurally empowering workplaces lead to lower rates of mental health symptoms, the presence of uncivil behaviour in the workplace diminishes positive effect of empowerment in new graduate nurses. If new graduate nurses do not have collegial relationships with nurses whose experiences are invaluable to their professional development, they may experience high levels of stress and anxiety, as they may not be able to rely on their colleagues for advice or encouragement during their transition into the profession.

Recommendations

It is important to provide empowering workplace structures for new graduate nurses that promote civil relationships, and in turn, positive mental health. Introducing empowering structures into the workplace as described by Kanter (1977) requires commitment and resources from nursing leadership to ensure new graduate nurses have access to the opportunities, information, resources, and support needed to perform their jobs. Nursing leadership also need to promote collaboration amongst all nurses experiencing the work environment in order to foster a healthy, collegial workplace.

Kramer and Schmalenberg (2008) assert that the presence of empowering structures in the workplace cannot in themselves achieve positive outcomes, but that collaboration by those experiencing the structures is needed to achieve healthy and effective work environments. This assertion is echoed in findings from Purdy et al. (2010) who found that group processes mediated the effect of structural empowerment on positive patient outcomes.

All nurses, particularly new graduates, need to learn to identify and address disruptive behaviour in the workplace. Despite low levels of incivility reported in this study, both coworker and supervisor incivility were significantly associated with increased mental health symptoms experienced by new graduates. Without education to help identify uncivil behaviour new graduate nurses risk being socialized into a hostile workplace with little preparation for addressing disruptive behaviour. Simons and Mawn (2010) caution that new graduate nurses can perceive disruptive behaviour as 'part of the job' when socialized into an unhealthy work environment. Andersson and Pearson (1999) propose that workplace incivility creates the potential for behaviours to spiral into overt and aggressive behaviours if left unaddressed. By implementing formal programs for all health care team members, health care organizations can foster civil working relationships among employees and reduce negative outcomes associated with uncivil behaviour. The Civility, Respect, and Engagement in the Workforce [CREW] intervention model described by Osatuke, Moore, Ward, Dyrenforth, and Belton (2009) is an example of an education and intervention program designed to engage employees in civil behaviour in the workplace. The CREW model is designed to support work groups and units in identifying areas of strength and areas in need of improvement with regards

to civility in the workplace by committing time, attention, and support to adopting new behaviours and policies. Nursing leadership needs to be able to assess the climate within the organization and at the unit level in order to proactively promote civil relationships in the workplace. Nursing leadership can take a proactive approach by communicating expectations for collegial relationships and supporting efforts to address workplace incivility. By introducing intervention models that target workplace incivility, nursing leaders promote empowering work conditions when they facilitate access to information, support, and resources needed to effectively introduce the model into the work environment. Such intervention models can promote empowering work conditions while actively working towards reducing the incidence of workplace incivility.

Nursing leadership must be committed to ensuring new graduate nurses feel supported throughout their early career transition into professional nursing. Consistent with Kanter's theory, structured support provides mutual benefit to the organization and the new graduate nurse (Buffum & Brandon, 2009; Beecroft et al., 2001). The New Graduate Guarantee Initiative (NGGI) is an example of a formal structured support program for new graduate nurses that was introduced in Ontario (Ministry of Health and Long-Term Care [MOHLTC], 2006). The provincial government provided funding for health care organizations to hire new graduates in full-time supernumerary positions, paired with a mentor for up to six months (HealthForceOntario, 2009). The NGGI was meant to promote full-time employment opportunities for new graduates, improve new graduate integration into the workforce, and improve retention of new nurses in Ontario (Bauman, Hunsberger, & Crea-Arsenio, 2010). Evaluation of the NGGI at this time has primarily focused on monitoring participation of new graduate nurses in the program.

Beecroft et al. (2001) introduced a formal mentorship program implemented in a pediatric hospital which contributed to job satisfaction in new graduates as well as improved retention. Preceptor and mentorship programs also provide new graduates with social support during their first months of practice. A lack of social support has been found to significantly contribute to turnover intentions in new graduate nurses (Lavoie-Tremblay, O'Brien-Pallas et al., 2008). Beecroft et al (2001) embedded classroom education, debriefing and self-care sessions, and clinical experiences in other areas of the hospital into the extended orientation program designed to better facilitate the new graduate transition into the workplace. Nursing administrators need to design orientation and mentorship programs that promote the professional and individual growth of new graduate nurses through access to empowering structures, such as those described by Beecroft et al. (2001).

Continued efforts are needed to promote the successful development and integration of new graduate nurses. Nursing administrators can enhance access to empowering work structures by encouraging interprofessional and interdepartmental collaboration and committee participation for new graduate nurses which can promote perceptions of formal power by increasing visibility and involvement in achieving organizational goals. Such opportunities can increase perceptions of informal power as new graduate nurses build communication, collaboration, and networking skills within the organization. Nursing administrators can also promote access to empowering work structures by encouraging and facilitating educational opportunities for new graduates, involving new graduates in policy evaluation and implementation, and by providing regular feedback and recognition of achievements to new graduate nurses. By investing

in empowering workplace structures targeted at new graduate nurses, nursing leaders can reduce negative mental health symptoms experienced by new graduates during their transition into the workplace.

Limitations

This study used a cross-sectional design which limits the ability to infer causation. However, as this study used a priori theory-driven hypotheses, this limitation is lessened to some extent, allowing for generalization to theory rather than to populations (Laschinger, Finegan, Shamian, &Wilk, 2001; Serlin, 1987). Another potential limitation is this study focuses solely on new graduate nurses in working in hospital settings and the findings may not be generalizable to other sectors. While participants sampled in this study indicated that they may be contacted to participate in research studies to the provincial college registry, it may be that these participants differ from those who requested not to be contacted to participate in research and were excluded from the sampling frame. Consideration must also be given to the potential for response bias when self-report questionnaires are used, as was the case in this study (Polit & Beck, 2008), as well as to the potential of negativity bias as there can be a tendency for individuals to focus their attention on negative events and outcomes (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001). The original dataset provided adequate sample size, and quality data collected using sound methodology and psychometrically sound measurement tools, negating the limitations of a secondary analysis (Doolan & Froelicher, 2009).

Conclusions

The results from this study provide further support for Kanter's (1977) theory of workplace empowerment. This study links structurally empowering workplaces to less workplace incivility and lower mental health symptoms in new graduate nurses. The findings suggest that workplace incivility reduces the effect of empowering workplace structures in lowering mental health symptoms in new graduate nurses. Upon entering the workforce, new graduate nurses are faced with unprecedented patient acuity and workloads which contributes to feelings of stress, anxiety, and burnout in new graduates (Duchscher, 2008; Cho et al., 2006). Hostile work environments compound the transition experience of new graduate nurses and directly result in a large percentage of new graduates leaving their first jobs (Bartholomew, 2006; Griffin, 2004). Health care organizations cannot afford to lose valuable health human resources to attrition. By introducing empowering structures into nursing work environments, decision-makers can reduce incidence of workplace incivility, and promote positive mental health for new graduate nurses.

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Part Three

Discussion

Kanter's (1977) theory of structural empowerment was tested in two hypothesized models. In the first model, empowering work conditions were significantly associated with low levels of supervisor incivility, and with fewer mental health symptoms experienced by new graduate nurses. In the second model, structural empowerment was significantly associated with low levels of coworker incivility, and with fewer mental health symptoms. The relevance of these findings are of interest to nursing administrators, nursing educators, policy makers, and leaders. New graduate nurses face a difficult transition into the workforce that can be improved with access to the opportunity, information, support, and recourses needed to perform their jobs in a meaningful way. By improving the workplace conditions new graduates encounter early in their careers, health care organizations can strengthen relationships within the workplace and reduce symptoms of anxiety and depression experienced by nursing's newest members.

Implications for Nursing Administrators

New graduate nurses perceived their workplaces to be moderately empowering and perceived access to opportunity as the most empowering structure in their workplace. Employees with access to opportunities to learn and develop professionally, and advance within the organization are motivated and engaged in their jobs (Kanter, 1977). Nursing leadership must ensure that opportunities for new graduate nurses to learn and develop professionally are matched by formal education programs and experienced colleagues willing and able to provide guidance and support as new graduate nurses' nursing

knowledge and skills mature. New graduate nurses in this study reported limited access to support. Kanter (1977) describes access to support as feedback, guidance, social, and emotional support from superiors and colleagues in the workplace. When new graduate nurses perceive their work environments as supportive they are likely to report low levels of psychological distress (Lavoie-Tremblay, Wright, et al., 2008). Mentorship programs offer new graduate nurses formal support during their transition into the workplace and have been associated with fewer negative mental health outcomes and lower turnover intentions (Romyn et al., 2009). The New Graduate Guarantee Initiative [NGGI] (Ministry of Health and Long-Term Care, 2006) in Ontario offers new graduate nurses support by allowing for an extended orientation program and mentorship during the first six months of practice, a transition period that has been described as the most difficult challenge a nurse faces (Boychuk-Duchscher & Cowin, 2004). In order for mentorship programs to successfully support new graduate nurses in the workplace, the mentor-mentee relationship should be consistent (Beecroft, Hernandez, & Reid, 2008) while matching personality traits and learning styles in order to promote collegial relationships (Baltimore, 2004). Nursing administrators that implement extended orientation and mentorship programs are investing in new graduate nurses mental health by facilitating access to opportunities, information, support, and resources new graduates need to do their job in a meaningful way.

In this study, structural empowerment was significantly associated with positive mental health scores of new graduate nurses, however this relationship was diminished by supervisor incivility and coworker incivility in the models tested. Nursing administrators need to be aware of the importance of empowering work conditions play

in reducing negative mental health symptoms and uncivil behaviour in the workplace. The presence of empowering structures in the workplace cannot in themselves achieve positive outcomes, but that collaboration by those experiencing the structures is needed to achieve healthy an work environments (Kramer & Schmalenberg, 2008). It is worthwhile for nursing administrators to invest resources into promoting and supporting collegial relationships in the workplace. The current generation of new graduate nurses needs to feel as though they belong as a member of their workplace and will seek out different jobs until they find meaningful work (Lavoie-Tremblay, O'Brien-Pallas, Gelinas, Desforges, & Marchionni, 2008).

Empowering work conditions were shown to be significantly related to lower levels of supervisor and coworker incivility in this study. Osatuke, Moore, Ward, Dyrenforth, and Belton (2009) propose that civil work relationships are dependent on an organizational culture that resists negative, disruptive behaviours and promotes collegial relationships. The Civility, Respect, and Engagement in the Workplace [CREW] model is an intervention program designed to educate and engage employees in civil behaviours in the workplace (Osatuke et al., 2009). In this study, workplace incivility, instigated by coworkers and supervisors, had a significant association with mental health symptoms experienced by new graduate nurses. Strategies to eliminate all forms of workplace violence, specifically workplace incivility, need to be introduced to work environments to promote the health of new graduate nurses. Thomas (2010) suggests that violence prevention should start with a change in the attitudes of nurses towards young nurses and nursing students that are treated as respected and valued as important members of the health care team. The Registered Nurses Association of Ontario [RNAO] (2008)

developed best practice guidelines for workplace health, safety, and well-being of nurses that advocates for resources and policies to develop healthy workplaces and work cultures with recommendations made at the organizational, research, educational, and system levels. Healthy workplaces may be achieved by incorporating empowering structures into the workplace.

Implications for Nursing Educators

Nursing educators can use the results of this study in preparing nursing students for their professional careers by incorporating Kanter's (1977) theory into undergraduate curricula. Formal and informal power may be enhanced by establishing effective interdisciplinary communication skills and relationships that promote greater visibility within the health care team. In doing this, nursing students and future new graduate nurses will be better positioned to access information, resources, support and opportunities necessary to perform their jobs. Babenko-Mould (2010) reported that nursing students who perceived their instructors to be using empowering behaviours within practice settings also perceived themselves as empowered, which contributed to greater self-efficacy in their professional practice. Nursing educators who are able to role model empowering behaviours may promote feelings of empowerment in new graduate nurses. Nurse educators can work to create allegiances between health care organizations and academic institutions may further increase access to empowering structures while introducing nursing students to various nursing work environments. Access to empowering structures early in the careers of nurses may further reduce mental health symptoms such as stress, anxiety, and depression experienced by new graduate nurses during their transition into the profession.

When new graduate nurses enter the workforce they need to be empowered to identify and defuse unacceptable and disruptive behaviours through educational programs (Thomas, 2010). To achieve this, nursing educators need to focus on and role model collegial interpersonal relationships and collaboration with nursing students. In doing this, nursing students will be positioned to begin their careers with an understanding of collegial behaviour needed to contribute in a healthy work environment. In taking a preventative approach to workplace incivility, nursing educators can provide empowering conditions for nursing students to learn and develop professionally.

Recommendations for Future Research

There is a need to continue to study how new graduate nurses transition into the workplace. The results of this study should be replicated across a number of provinces and would benefit from including new graduate nurses from non-acute care settings. Certainly the impact of empowering work conditions on new graduate nurses' health outcomes over the course of a longitudinal study would provide insight into whether mental health symptoms improve or worsen during their transition into the profession. Longitudinal studies would also provide understanding as to whether perceptions of empowerment, incivility, and mental health scores change over time. Future research should focus on the introduction of empowering workplace structures into the workplace and how these structures impact workplace incivility and new graduate nurses' mental health. While incivility was significantly associated with increased mental health symptoms in this study, new graduate nurses reported low levels of workplace incivility, suggesting that future research should examine if certain uncivil behaviours have a greater impact than other on mental health symptomology. Research needs to focus on

evaluating the effectiveness of interventions designed to help new graduate nurses identify and address workplace incivility.

Conclusions

This study provides additional support, in a growing body of research, for Kanter's theory of structural empowerment. Nurse leaders and administrators that provide new graduate nurses with access to the opportunity, information, support, and resources needed to perform their jobs in a meaningful way will be taking steps towards promoting better mental health symptoms and reducing uncivil behaviours. Today's cohort of new graduate nurses will actively seek out positions and careers that can offer meaningful work in a supportive environment (Lavoie-Tremblay, Wright, et al., 2008). Nursing administrators need to devote time and resources to creating healthy and work environments that will meet the needs of new graduate nurses. Given the effect of work conditions on employee mental health in the current climate of a nursing human resource shortage, ongoing efforts by nursing leadership to support structurally empowered work environments, minimize incivility and improve the mental health of nurses are needed to sustain the delivery of quality health care (Way & MacNeil, 2006).

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Appendix A

Study Instruments

Conditions of Work Effectiveness Questionnaire-II (CWEQ-II) (Laschinger, Finegan, Shamian, & Wilk, 2001)

Please use the following rating scale to indicate the extent to which the following are applicable in your workplace.

How much of each kind of opportunity do you have in your present job?

	None		Some		A Lot
1. Challenging work.	1	2	3	4	5
2. The chance to gain new skills and knowledge on the job.	1	2	3	4	5
3. Tasks that use all of your own skills and knowledge.	1	2	3	4	5
How much access to information do you have in your present job?					
4. The current state of the hospital.	1	2	3	4	5
5. The values of top management.	1	2	3	4	5
6. The goals of top management.	1	2	3	4	5
How much access to support do you have in your present job?					
7. Specific information about things you do well.	1	2	3	4	5
8. Specific comments about things you could improve.	1	2	3	4	5
9. Helpful hints or problem solving advice.	1	2	3	4	5
How much access to resources do you have in your present job?					
10. Time available to do necessary paperwork.	1	2	3	4	5
11. Time available to accomplish job requirements.	1	2	3	4	5
12. Acquiring temporary help when needed.	1	2	3	4	5
In my work setting/job:					
13. The rewards for innovation on the job are	1	2	3	4	5
14. The amount of flexibility in my job is	1	2	3	4	5

15.	The amount of visibility of my work-related activities within the institution is	1	2	3	4	5

How much opportunity do you have for these activities in your present job?

16.	Collaborating on patient care with physicians.	1	2	3	4	5
17.	Being sought out by peers for help with problems.	1	2	3	4	5
18.	Being sought out by managers for help with problems.	1	2	3	4	5
19.	Seeking out ideas from professionals other than physicians, e.g., Physiotherapists, Occupational Therapists, Dieticians.	1	2	3	4	5

Please use the following rating scale to indicate the extent to which you agree or disagree with the following statements.

		Strongly Disagree				Agree
1.	Overall, my current work environment empowers me to accomplish my work in an effective manner.	1	2	3	4	5
2.	Overall, I consider my workplace to be an empowering environment.	1	2	3	4	5

Workplace Incivility Scale (WIS) (Cortina, Magley, Williams, & Langhout, 2001)

Please rate how frequently you have encountered each of these behaviours in the previous month from your supervisor and a co-worker.

Provide a separate rating for each of the items listed below.

		Never	Once or twice a week	About once a week	Several times a week	Everyday
My Supervisor:						
1.	Put you down or was condescending to you in some way.	1	2	3	4	5
2.	Paid little attention to a statement you made or showed little interest in your opinion.	1	2	3	4	5
3.	Made demeaning, rude or derogatory remarks about you.	1	2	3	4	5
4.	Addressed you in unprofessional terms, either publicly or privately.	1	2	3	4	5
5.	Ignored or excluded you from professional camaraderie.	1	2	3	4	5
6.	Doubted your judgment in a matter over which you have responsibility.	1	2	3	4	5
7.	Made unwanted attempts to draw you into a discussion of personal matters.	1	2	3	4	5
Co-Workers:						
1.	Put you down or was condescending to you in some way.	1	2	3	4	5
2.	Paid little attention to a statement you made or showed little interest in your opinion.	1	2	3	4	5

3.	Made demeaning, rude or derogatory remarks about you.	1	2	3	4	5
4.	Addressed you in unprofessional terms, either publicly or privately.	1	2	3	4	5
5.	Ignored or excluded you from professional camaraderie.	1	2	3	4	5
6.	Doubted your judgment in a matter over which you have responsibility.	1	2	3	4	5
7.	Made unwanted attempts to draw you into a discussion of personal matters.	1	2	3	4	5

State of Mind Subscale (Williams & Cooper, 1999)

How much of the time during the past 4 weeks...

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
1.	Have you been a very nervous person?	1	2	3	4	5	6
2.	Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
3.	Have you felt calm and peaceful?	1	2	3	4	5	6
4.	Have you felt downhearted and blue?	1	2	3	4	5	6
5.	Have you been a happy person?	1	2	3	4	5	6

Demographic Questionnaire

Please tell me a little bit about yourself and your workplace.

1. Gender: Female ____
   Male ____

2. Age: ____ years

3. Education: Diploma ____
   BScN ____

   Other ____ (please specify)

4. Specialty area of your current unit:
   Med-Surg ____
   Critical Care ____
   Maternal-Child ____

   Mental Health ____

5. Current employment status:
   Full time ____
   Part time ____
   Casual ____

6. My preferred employment status:
   Full time ____

   Part time ____

   Casual ____

7. How many patients were on your unit during the last shift? ____ # of pts.
8. How many of these patients were assigned to you? ____ # of pts.

9. How long have you worked:

As an RN: ____ years ____months

As an RN at your current organization: ____ years ____months

As an RN on your current unit: ____ years ____months

10. Average hours worked per week?

   <20 hours ____

   20-39 hours ____

   Over 40 hours ____

11. My immediate supervisor is:
    A registered nurse ____
    Other, please explain ____

12. In the past year, has the amount of overtime required of you:
    Increased ____
    Remained the same ____
    Decreased ____
    Not Applicable ____

13. In the past year, how many times have you missed work due to illness/disability?
    ____ # of times

14. In the past year, what is the most common reason you missed work? (choose one only)
    Physical illness ____
    Injury (work related) ____
    Family situation ____
    Mental health day ____

Correlations between Study Variables

Table 4.

Correlations between Study Variables

	Variable	1	2	3	4	5	6	7	8	9	10
1	Opportunity	1									
2	Information	.24**	1								
3	Support	.34**	.42**	1							
4	Resources	.21**	.39**	.44**	1						
5	Formal Power	.26**	.44**	.54**	.49**	1					
6	Informal Power	.32**	.37**	.41**	.43**	.51**	1				
7	Structural Empowerment	.54**	.71**	.77**	.70**	.77**	.71**	1			
8	Supervisor Incivility	-0.05	-.23**	-.16**	-.22**	-.14**	-.25**	-.25**	1		
9	Coworker Incivility	-0.03	-.14**	-.17**	-.21**	-.19**	-.24**	-.23**	.49**	1	
10	Mental Health Symptoms	-.13**	-.13*	-.16**	-.24**	-.32**	-.23**	-.29**	.31**	.31**	1

**p<0.001

Appendix B

Ethics Approval

B. 01 The University of Western Ontario Review Board of Health Sciences Research Involving Subjects Certification of Approval

Office of Research Ethics
The University of Western Ontario
Room 4180 Support Services Building, London, ON, Canada N6A 5C1
Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca
Website: www.uwo.ca/research/ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. H.K.S. Laschinger
Review Number: 16093E **Review Level:** Expedited
Review Date: Apr 16, 2009

Protocol Title: New Graduate Experiences of Incivility and Burnout in the Workplace: Impact of Empowering Professional Practice Environments on New Graduates' Health and Wellbeing

Department and Institution: Nursing, University of Western Ontario
Sponsor: MOHLTC-MINISTRY OF HEALTH
Ethics Approval Date: April 28, 2009 **Expiry Date:** March 31, 2012
Documents Reviewed and Approved: UWO Protocol, Letter of Information (Survey), Letter of Information and Consent (Interview), Contact for Interview Form
Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Joseph Gilbert

Ethics Officer to Contact for Further Information

☐ Janice Sutherland (jsutherl@uwo.ca)	☐ Elizabeth Wambolt (ewambolt@uwo.ca)	☐ Grace Kelly (grace.kelly@uwo.ca)	☒ Denise Grafton (dgrafton@uwo.ca)

This is an official document. Please retain the original in your files. cc: ORE File

Appendix C

C. 01. Letter of Information

Letter of Information

New Graduate Experiences of Incivility and Burnout in the Workplace: Impact of Empowering Professional Practice Environments on New Graduates' Health and Wellbeing

Letter of Information for New Graduate Nurses

Principal Investigator:

Heather K. Laschinger, RN, PhD, The University of Western Ontario

Funding: Social Sciences and Humanities Research Council (SSHRC)

Introduction

We are inviting you to take part in our research study named above. This form provides information about the study. You do not have to take part in this study. Taking part is entirely voluntary (your choice). You may contact the Principal Investigator at the contact below with any questions you have. You may decide not to take part or you may withdraw from the study at any time. This will not affect your employment status in any way.

Purpose of the Study

New graduates face many challenges as they begin their nursing careers. Transitioning from student status to the full professional role requires gaining clinical expertise and self-efficacy for practice within a work environment that supports both professional practice and personal development. Research has shown that nurses who are empowered to provide care according to professional nursing standards experience greater satisfaction with their work, and are less likely to leave their jobs. However, current nursing work environments with their heavy demands are stressful for even the most seasoned nurses who are reporting high levels of burnout and absenteeism. The future of professional nursing depends on finding ways to create high quality work environments that retain newcomers to the profession. The purpose of this 3 year longitudinal study is to examine the combined effect of supportive professional practice environments and

empowerment on new graduates' experiences of workplace incivility, burnout, and subsequently, their physical and mental health at 2 points of time.

Procedures for this Study

The proposed project consists of two waves of surveys over a period of 3 years. The **survey** consists of a comprehensive questionnaire examining the combined effect of aspects of the work environment on new graduate nurses' physical and mental health. We will obtain a random sample of 1425 new graduate nurses from the Ontario College of Nurses. If you are not a new graduate nurse within the past 2 years then you should not participate in this study.

You will be asked to complete a **survey**, which should take approximately 20 minutes of your time. You may decide whether to complete the survey on your own time or at work. Survey questions may ask about your current work environment, and your reactions to your working environment. Once you have completed your survey, please place it in the self-addressed envelope provided and put it in the mail. You may keep the enclosed $5 Starbucks card whether or not you choose to complete the survey.

Included with your survey package, you will find a ballot to enter a draw to win one of 2 Nintendo Wii™ consoles. You are invited to complete this ballot and return it with your survey in the sealed opaque envelope that is included in the package. You are also invited to take part in a 45-60 minute telephone interview for the second phase of our study, which will discuss issues related to the experience of new graduate nurses. If you would like to be contacted for an interview or to receive further information about an interview, please complete the interview slip and place it in the opaque envelope and return it with your survey. Once we receive the survey package, we will immediately separate the opaque envelope with your prize ballot and/or your interview contact slip from your data and your personal information will in no way be associated with your survey responses. Also, your willingness to participate in an interview is in no way related to your eligibility to win a prize in the draw.

Our research team will receive participant contact information from the Ontario College of Nurses. All data will automatically be sent to the Nursing Research Unit at The University of Western Ontario. Only members of our research team will be able to access the data. All data will be stored in a locked cabinet in a secure room. Representatives of The University of Western Ontario Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.

Risks and Discomforts to You if You Participate in the Study

There are no anticipated burdens, harms or potential harms for participation in this study. There is a chance that you may feel uncomfortable answering questions about your work environment on the survey. Care will be taken to ensure confidentiality of survey data and we will respect your privacy. Also, you will not have to answer any questions if you feel uncomfortable. You may refer to your Employee Assistance Plan representative if you need to talk to someone further about these issues.

Benefits to You if You Participate in the Study

Nurses will not be guaranteed any direct benefits as a result of their participation in this study. However, this study will provide data to document the extent of workplace incivility in current nursing workplaces that could inform policy development and workplace interventions to prevent this negative and counterproductive workplace behavior. The results will be useful for nursing administrators in creating positive work environments that support new graduates as they enter the profession.

Voluntary Participation and Withdrawing from the Study

Before deciding to participate, you should know that you do not have to take part in the study. Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your employment status. If, during the course of this study, new information becomes available that may relate to your willingness to continue to participate, this information will be provided to you by the investigator.

Costs Associated with the Study

Participation in this study will not result in any expenses to you.

Information about Study Results

The results of the study will also be given at conferences held in 2010 and 2011.

Confidentiality and Privacy

For the surveys, no identifying information of participants will be linked to the data. Only grouped data will be reported during the dissemination of our findings. Individual responses will not be reported. If the results of the study are reported in a publication, this document will not contain any information that would identify you. Representatives of The University of Western Ontario Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research.

Each participant will be given a personal identification number (PIN) in order to link individual data across timeframes for the survey. The Research Assistants at The University of Western Ontario will link study PINs to your name only for the purposes of distributing information letters and surveys to you. Data will be sent directly to Western with only the PIN as the identifier. All participant names and assigned PINs will be destroyed as soon as the data collection is complete. The survey distribution will consist of the survey as well as a reminder letter, followed by a reminder letter a few weeks later, and finally a second distribution of the survey asking non-respondents to complete the survey if they haven't yet done so.

Contacts for Study Questions or Problems

If you have any further questions about this study, please feel free to contact Dr. Heather Laschinger at the contact below. We would very much appreciate your participation in this research project. If you choose to participate in the survey, please use the pre-addressed, stamped envelope enclosed to return your completed written questionnaire to the research office. If you choose not to participate, please return the blank questionnaire, after which you will not be contacted further. Thank you very much for considering our request.

You indicate your voluntary agreement to participate by completing and returning this questionnaire. This letter is yours to keep. If you have any questions about your rights as a research participant or the conduct of the study, you may contact Dr. David Hill, Scientific Director, Lawson Health Research Institute, (519) 667-6649 or The Office of Research Ethics (519) 661-3036, email ethics@uwo.ca.

Sincerely,

Heather Laschinger, RN, PhD

Professor, Co-Principal Investigator

School of Nursing

University of Western Ontario

(519) 661-4064, hkl@uwo.ca