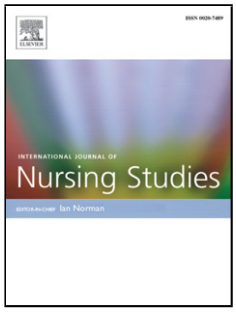

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PII: S0020-7489(19)30050-1
DOI: https://doi.org/10.1016/j.ijnurstu.2018.09.020
Reference: NS 3299

To appear in:

Received date: 23 May 2018
Revised date: 11 September 2018
Accepted date: 27 September 2018

Please cite this article as: Hawkins N, Jeong S, Smith T, New graduate registered nurses' exposure to negative workplace behaviour in the acute care setting: An integrative review, *International Journal of Nursing Studies* (2019), https://doi.org/10.1016/j.ijnurstu.2018.09.020

New graduate registered nurses' exposure to negative workplace behaviour in the acute care setting: An integrative review

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Abstract

Background: Negative workplace behaviour among nurses is a globally recognised problem and new graduate nurses are at high risk for exposure. Negative behaviour has detrimental effects on new graduate nurses, the nursing profession and patients.

Objectives: To synthesise evidence on negative workplace behaviour experienced by new graduate nurses in acute care setting and discuss implications for the nursing profession.

Design: An integrative review guided by Whittemore and Knafl's (2005) framework.

Data sources and review methods: A search of evidence-based research from five electronic databases (CINAHL, MEDLINE, ProQuest, JBI and Scopus) was conducted for the period of 2007-2017. Eligible articles were critically appraised using the Mixed Methods Appraisal Tool.

Results: Eight qualitative and eight quantitative studies were identified and reviewed. There was a variety of terms and definitions used to describe the disrespectful, unprofessional and uncivil targeted behaviour towards new graduate nurses. The incidence of negative workplace behaviour varied from 0.3% as a daily occurrence to 57.1% experiencing sporadic exposure. The precipitating factors included the new graduates' perceived lack of capability, magnifying power and hierarchy, leadership style and influence of management. The negative behaviour was identified as either a personal or professional attack, which left new graduates feeling emotional distress, anxiety or depression, which in turn impacted upon job satisfaction, cynicism, burnout, and intention to leave. The lack of a definitional consensus and the range of negative workplace behaviour make identification, seeking assistance and intervention difficult. Specific or ongoing organisational support to address negative behaviours towards new gradute nurses was not identified. Instead, the way they used to deal with these behaviours were personal.

Conclusion: Negative workplace behaviour towards new graduate nurses continues to be an international problem. Available studies are descriptive and exploratory in nature and there have been few effective strategies implemented in acute care setting to address towards new graduate nurses. Multi-level organisational interventions are warranted to influence the 'civility norms' of the nursing profession. With a new understanding of the theoretical underpinnings of negative workplace behaviours towards new graduate nurses and the identification of limited intervention studies being undertaken, the nursing profession is provided with new directions in their future endeavours.

Keywords: Acute care; Bullying; Hospital; Incivility; New graduate nurse; Nurses; Workforce

Contribution of the paper

What is already known about the topic?

- The existing literature reports that an unsupportive workplace culture is a significant and ongoing problem for new graduate nurses in acute care settings.
- Negative workplace behaviour has far-reaching affects upon the victim, the profession, the organisation and also the patient.

What this paper adds?

- There is a lack of conceptual clarity around the terms associated with negative workplace behaviour.
- The leadership style and influence of management are integral in establishing respectful and positive workplace culture.
- Specific and ongoing multi-level organisation interventions need to be implemented and tested to directly address the problem.

1. Introduction

Nursing is known as the 'caring profession' (Benner, 2009); however, while nurses provide care for their patients, they do not always care for each other (Broome & Williams-Evans, 2011; Baltimore, 2006). This phenomenon is internationally recognised (Sanner-Stiehr & Ward-Smith, 2017). The various forms of negative workplace behaviour experienced by nurses include workplace aggression, incivility, bullying, harassment and horizontal violence (Vessey et al., 2011). It is acknowledged that this negative workplace behaviour has far

reaching implications for not only the victim, but also the profession, the organisation and, more importantly, the patient (Becher & Visovsky, 2012).

Due to the various terms used interchangeably within the literature, the term negative workplace behaviour will be used throughout this review to provide a comprehensive description of the bullying, harassment, horizontal violence and incivility experienced by nurses. Vessey et al. (2011) defined bullying, harassment, and horizontal violence as 'repeated, offensive, abusive, intimidating or insulting behaviour, abuse of power, or unfair sanctions that make recipients upset and feel humiliated, vulnerable, or threatened, creating stress and undermining their self-confidence' (Vessey et al. 2011, p. 136). In addition, while not specifically referred to by Vessey et al. (2011), 'incivility' is also prevalent and is defined by Pearson, Anderson and Wegner (2001) as 'low-intensity deviant behaviour with ambiguous intent to harm the target, in violation of workplace norms for mutual respect'.

While negative workplace behaviour and various types of violence against nurses has been previously explored (Spector, Zhou and Che, 2014; Johnson, 2009; Edward, Ousey, Warelow, Lui, 2014), it is apparent that particularly at risk of exposure to negative workplace behaviour within the nursing workforce are new graduate registered nurses in acute settings (Chang & Cho, 2016; Rush, Adamack, Gordon & Janke, 2014). This is reportedly due to their inferior position within the nursing hierarchy (Rush et al., 2014) and the unrealistic expectation for new graduate nurses to 'hit the ground running' (Wolff et al., 2010). The acute care/hospital setting is the first choice of employment of new graduate nurses in various countries, including in Australia (Health Workforce Australia, 2014a) and America (Bowles & Candela, 2005). However, the hospital setting is often a fast-paced work environment where nurses are confronted with high acuity of patients, shorter lengths of stay and high patient to nurse ratios, all of which puts increased pressure upon new graduate nurses (Clark & Springer, 2012). The literature on new graduate nurses' transition to practice points out that an unsupportive workplace culture is a significant and ongoing problem in acute care settings with potential risk of endemic bullying behaviour (Pellico et al., 2009; Parker, Giles, Lantry & McMillan, 2014;

Kumaran & Carney, 2014). Trepanier, Ferret, Austin and Boudrias (2015) support the notion that aggressive acts are most often committed by nurses who are impacted by negative job characteristics, such as increased workload, emotional demands and role conflict. It is suggested that this leads to feelings of frustration and a sense of having no control and, therefore, nurses commit negative workplace behaviors in order to release the feelings of frustration and regain a sense of control (Salin & Hoel, 2003). This is of particular concern for new graduate nurses transitioning into the acute care setting, as they are often overwhelmed and stressed due to heavy workloads and inexperience. This is the crucial time when they rely upon the support of other nurses (Rush et al., 2014; Becher & Visovsky, 2012; Laschinger, Cummings, Leiter et al., 2016).

It is well known that negative workplace behaviour is common within the nursing profession (Laschinger, Cummings, Leiter et al., 2016; Laschinger, Wong & Grau, 2012; Broome & Williams-Evans, 2011; Spector, Zhou & Che, 2014). Although the phenomenon of negative workplace behaviour in nursing has been previously investigated, it continues to be a significant issue impacting nurses both personally and professionally (Laschinger & Read, 2016, Laschinger, Wong & Grau, 2012). The bulk of current literature examining negative workplace behaviour focuses on the general nursing population and among them new graduate nurses have been identified as a high risk group as victims of these behaviours (Ditmer, 2010; Trepanier et al., 2015; Laschinger, Wong & Grau, 2012). Previous literature has provided an insight into the detriment caused by an unsupportive workplace culture towards new graduate nurses in the acute setting; however, less is known about to what extent it affects new graduate nurses and why some new graduate nurses leave and others 'survive and thrive' (Jackson, Firtko & Edenborough, 2007), despite the exposure to negative behaviour. Therefore, if an effort is to be made to improve their transition experiences and retain them within the nursing workforce, an exploration of the phenomenon experienced by new graduate nurses in the acute care setting is warranted. An integrative review framework was chosen to synthesise past empirical and theoretical literature to provide a comprehensive

understanding of negative workplace behaviour and its impact upon new graduates. The framework that guided this unregistered review was modified from Whitemore and Knafls (2005), which consists of five stages (problem identification, literature search, data evaluation, data analysis, and presentation) and allows for the inclusion of various methodologies (Wittemore & Knafl, 2005).

2. Aim

The initial stage of this review began with clearly identifying the problem, as described above, and determining the aim. The aim of this intergrative review is to synthesise evidence on negative workplace behaviour experienced by new graduate nurses in acute care setting and to discuss implications for the nursing profession. Framework questions used to guide the review and ensure clear boundaries and focus were:

- What is the nature of available evidence?
- How is negative workplace behaviour defined in the literature?
- What are the theoretical frameworks that underpin negative workplace behaviour?
- What is the incidence of negative workplace behaviour against new graduates in acute care setting?
- What are the precipitating factors identified?
- What kind of negative workplace behaviour are new graduates exposed to?
- What are the impacts of negative workplace behaviour?
- What organisational support to address negative workplace behaviour is provided to new graduate nurses?
- How do new graduates deal with negative workplace behaviour?

For the purpose of this review, new graduate nurses are defined as registered nurses with less than 24 months of experience given the increasing part time nursing workforce in some

countries (Berkow, et al., 2009). The acute care/hospital setting refers to the health system components, or care delivery platforms, used to treat sudden, often unexpected, urgent or emergent episodes of injury and illness that can lead to death or disability without rapid intervention (Hirshon, Risko, Calvello et al., 2013). However, in the context of this article, the definition excludes dedicated mental health care facilities.

3. Data sources and review methods

The literature search began with devising the search strategy. The authors initially began by searching MeSH terms and utilising the terms bullying, incivility and nurses. From previous background reading and using key words listed on relevant articles, the authors increased their awareness of terms used to describe the phenomenon of negative workplace behaviour. These terms were included in the search strategy to ensure relevant data was not missed. After the intial planning stage, a search of five electronic databases (CINAHL, Medline, Scopus, Joanna Briggs Institute (JBI) & ProQuest) was conducted in June 2017. The search used a combination of the terms “horizontal violenc*, “lateral violenc*”, “workplace violenc*”, “bully*”, “incivility”, “harass*”, “workplace behaviour” and “graduate nurs*”, “new nurs*”, “nurs* n3 graduate”, “novice nurs*” and “acute care” or “hospital”, which were combined using Boolean operators and truncation to broaden or narrow results. An example search strategy is included in Table 1.

As suggested by Whittemore and Knafl (2005), alternative search strategies were also used, including a search in Google Scholar and hand-searching of the reference lists of all retrieved articles to identify any articles not picked up in the initial database search. These results were then assessed against the eligibility criteria for inclusion or exclusion. The search results are presented in Figure 1.

The inclusion criteria were that: articles had to report original research; study participants were new graduate registered nurses with less than 2 years of experience; the research targetted negative workplace behaviour in relation to the new graduate; and, studies were inclusive of the acute care/hospital setting. The exclusion criteria included: papers published prior to 2007, as the authors wanted to examine the phenomenon as it is being experienced currently, rather than historically; non-English papers; non-research papers; and, papers primarily examining nurses with more than 2 years of experience. The study selection process included scanning all retrieved articles by title, then by abstract, and finally full text articles were scrutinised against the above criteria.

At the data evaluation stage, all of the articles were assessed for methodological quality by all authors. Whittemore and Knafl (2005) recognise that appraising data from varied methodologies for inclusion in a review is complex and they acknowledged that there is no gold standard for calculating scores. The Mixed Methods Appraisal Tool (Pluye, Cargo, O'Cathain et al., 2011) was chosen for its ability to assess the quality of various methodologies against a set of assessment criteria. This allows for easy appraisal and also comparrison between studies as results are converted into a total score out of 100% (Pluye et al., 2011). The Mixed Methods Appraisal Tool does not appraise the quality of the writing/reporting of the research, an important feature as good quality research may not always be well reported (Pluye et al., 2011). The scores for each study are included in Table 2. The majority of articles had MMAT scores over 75%; however four articles scored 50% (Evans et al, 2008; Kerber et al., 2015; Laschinger, 2012 & Russell, 2016). Only one article (Hilliard, 2010) was excluded on the basis of the Mixed Methods Appraisal Tool, as the instrument selected was designed to measure hyperarousal, intrusion and avoidance symptoms and did not clearly achieve the aims of that study.

.The fourth stage of this review, data analysis, was initially undertaken by the primary author (NH) and later scrutinised by the other authors to ensure accurate interpretation and credibility. The method of analysis consisted four phases: data reduction; data display; data comparison; and drawing conclusions and verification (Whittemore and

Knafl, 2005). Analysis used ten key elements, as described by Whittemore & Knafl (2005) and based upon the work of Miles and Huberman (1994), Sandelowski (1995) and Patton (2002). Data was extracted into Word® documents, allowing for the *identification of patterns and themes*. This process was achieved by *counting*, *looking for common and unusual patterns*, and by *making contrasts and comparisons* between the patterns and themes (Whittemore & Knafl, 2005). The primary author *noted relationships between themes* and *intervening themes* (Whittemore & Knafl, 2005). Similar themes were then *clustered* together and *subsumed into more general themes* (Whittemore & Knafl, 2005). The primary author moved back and forth between the literature and the conclusions drawn, in order to verifiy the findings and check for *plausibility*. This data analysis process allowed for a *logical chain of evidence and reasoning to be established* and for further synthesis of the data to higher levels to form an assimilated synopsis of the phenomenon under investigation (Whittemore & Knafl, 2005).

4. Results

The fifth and final stage of Whittemore and Knafl's (2005) integrative review framework is the presentation of the results stage. Table 2 presents the summary of literature reviewed. The initial search yielded 247 articles of which 16 articles were selected for final inclusion. The articles included 14 published articles and 2 dissertations, including eight qualitative and eight quantitative studies.

4.1. Study characteristics

The articles selected for inclusion were from various countries including Canada, USA, Australia, Korea, Taiwan, Singapore and Ireland. The majority of studies included a sample of only new graduate nurse participants, except three articles that included a small sample of RNs (preceptors) (Leong and Crossman, 2016; Evans et al, 2008) or final semester nursing students (Kelly & Ahern, 2009). Although those studies included participants other than new graduate nurses, they were included based on the data, which contributed to the understanding of the topic under investigation.

The quantitative studies (Laschinger, Wong, Regan, Young-Ritchie & Bushell, 2013; Laschinger, 2012; Rush et al., 2014; Laschinger & Read, 2016; Russell, 2016; Chang & Cho, 2016; Laschinger & Grau, 2012; Laschinger, Wong & Grau, 2012) were all cross-sectional

surveys using various standardised instruments in order to measure and assess negative workplace behaviour exposure (See Table 2). The most common instruments used were The Workplace Incivility Scale (Cortina et al., 2001) and the Negative Acts Questionnaire Revised (Einarsen, Hoel & Notelaers, 2009), both of which have a Cronbach's *α* of greater than 0.90.

Sample sizes ranged from 35 participants (Russell, 2016) to 1,020 participants (Laschinger & Read, 2016). The sampling strategies for all of the studies were appropriate to address the research questions and the samples were a representative of the new graduate population. However, none of the studies included had an acceptable response rate (according to the Mixed Methods Appraisal Tool) of 60% or above. The response rates ranged from 45% (Laschinger & Grau, 2012) to 22% (Russell, 2016).

The qualitative study designs were described as: descriptive (Evans et al., 2008; Feng & Tsai, 2012); exploratory (Kerber et al., 2015); Husserl's phenomenological approach (Kelly & Ahern, 2009); phenomenology (Lee et al., 2013; Reuter, 2014); grounded theory (Mooney, 2007); and, constructivist grounded theory (Leong & Crossman, 2016). Data were collected via various methods, including: interviews (Evans et al., 2008; Feng & Tsai, 2012; Mooney, 2007; Leong & Crossman, 2016; Reuter, 2014); multiple, longitudinal interviews (x 3) (Kelly & Ahern, 2009); focus groups (Lee et al., 2013); and, an open ended questionnaire (Kerber et al., 2015). Sample sizes for the qualitative studies ranged from 7 (Feng & Tsai, 2012) to 31 participants (Leong & Crossman, 2016).

4.2. Definitions of negative workplace behaviour

The literature reviewed confirmed that various terms are used interchangeably to describe negative workplace behaviour. The terms utilised within the studies were: nurse co-worker violence (Lee et al., 2013); workplace incivility (Laschinger et al., 2012, Laschinger, 2012, Laschinger & Grau, 2012); bullying (Kelly & Ahern, 2009; Evans et al., 2008; Rush et al., 2014; Chang & Cho, 2016; Laschinger & Grau, 2012); eating their young (Kelly & Ahern,

2009); workplace civility (Kerber et al., 2015; Laschinger, 2012); nurse to nurse bullying (Feng & Tsai, 2012); tough love behaviours (Leong & Crossman, 2016); workplace bullying (Leong & Crossman, 2016; Laschinger, Wong & Grau, 2012); horizontal violence (Rush et al, 2014); co-worker incivility (Laschinger & Read, 2016); and, Lateral violence (Reuter, 2014; Russell, 2016). Fourteen out of the 16 papers gave a definition of the chosen term.

The key aspects of the definitions included that: the behaviour was repeated or reoccurring, although there was no stipulation of how often; the behaviour was humiliating, disrespectful, and intimidating to the victim; and, there was intent to do harm. Incivility was defined as lower level, 'subtle' forms of workplace mistreatment (Laschinger et al., 2013). Five of the articles also specified that negative workplace behaviour often includes an aspect of abuse of a power relationship (Kelly & Ahern, 2008; Evans et al., 2008; Russell, 2016; Mooney, 2007; Laschinger & Grau, 2012).

4.3. Theoretical frameworks

Theoretical frameworks that underpinned the studies included 'Social Capital Theory', which suggests that positive changes occur when social relationships within communities are benevolent (Kerber et al., 2015). The 'incivility spiral', which was introduced by Anderson and Pearson (Anderson & Pearson, 1999, p 458), underpinned the study conducted by Laschinger et al. (2013). The key notion is that, when exposed to uncivil behaviour in the workplace, an individual will have an emotional reaction (anger, fear, sadness) that may result in the desire to retaliate. Laschingern & Grau (2012) built upon Leiter and Maslach's (2004) original Six Areas of Worklife model, which has demonsrated the relationship between the organisational precursors of work engagement and burnout. These were named manageable workload, control, reward, community, fairness and values (Leiter & Maslach, 2004).

Laschinger, Wong & Grau (2012) used Avolio et al's. (2004) authentic leadership model in their study, which investigated the impact of authentic leadership upon new graduate nurses' experiences of workplace bullying, burnout and retention. Authentic leadership, as

described by Avolio et al. (2004), is a 'pattern of transparent and ethical leader behaviour that encourages openness in sharing information needed to make decisions while accepting input from those who follow (Avolio et al., 2009, p. 424). Authentic leaders establish honest and open dialogue with employees and nurture compassionate relationships (Laschinger, Wong & Grau, 2012).

Lastly, 'Oppression Theory', based upon the work of Freire (1972), is used, which proposes that members of a group who are oppressed internalise the opinion of themselves held by the oppressor and then replicate the oppressor's behaviour (Kelly & Ahern, 2009; Mooney, 2007; Reuter, 2014). Mooney (2007) cautioned that if nurses continue to feel powerlessness then the cycle of oppression will continue. A Chinese proverb cited in Feng and Tsai (2012) also describes this endemic oppressive phenomenon stating that, 'A daughter-in-law who suffers will one day become a mother-in-law', which infers that those who have suffered negative workplace behaviour may one day become the perpetrators.

4.4. Incidence and frequency of negative workplace behaviour

The incidence of negative workplace behaviour varied in the studies, as follows: 0.3% (n=3) (Laschinger & Read, 2016) and 12% (n=32) (Laschinger et al, 2013) as a daily occurrence; 29.2% within the previous month (Laschinger, Wong & Grau, 2012); 14.7% (n=5) (Russel, 2016) and 24.6% (n=40) (Laschinger & Grau, 2012) within the previous 6 months; 25.6% within the previous 12 months (Chang & Cho, 2016); and, 57.1% (n=567) experiencing sporadic exposure (Laschinger & Read, 2016). Rush et al. (2014) examined the relationship between access to support, workplace bullying and new grad transition in Canada. They compared the horizontal violence rates between new graduates within a transitional support program and those who had no support. New graduate nurses were asked if they had experienced 'any bullying and/or harassment in their workplace as a new graduate nurse?' The incidence of bullying was the same (39%) among the nurses (n=142) who attended a formal transition program and the nurses (n=100) who did not (Rush et al., 2014). Laschinger

(2012) reported that 39% (n=59) of nurses in their first year and 51% (n=96) of nurses in their second year reported witnessing bullying and 24% (n=36) and 27% (n=51), respectively, reported being subjected to bullying themselves (Laschinger, 2012). Chang and Cho (2016) examined the incidence of workplace violence, including verbal abuse, physical violence, threats of violence, sexual harassment and bullying towards new graduate nurses in Korea. It was found that 73.1% (n=228) of nurses had been exposed to at least one of the five types, with verbal abuse having the highest incidence (59.6%). The overall incidence of bullying (described as a persistent form of abuse) was 25.6%.

In qualitative studies themes associated with horizontal violence were reported (Lee et al., 2013; Reuter, 2014; Leong & Crossman; 2016; Mooney, 2006; Evans et al., 2008; Feng & Tsai, 2012). Kerber et al. (2015) used a three item open ended questionnaire to obtain a description of new nurses' perceptions of incivility. Seventeen participants who completed the online survey reported witnessing incivility in the workplace. In another study, Kelly and Ahern (2009) explored the experiences of newly graduated nurses during their first six months of employment. They found that after six months of employment, all participants (n = 13) had their 'ideal view of belonging to a noble profession replaced with being in a culture that eats their young' (Kelly & Ahern, 2009, p.914).

Frequency levels of negative workplace behaviour varied from daily exposure (Laschinger & Read, 2016; Laschinger et al., 2013) to exposure over the previous 6 months (Russell, 2016; Laschinger, 2012) and 12 months (Chang & Cho, 2016). Athough, the reported incidence rates are noted above, they are not comparable due to the lack of a standardised definition and the use of several measures with varying frequency levels of the negative workplace behaviour assessed.

4.5. Precipitating factors

There were various precipitating factors identified that contributed to the manifestation and continuation of negative workplace behaviour. These included the new graduates'

perceived lack of capability, magnifying power and hierarchy, and leadership style and influence of management that may result in bullying becoming a culturally accepted, endemic phenomenon. First of all, new graduate nurses naturally possess less professional competency than existing staff, which places them in the vulnerable position of relying on peer support to provide safe and effective care (Rush et al., 2014). This reliance puts them in a precarious position, potentially at the mercy of their nursing colleagues (Rush et al., 2014). Laschinger & Grau (2012) identfied that new graduates with a poorer reported overall fit to worklife (how their expectations of their job fit with the reality) were more likely to experience bullying. New graduates who were perceived as incapable and 'not up to scratch' soon found themselves the target of negative workplace behaviour (Evans et al., 2008). Lee et al. (2012) suggested that negative workplace behaviour was often justified by more experienced nurses as a means to improve new graduates' capabilities.

This misuse of knowledge and experience as power was another precipitating factor, which was well described by a participant who stated that 'a lot of RNs out there are on a power trip and think that the best way to teach ... is by humiliating and putting them down as much as possible and saying, "surely you know that"' (Kelly & Ahern, 2009. p. 913). In Mooney's (2007) study, new graduate nurses reported that on some wards they were collectively known as 'the juniors', which was said to highlight the power and authority of being a 'senior'. Negative workplace behaviour was amplified when new graduates were placed in a position of power, seemingly upsetting the natural hierarchy (Reuter, 2014). For example, when new graduates were put in charge of shifts by nurse unit managers as part of training, senior nurses would ignore their directions and directly question their authority (Reuter, 2014). Lee et al. (2013) reported that it was only when new graduate nurses were viewed as being 'capable' and were able to complete their workload that they became 'insiders in the team' and their position within the team hierarchy changed.

Another precipitating factor of negative workplace behaviour identified in the literature was the influence of the Nurse Unit Manager and their leadership style upon ward culture.

The nurse unit manager was depicted as being a powerful figure with considerable influence over the attitude of staff within a clinical area (Evans et al., 2008; Kelly & Ahern, 2009; Mooney 2007; Laschinger, Wong & Grau, 2012). For example, one of the participants from Kelly and Ahern (2009) described the ward as being a reflection of the nurse manager's attitude towards negative workplace behaviour. When examining the impact of authentic leadership upon levels of workplace bullying, Laschinger, Wong & Grau (2012), found a significant correlation. It was also reported by Laschinger and Read (2016) that it was the nurse unit manager who determined the 'civility norms' for the ward, that is, what the expected acceptable behaviour is of the staff within that unit. Laschinger & Grau (2012) highlighted the importance of the role of the nurse unit manager in introducing the new graduate nurses into a workplace free from bullying and emphasised that bullying was not a component of the job that new graduate nurses should learn to cope with. However, unfortunately the literature suggested that negative workplace behaviour in some workplaces was accepted and 'normalised' (Leong & Crossman, 2016; Lee et al., 2012; Feng & Tsai, 2012; Evans et al., 2008).

4.6. The impacts of negative workplace behaviour

Table 3 presents the various behaviours that constitute negative workplace behaviour, which are categorised as a either a personal or professional attack. As a result of these behaviours, new graduates reported feeling emotional distress (Reuter, 2014; Laschinger & Read, 2016), feelings of low self-esteem, anxiety, depression and disempowerment (Leong and Crossman, 2016). The exposure to negative workplace behaviour has also been shown to affect new graduate nurses' job satisfaction, cynicism, burnout, and their intention to leave (Laschinger, 2012; Chang & Cho, 2016, Laschinger & Grau, 2012; Laschinger, Wong & Grau, 2012). One participant in a study by Reuter (2014), when asked about their turnover intentions, replied 'yes, I've definitely considered leaving nursing, it was literally killing me. They just didn't seem to care I was there' (Reuter, 2014, p. 82). This impact of negative workplace behaviour upon new graduates' turnover intentions has the potential to negatively impact the nursing profession (Laschinger & Grau, 2012). Reuter (2014) reported that negative behaviour within

an organisation have the potential to impact upon staff morale, absenteeism, attrition of staff, and nurses leaving the profession of nursing completely.

Negative behaviour has also affected the delivery of patient care (Kerber et al, 2015; Reuter, 2014). Factors included the negative act itself, such as withholding patient information that may be critical in delivering care (Leong & Crossman, 2016; Kerber et al., 2015), and also the new graduate nurse taking time away from the bedside to deal with the negative behaviour (Kerber et al., 2015). One study participant described a situation where patient care was delayed as a result of inappropriate questioning over a graduate's ability to effectively care for a patient (Reuter, 2014). Time taken away from the bedside to justify capability resulted in the patient experiencing increased levels of pain that would have been addressed earlier if the new graduate was left to attend to the patient (Reuter, 2014, p 88). This negative behaviour can also have an impact upon patient care due to new graduates' state of mind, thereby affecting their work (Reuter, 2014) and willingness to seek assistance when needed (Reuter, 2014; Kerber et al.,2015; Kelly & Ahern, 2009; Evans et al., 2008). Avoidance of some staff and not seeking assistance when needed was an obvious result of negative workplace behaviour (Reuter, 2014; Feng & Tsai; 2012; Kelly and Ahern, 2009). Kelly and Ahern (2009) reported that new graduates soon recognised that there were registered nurses who could be asked questions and others who could not. New graduate nurses reported that they often got the most support from other new graduates but identified that it was like 'the blind leading the blind' (Kelly & Ahern, 2009).

4.7. Organisational support to address negative workplace behaviour

One form of organisational support identified in the literature was the involvement of new graduate nurses in transition to practice or residency programs (Evans et al., 2008; Feng & Tsai, 2012; Kelly & Ahern, 2009; Rush et al, 2014; Russell, 2016). The type and level of support provided appeared inequitable, however, with a difference in support provided not only between hospitals but between units within the same hospital (Mooney, 2007; Evans et

al., 2008). Laschinger (2012) reported that new graduates attended study days that were helpful and learned skills such as stress management, communication skills and networking opportunities. However, within the literature reviewed, specific anti-bullying or ongoing organisational support to address negative behaviour towards new gradute nurses was not identified. Only one study (Rush et al., 2014) reported that nurses who were part of a transitional program had better access to support when exposed to negative workplace behaviour and had higher transition scores (better transition), compared to nurses who were not part of a program.

4.8. New graduate nurses' ways to deal with negative workplace behaviour

The strategies that new graduate nurses reportedly used to deal with the negative workplace behaviour exposure were personal, including: hiding their true feelings and emotions while at work (Lee et al., 2013); 'stockpiling human favours' by helping senior nurses with their workload so that the senior nurses would help them in return (Lee et al., 2013); talking with family and friends (Leong & Crossman, 2016); undertaking relaxation and non-work-related activities where they could be themselves (Lee et al., 2013); and, trying to remain positive and resilient (Leong & Crossman, 2016; Laschinger et al., 2013; Lee et al., 2013). Evidence of resilience was reflected in various comments of study participants, such as, 'never have too many negative thoughts, otherwise they will make you unhappy … So I will think positively and I won't be too miserable' (Lee et al., 2013, p.793). Laschinger et al. (2013) also reported that when resilience was present in participants, the negative effects of incivility on new graduates' mental health was lessened.

It was noted by Lee et al. (2013) and Evans et al. (2008) that, late in the transition process, new graduates began to demonstrate negative strategies in response to the negative behaviour. One coping strategy identified by a participant for the inequity of rosters (Evans et al., 2008) was, 'Don't ask for the day off, just be sick!' It was reported that, towards the end

of the transition year, new graduates were no longer willing to be laughed at or attacked and that they began to use 'passive aggression' to respond to mistreatments' (Lee et al., 2013).

5. Discussion

The internationally recognised phenomenon of negative workplace behaviour in the nursing community has been researched over the last 20 years and it is reported that new graduate nurses are at greater risk for exposure to negative workplace behaviour due to their vulnerability in the profession (Ditmer, 2010; Rush et al., 2014). Where previous literature has focused upon the nursing profession as a whole (Specta, Zhou & Che, 2014; Johnson, 2009; Edward, Ousey, Warelow, Lui, 2014; Farrell & Shafiei, 2012), this integrative review has further investigated the phenomenon, specifically towards new graduate nurses in acute care setting. This not only contextualises and gives further structure to understanding negative workplace behaviour, but provides a platform for discussion of the critical issues identified and the implications for the nursing profession.

5.1. Conceptual differences and variety of the terms

The first issue noted is the variety of terms and definitions used to describe the disrespectful, unprofessional and uncivil targeted behaviour towards new graduate nurses. This seems unhelpful in understanding the true nature of negative workplace behaviour and, therefore, dealing with it effectively.

Of the 16 studies reviewed, 12 (Chang & Cho, 2016; Evans et al., 2008; Feng & Tsai, 2012; Kelly & Ahern 2009; Lee et al., 2013; Leong & Crossman 2016; Rush et al., 2014; Russell, 2016; Reuter, 2014, Laschinger, 2012, Laschinger & Grau, 2012; Laschinger, Wong & Grau, 2012) used the terms bullying, harassment and/or violence, while others (Kerber et al., 2015; Laschinger, 2012; Laschinger et al., 2013; Laschinger & Read, 2016) focused on 'incivility' as a form of neagtive workplace behaviour. In 2012, Laschinger used the terms

'incivility' and 'workplace bullying' but in later work published in 2013 and 2016, the primary focus shifted to 'incivility', with a firmer realisation of 'incivility' as a subtle, and potentially common form of workplace mistreatment. The international variation in levels of reported negative workplace behaviour could be partly explained by the differences in definition and description.

The further implication of the lack of a uniform definition and clarity of the concept of negative workplace behaviour in the nursing profession is that those who are exposed to such behaviour, including new graduate nurses, senior nurses, and nurse unit managers would have reported based upon their own understanding of these behaviours, therefore the incidence rates reported require careful interpretation, and the extent of the problem may infact be underreported or misrepresented. This is evident in this review and other studies that the lower level, 'subtle' and 'covert' behaviours, which occur on a daily basis are accepted as part of the 'professionalisation' process or 'office politics' in the nursing profession despite of significant consequences on new graduate nurses (Becher & Visovsky, 2012).

Regardless of the focus and terms used, the precipitating factors, as well as the types and impact of negative workplace behaviour is similar. The conceptual differences and variety of behaviours are also of significance in that the absence of a comprehensive descriptive framework capturing and cataloguing those behaviours make identification, seeking assistance and intervention difficult (Hutchinson, Vickers, Wilkes et al., 2010). According to Field (2012), in most bullying cases reported, there is insufficient legal evidence to prove the bullying, which often relates to the varying interpretations of the definition of bullying. Field (2012) reported that when this occurs, the victims of bullying are hurt more by their perceived denied request for help, on top of the initial effect of the negative workplace behaviour. The perceived lack of action and a belief that nothing will be done about bullying, was a reason for non-reporting by 64.1% of nurses (n=200) (Hutchinson, 2007). In another study, Koh (2016) reported that even though 33.7% of nurses have experienced verbal abuse, with 17.6% alleging abuse by nurse managers, more than 70% chose not to report the incident. There is

a perceived need for a synthesis of terms and greater conceptual clarity in order to improve reportability and accountability.

When covert, uncivil behaviours towards new graduate nurses are justified as part of professionalisation or due to perceived incompetence, the 'flow-on-effect' to patient care delivered by the victims of negative workplace behaviour has not been well captured in nursing research to date (Hutchinson et al., 2013; Jackson & Wilson, 2016). The negative effects of the lack of collegial support, sharing of essential patient information and collaborative decision-making may not be fully understood. Yet, these barriers are known to be associated with increased risk of clinical errors and potentially poorer patient outcomes (Vessey, DeMarco & DiFazio, 2011). This further strengthens the argument that, without a definitional consensus and clarity, bullying and incivility research has lacked focus, direction and depth (Goldsmid & Howie, 2014).

5.2. The strategies to address negative workplace behaviour

In the literature, strategies to prevent negative workplace behaviour in general within the health care setting can be grouped into two categories: 1) those with a victim focus, with the aim of improving coping mechanisms or responses to negative workplace behaviour (Clark, Ahten & Macy, 2013; Griffin, 2004; Stagg et al., 2011); and, 2) those with an organisational focus, the aim being to increase organisational wide civility and decrease negative workplace behaviour (Osatuke et al., 2009; Leiter et al., 2011). Available evidence provides insight into the incidence and types of this negative behaviour and the impact of these behaviours upon new graduate nurses, the nursing profession and also on patients. However, given that all 16 studies reviewed are descriptive and exploratory of the experiences of new graduate nurses exposed to negative workplace behaviour, there is no apparent evidence of effective strategies implemented and tested to directly address the problem.

With the future nursing workforce shortfall looming internationally (Buchan,Twigg, Dussault, Duffield & Stone, 2015), this review highlights the correlation between workplace

culture, nurses job satisfaction and intention to leave (Laschinger, 2012; Chang & Cho, 2016, Laschinger & Grau, 2012; Laschinger, Wong & Grau, 2012). In addition, the evidence identified in this review clearly points out that new graduate nurses' well-being is compromised with the reports of emotional distress, anxiety and even depression (Reuter, 2014; Laschinger & Read, 2016; Leong and Crossman, 2016). Given that new graduate nurses' attrition is closely associated with their first year experiences (Cubit & Ryan 2011; Kelly & Ahern 2009), and a lack of organisational support is noted in this review, it highlights the responsibility of the whole nursing profession to welcome and support new graduate nurses if they are to be retained in the workforce.

However, the level of commitment of the nursing profession and employers to address the issue is noted only in a number of policies and procedures, which describe negative workplace behaviour and outline protocols for their management. These policies usually take the stance of 'zero tolerance', as failure to take steps to mitigate bullying behaviour and provide a safe workplace can result in employers facing litigation (Safe Work Australia, 2017). Along with the implementation of zero tolerance policies, nurses are also expected to practise under a code of ethics (NMBA, 2008). It is specified that nurses should 'practise kindness and model consideration and care towards each other and that dismissiveness, indifference, manipulativeness and bullying are intrinsically disrespectful and ethically unacceptable' (NMBA, 2008). However, the mere existence of or passive distribution of such policies will not promote the desired behaviour (Coursey et al., 2013). In fact, Johnson, Boutain, Tsai and De Castro (2015) in their study identified that most frontline nurses were unaware of the existence of a workplace violence policy. The existence of these policies also does not guarantee their enforcement by management (Laschinger, Wong & Grau, 2012). It was suggested by Laschinger, Wong and Grau (2012) that nurse unit managers need to implement authentic leadership practices in order to establish a culture of trust for staff to firstly feel able to report negative workplace behaviour. It was also emphasised that managers need to ensure that these behaviours are managed and that zero tolerance is in fact the stance taken.

This review adds to the theoretical understanding of the phenomenon of negative workplace behaviour towards new graduate nurses. It captures and explains the nature and extent of the cycle of negative workplace behaviour towards new grauate nurses, implying that efforts to address the issue should be inclusive and comprehensive within both the profession and employer organisations. Available literature affirms the need to intervene at multiple levels with a clear focus on the change of culture and practice. It is evident in nursing and other disciplines that interventions with integrated, organisation-wide approaches demonstrated improvements in 'civility' (Hodgins et al., 2014; Meloni & Austin, 2011; Osatuke et al, 2013; 2016; Leiter et al., 2011), whereas individually focused interventions are likely to have less impact (Chipps & Mcrury, 2012; Kirk et al., 2011).

The only organisational approach supported by the nursing profession to address negative workplace behaviour towards new graduate nurses is apparently the provision of an orientation and access to support through a transitional program. Nurses who had better access to organisational support through a transitional program demonstrated higher transition scores, despite the presence of workplace bullying, in part attributable to specific, one-on-one support for new graduates by preceptors or mentors (Rush et al., 2014). However, this approach has limited applications and outcomes, particularly given the often limited availability of preceptors to work the same roster or, in fact, any shifts at all with the new graduates (Clark & Springer, 2012; Odland, Sneltvedt & Sorlie, 2012). For this reason, Rush et al. (2014) suggested that the establishment of a supportive culture at a ward/unit level was equally valuable. This is confirmed by Laschinger et al. (2016) who examined the relationship between the authentic leadership of managers, co-worker incivility and burnout among new graduate nurses. The authors suggested that authentic leadership plays an integral role in reducing new graduate nurses' exposure to workplace bullying and establishing respectful, positive workplace culture. The leadership style of management was evidently a precipitating factor to endemic negative workplace behaviour and further research is recommended of that relationship.

5.4. Limitations

The limitations of this review include that data was only retrieved from electronic databases and published sources. It is possible that some relevant 'grey' literature was not included. Due to an inclusive approach being taken, quantitative studies with questionable methodological quality, such as the low response rates, small sample sizes, often from only one either hospital or university, were included, raising questions of generalisability. In qualitative studies sampling bias and dependence on self-reporting suggests a need for caution in the interpretation of findings. The authors minimised the risk of bias of each study and across studies by scrutinising the whole process and outcomes of each stage. Reporting bias is minimised by strictly following the integrative review framework chosen.

6. Conclusion

New gradaute nurses can find themselves in vulnerable positions and reliant on collegial support to provide safe and effective patient care, as their skills continue to develop. While they deal with the shock of transitioning from the student to registered nurse role, they also face exposure to negative workplace behaviour in the acute care setting. This review has shown that new graduate nurses often feel like they do not receive the level of support they require and are at times humiliated and belittled in public for their perceived insufficiencies. This lack of collegial support and targeted negative workplace behaviour has detrimental effects not only upon the new graduate themselves, but also upon the safety of patients, the organisation, and the whole nursing profession. This review has identified that negative workplace behaviour towards new graduate nurses continues to be problematic, and that there is a need for multi-level comprehensive interventions in order to transform the 'civility norms' of the nursing profession.

Conflict of interest

The authors declare no conflict of interest.

Acknowledgments

This work received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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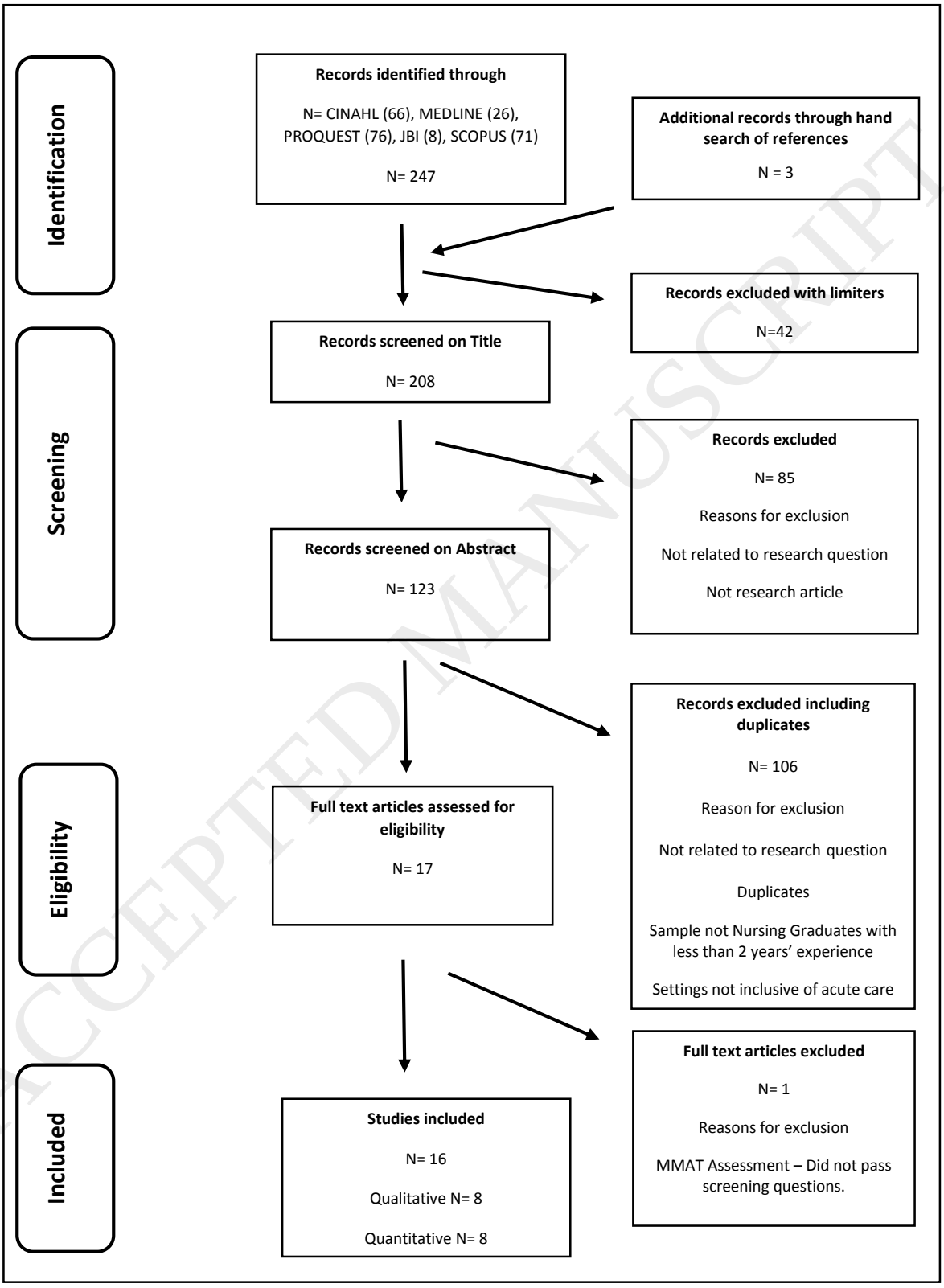

Figure 1: Search results and selection process

Table 1: An example of the search terms in a database.

Database	Search Terms	
CINAHL	**S19**	**S9 AND S15 AND S18**
	S18	**S16 OR S17**
	S17	hospital
	S16	acute care
	S15	**S10 OR S11 OR S12 OR S13 OR S14**
	S14	novice nurs*

	S13	nurs* n3 graduat*
	S12	new nurs*
	S11	neophyte nurs*
	S10	graduate nurs*
	S9	**S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8**
	S8	harrass*
	S7	workplace behaviour
	S6	incivility
	S5	bully*
	S4	lateral violenc*
	S3	workplace violenc*
	S2	vertical violenc*
	S1	horizontal violenc*

Table 2: Literature summary & Mixed Methods Appraisal Tool (MMAT) scores

Authors/Years/Country	Research Aims/ Questions	Research design	Terms and Definition used to describe phenomenon	Key findings
1.Chang & Cho (2016) SOUTH KOREA	To examine the prevalence of workplace violence toward newly licensed nurses and the relationship between workplace violence and job outcomes	Quantitative Cross sectional Survey Longitudinal (3 years) Sample N= 312 Response rate: Group 1 (2012) = 47.8% Group 2 (2013) – 39.3% MMAT: 100%	verbal abuse and bullying Defined as a "persistent form of abuse, conducted both overtly and covertly, in which others can participate along with the main perpetrator, while others can be witnesses or bystanders"	73.1% had been exposed to at least one of the five types (verbal abuse, physical violence, threats of violence, sexual harassment and bullying). 59.6% verbal abuse 25.6% bullying Violence by nurse colleagues had greater impact upon job satisfaction and intent to leave than any other perpetrator (patient, patient family, doctors, nurse unit manager)
2.Evans, Boxer & Sanber (2008) AUSTRALIA	To determine the strengths and weaknesses of transition support programs for newly registered nurses.	Qualitative Descriptive, Semi Structured Interviews Sample 9 newly graduated nurses MMAT: 50%	Bullying "behaviours such as excessive abuse or criticism, threats, ridicule and humiliation, making excessive demands on any one person, inequitable rostering or a misuse of power to encourage other people to exclude the victim as indicative of bullying" (Farrrell 1997; Patterson et al 1997).	"Most of the nurses interviewed spoke of bullying or horizontal violence among their peers and knew of the wards in each of the hospitals where bullying was known to regularly occur" Nurse unit managers play a key role in condoning the behaviour of the nurses in their wards.
3.Feng & Tsai (2012) TAIWAN	To explore the socialisation experiences of new graduate nurses to practicing nurses	Qualitative Descriptive, Semi Structured Interviews Sample N=7 (full time position) MMAT: 100%	"Nurse-to-nurse bullying" – No definition offered.	They risked being 'yelled at in Socialisation of new practising nurses in front of others' if they failed to conform to the norms of the ward. "They always find something to criticise. It is really hard to work with those people; unfortunately, you need their help". 'A daughter-in-law who suffers will one day became a mother in-law'. This means that those who suffer will one day get their chance, what goes around comes around.
4.Kelly & Ahern (2009) AUSTRALIA	To describe the experiences of newly graduated nurses during their first six months of employment as registered nurses.	Qualitative Husserl's phenomenological approach Semi-structured interviews at three intervals: prior to commencing employment and at	"Bullying" and "Eating their young" "The metaphor 'eating their young' appears to apply when bullying is directed towards a less experienced nurse by a more	For the participants, concepts that aligned with being 'eaten' included power games, hierarchy and 'bitchiness'. Hierarchy in the workplace – nurse unit managers (all female) were identified as having

Authors/Years/Country	Research Aims/ Questions	Research design	Terms and Definition used to describe phenomenon	Key findings
		one and six months' post-employment. Sample N = 13 participants MMAT: 100%	experienced nurse (Bartholomew 2006)"	considerable impact within the working environment and on socialisation processes. Experienced nurses are interacting with less experienced nurses in much the same way that they were treated. This notion supports Freire's (1970) original work on oppressed groups, which theorised that oppressed group members internalise the view of themselves held by the oppressor and imitate patterns of oppressor behaviour.
5.Kerber, Mann Woith, Jenkins & Astroth (2015) *USA*	To obtain a rich description of new nurses' perceptions of incivility in the workplace to explore the impact of incivility on new nurses and patients.	Qualitative Exploratory, Online, three-item, open-ended questionnaire Sample N=17 completed full survey online RR: 21.5% MMAT: 50%	"Workplace Civility" The social capital theory (Adler & Kwon, 2002; Taylor, 2013) guided the definition of *civility* as benevolence, trust, reciprocity, collaboration, cooperation, and inclusion; conversely, *incivility* was defined as the absence of those attributes.	Participants described being yelled at by doctors and nurse unit managers in front of others, being accused of things unfairly, and reported being belittled in front of patients and families, and being bullied by more senior nurses. Thirteen participants believed incivility contributed to patient needs going unmet, and four asserted that incivility undermined patients' faith in their health care.
6.Laschinger, Wong, Regan, Young-Ritchie & Bushell (2013) CANADA	To examine the relationships between co-worker, physician and supervisor workplace incivility and new graduate nurses' mental health and the protective role of personal resiliency	Quantitative Survey Instruments Workplace Incivility Scale (WIS) Resiliency subscale from Luthan's Psychological Capital Questionnaire The Mental Health Inventory (MHI-5) SPSS for Data Analysis Sample N=272 RR = 32.6% MMAT: 75%	"Workplace Incivility" ''low intensity deviant behaviour with ambiguous intent to harm the target, in violation of workplace norms for mutual respect.'' Examples of incivility include dismissing an employee's ideas or opinions, making derogatory or demeaning remarks about individuals at work, and excluding people from social activities.	12% reported daily uncivil behaviours from co-workers which was greatest source of incivility; second source was physician incivility and then supervisor incivility. Uncivil behaviours they are implying that this behaviour is acceptable and perpetuating the negative culture. All forms of incivility were significantly related to poor mental health, although co-worker incivility had the strongest correlation. When resiliency levels of new graduates were higher, the effect of co-worker incivility on mental health was lower.
7.Lee, Hsu, Li, Sloan (2013) TAIWAN	To obtain a comprehensive understanding of the transition process of new nurses in Taiwan	Qualitative Phenomenology Focus Groups Sample N=16	"nurse co-worker violence" Co-worker violence often included repeated intimidation,	Senior nurses were abusive to new nurses, and the nurses justified this because of their inferior position and abilities.

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		MMAT: 100%	aggression, tyranny or harassment. These behaviours were intended to do personal or professional harm to the abused co-worker (Leck & Galperin 2006)	Abuse under the guise of necessity of training 'Stockpiling human favours' became a strategy of adaptation. "While in western culture the abuse and indoctrination of new nurses is seen as toxic, in Chinese traditions yield, tolerance self-oppression and following hierarchy are interpreted differently.
8.Leong & Crossman (2016) SINGAPORE	To report on the transition experiences of new nurses and preceptors in Singapore, focussing on the construction of a supervisor strategy termed 'tough love'.	Qualitative Constructivist grounded theory approach Semi structured interviews New nurse participants also submitted reflective journals (x 8) on their transition experiences for analysis. Sample New nurses (n = 26) and preceptors (n = 5) MMAT: 100%	"tough love behaviours" and "workplace bullying" humiliating, intimidating or demeaning behaviours (Cleary et al. 2010)	Participants were commonly exposed to supervisor sarcasm, insults and criticism Scolding directed towards new nurses occurred by senior nurses and doctors. Strategically withholding information is also characteristic of bullying behaviour and has clear and disturbing consequences for the safety and wellbeing of both new nurses and patients. Tough love = great emotional distress to targets, manifesting as feelings of low self-esteem, anxiety, stress, depression and disempowerment. Relied on family and friends for support. Reflection, maintaining a positive attitude, disassociation from the immediate emotional effects of scolding and refocusing on higher objectives all constitute coping strategies in experiences of tough love Tough love is an endemic, tolerated aspect of the organisational and professional culture, perpetuated across generations.
9.Mooney (2007) IRELAND	To ascertain New graduate nurses perceptions of becoming newly qualified nurses	Qualitative Grounded Theory Interviews Sample N= 6 MMAT: 100%	Theme titled "without a voice", where participants spoke about "powerlessness", "vulnerability", "hierarchy", & "unfair sanctions"	Vulnerability and powerlessness experienced by the newly qualified nurses. They were collectively known as 'the juniors' and accentuated the supremacy of being senior while highlighting the prevalence of hierarchy.

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				Blamed disproportionately and distrusted when things went wrong. Eleven of the 12 respondents described how the nurse manager holds the reigns of professional nursing power within clinical areas. If nurses are subjected to domination and powerlessness, then the cycle of oppression will continue, which has implications not only for newly qualified nurses but for those patients in their care.
10.Rush, Adamack, Gordon & Janke (2014) CANADA	To examine the relationship between access to support, workplace bullying and new graduate nurse transition within the context of new graduate transition programs.	Quantitative Online Survey Instruments included from Casey Fink Graduate Nurse Experience Survey Sample N=245 MMAT: 75%	"horizontal violence" and "bullying" No definition given	39% reported they experienced bullying/harassment. Prevalence was same for those in transition program and those that were not. Bullying/harassment in workplace was found to be a statistically significant moderator of the relationship between new graduates' ability to access support when needed. Bullying/harassment has a diminishing effect on transition because it slows down "doing" and skill development.
11. Laschinger (2012) CANADA	To describe new graduate nurses work life experiences in Ontario hospital settings in the first 2 years of practice and to examine predictors of job and career satisfaction and turnover intentions.	Quantitative Survey A descriptive correlational design Instruments Areas of Work Life Scale (AWS); Conditions for Work Effectiveness Questionnaire (CWEQ-II); Authentic Leadership Questionnaire (ALQ); Core Self-Evaluation (CSE); Utrecht Work Engagement Scale (UWES) Maslach Burnout Inventory-General Scale (MBI-GS); Negative Acts Questionnaire-Revised (NAQ-R); Workplace Incivility	"incivility" and "workplace bullying" Defined as "a situation where someone is subjected to social isolation or exclusion, his or her work and efforts are devalued, he or she is threatened, derogatory comments about him or her are said behind his or her back, or other negative behaviour aimed to torment, wear down, or frustrate occur (Kivimaki et al.2000, p. 656)."	39% of nurses in their first year and 51% of nurses in their second year reported witnessing bullying. 24 and 27%, respectively, reported being subjected to bullying themselves. Higher levels of bullying and incivility are significantly related to job and career dissatisfaction, particularly in the first year of practice. Both nursing cohorts reported moderate levels of negative physical and mental health symptoms. Negative work experiences (incivility and bullying) were significantly related to job satisfaction and intent to leave.

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		Scale (WIS); Pressure Management Indicator (PMI); Satisfaction Scale); Turnover Intent Sample N = 342 RR: Not given MMAT: 50%		
12. Laschinger and Read (2016) CANADA	To examine the influence of Authentic leadership, person-job fit with 6 areas of work life, and civility norms on co-worker incivility and burnout among new graduate nurses.	Quantitative Survey Instruments: Authentic Leadership Questionnaire, Areas of Work life, Civility Norms Questionnaire Scale, Straightforward Workplace Incivility Scale, Co-worker Incivility Subscale, Maslach Burnout Inventory (MBI) Emotional Exhaustion Subscale Sample: N= 1020 RR: 27.3% MMAT: 75%	**Used the term "Co-worker Incivility"** "Workplace incivility describes behaviours with an ambiguous intent to harm others that violate social norms of courteous and respectful conduct and demonstrate disregard for others"	All variables were significantly correlated with one another. Authentic leadership was positively related to civility norms (r = 0.37) and negatively related to co-worker incivility (r = j0.23). Co-worker incivility was associated with higher levels of emotional exhaustion, providing additional evidence that uncivil interactions with co-workers are emotionally draining and stressful for new nurses, contributing to job burnout Authentic leadership plays an integral role in reducing new graduate nurses' exposure to workplace bullying.
13. Russell (2016) USA	To determine if new graduate nurses continue to experience the negative acts of lateral violence	Quantitative data Descriptive survey Instruments Negative Acts Questionnaire - Revised (NAQ-R) Sample N=35 RR: 22% MMAT: 50%	Lateral violence The Centre for American Nurses (2008) described bullying as "an offensive, abusive, intimidating, malicious or insulting behaviour, or abuse of power conducted by an individual or group against others" (p.1).	According to participants, 14.29% experienced bullying at this facility in the last 6 months. Acts of violence included Being exposed to unmanageable workload (44.11%) Being ignored or excluded (34.29%) Teasing, pressure not to claim something, which by right you are entitled, and practical jokes carried out by people you do not get along with (2.94%)
14. Reuter (2014) USA	The purpose of this study is to research the newly licensed nurses' experience of lateral violence and the ramification of these events.	Qualitative Phenomenological Theoretical Framework The Theory of Oppression Sample N= 11 MMAT: 100%	"Lateral violence" Behavioural acts of lateral violence are noted by fighting among nurses, the withholding of pertinent information (in other words, sabotage, turning away, criticism, failure to respect confidences and privacy, eyebrow raising, snide remarks, and	Participant noted lack of support from manager. Hospital have a lack of accountability and a culture of blame rather than one of accountability for action which creates an atmosphere of intimidation and prevents nurses from asking authorities appropriate actions. Decreased staff often meant that the newly licensed nurse has to take on the role

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			scapegoating) (Griffin, 2004)	of charge nurse who encountered passive aggressive behaviour. Communication decreases when individuals feel too intimidated to communicate with members of the healthcare team who are known instigators of these negative behaviours. Avoidance of some staff may have an effect on patient care. I was not thinking well and was not giving 100% to my job. I just couldn't think straight and my patients were affected
15. Laschinger, Wong & Grau (2012) CANADA	To test a model linking authentic leadership to new graduate nurses experiences of workplace bullying, burnout, job satisfaction and intention to leave	Quantitative Cross sectional Survey Instruments Authentic Leadership Questionnaire Negative Acts Questionnaire-Revised Emotional Exhaustion Subscale Retention Outcomes Sample N=342 RR = 38% MMAT 75%	"Bullying" 'A situation where someone is subjected to social isolation or exclusion, his or her work and efforts are devalued, he or she is threatened, derogatory comments about him or her are said behind his or her back, or other negative behaviour aimed to torment, wear down, or frustrate occur (Kivimaki et al., 2000, p656).	29.2% of participants met criteria for workplace bullying (at least two bullying behaviours on a weekly or daily basis in the last month). Participants were already approaching severe burnout, and were only somewhat satisfied with their current jobs. Authentic Leadership was significantly correlated with all study variables but most strongly associated to Work-related bullying. Bullying had significant effect of job satisfaction and indirectly affected emotional exhaustion. Authentic leadership influenced job satisfaction through workplace bullying and emotional exhaustion.
16. Laschinger & Grau (2012) CANADA	To test a model derived from Leiter and Maslach's (2004) Six Areas of Worklife model linking workplace factors (six areas of worklife, experiences of bullying and burnout) and a personal dispositional factor (psychological capital) to new graduates mental and physical health	Quantitative Cross Sectional Survey Instruments Areas of worklife scale Pyschological Capital Questionnaire Negative Acts Questionnaire revised Emotional Exhaustion & cynicism subscale Sample N=365 RR = 45.2%	"Bullying" Outline three forms of workplace bulling 1) Work related 2) Personal 3) Physical To be considered bullying the behaviour must occur a minimum of once a week over a period of approximately 6 months and the instigating party must have power over the intended target (Einersen ^ Hoel, 2001).	26.4% were classified as bullied. New graduates reported mismatch between expectations and reality associated with workload and fairness. Reported moderate levels of physical and mental health problems Average scores for emotional exhaustion were relatively high, the average nurse in first year of nursing just under cut-off of being classified as severely burned out.

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	in their first year of practice.	MMAT- 75%		

Table 3: Inventory of negative workplace behaviours.

Personal attack	**Professional attack**
Verbal abuse (Lee et al., 2013; Feng & Tsai, 2012; Russel, 2016)	Questioning of competence (Reuter, 2014; Russel, 2016; Kerber et al., 2015)
Being ignored (Kelly & Ahern, 2009; Evans et al., 2008)	Blame for Incompetent care or low quality care (Mooney, 2007)
Public humiliation (Kerber et al., 2015; Leong & Crossman, 2016; Russel, 2016)	Excessive criticising on performance? (Leong & Crossman, 2016; Russel, 2016; Lee et al., 2013)
Exclusion from socialisation? (Kelly & Ahern, 2009; Evans et al., 2008; Russel, 2016)	Unfair allocation of workload (Evans et al., 2008; Kelly & Ahern, 2009; Lee et al., 2013; Leong & Crossman, 2016; Russel, 2016)
Gossip or rumours being spread (Russel, 2016)	Inequitable rostering (Evans et al., 2008; Kelly & Ahern, 2009; Lee et al., 2013; Leong & Crossman, 2016; Mooney, 2007)
	Last meal breaks (Kelly & Ahern, 2009)
	Withholding information (Russel, 2016)
	Being ordered to work below level of competence (Russel, 2016)