EXPLORING EMERGENCY NURSES' EXPERIENCE OF VIOLENCE
IN THEIR WORKPLACE

by

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ABSTRACT

This paper describes emergency nurses’ experience of violence in their workplace and how they perceived their workplace as contributing to their experience and their ability to care for their patients. A review of the literature pertaining to nurses and workplace violence which highlighted work on nurses’ experience with violence, the extent of violence in health care, determinants of violence, workplace design, and the impact of violence on nurses. This qualitative descriptive study using a naturalistic, retrospective design employing qualitative content analysis was conducted in two large urban emergency departments in the lower mainland of British Columbia. Two male and four female emergency nurses who were registered nurses or registered psychiatric nurses with a range of 3 to 20 years experience were individually interviewed who described the frequent and potentially lethal verbal and physical violence they experienced on a daily basis. They identified a culture of violence within a fractured environment that reduced their safety. The study found that the provision of physical barriers sometimes had a paradoxical affect of increasing aggressive incidents. The culture of violence contributed to nurses’ inability to provide care and comfort to emergency patients, which increased the likelihood of a violent event occurring. Lack of response to the culture of violence by management is demonstrated. This study has implications not only for nurses’ safety, but for the recruitment and retention of nursing staff and the design of emergency departments to reduce violence against nursing staff.
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DEDICATION

For Sadie Merrick and Dorothy Kelley who taught me what it means to be a nurse.
CHAPTER 1
Overview of the Research Problem

Violence traditionally had been considered a problem exclusively within the
domain of criminal justice (Mair & Mair, 2003) but is now widely viewed as a global
public health issue that has become a priority in industries world wide (Glasson, 1993;
WHO, 2002). It is a significant social problem that is spilling over from homes and
communities into emergency departments where the threat of violence is of increasing
concern to the nurses who work there (Henderson, 2003; Kuhn, 1999). No longer is the
emergency department a safe haven from the violence but rather an environment where
the violence continues with significant frequency (Workmen's Compensation Board of
British Columbia, 2004). Nurses are more likely to be attacked than police officers or
prison guards (Kingma, 2001) and emergency departments are vulnerable to violence in
part because patients who are the victim or perpetrators of violent acts can be treated
there (Joint Commission on Accreditation of Health Care Organizations, 2006). While an
increasing body of literature on violence against nurses is developing (Armstrong, 2006;
Duncan et al, 2001; Henderson, 2003; Hislop & Melby, 2003; Levin, Hewitt & Misner,
1988), little of this has asked about the nurse's perception of the violence. Moreover, even
less research has explored nurses' perception of the impact of the work environment on
their experience of violence at work (Henry & Ginn, 2002; Hislop & Melby, 2003).

Definitions of violence vary, with verbal abuse or threats being the most common
types of violence cited (Lavoie, Carter, Danzl & Berg, 1988; Levin, Hewitt, Misner,
1998; National Institute for Occupational Safety and Health, 2002). For the purpose of
this research, I defined workplace violence as the act of inflicting harm on or towards a
person at work including physician assaults or the threat of assault or harm (Breakwell, 1997; National Institute for Occupational Safety and Health, 2002).

Impact of Violence

There is a considerable body of research that has investigated the impact of violence through injury severity ratings, loss of work, or predictors of violence. It is of critical importance to expand our body of knowledge beyond these types of data, seeking instead to hear and understand the voice of the nurses themselves as they describe their own experiences in their practice (Benner, 1994; Morse & Field, 1995). While researchers have begun to examine the impact of the violence on nurses, it is important that we recognize the individual’s own description of and interpretations of the event (Benner, 1994). In this way we may better understand the impacts on nurses and can make changes to improve safety for all emergency room staff.

In fact, a body of empirical work is emerging to focus on the impact of violence on nurses in acute settings. This body of work demonstrates the feasibility of allowing nurses to speak for themselves and describe what they experience and what it means to them (Duncan et al., 2001; Findorff-Dennis, McGovern, Bull & Hung, 1999; Henderson, 2003; Levin, Hewitt & Misner, 1998; Varcoe, 2001; Williams, 1996). The research has been based on case studies or critical ethnographic studies employing interviews or written responses from nurses who have experienced some form of violence in a health care setting. The findings have demonstrated that important and meaningful data can be generated from nurses to inform our understanding of this important problem.
Recruitment and Retention

One of the key reasons that violence needs to be understood from the perspective of the nurses themselves, is that violence may well be one of the most important factors influencing the recruitment and retention of nurses in the health care system (Jackson et al. 2002). Our nursing workforce is aging, and one in three nurses in Canada is over the age of 50 and is eligible to retire in the next five years or less (Canadian Nurses Association, 2005). The recruitment of additional nursing staff is critical as the workforce ages, and retention of that skilled nursing staff is vitally important to employers. It has been suggested that in areas with higher rates of workplace violence in a lower mainland hospital in British Columbia, nursing vacancy rates are rising (Doyle, personal communication, July 22, 2005). The recruitment and retention of nursing staff is a significant issue for employers who need to understand how the experience of the working environment can impact their aging nursing staff.

The Work Environment

The culture of silence that has existed around workplace violence requires sensitivity on the part of researchers in allowing informants to feel safe in discussing their experience. Some of the literature points to self blaming by nurses which, combined with the culture of silence, fuels the sense of isolation while increasing their frustration over the lack of action by supervisors (Jackson, Claire & Mannix, 2002). The perception of some of the public that this type of violence is acceptable towards a nurse may likely fuel the nurse’s anger and sense of helplessness. The effect of the nurse’s work environment and the nurse’s perception of what fuels the culture / environment around them to allow this violence to continue is something that is poorly understood.
Researchers have not asked about nurse's description of violence across different emergency departments while considering whether any aspects of the setting impacted that experience from the perception of the nurse. How does the nurse describe the violent incident, what did they experience at the time, how has the violence affected them since then, and how do they describe the setting as contributing to their experience or their role in that experience? In order to develop effective individual and organizational interventions, it is first necessary to ask these questions of nurses working within emergency departments. It is therefore important to ask nurses to describe their experience of violence within their emergency department and how they see the workplace contributing to that violence.

This study will help increase our understanding of that violence for nurses, and whether any aspects of their environment contributed to how they perceived their experience. Such knowledge can assist employers in making changes to the work environment and improve safety within the work environment. Such changes may have profound effects beyond that of the individual nurse as Henderson (2003) concluded:

Administrators, educators and leaders in the field of practice need to begin to tackle the narrow focus of violence in the workplace more consistently. This action might be the beginning of a wider focus on the problem of nurses' lack of a sense of being valued and respected in their profession. Such actions will benefit not only nurses but also groups of marginalized clients, including abused women, by sending a message that violent or abusive behaviors will not be tolerated by anyone or against anyone. Administrators in healthcare settings must make clear to both their staff and the public that theirs is a zero tolerance environment - that
violence will not be condoned. Failure to recognize this imperative represents not only a moral failure, but a pragmatic and strategic one with profound implications for future healthcare delivery (p. 97).

Study Purpose

The purpose of this study was to investigate how emergency department nurses describe their experience with violence in their workplace, how they coped with the impact of that violence, and what role the work environment may have played in their experience. There were four specific objectives:

Objective 1: To record how emergency room nurses describe violent incidents in their workplace.

Objective 2: To describe how nurses recall the impact the violence had on them.

Objective 3: To describe how nurses respond to the violence they experienced and what they believed helped them and / or hindered them.

Objective 4: To understand why nurses believe the violence they experience occurred, and what role, if any, the work environment played in their experience.
CHAPTER 2

Literature Review

As violence within hospital settings gains increasing attention, there has been an increase in the scientific research published on the topic (Wells & Bowers, 2002). The growth in the literature has been significant, from 32 articles in 1998 (Poster & Ryan, 1989) to thousands of articles on the subject of nursing and violence available today (National Library of Medicine, 2004). The increasing breadth of literature on nursing and violence is a sober reminder of the significance of violence as an extremely dangerous occupational hazard for nurses (Armstrong, 2006).

Despite the growing depth and breadth of this research, the lived experience of nurses as they are exposed to patient, visitor, and co-worker violence has largely gone unexamined until recently. Much of the current literature focuses on emergency nursing in relation to violence against women, the impact of work related assaults, the determinants of violence, and violence prevention (Fernandes, 2000; Findorff-Dennis et al, 1999; Henry & Ginn, 2002; Oster, Bernbaum & Patter, 2001; Varcoe, 2001).

Violence is increasingly recognized as a concern in the work life of nurses no matter where they are employed (Henderson, 2003). In Canada, a national study found that 80 percent of nurses reported some form of violence during their career, while another study found that 33 percent of nurses reported experiencing physical or verbal abuse in the last five shifts worked (Duncan, et al., 2001; Graydon, Kasta & Khan, 1994). An Alberta study also demonstrated how dangerous the workplace is for nurses, with 169 nurses per 1,000 experiencing some form of physical assault in the last five shifts worked (Ducan, et al, 2001). In British Columbia and Alberta, 46 percent of nurses reported
experiencing violence in their last five shifts worked with patients being the main source of all types of violent episodes (Duncan et al., 2001).

Hegney, Eley, Plank, Buikstra, & Parker (2006) studied a random sample of 3000 nurses from the Queensland Nurses Union in Australia, and found that there was an increase in workplace violence in public, private and aged care sectors. They also found that although the majority of nurses reported the existence of workplace violence policies, these were perceived as being inadequate. Hesketh et al. (2003), as part of a five-nation study including the United States, England, Scotland, Germany and Canada, surveyed 9000 Alberta and British Columbia nurses, and found that while the majority of workplace violence was perpetuated by patients, a significant portion was committed by hospital co-workers and that workplace violence was underreported, especially if a co-worker was the abuser. Henderson (2003) concluded that tolerating nurses’ experience of violence within their working lives has profound implications for the level of care the nurse is able to provide for the patient and “may well have a significant effect on the number of people willing to consider nursing as a career at all” (p. 96-97).

**Extent and Nature of Violence in Health Care**

Violence in health care settings is increasingly common but is difficult to describe fully due to its complex and variable nature. Different types of violence in health care are documented in the literature with the incidence varying according to type. Assaults were perpetrated most often by patients with cognitive dysfunction (79.1%), patients with substance abuse (60.5%), and persons who were angry because of the patient’s condition (55.8%) (May & Grubbs, 2002). From 1987 to 1992, the National Institute for Occupational Safety and Health (2003) reported that 971,517 workers experienced
violence at work that included simple assault, aggravated assault, robbery, or rape. Health care staff in a British Columbia Emergency Department reported being physically assaulted, physically threatened/intimidated or witnessing a physical threat or assault (Fernandes, et al., 1999). Documented incidents in hospital settings include verbal threats, sexual assault, arson, battery, armed robbery, kidnapping, homicide, suicide, theft and bomb threats (Kramer & Jacobsen, 1991).

A Canadian study of 9,000 nurses found one in five reported having experienced more than one type of violence, including physical assault, threat of assault, emotional abuse, verbal sexual harassment and sexual assault within the previous five worked shifts (Hesketh et al., 2003). A British Columbia and Alberta study with a combined sample of 8,780 registered nurses, reported emotional abuse, the threat of assault, and physical assault as the top three types of violence they experienced in the hospital (Duncan, et al., 2001, p. 67).

Violence for nurses is not limited to a single setting. Research had previously indicated that the majority of nurses in psychiatric and emergency units were thought to be at greatest risk for workplace violence; however, a recent Canadian study found the highest level of physical assaults were reported in medical – surgical units (Hesketh et al. 2003). May and Grubbs (2002) conducted a survey of emergency department, intensive care unit and general floor nurses in a 770-bed acute care medical center and found 88% of nurses reported being verbally assaulted and 74% reported being physically assaulted by patients and family members or visitors at work in the last year. The National Institute for Occupational Safety and Health (2003) reported that 27% of nonfatal assaults occur in nursing homes, 13% in social services and 11% occur in hospitals. Perhaps most
disturbing is that despite the increased calls for intervention, recent research indicates that workplace violence for nurses is increasing in public, private and aged care sectors (Hegney et al, 2006).

Despite the emergency department being recognized as a violent environment, violence in emergency department settings is underreported (Hewitt & Levin, 1997; Levin, Hewitt & Misner, 1998; Mahoney, 1991; Pane, Winiarski & Salness, 1991). In her work, Mahoney (1991, p. 284) states “participants believe that there was insufficient time to complete reports and that no real benefit was gained from reporting incidents”. This is supported by an Alberta survey that found that of nurses who experience one or more forms of violence, 67% do not report the incident (Duncan, 2000). This same survey also found that threats of assault were more often reported (40%) but only 29% of emotional abuse and 20% of sexual harassment were reported by nurses (Duncan, 2000). The non-reporting of violence could be related to victims blaming themselves for not preventing the incident, or others blaming the victim for allowing it to happen (Lyneham, 2000). Much of this underreporting, it can be argued, relates to the socialization of women and society’s previous view that women deserved what happened to them and therefore are somehow to blame (Bala, 1999). Others state the lack of reporting may be related to insufficient training, administrative support or an expectation of violence as a part of nursing (Lanza & Kane, 1995; Poster, 1996). Nurses perceive a lack of institutional support and an institutional emphasis on patient rights and satisfaction, and do not feel safe in the workplace (May & Grubbs, 2002).
Determinants of Violence in Health Care

Part of the body of literature has examined determinants of violence from both an empirical as well as a theoretical perspective (Chermack & Taylor, 1995; Cordell & Coughlin, 1991; Mair & Mair, 2003; Oster, Bernbaum & Patten, 2001). According to Oster, Bernbaum and Patten (2001), the main predictors were related to diagnosis and included substance abuse, substance-induced psychosis, depressive disorder, adjustment disorder, schizophrenia or psychosis not otherwise specified, bipolar disorder, anxiety disorder and others. In one more medical model, violence was most strongly associated with three variables: a history of violence, a diagnosis of schizophrenia or other psychotic disorder not otherwise specified, and having a low score on the Global Assessment of Functioning (GAF) Scale (Beck, White & Gage, 1991). May & Grubbs (2002) found the most common cause of assault by family members and visitors was anger related to: enforcement of hospital policies (58.1%); the patient's condition/situation (57%); long wait times (47.7%); and the health care system in general (46.5%). Their results indicated that nurses are experiencing abusive and assaultive behavior from family members and visitors as often as they are from patients, and emergency department nurses are at higher risk for such behavior (May & Grubbs, 2002).

In theoretical models, violence has been associated with increasing levels of frustration brought on by a variety of factors (Akerstrom, 1997, 2002; Berkowitz, 1989; Breakwell, 1997; Hislop & Melby, 2003). Other sociological models have examined the relationship of television and the media (Murray, 1999), while social-situational models attribute violence to stress, such as that caused by low income, unemployment, or illness, and although not suggesting that everyone exposed to violence will repeat it, the model...
does suggest that those exposed to violence are at a greater risk of being violent themselves (George, 2000). It further attributes violence against women to the economic and social structures that directly or indirectly support a patriarchal society (George, 2000). Exchange theory argues that people choose violence when the benefits of violence outweigh the costs. In other words, people will use less violence when the costs associated with violence outweigh the rewards. These costs may include police intervention, criminal prosecutions, discipline at the workplace, and other forms of societal disapproval (George, 2000).

Workplace Design

In terms of the work environment, Newman (1996), an architect and urban planner, suggests that the environment is a contributing cause and a potential solution to crime and violence. Newman (1996) suggests that a physical layout can contribute to a secure environment. The criminology literature suggests principles with respect to modifying the environment to help prevent and control violence (Mair & Mair, 2003), yet despite this research, design of emergency departments is based on patient access, flow, patient comfort, and the provision of care, rather than including the prevention of violence. In North Carolina, Loomis, Marshall, Wolf, Runyan and Butts (2002) demonstrated that employees were 50% less likely to experience a workplace homicide after environmental and administrative measures were put in place including exterior bright lighting, barriers between the employees and the public, video cameras, mirrors, locked entrances, employee identification and warning signs.
Impact of Violence on Nurses

The bulk of research on the impact of violence for nurses focuses on fiscal costs for the health care sector in terms of absence from work and the associated medical expenses. That there is more concern with researching the costs to the system than the impact on caregivers is a profound statement about the value placed on nurses. Henderson (2003, p. 96) reports that nurses see themselves as “invisible, misunderstood and taken for granted.” A number of articles conclude that violence is a significant factor in the ability to hire and retain nurses (Jackson, Mannix & Daily, 2001) which is consistent with research demonstrating the relationship between the exposure to violence and lower job satisfaction, burnout and the intent to leave jobs (McKenna, et. al, 2003; Taylor & Barling, 2004).

Duncan et al. (2001) identified some of the impacts of abuse for nurses. Nurses report emotional reactions to assault such as anger (61.7%), anxiety (45.7%), and shock and disbelief (26.6%). The majority of nurses also report experiencing some form of physical trauma with 25% requiring treatment for their injury (Williams, 1996). Findorff-Dennis et al. (1999) concluded that 80% of workers have sleep disturbances due to violence, 70% changed jobs to decrease their exposure to violence, 60% stated that they had recurring pain or discomfort as the result of an assault, and 40% stated they had an increase in the use of chemical substances (not including prescribed medication) following a workplace assault. Fernandes et al. (1999) found that 49% reported impaired job performance, 73% were afraid of patients, and 67% reported they left the job at least partly because of violence.
Summary

The impact of violence on nurses is stunning. Research demonstrates a variety of effects, including emotional (e.g. anxiety, helplessness), social (e.g. fear of patients, difficulty returning to work), cognitive (e.g. preoccupation with assault), and physiological (e.g. startle response, sleep disturbance) (Lanza, Zeiss, Rierdan, 2006). Conspicuous in the research is the lack of consideration of any impact the work environment may have played in nurse’s experience of violence. Little evidence exists to demonstrate how the work environment contributed to the violent event.
CHAPTER 3

Study Methods

This study was a naturalistic, retrospective design that used the method of qualitative description (Sandelowski, 2000). This approach was chosen because of the paucity of research in this area, therefore a qualitative approach was desirable. More specifically, because the research objectives focused on describing the experiences of nurses, generic qualitative description seemed the most appropriate choice, given that it is an approach that provides a comprehensive summary of events in the everyday terms of those events (Sandelowski, 2000). While phenomenology has to do with defining the essence of an experience, or interpreting underlying meanings of experience (Bergum, 1991), generic qualitative description provides a low-inference description that agrees more readily with the facts of the phenomena without transforming the experience or event (Sandelowski, 2000). Using this method, the final product of the research is a descriptive summary of the contents of the data organized in a way that best fits that data (Sandelowski, 2000), thus contributing to a more extensive understanding of the phenomenon.

This method assumes that an individual has a unique reality that is influenced by their own personal experiences (Giorgi, 2005). There is a lack of understanding in the literature of how the nurse experiences her environment as contributing to the violence, or of the context of her experience. Understanding this experience for nurses can only be achieved by having nurses reflect on the context and meaning of the situation (Bergum, 1991). Qualitative description is well suited to help describe the emergency nurse's
experience of workplace violence and what contribution they believe their work environment held for them in relation to the violence.

This method does not require developing a set of steps, but instead proceeding in the direction the experience indicates and towards discovering the who, what and where of the events and experiences (Giorgi, 2005; Sandelowski, 2000). Sandelowski comments on data collection in qualitative description which usually includes “minimally to moderately structured open-ended individual and / or focus group interviews… Data collection techniques may also include observations of targeted events and the examination of documents and artifacts (2000, p. 338).”

Intuiting is the process of looking at the experience with wide-open eyes and with knowledge and facts set aside (Oiler Boyd, 1993). The researcher would attempt to meet the phenomenon in as free and as unprejudiced way as possible so that it can present itself and be accurately described and understood (Oiler Boyd, 1993). As each individual has their own reality which is subjective and unique to that individual (Burns & Grove, 1993), I wanted to describe that reality for the nurse as it related to their experience of violence within their work environment.

Sample

This study used a convenience sample of seven nurses who were working in the emergency departments of two major urban teaching hospitals. Inclusion criteria were: (1) They had to be currently employed as a registered nurse or a registered psychiatric nurse for at least one year in an emergency department; (2) they had to express their ability and willingness to participate; and (3) they had to indicate that they have been involved in more than one incident of violence as previously defined in this study.
One exclusion criteria existed for participants in this research. As I am also employed by one of the hospitals where the research occurred and I work in a supervisory capacity within one program there (outside the emergency department), participants were excluded if they worked in that program as well as the emergency department. As no potential participants worked in both settings, none were excluded from the research.

Participants were recruited between February 1, 2006 and July 15, 2006. Posters were placed in various locations in the emergency department of each hospital, including staff rooms, bulletin boards, washrooms, and medication rooms. (While I had offered to also provide voluntary information sessions about the research at each recruitment site, neither site agreed so this approach was not pursued.) After seeing the poster, interested nurses could receive a participant information sheet from either myself or from the nurse educator in their department. After reading the participant information sheet, interested nurses could contact me for any additional information, to ask questions, or to set up an appointment for an interview. Ultimately, all the participants contacted me by either by telephone or by e-mail to receive a participant information sheet and then again to voluntarily set up an appointment for an interview.

Of the seven nurses who participated in the study, two were male and five were female. Four of the participants were registered nurses, two were dually trained as both a registered nurse and a registered psychiatric nurse, and one was a registered psychiatric nurse. All participants had worked in the emergency department for over one year and each stated they had experienced multiple incidents of violence. The range of time the participants worked in their emergency department ranged from three to seventeen years. Six of the participants were from one hospital, and one was from the second.
Setting

The two emergency departments used for recruitment provide a variety of levels of service from a local community emergency for citizens who live nearby, to highly specialized programs. Each serves the lower mainland in British Columbia with a population of approximately 2.2 million people and some of the specialized programs serve patients from the province of British Columbia with a population of approximately 4.1 million (Statistics Canada, 2001). These two are large comprehensive teaching hospitals seeing a variety of complex patients including mental health, trauma, HIV and substance abuse. These hospitals each see 70,000 – 80,000 patients a year in each of the emergency departments. Each emergency department frequently has more patients than available stretchers, so waiting rooms can be full or patients may be on stretchers waiting in a hallway.

Data Collection

Each participant was interviewed on one occasion to obtain a description of their experience of violence and what contribution their workplace may have made to that experience. The interviews ranged from 55 minutes to 80 minutes and were audio-taped. The tapes were then transcribed verbatim by a transcriptionist who was bound through a written agreement to maintain the confidentiality of the interviews. All identifying information was removed from the transcripts. Field notes were also written after each interview to describe the context of the interview and observations made during the interview.
The interviews followed an open-ended semi-structured format, and were conducted either in my office (5 interviews) or in an office in the participant's emergency department (2 interviews) as per each participant's request.

I developed an interview guide based on an extensive review of the literature and on my own knowledge of working in an emergency department, that would assist nurses to provide a more detailed in-depth description of their experience of violence. It was also designed to provide an opportunity to discuss factors within their work environment that impacted their experience of violence. For example, each participant was asked to describe what it was like to work in their emergency department, to describe their experience with violence in the emergency department, to give one or more examples that highlight their experience, to discuss why they thought the event happened and how they responded, to discuss what helped or hindered them, to discuss whether the workplace contributed to the outcome of the violent event, and whether they accessed any resources for support. A copy of the interview guide is available in Appendix 1.

I was the interviewer for all participants. I am a registered nurse with three years of experience in emergency settings and over ten years experience in mental health settings. My most recent clinical work involved assessments and interviews either with police or mental health emergency services by responding to emergency calls in the community as well as interviews and assessments in one of the emergency departments used in this study. I also have several years experience providing mental health assessments in the community and follow up support. For this study, I conducted one interview for each of the seven participants.
Data Analysis

Data was analyzed using methods of qualitative content analysis (Sandelowski, 2000). Qualitative content analysis is a dynamic form of verbal and visual data analysis orientated to summarizing the informational content of that data (Morgan, 1993). Interviews were transcribed in full and field notes were written following each interview. The interview and field notes for each nurse were analyzed according to the research objectives. These objectives served as a guide for critical reflection to allow data to be considered from multiple perspectives (Benner, 1994). The focus of the analysis was to discover the commonalities and differences across different participants (Benner, 1994).

Each transcript was first read in full, and then I spent time reflecting on the content of the transcript and the descriptions within it. Then I re-read the transcript making notes in the margins to highlight comments made by each participant that related to the objectives of the research. After reflecting on those comments, often for several days, I then re-read the transcript making notes of questions to look for in other transcripts as well as noting any further comments from the participants that related to the research objectives. I repeated this, reading through each of the transcripts several times, allowing time between each reading for reflection. As I engaged in this process over time, themes or categories began to emerge from the data. With each subsequent transcript I would determine where the commonalities and differences existed within the categories thus far.

The literature on classical qualitative content analysis has few answers to the question from where do the categories come, and provides little information on how the system of categories is actually developed. The definition of categories is an art and little
has been written about it (Mayring, 2000, p. 1.). As themes emerged, I engaged in classic content analysis according to Sandelowski (2000) by counting responses and the number of participants in each response category (Sandelowski, 2000). I recorded the categories as they emerged and recorded participant responses as they fit into the categories. Initially, I had a large number of categories but as I spent time reflecting on participant responses and on the categories themselves, I amalgamated groups together based on the commonality of themes, the frequency of responses, and the levels of abstraction within a single theme. I reduced the number of categories as I progressed. The counting of the responses was a means to an end, not the end itself. Following the classic qualitative content analysis approach, I spent further time reflecting on and interpreting the responses in the categories in an effort to understand them; however, within the methodology, there is no mandate to re-present the data in any other terms but their own (Sandelowski, 2000).

As I proceeded with the analysis, I attempted to develop the categories as near as possible to the data and the research objectives (Mayring, 2000). For that purpose, I followed the qualitative content analysis procedures of inductive category development (Mayring, 2000). This inductive approach is detailed in Figure 1.
Figure 1. Inductive approach for qualitative content analysis (Mayring, 2000, p. 4).
Using the data source of the interview transcripts within the context of the research questions, I determined a few basic categories that the participants’ responses could be placed into. I formulated categories out of the material that included different levels of abstraction of a single concept; for example, nurses experience of violence. As I moved through additional material I summarized old categories together or formulated a new category. Category revisions tended to occur after a review of fifteen to fifty percent of the data, and following that review a formative reliability check of the text reviewed thus far was conducted to see how effective the categories were in summarizing and grouping the data. A final working through of the text with the revised categories occurred, with a summative check of reliability leading to the organization and presentation of the results that is detailed in the next two chapters. A sample of my analysis is included in Appendix 2.

*Rigor and Credibility*

In order to ensure the trustworthiness of these findings, I employed the four categories of credibility, dependability, confirmability and transferability as discussed by Polit & Hungler (1999). To increase credibility of the data, I ensured prolonged engagement in the data collection activity to have an in-depth understanding of the experience of violence in the emergency room setting for nurses. The questions asked of the informants helped to ensure a deeper understanding of their experience as well as increase rapport between the participants and I (Polit & Hungler, 1999). To further accomplish that understanding, I employed persistent observation to examine the aspects of the situation being described by the informant; for example, as participants recounted examples of violence they had experienced, I asked additional questions such as where
exactly they were standing when the violence occurred; who was around them; what was the sequence of events as they experienced then; what did they feel at that moment, etc. I also employed data triangulation by involving different informants in order to obtain diverse views for the purpose of validating the conclusions of the research (Polit & Hungler, 1999). Space triangulation was used as I collected data from informants who worked at multiple sites so that the data could be validated for consistency across those sites. As this research is conducted by a student as part of the requirements for a graduate degree, a form of debriefing was also employed to enhance credibility by exploring aspects of the research with a three member review committee as part of the requirements to complete a graduate degree. This committee was comprised of faculty with expertise in qualitative methodology, violence, nursing and mental health.

In order to enhance the dependability of the data, an inquiry audit was in place through the scrutiny of the data and supporting documents by the Chair of the review committee as well as the review of the analysis by the full committee. To ensure confirmability of the research, an audit trail was developed (Polit & Hungler, 1999). This included the raw data, the field notes, analysis notes, category development notes, materials related to the intention of this research such as the ethics applications, and all data reconstruction products (for example, drafts of the proposal and the final research report).

Finally, I followed Polit & Hungler’s (1999) account of Lincoln & Guba’s framework on transferability where I provided sufficient descriptive data in the research report so that consumers of the research can evaluate its applicability to other contexts. In
addition, a thick description of each informant's experience and the context of their environment were collected.

Reflexivity was also considered in terms of the rigor and credibility of this research. Reflexivity has been explained as follows:

Reflexivity requires an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgment of the impossibility of remaining 'outside of' one's subject matter while conducting research. Reflexivity then, urges us "to explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research (Nightingale and Cromby, 1999, p. 228).

As the researcher, it is important for me to highlight my previous experience and background for the reader. I have in excess of ten years experience working in multiple hospital and community based mental health settings as well as on the street in the lower mainland of British Columbia. I have also worked as a staff nurse and clinical nurse leader within one of the emergency departments used as a site in this study. Due to that past experience, it is important to note that when I began this research I did so with certain assumptions and biases. Assumptions are “basic principles that are accepted as being true on the basis of logic or reason, without proof or verification” (Polit & Hungler, 1999, p. 695). There are two sets of underlying assumptions I had in this study.

Assumptions related to the method:

1. Informants are willing to disclose their experience as subjectively lived.
2. Informants are able to describe their perception of their original awareness of the phenomenon under investigation.
Assumptions related to the research topic

1. Violence directed towards nurses should not be an expected part of their job and should not be the expected norm in an emergency setting.

2. Violence is the product of a person – environment interaction.

3. There are social and political factors which render institutions disinclined to address violence proactively (Love, 2002).

As I progressed through the interviews, each of my assumptions appeared to hold true with the exception of assuming violence towards nurses should not be an expected part of the job nor the norm. I had assumed that nurses would not see violence as an expectation so was surprised in my first interview when a culture of violence was described that included the expectation that as a nurse you would have to deal with this as part of your job. Each subsequent nurse interviewed stated the same. I have also worked in one of the emergency departments used in this study approximately seven years ago, and so having that intimate knowledge of the work environment certainly influenced my interest in completing this research, informed the structure of my interviews, and may have influenced how I categorized the data.

Ethical Considerations

There were several ethical concerns for this study which had to be addressed. First, as multiple sites were involved, ethics approval was obtained from each organization as well as the University of British Columbia and approval to conduct the research was obtained from each department’s manager.

As the researcher, I am a supervisor within one of the hospitals identified as a research site; therefore, additional considerations for nurses at that site had to be engaged
in. To protect potential participants, they could not be a nurse who worked within the program I supervised. I did not interview or involve any participant in that program or who reported directly to me, or where I could hire or fire the participant in their present position. As the definition of violence for this research could include perpetrators who were other health care professionals, the informed consent form included a statement at the request of the ethics board which highlighted to potential informants the potential that they could be sued for slander.

The potential for sensitive information to be revealed during the interview process meant that all interview tapes and transcripts were identified only by a coded number to protect the identity of all participants. The identity of the participant was never mentioned during the taped interview, therefore, I am the only person who knows the identity of each participant. The interview tapes and transcripts are kept in a locked file cabinet accessible only to me, and consent forms are stored separately. Moreover, the transcriptionist completed a signed confidentiality agreement.

Strict confidentiality around the identity of the participant and all identifying information was maintained. All information presented in the interview remains confidential and would not be used in any want that may jeopardize the informant’s employment status. In preparation for the interview, it became clear that the possibility existed for a participant to disclose information that I would legally have been required to report (for example child abuse). Should that have occurred, the participant would have been given the opportunity to stop the discussion and made aware of the potential disclosure by the researcher if they chose to continue.
The primary risk of participating in this research was the creation of emotional distress associated with the subject matter as the participant recounted their experiences. Prior to the start of each interview, participants were made aware of this possibility, as well as assistance available within their own organization and external to the organization. During the data collection phase of the research, current or potential participants could reach me 24 hours a day by pager.

Consent was obtained from each participant at the interview appointment before any interview began. The consent form was reviewed in full with the participant by me, and each participant was given the opportunity to ask questions. Participants were fully informed of the purpose and design of the study as well as any potential risks from discussing the sensitive subject matter. Due to the sensitive nature of the subject matter, participants were made aware that they could stop the interview at any time without explanation and were free to not answer any or all questions asked of them. All participants were provided a resource sheet outlining a number of sources they could contact for support if required. Upon reviewing the consent form, the participant initialled each page and signed the consent. I witnessed the signing of the consent, and the participant was provided a copy of the signed consent for his or her own record.
CHAPTER 4

Study Findings

The nurses interviewed for this study richly described the violence they experienced and how they saw their work environment contributing to their experience. In this chapter I present the results of my interviews by first describing the nurse’s experience of workplace violence. I then discuss how nurses perceive their work environment in relation to violence through descriptions of the five main themes of my interviews that were induced using qualitative content analysis (Mayring, 2000). These themes are: safety in a fractured workplace, the provision of care and comfort, the challenge of design barriers, taking care of the nurse, and losing oneself in a culture of violence. Each of these themes intersects with the others to both affect the work environment, as well as be affected by the work environment. It is the matrix relationship they have that ultimately fuelled the culture a violence in which nurses found themselves becoming lost. I will discuss findings from the study in two sections: first, the findings related to nurses’ experience of workplace violence and second, findings related to how nurses perceive their work environment in relation to violence.

Nurses’ Experience of Workplace Violence

All participants reported that they found working in an emergency department a demanding experience. Each recounted being intimidated by the setting when they began their work there, and despite the many settings they had collectively worked in (home care, inpatient medicine, psychiatry, cardiac care, forensic hospitals, and community mental health teams) each stated in one way or another, that the emergency department was by far the most "stressful and challenging". For many, the challenge was a result of
the diverse patient population and the fact that their work environment was unpredictable. “We see people from all ages, all cultures, all walks of life, and all kinds of social strata.... emergency departments are always challenging because you never know what is going to come through the door”. Another referred to the emergency as a “fractured environment” because of the constantly changing staff, the acute demands for complex patient care, and the “pressured” environment.

One nurse said it best when she described the emergency department as a “highly pressurised area.... a kind of microcosm of the whole healthcare system being felt very directly in the emergency department”. The challenge was made more difficult in part by the sheer amount of work being done in a small space. "You have to be prepared to meet a great deal of variety working in cramped, crowded circumstances, under busy conditions."

Given this context, it is little surprise that the nurses interviewed from both emergency departments reported that they routinely experienced workplace violence or the threat of violence during their work. Each nurse stated they had witnessed multiple incidents of violence to their colleagues, had been verbally threatened numerous times, and had been physically threatened at work themselves. Two had been threatened with death, and several had been physically assaulted. One of the participants had recently decided to resign from her position within the emergency department to take another position where she would not face the same level of threat. One participant recalled the need to request that police send “the SWAT team” to demonstrate a show of force with a Taser® gun before being able to safely secure a violent patient.
At times, nurses described a sense of desperation as they tried to exert control over what they perceived as an out of control environment.

And without me realizing it they bolted through our doors and grabbed the security guard’s neck and started choking him. So I was trying to push the alarm button. I’m trying to call. I’m screaming for help as everybody else is dissipating and I’m thinking what can I hit him with so they can get off the security guard?

Within the sample, participants had also been kicked, spit at, punched, pushed, been threatened with a weapon, and several expressed concern for their family because of the frequent violence. Nurses were intimidated by some patients and fearful they would “recognize my family because they’ve seen me with them”. Others recalled needing to explain their work life to their children when they were being summoned to testify in court or when they charged a patient for threatening to kill them and their family.

Despite the dramatic nature of their experiences, all the nurses described these episodes in a very matter of fact way, seeming to assume all health care professionals were aware of the degree of lethality present in the emergency department. Each nurse spoke not only of potentially lethal violence directed toward them, but also of their experience witnessing horrific violence perpetrated against colleagues. In a calm and direct manner, one nurse told the story of his colleague by describing how she had been violently thrown to the floor and struck repeatedly. “It was just like that, she was on the floor getting her head pounded onto the floor and then security of course responded as quickly as they could.” In addition, most commented on how “troubled, worried, frustrated or saddened” they were over the violence that visitors and families witnessed when they visited the emergency department. One nurse commented on the number of
patients and family members who walk out of the department without ever being seen by a physician because of the level of violence. These nurses were distressed, commenting on how "personally worrying" it was for them to recognize that they are too busy managing violence to be able to help those patients who walk out. While hospital security did respond to nursing staff requests for assistance, generally these nurses found that security was too busy elsewhere with aggressive patients and families to be present in the waiting room to make it more secure.

The nurses also commented on how angered they were that when they were being assaulted and required help, not every available health care provider would assist them. Often nurses felt that other community health care providers, ambulance personnel or police stood by without offering help. One participant stated that a patient unexpectedly made a fist and hit her and while she repeatedly yelled for security, the ambulance crew that brought the patient to emergency stood by and did not intervene. One group that did intervene to assist the nursing staff were family members, friends or other patients still waiting to be seen. One participant, notably pregnant at the time, recounted how a visitor in the waiting room prevented her from being assaulted by a patient. "There was no denying my pregnancy and he took a swing at me and a civilian got in between us. And I just thought this is beyond ridiculous."

Despite the myriad of violent events each nurse had experienced, none of the participants recalled being off work due to a specific violent event. They did, however, discuss how the violence affected them over time. The participants recounted becoming immune to violence and how they eventually came to normalize the daily incidents. One nurse told a story of how on one occasion he was being threatened to the point that other
staff called for assistance from hospital security, but he had not noticed anything out of the ordinary.

I have to say that over time I’ve become, over time, very inert to violence. I had a code white security call while I was triaging. I didn’t even realize this guy was screaming at me and threatening to kill me. I didn’t even pick that up.

In describing how violence becomes normal, nurses discussed how they adopted the same viewpoint as their colleagues so as not to be seen as different. Explaining how she came to recently decide to resign from the emergency department, one nurse said, “I think I fell in line. Everybody was doing it. I normalized it too. It was just a part of the routine unfortunately, and that’s why I left.”

The nurses in this study clearly articulated how the routine of violent events affected them. In general, they described not being aware of any impact while the event was occurring, as they were so intensely focused on managing the situation safely. However, immediately following the conclusion of the event, they told of how they would find themselves “trembling”, or being “shaken up”, and needing to “do some deep breathing” for several minutes to refocus. Nurses reflected that over time, they experienced profound physical and psychological symptoms which they attributed to the repeated exposure to violence.

While I work here now, I left here two years ago and went and did community work. I didn’t recognize it but I was quite burnt out. I was aware and I noted it but didn’t do anything about it in that I was having the startle response, I was suffering from insomnia, I was suffering from nightmares, felt irritable.
Even while describing how they had been impacted by the violence, there were suggestions in the data that they used humour as a means of coping with their experience. One nurse laughed while describing his use of dark humour as a prerequisite to working in an emergency department, and despite the frequent violence, all participants mentioned how they did enjoy much of their work and the camaraderie that existed among the staff and physicians.

You can come here for a shift and actually have a very enjoyable 12 hour shift, even with abusive patients kind of coming and going because we all work together closely and support each other. You have really good shifts and once in a while when something like that has an affect I think it reminds us all that the potential is there for any one of us to get hurt.

This sense that there was always a potential for violence led the nurses to be constantly vigilant. In the middle of any task, any assessment, or any interview, they were constantly on the watch for someone or something that could seriously hurt them. One nurse described this as being “hyper-alert”, but at the same time “saddened” that the level of violence required this constant state.

While nurses described violence that most often involved a patient or family member as the perpetrator, two participants recounted experiences with colleagues as the perpetrator. One nurse had a senior emergency staff physician “absolutely humiliate me in front of another physician and in front of several colleagues, nurses as well as the charge nurse and several paramedics. I still shake a little bit thinking about that experience.” Another recalled being verbally humiliated by a nursing colleague working the same shift.
The sadness over the reality of their work environment was perhaps most evident in the face of one nurse who, after the research interview was concluded and she was getting ready to leave, turned to me to say with some despair, “Do you think people will believe that we really have to put up with this?”

**How Nurses Perceive Their Work Environment In Relation To Violence**

Given their experience of violence in the workplace, it is of little surprise that the nurses I interviewed were very concerned about being safe. They spoke about the issue of safety within their workplace in terms of a number of variables within their “fractured” environment.

**Safety In A Fractured Workplace**

Nurses saw a relationship between safety in their workplace and the violence they experienced. They felt a number of variables within their environment contributed to the fluctuating levels of safety and the violence they had to manage; for example, nursing staffing levels, physician staffing levels, security staffing, the response of management to their concerns, and the mix of skill level amongst staff on any shift each affected nurses’ perceptions of how safe their environment was.

Nurses most frequently mentioned staffing levels as contributing to their lack of safety as well as to the inability for required staff to respond in a timely and appropriate manner. While participants understood why there were shortages of nursing staff, and appreciated that there were recruitment efforts underway for experienced nursing staff, they were more critical of what they described as a low level of staffing for security personnel on all shifts and for physicians on night shifts. These nurses felt that the level of staffing needed to allow a rapid response from security or the physician during a
violent or potentially violent incident. The participants were frustrated at the low number of security guards available, often only three individuals to cover an entire hospital including the emergency. The hospital sites used in this research each had at least three adjoined buildings and over 400 inpatient beds each. Nurses expressed anger that security did not remain in the department but often had to “truck all the way back down here and a lot of damage can be done [in that time]”. Nurses described how the need to patrol the entire hospital often resulted in delays for security in attending to serious violent events within emergency. Participants felt that just the visible presence of security in the department at all times would assist in reducing the level of aggression and the number of incidents of violence.

I’m surprised we don’t have security assigned to each area all the time. You know because the presence of security does calm things down...just having them present. Like the number of security for the entire hospital. Sometimes there may only be two in emergency and if they’re busy and you have anything go wrong you’re lucky to get one person respond in five minutes.

Physician coverage during night shifts was reduced in each department as compared to day or afternoon coverage. Nurses described how helpless they sometimes felt when the single emergency physician was treating a critical injury, when at the same time their assessment and immediate medication orders were required elsewhere in the department to contain an out of control patient. One nurse described trying to interrupt the physician who was in the middle of running a trauma in order to get a verbal order for medication. She was fearful that a patient being restrained by police in the back of a
vehicle “could possibly have an MI at any moment and who could definitely get more out of control”.

As nurses managed with reduced staffing and what they saw as system deficiencies that needed to be change, they were not silent. Six of the seven nurses recalled bringing forward suggestions to management on how to make improvements to the safety of the department, but felt discouraged after repeatedly doing so and seeing no changes as a result. In many instances, nurses felt there was no importance given to their concern, or that management did not see that concern as being valid. All participants reported that patients sometimes carry weapons into the department but two nurse’s suggestions for preventative measures were ignored. Being ignored by management left nurses feeling angry, unsupported, and for one nurse the lack of support by management in dealing with the level of violence was the main reason she had recently resigned.

I think there should be metal detectors at the door. And I know when I suggested that the manager said to me, “Oh that will make the public feel unsafe.” I said, “No it won’t. It will make them feel more safe.” Maybe it will be a bit alarming like, “Oh is it that bad that they need this?” But it is that bad that we need it. I think she also said to me something about there being legalities around that and I thought, ‘There are going to be legalities around when one of your nurses gets killed too.’

Nurses spoke about the need to examine the staffing mix in the department in the context of maintaining a safe work environment. They described having fewer and fewer nurses trained in the advanced roles in the department such as triage, trauma, and charge, so those staff who were trained tended to do those roles, leaving the less experienced
nurses providing the acute bedside care, the psychiatric care, and managing much of the violence. The opportunity to learn from and be mentored by the more experienced nurses was therefore greatly reduced. In one department, nurses reported that more than half of their staff were new with less than three years experience, and nurses were often orienting new staff after having spent only a few months on the job themselves. With reduced staffing levels and a busy department, nurses had little time but to engage in the required assessment and nursing interventions for their patients. Absent from their care was the time to spend talking to a patient and their family, counseling patients or their families, or finding the time to provide those small, but incredibly important, comfort measures. Nurses described how the ability to provide comfort measures to patients helped to reduce the level of aggression that needed to be managed.

*The Provision of Care and Comfort*

When reflecting on how the environment contributes to their experience of violence, the nurses articulated the lack of adequate time and space to provide those nursing interventions that are most important to a patient and their families: comfort measures. The nurses in this study stated that the need to establish that connection, that rapport, is paramount in reducing the frustration of patients and the potential for further aggression. One nurse recounted how she had become so busy that the tasks that give patients so much satisfaction, “the giving comfort to the patient, making sure their beds were comfortable, make sure they had ice water, spending time at the bedside” had become less important. Nurses felt that perhaps nurses have forgotten that patients “don’t care about how many degrees you have after your name, they really don’t care. They don’t care how smart you are, they just care about how kind you are to them.” The impact
of this loss of comfort measures for the patient was perhaps best articulated by one nurse who described what she thought patients must see in her emergency department.

This is like third world medicine or people lying in the hallway or my family hasn’t eaten for you know fourteen hours or you know this bed hasn’t been changed, you haven’t had a bath in two days. So I think all those things are hugely important because it gives them objective ways to look at how you care about somebody.

As nurses engaged in comfort measure less frequently, their ability to connect to their patient was reduced. One participant commented, “I don’t know if nurses realize that perhaps some of the burnout isn’t because they’re busy or frustrated about the system. It’s because they’re not communicating to the patient”. Repeatedly, nurses spoke of the need to connect with their patient and to ensure that the patient knew they had been listened to and knew they had been understood. “If you connected to the person and you helped them in some way along their journey when they’ve got an issue. That’s what they remember right. They’re not going to remember if you were some hero.” Nowhere was that connection more important for these nurses than at triage.

Six of the participants felt that the personal touch of the nurse and establishing rapport at the point of triage would help to reduce levels of aggression in patients as they move into other areas of the emergency department. Despite this claim by each nurse, the triage desk itself was anything but conducive to demonstrating caring on behalf of the triage nurse or making the patient feel comfortable. One nurse described her experience triaging patients and her attempt to create some privacy and covey her genuine concern for them:
We were supposed to speak to patients via an intercom system or through a little window and I have consistently chosen when I triage not to do that. I go around the desk and I meet with the patients and the public face-to-face and I have been fairly fortunate that works for me. It also allows me to hopefully convey a sense that I am open and therefore receptive to what information they have.

The participants described several factors that interfered with their ability to engage patients so they felt listened to and felt comforted. Some of those factors, such as the volume of patients affecting how much time the nurse has, or the level of violence that can focus them elsewhere have already been mentioned. One other that was consistently mentioned by all of the nurses was that they lacked adequate training and proper orientation to allow them to care appropriately for patients with psychiatric illness or substance abuse. They identified this as a critical issue, as they felt ill prepared to deal with the onslaught of alcohol, cocaine, heroin, crystal methamphetamine, ecstasy, cannabis and other substances they dealt with hourly. Nurses often felt confused as to how to intervene appropriately with a patient with a mental illness, or what action to take to deescalate rising aggression. The lack of response to these issues by management, and indeed the healthcare system, to the state they work in has left them feeling abandoned, powerless and without control.

The nurses also readily admitted that even though they knew how they should respond to patients, and they recognized the importance of people feeling comforted and listened to, there were times that the constant and repeated violence, along with fatigue from extended shifts and overtime, had them responding in a different way:
I remember one [nurse], he was down in one area. I was two assignments away and somebody was all over him and swearing at him. He came along, I think he came to grab something out of my section and he said, "I just told a patient to fuck off for the first time." And I thought, 'Oh I know about that,'

Providing a sense of caring and comfort at the triage desk or elsewhere in the department was not the only challenge nurses described having to overcome in their workplace. Nurses described different aspects of workplace design that affected their experience of violence.

The Challenge of Design Barriers

The design of the emergency department was a subject where the nurses had a significant vision for change. Perhaps the most surprising data came from their discussion of barriers within the department. While nurses fully acknowledged and desired the presence of barriers to maintain the safety of staff and patients, their experiences in triage suggested that barriers between the triage nurse and patient may paradoxically increase the aggression between the triage nurse and patient and set a course for the aggression to continue throughout the patient’s stay in the department. The nurses stated the barriers at triage had been increased as an infection control measure. One nurse reflected on how, during the construction phase, they discovered that the removal of barriers at triage reduced the amount of violence and increased reports of patient satisfaction within their department. Further, nurses described how the design of the triage desk was problematic as the volume of patients could be far greater than the waiting area could support so they would quickly have a queue of sick patients needing attention in a crowded, noisy area.
The longer patients waited at triage, the louder and more demanding many would become.

While we were doing the renovation, we had to close the triage area and have just an open desk where people would come up and it was interesting that people were far more pleasant when there were fewer barriers between us. Some of our triage nurses kind of noted that, “gosh, everybody’s so nice,” cause your desk was here and they’d come right up… and because they had to walk past your desk to leave they got so many more “thank you’s” than they every did when there was a barrier there as people weren’t stopping by to say thanks very much.

Most importantly, nurses described how critical it was for the triage nurse, in the middle of this sea of growing numbers of people, to maintain a calm, confident manner and not escalate any patient’s level of frustration with the wait. One participant reported needing to discuss attitude with some of her colleagues because if you “escalate a patient so much at triage by the time I get them in treatment, guess what? They are ready to fight. So you are in effect putting the rest of your colleagues at risk by your attitude.” In addition, overcrowding within the department was cited by nurses repeatedly as a contributor to frustration and aggression by patients and families. Nurses described how when one patient behaved in an abusive or violent manner and then was taken into the department, other patients would perceive acting out as a way to acquire faster service.

The availability of space between and around a patient stretcher was repeatedly mentioned as problematic, as nursing staff did not have enough space to safely manage aggressive behavior. The small amount of space between stretchers often placed nearby patients and their families at extreme risk for injury. Equipment that was placed near the
patient, such as blood pressure machines and IV poles, can quickly turn into weapons. One nurse recalled assessing a patient with security already present but despite her precautions, the patient became so violent he physically shoved three stretchers on either side of him, with patients in them, down the emergency department corridor.

The guy went totally crazy... he jumped at the security guard and pushed and they ran into stretcher 3 and 3 – 2 – 1 all went over the side and then... 5, 6 and 7 got pushed the other way. There were a few male nurses around and they all jumped in. The staff member was on his back. Another one was kind of on him too. So he ended up with these people on him and they were just flailing around, like bouncing off the walls and stuff. I had a bad fight or flight response. I was just like, “Oh, God I can’t believe this is happening.”

Control of the existing space was an important design flaw according to the nurses interviewed. Nurses worked in fear that a catastrophic event would happen when a gang member or revengeful spouse gained access to the department and killed a patient or staff member. One nurse described how she frequently thinks of such an event “because you hear these nightmares of gang related issues where one person just wanders up to the OR and finishes the job or up to the ward and finishes the job”. Each of the departments included in this study had multiple points of entry into the department, which nurses felt placed them at risk. Restricting access to staff that need to be in the department as well as to invited patients and family members was seen as imperative. Nurses felt that the emergency department needed to be sealed off from public access except for one main point of entry. According to one participant, their emergency department was exploring the potential for a “lock down system” that would prevent access without a key card.
Given the unanimous belief by participants that access needed to be restricted, the nurses were outraged at the carelessness of their colleagues or security in providing access to the public. Once nurse recounted how, at two o’clock in the morning, the security staff allowed an unknown taxi driver who stated he had a delivery for the operating room to enter the hospital without any check of the man’s identification and without checking what was in the package.

He said he was bringing some equipment for the hospital to go up the OR and I thought, ‘that’s bizarre,’ so I sent him over to security. And I said, “Why don’t you speak to security and make them call upstairs,” and the Security Officer said, “Oh just take that elevator up to the second floor.”

Six nurses repeatedly spoke of the importance of secure, lockable seclusion rooms to be accessible in the emergency department, which was not surprising given their previous comments about the lack of training and understanding around the management of mental illness and substance abuse. The seventh participant commented that it was vital for nurses to have the ability to restrain patients as required to maintain safety.

While much of the discussion around workplace design focused on the physical environment, shift rotation was another element of workplace design that several participants spoke passionately about. Participants felt the rotations as they existed were not conducive to maintaining the highest degree of safety. Working twelve hour shifts, with a high amount of overtime, and rapid turnover between days and nights was felt to be a “crappy idea” because it “increases tiredness” and “no one’s rhythms are right” so the chance for error that could result in an injury to themselves or to a colleague is high.
The participants in this study felt that some degree of follow up was critical when injury occurred as a result of a violent incident. At the very least, they felt that some kind of review should be done to identify factors that contributed to the incident. However, the nurses’ experiences suggested that follow up was not a regular occurrence.

_Taking Care Of The Nurse_

All participants cited the lack of any formal debriefing following a severe incident of violence as well as the lack of follow up by management as an issue. Nurses were frustrated by the lack of attention by management to their experience and even when they called management directly, there was sometimes no response to their call.

What pissed me off more than anything, well my manager didn’t call me. We should have had a debriefing and we didn’t have that. I eventually called my manager and they still didn’t call me back. I know there’s nothing they can do and it’s not their fault but you have to know that people actually care or are wondering if you are ok.

They had a rather bleak view of the potential for interdisciplinary follow up given their experience of their non-nursing colleagues’ assistance during any violent incident, although they did articulate how beneficial they would find such a service, or example, “having a place to say, ‘Why did it take so long?’ or ‘Why did it happen like that?’”

The nursing staff most often debrief informally amongst themselves or with a charge nurse. Despite all participants indicating that they believe the variety of services available for support are of critical importance and are accessed by their colleagues, not one of the participants had ever used any of the services available to them. There was a clear disconnect between their recognition of the available resources, their belief that they
were of value, and their propensity to actually see them of benefit and contact them when they were personally involved. Some participants reported working as a nurse in excess of twenty years, and yet they had never had accessed a single resource for any form of support in relation to violence.

While the majority of participants did not participate in any formal debriefing sessions, one participant did comment on how participating in such a forum assisted him with coping with a devastating injury to a colleague that resulted in her being absent from work for several months. The one nurse participated in a formal critical incident stress debriefing following an incident where a colleague had their head repeatedly slammed into a wall by a psychotic patient. The session was led by trained debriefing staff who were employed by the organization and available by pager twenty-four hours a day. The charge nurse who was present on shift called for the debriefing session. The nurse found the session to be of great benefit in coping immediately and then over time with what had occurred. The nurses reported that while there may be a debriefing arranged, the department does not follow through on any outcomes of the debriefing to prevent a similar event from occurring in the future.

What we’re not very good at is following through and seeing what about the structure of how we work and how we work and where we work. We really deal with it in the here in now but we don’t do anything that’s preventative.

The nurses not only described the need for increased follow up in order to take care of themselves, they also commented on the need to follow up with their family as a result of violence they experienced at work. Three participants spoke of the effect on their family as the result of the violence they experienced. Despite stating they were
aware of available resources and that those resources were well used and an excellent service, each of the three contradicted themselves by reporting not having anywhere they felt they could properly follow up with the effect of the violence on them and their family. One recalled having to tell her children that “Mommy sometimes deals with people at work who are not so nice” after charging a patient who threatened to kill her and her family. That patient had a history of stalking police and care providers as well as a history of pedophilia. Miscommunication with her day care resulted in them refusing to release the children to her husband after she alerted the day care to the potential danger. Another nurse spoke of the impact of watching young men in the emergency department who were the same age as his son. He described how kids from his son’s school have been in the emergency department after being assaulted and “that kind of pisses me off a little. I don’t like to see it. So, yeah, I take that home”. The lack of attention to such events, the lack of response by management, and the acceptance of some patient and colleague behavior as acceptable fueled what nurses described as a pervasive culture of violence within the emergency setting.

Losing Oneself In A Culture of Violence

Nurses described the existence of a culture where violence in their job was the norm and an expected condition of their employment. Violence within their work environment was ever present and they lived with a constant fear related to their lack of personal safety. The lack of response by middle and senior management to their concerns left nurses with the impression that their lives and personal safety were not as important as patients being served or the manager’s budget deficit being reviewed.
A new and increasing amount of horizontal violence was described by three of the participants (perpetuated by physicians or other nurses against nurses) while four other participants stated the only source of violence came from patients and their families. The participants also described how they occasionally witnessed violence perpetrated by other nurses against patients within the emergency department and how the culture they worked in shaped their response.

Nobody gets out of nursing school and thinks, 'I'm going to go and one day twenty years from now I'm going to be behind a curtain and I'm going to flail somebody and I actually saw that happen. I was horrified and I should have reported it and I should have done all kinds of things but I thought that person never wanted to do that. And I'm not saying that that's acceptable because its not but you get to the point...

The nurses interviewed described a clear difference in their experience of violence when they believed the patient had no insight into their behavior or when their judgment was significantly impaired because of their illness. When they believed the patient possessed insight into their behavior the violence was taken far more personally and has a lasting effect.

How a victim of violence responded to their injury was also a part of the emergency department’s culture of violence. Nurses commented on their colleagues who had left work because of an injury, and stated surprise when they did not return within a short period of time as if to blame their colleague for the inability to cope within the culture that exists. One nurse described being upset with his nursing colleagues who expected a seriously injured nurse to have already returned to the department. He showed
his surprise with their reaction as he recalled how he was affected when he was pushed once by a patient trying to leave the hospital “because it’s definitely hit me way harder and I consider myself pretty toughened to this environment after working in the areas that I’ve worked for years. They can still really get to you.”

In addition to unwritten rules about how quickly a nurse should return after being assaulted, there were expectations of staff for how they should respond to witnessing severe violence. When the nurses I interviewed did not conform to usual expectations, they reported having been ridiculed by their colleagues for their reactions.

Sometime later when we are talking about the incident and she kind of said something to me like, “Oh remember you just took off and you were just freaked right out.” And I thought, ‘Was that a weakness on my being an emergency nurse that I’m like freaked out by this gigantic guy being crazy and beating the hell out of people?’ And I just thought there’s that little bit of culture right, and you’re got to be tough and I am tough. There’s no doubt about that. But it’s not a contest and it doesn’t make me a better nurse or anybody else a better nurse.

Over time, the nurses reported becoming “immune” or “inert” to the repeated incidents of violence that they had witnessed. Whether they saw the violence perpetrated by a patient or by another nurse, they did not act on what they had witnessed but simply tried to ignore the experience and “fall in line”. On reflection, nurses described how the violence had affected their practice over time and although profoundly vulnerable to injury, they became resolved to accept violence as part of their job given the lack of response on the part of administration as well as the lack of importance their non-nursing colleagues give to nurses being assaulted literally in front of them. As one nurse stated, “I think there is a
certain inherent sense that it’s expected, it goes with the job. Do I agree with it? No. I don’t agree with it but yeah it goes with the territory.”

Perhaps the comment of one nurse describing the effect of this culture on his practice of nursing within such a volatile environment best summarizes the sense nurses had of being abused by the system, and their anger and frustration at how powerless they felt at being able to prevent patients from being victims of the nurses’ experience. He eloquently and calmly spoke of being lost in the violence, his regret at being unable to stop his own reactions, and to hold on to the person he is.

I think we lose part of ourselves. Nobody came into nursing, I would hope, to be nasty and I know that’s where I’ve lost and I don’t think I’m on my own there. Somebody’s pushed my buttons so if somebody reminds me of them so now my back’s up a little bit before I even start so I’m sort of less likely to get a positive reaction from this person even though their reaction to what you’re doing might be totally different and much more reasonable. I don’t think I’m the only person in that boat. That’s a regret for me. That’s what I’ve lost. I have to really, really hold on to myself and take a step back sometimes.

Summary Of Findings

The purpose of this study was to investigate how emergency department nurses described their experience with violence in their workplace, how they coped with the impact of that violence and to determine what role the work environment may have played in their experience. First, nurses described the frequent and often lethal types of violence they encounter on a day to day basis within their respective emergency department. Second, the nurses described the impact the violence had on them, from
initially being so focused on managing the aggression they could think of nothing else, to significant physical and psychological symptoms that persisted over time. Third, the nurses I interviewed described how they responded to the violent event as well as aspects of their experience that both assisted them at the time as well as aspects which hindered their care and their successful management of the aggression. Finally, nurses articulated why they believed the violence occurred, and through five categories created through qualitative content analysis, they described the role their work environment played in that experience.

The five created categories were safety in a fractured workplace, the provision of acre and comfort, the challenge of design barriers, taking care of the nurse and losing oneself in a culture of violence.
CHAPTER 5
Discussion

Violence occurs in all domains of nursing (Canadian Nurses Association, 2005). A body of research supports the descriptions provided by nurses interviewed for this study and these nurses clearly understand that the work they do is dangerous and is often exacerbated by the addition of variables like alcohol and street drugs, weapons, mental illness, language barriers, knowledge deficits and a host of other factors which add to the aggression they face on a daily basis (Chermack & Taylor, 1995; Davidson & Jackson, 1985; Duncan, et al, 2001; Graydon, Kasta & Khan, 1994; Jackson, Claire & Mannix, 2002; Lanza, Zeiss & Rierdan, 2006; Williams, 1996). The level of danger faced by nurses has been acknowledged by a number of nursing regulatory bodies and nursing policy makers in Canada (Canadian Nurses Association, 2005). This year British Columbia’s nursing strategy includes the allocation of $350,000 towards implementing the Canadian Nursing Advisory Committee recommendations including examining the impact of staff patient ratios on patient outcomes and a zero tolerance towards violence and abuse in the workplace (Canadian Nursing Advisory Committee, 2002; Government of British Columbia, 2006). Despite both recognition and direction from government and policy makers, the descriptions of workplace violence from the nurses interviewed for this study clearly demonstrate the frequent and potentially lethal levels of violence they experience in their workplace. As nursing recruitment and retention are paramount to employers and nursing policy makers, it is stunning to hear nurses recount the glaring lack of support from their managers and the organizations that employ them. The
Canadian Nursing Advisory Committee (2002) reports serious alarm given the rates of violence against nurses has changed little over the last decade.

The nurse’s own description of violence in this research, and their vulnerability to workplace violence, is supported by a growing body of literature (Fernandes et al. 1999; Findorff-Dennis et al. 1999; Henderson, 2003; Kingma, 2001). The response of nurses interviewed as they describe their experience after the violent event and over time, corresponds to research examining the relationship between verbal and physical violence as well as nurses own perception of the acceptability of the violence (Lanza, Ziess & Reirdan, 2006). Nurses are more likely to report incidents of physical violence than verbal but this does not mean verbal violence is less important to nurses, but that employers must be even more vigilant in assisting nurses to document and prevent verbal violence (Hesketh et al., 2003; Lanza, Zeiss & Reirdan, 2006). Nurses within both emergency departments reported a high level of abuse not only from patients and their families but also a growing amount of abuse from other nursing staff and physician colleagues. Based on their experiences, most nurses in this study felt there was little evidence to suggest that anyone other than the nurses working in that department were taking the threats against them seriously, a finding that was also supported by Henderson (2003).

Threats against the nursing staff may be explained by considerable research support for both a frustration – aggression theory for violence (Berkowitz, 1989) and a hierarchical based or continuum theory of patient aggression (Morrison, 1992). The description of violence by nurses in this study corresponds to these previously established theories. In this view, physical violence is a last step on a continuum of escalating
behaviour that can begin with excess movement, followed by verbal violence, to violence against property and end with violence against another person (Lanza, Zeiss & Reirdan, 2006). Berkowitz (1999) would claim that the growing frustration of the patient in not having his needs met results in the continuum of violence being initiated. Certainly the nurses interviewed described the importance of listening to patients at triage and ensuring they were clearly understood. They further related how not providing comfort measures for the patient increased the likelihood patients would be dissatisfied with the service provided and ultimately become frustrated. It is important to recognize that patients who present to an emergency department already have some frustration and may not behave as we expect: they may be in pain, they may have been hurt, they may be frightened or they may panic out of fear for a loved one.

Relational Care

It is not difficult to care for patients who meet our expectations, who behave in ways we consider safe and appropriate, and who align their actions with our nursing goals (Doane & Varcoe, 2006) but many patients who present to emergency behave in ways that perhaps do not align with those nursing goals and who come from life situations far different from our own. Emergency nurses may find themselves dealing with a patient where it is difficult to connect, perhaps because the patient may not want a connection with us. It is these patients that the nurses interviewed for this study identified with when they spoke of the importance to lessen the divide between “them and us” and establishing a connection across these differences to more effectively work with the patient and ultimately reduce the level of aggression. Doane & Varcoe (2006) have described how nurses can provide good care for families in a world characterized by
pervasive inequities in social and health resources. Their work could also be applied to emergency nursing, viewing it as a relational process of inquiry. This approach was evidenced by these nurses’ descriptions of the importance of establishing a connection with the patient, ensuring the patient is heard and also feels listened to, because this ultimately reduced the aggression the nurse had to manage in the department. Doane & Varcoe (2006) refer to this a “taking a stance of inquiry”, where our ability to connect as nurses is enhanced if we think of differences ad locate problems in a relational context; that is, we enquire into the patient’s experience and concerns, as well as our own as nurses, and then find “the join” between our experiences. What the nurses interviewed have done is provide examples of approaching the patient in a relational way while providing care and comfort, providing understanding instead of defensiveness and providing effective nursing interventions instead of a sense of powerlessness and frustration on both the part of the patient and of the nurse. The provision of a warm blanket, for example, helps the patient feel understood and cared for and the resulting relation decreases the risk of aggression and reduces the effect of the existing culture of violence.

*Environmental modification.*

The provision of care and comfort was not the only aspect of the nurses’ work place that affected their experience of violence. Nurses discussed violence prevention and control through environmental modifications within the emergency department as well as considering the modification of organizational protocols on critical incident follow up and shift rotation design. Through the efforts of policy makers and the public health sector, the link between violent crime and public health is now well established and
continued increases in the amount of violence over the last decade have placed a significant burden on an already strained health care system (Mair & Mair, 2003). As one nurse interviewed stated, the emergency department is a microcosm of the entire health care system.

For several decades criminologists and industrial psychologists have sought to prevent violence and other crimes through environmental modifications (Mair & Mair, 2003). While the public health sector has long recognized the environment as one of the main determinants of disease and injury (Frerichs, 2006) we have failed our health care providers in not recognizing it as a determinant of violence within their workplace (Newman, 1996). Nurses in this research expressed outrage at the lack of care given to their safety both from colleagues and through design; for example, the security guard who let an unknown taxi driver into the operating room at 2:00 a.m. While some efforts are being made such as the installation of card control devices, research has demonstrated for a decade that a defensible space can be created in residential and business environments (Newman, 1996). The findings of this study show that nurses do not perceive that these techniques in the design of health care settings have been employed, and they feel unprotected as a result.

Crime prevention through environmental design (CPTED) is a term established by C. Ray Jeffery to describe a multidisciplinary approach to preventing crime (Government of South Australia, 2005; Mair & Mair, 2003). CPTED uses three main concepts that encompass the descriptions provided by nurses to reflect the changes they desired. These concepts are access control, surveillance, and territorial reinforcement (Government of South Australia, 2005).
Access control can be defined as reducing opportunities for violence by denying access to targets (nurses and other staff) and creating a perception of risk to the potential offender (Mair & Mair, 2003). Nurses interviewed stated that access to the emergency department needs to be restricted to only those staff, patients and families who need to be there and the multiple entry points into the department have to be reduced. They further commented on the inadequate number of security guards and the need to have guards that are present in each area of the department to ensure an immediate response. Nurses further describe the presence of security as reducing the incident of violence because of the perceived risk to the perpetrator.

Surveillance can be defined as keeping potential offenders under observation by providing increased opportunities for close observation so that offenders perceive themselves to be at increased risk for detection (Government of Australia, 2005). Nurses in this research commented on how difficult it was to establish rapport with patients and to closely observe patients who may be at risk for violence because of staff shortages. It is imperative that employers recognize the link between reduced staffing levels, the inability to closely observe patients, and the increased risk for violence. If employers are hampered by the nursing shortage in recruiting for vacant positions, then examining the use of non-nursing staff in a dialogue with their emergency department providers will be critical to achieve an adequate level of surveillance and reduce the number of violent incidents. Another form of surveillance utilizes existing technology. Nurses describe the frequency with which they encounter weapons in the department, yet any suggestion to employ the use of a metal detector is dismissed for fear it would upset the public. The
nurses felt that the fact that they may be stabbed or killed was not as important as the optics of safety.

The last of the strategies, territorial reinforcement, uses architectural and design strategies to delineate a change from public to private space, so that it is clear the staff working within it have influence over the space and the work within it (Government of South Australia, 2005). Nurses described the need for barriers within the department to increase safety, the increased need for space between stretchers and around patient care areas, and articulated how the current design of the triage area can set off a chain of frustration for the patient that escalates into aggression and ultimately violence directed to caregivers. The use of barriers at triage, an intimate process where the patient must reveal very personal information on their health status, appears to prevent nursing staff from conducting a thorough and private assessment as well as inhibits establishing rapport so the patient feels understood and cared for. Nurses interviewed who had worked at triage described their disappointment with the current design in their department.

The use of technology is also available to increase territorial reinforcement. Personal protection devices that pinpoint the exact location of a staff member requiring assistance and then notify security for an immediate response are currently available and in use in certain health care and correctional settings (Sentry Communication Systems, 2006). Nurses described how frequently they had to scream for help and were even ignored by other health care professionals while they were being assaulted. The use of such devices within a department could activate an immediate response and in lethal situations could have the potential to save lives.
Support of nurses by administration

Nurses’ description of their experience and the changes they see as important to their environment are overshadowed by their relationship with administrators and with the other members of the health care team, for example, the ambulance service. Henderson (2003) discusses how problems with these relationships are well supported by the literature, and that when hospital administrators tolerate the continued violence against nurses they “send a message that violence is condoned; they also send a message to the public (and to nurses) that nurses are not valued.” The actions of the two organizations as described by nurses in this research sent the same clear message that nurses are not valued, that they are invisible, not supported nor treated with respect. It is unclear why an organization would respond to the needs of their largest human resource by demonstrating a lack of regard for their personal safety. One explanation, say Holmes & Marra (2004) is that nurses are seen as having relational skills and those are typically associated with women, “and hence devalued” (p. 377). Despite it being a critical skill in the practice of nursing, relational practice goes largely unrecognized and unrewarded in the workplace (Holmes & Marra, 2004). Relational skills are often overlooked, but as Doane & Varcoe (2006) point out, the ability to shift from placing our own unhelpful expectations and responsibilities on patients and instead enhancing our own responsibilities as nurses, are key to establishing a relational process of inquiry. As our participant’s recounted, such relational skills are also key to reducing the likelihood of a violent event.

In addition to describing the importance of supporting the patient at triage and throughout their stay, nurses recounted their own need for support during and after
violent events. As part of the need for support, nurses speak loudly about the importance of critical incident debriefing following a violent event. Research on post traumatic stress indicates that nurses are experiencing the cumulative effect of repeated exposure to violence and the corresponding reactions that ensue over time (Davison & Jackson, 1985). Often traumatic events, such as assault, are so unexpected and stressful that they shatter the foundation of victims' belief systems and overwhelm their capacity to cope (Coulter, 2005). The primary goal of critical incident stress management is in fact to support the staff member (Mitchell, 2002) and the fact that organizations do not pay strict attention to ensuring this occurs speaks volumes about the priority place on the support and retention of nurses within their department. One nurse interviewed stated she had recently left the emergency department because of the frequency and intensity of violence and the lack of support she received following some serious incidents of violence as well as the disinterest in implementing her ideas to increase safety.

Emergency nurses have richly described the culture of violence in which they provide care. Evidence demonstrating a link between verbal and physical violence has been established in recent studies that surveyed nurse participants about their exposure to violence (Lanza, Zeiss & Reardon, 2006). Although nurses here indicated a smaller number of incidents where violence was perpetrated by a colleague, recent research demonstrates that verbal assault is just as likely to be perpetuated by a co-worker as by a patient (Hesketh, et al., 2003; Lanza, Zeiss & Reardon, 2006). The fact that violence is not only a result of patient actions but also of staff may be contributing to the culture of violence and nurses description of falling in line with what they observe so as not to be
seen as different. One explanation of the perpetuation of this culture is offered by Lanza, Zeiss & Reardon (2006):

Broken Windows Theory...explain[s] the way in which acceptance of petty crimes in a community signals a lack of concern about community integration and an implicit message that crime will be tolerated (p. 78).

Nurses describe the challenges of relational practice within the emergency setting where violence perpetrated against them continues to be tolerated. They recognize the importance of providing care and comfort measures to patients in the emergency department and how engaging in those measures reduces the incidence of violence and lessens the fuel for a culture of violence. Nurses feel a great deal of moral distress over losing themselves as nurses within the culture of violence they describe. They recognize the need to find that “join” between their experience as a nurse and that of the patient, but are often distressed by the competing priorities and the resources available to address them. At times their desire to maintain a stance of relational inquiry is lost within the culture of violence and they find themselves exhibiting countertransference. They described how their “back’s up a little bit before I even start” when dealing with some patients who “push their buttons”. Within the emergency department, the acceptance of violence by administrators and health care workers alike sends the message that it will be tolerated which further adds to nurses’ distress over providing care to this group of patients. As mentioned, the Canadian Nursing Advisory Committee (2002) recommended a zero tolerance policy for violence be in place by 2003, yet the violence towards nurses continues.
If change is to occur within the emergency department setting, nurses must feel safe and supported in bringing forth their concerns to an organization that demonstrates the value they place on the voice of nursing at all levels. In one organization used as a setting within this research project, the Chief Nursing Office does not report to the CEO but to a Physician Leader. That structure sends a clear message to the nursing staff about the importance of their voice in policy level decisions. Organizations need to clearly articulate what it means for them to have a zero tolerance for violence and how they will operationalize such a policy. Failure to do so has great implications for nursing recruitment and retention and ultimately the level of care provided to patients (Jackson, et al. 2002). We spend considerable time orienting new staff on how to manage aggressive behavior through non-violent crisis intervention but little time on demonstrating how we value nurses in the organization and how we will demonstrate our zero tolerance stance.

Evidence is mounting that as our population lives longer healthier lives, our health care system is not functioning effectively for those who are served as well as those who work in it (Canadian Nurses Association, 2006). When employers and health care organizations embrace the voice of their nursing staff and implement the measures identified through the voice of these nurses for workplace safety, improving the provision of care and comfort to patients and their families, considering safety and violence prevention in workplace design, recognizing the importance of systematic incident follow and working with nurses to eradicate a pervasive culture of violence then nurses will be safe and secure enough to provide excellence in the care and service of our communities as they want to be.
Study Limitations

Participants for this research were not selected randomly but were recruited directly from emergency departments of interest to the researcher and therefore the results cannot be generalized to a larger population of nurses. Additional limitations include that the interviews were conducted with people who were willing and able to talk about their experience. The experiences of nurses who were not willing to participate may have been quite different. The nurses interviewed were all experience emergency department staff although half of emergency nurses have less experience than this sample; therefore, the experience of newer emergency nurses may be quite different. The interviews were restricted to nurses who work in large urban tertiary care settings. Although a smaller community based hospital was included as a recruitment site, there were no volunteers from that department. Nurses from smaller community based hospitals may describe a much different experience in their department. Participants in this study appear to have been forthright with their experience of violence and the contributions they saw the work environment make to that experience; however, participants may have expressed some views that they felt were more in line with acceptable social or departmental standards so as not to present themselves too negatively as I interviewed them. Finally, for the purpose of this research, there were no validation interviews or feedback solicited from participants to validate the findings or interpretation. Future research should employ a larger sample, across multiple settings and systems and incorporate validation mechanisms with the research results.
Implications For Nursing Practice

The results of this research suggest implications for nursing practice, research and administration. For nursing administrators, an immediate action plan on enforcing a zero tolerance policy for violence is critical to continue to recruit and retain nursing staff. Administrators should implement mandatory critical incident debriefing to appropriately care for their staff as well as to learn what may have caused an event and how to prevent it. Such a mandatory session would allow administrators to learn directly from the voices of their front line staff. Policy development will be key for managers and nursing leadership. First, a policy around violence and critical incident debriefing needs to be developed collaboratively with nursing leadership at all levels of the organization. Second, policies to expand the current mentorship programs could be implemented to include nurses with many years of experience. The goal of such a policy would be to expand to include practice support for nurses at all levels of experience as well as collegial support that can be both formal and informal. Administrators must collaborate with nurses at the practice level in implementing existing tools such as the Quality Practice Environment framework published by the College of Registered Nurses of British Columbia (2004) that will assist in the retention of nursing staff and create an infrastructure to support nursing practice. Opportunities to move from reactive practice at the point of care to formal sessions using reflective practice should be fostered and built into unit and staffing schedules. Links to nursing schools and the organization’s research institute could be strengthened to support such evidence based practice around the management of violence, relational practice, and other issues as identified by staff. Administrators’ need to ensure adequate nursing supports (clinical leaders and educators)
are in place to support staff including clearly articulated supports for the family of staff members that better meet the needs of the staff and their family. Finally, shift rotations and patterns should be examined to address issues such as fatigue and excessive overtime as identified by nurses in this study.

Within the practice of nursing, a mandatory extended orientation to the emergency department should be developed with ongoing required updates for all staff. Such an orientation must have a well developed section reviewing the assessment and management of psychiatric illness and substance misuse. Nurse educators must work with their emergency nursing staff to assist them in understanding the links between relational practice, the provision of comfort measures, and reducing the frequency of violence. Over time, such work may extinguish a culture of violence and replace it with a culture of non-violence and support. In conjunction with policy makers, nursing practice should review the completion of incident reporting mechanisms so they are easily completed by staff and a mechanism of review for both practice and policy issues resulting from those reports needs to be in place.

Nursing researchers can focus on further examining the use of relational inquiry in managing aggression. Additional research is needed to determine the relationship between physical barriers between the nurse and patient and the frequency and severity of violence. Researchers must collect data to report the frequency of violence against nurses as well as the type of violence, what intervention was used and the degree of success of that intervention. Further research could be developed from the work on crime prevention through environmental design to extend it to emergency and health care settings to look
at violence prevention through environmental design. Finally, nurses clearly felt ill prepared to manage mental illness and addictions so researchers should determine who are the users of emergency departments with a mental illness and addiction? What resources are this group accessing and are those resources effective or not in improving health outcomes? How do emergency nurses best support patients with a mental illness and addiction?

Conclusion

The experience of violence for nurses is a complex matrix of variables that include the design and function of their work environment. Listening to the voice of the nurse to reduce violence within the emergency department as well as to improve the design of the department to assist in violence prevention is critical. Administrators and health care organizations must adopt a zero tolerance policy against any violence and demonstrate the value they place on nurses by responding quickly to their needs, ensuring adequate and appropriate staffing to prevent violence, and create the physical environment and practice culture that will attract and retain nurses. By ensuring that safe and secure environment, nurses can then focus on the provision of quality patient care within an environment designed to prevent violence and ensure appropriate levels of observation for patients who are at risk for demonstrating aggression. A failure to respond by employers will have a significant effect on their ability to recruit and retain talented nursing staff and, more importantly, signal the continued destruction of safe, quality care within the emergency environment and perhaps for all health care.
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APPENDIX 1

Interview guide

1. Tell me about what it's like to work in your emergency department.

2. How long have you been working as a nurse?

3. Tell me the story of what happened with one of your experiences of violence in the Emergency Department.

4. Why do you think it happened?

5. How did you respond?

6. What helped you?

7. What hindered you?

8. How did the experience affect you, if at all?

9. How was your workplace involved in the outcome, if at all?

10. Was this typical of your experiences of violence in the Emergency Department? If not, how was this different?

11. What would the other staff around you at the time say that they saw?

What resources if any did you access after this event?
APPENDIX 2

A sample of qualitative content analysis

After completing the first interview, I wrote field notes that described the setting, the demeanor of the subject being interviewed, as well as points of interest that stood out for me immediately following that interview. I read through the transcript and began to write comments on the margins of the interview transcript. For example, for the following quote about critical incident debriefing from the transcript, I wrote “initial debriefing – no follow through or analysis. No link to prevention or change for improvement – he supports need for this process”.

What we’re not very good at it following through and seeing what about the structure of how we work and how we work and where we work. We really deal with it in the here and now but we don’t do anything that’s preventative. Or we don’t do as much as we should be doing.

After reading through the first interview completely several times and making additional notes that tied their comments to the literature where possible, I created two categories: nurses’ experience of violence and the effect of the workplace on violence. I placed my notes and certain quotes within these two categories. As I read the next interviews, I followed the same process, including my notes and quotes from the interviews into these two main concepts. As the amount of data increased I created subcategories that were different levels of one of the two concepts. For example, after several reading of interviews I created the sub-category of “comfort measures” after reviewing the following section in an interview:
Because I think most of our clientele, even the sort of drug addicted or substance misusing respond to having people spend a little bit of time with them and address their problems of at least give them some time to express their issues.

Although initially thinking it may link communication to comfort, ass I continued to analyze the data, I discovered a greater number of quotes that corresponded to the actual provision of comfort. I kept numerical counts of the number of quotes that fell within the categories. Over time and with further analysis, I would collapse categories together: for example, the category of providing care and the category of comfort measures collapsed into a category called the provision of care and comfort.

A similar process was followed in creating each of the categories within this study. A formative check of categories occurred including the use of external feedback from my thesis committee. This resulted in a review of the category titles to more accurately reflect the voice of the participants while maintaining the integrity of the theme. For example, one category was initially called “workplace safety” but was changed to “safety in a fractured workplace” to reflect the voice of the participants in the creation of the category.