Nurses' Experience of Workplace Violence: Towards Effective Intervention

April 2010

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**Nurses' experiences of workplace violence:
Towards effective intervention**

Final Report: April 2010

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Acknowledgement

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Main Research Findings and Policy and Prevention Implications

- All the nurses had encountered physical violence or the threat of it, at the hand of patients, at least once in their careers.

- All the nurses in the study report experiencing verbal abuse, directed either at themselves or a colleague, from patients, relatives and/or visitors on a daily basis.

- Nurses theoretically valued the notion of working in partnership with the patient's family and friends and yet, pragmatically, they often found such involvement made matters harder to deal with.

- Nurses recognize that patients frequently have legitimate reasons to be angry.

- One of the most commonly utilized responses that nurses report using following violence or abuse from a patient is to avoid the patient.

- Nurses feel strongly that there is a lack of support from management, both in the form of lack of procedures to help nurses prevent, cope with and handle the effects of workplace violence in all its forms and in the form of lack of follow up.

- Nurses believe that effective critical incident stress debriefing is no longer available to them immediately following an incident.

- Nurses feel unprepared in the areas of violence anticipation and prevention, de-escalation techniques and in the use of personal safety techniques when violence does occur.

- Educators specializing in anti-violence feel that unless nurses have frequent opportunities to practice physical personal safety technique they may be at risk of injury, due to a sense of over-confidence; thus, educators are reluctant to teach any these safety skill.

- Any education designed to prepare nurses to feel competent to handle potentially violent situations needs to be repeated annually.

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Executive Summary

This study explores nurses' experiences of violence they encounter in the context of their work. While much information is available regarding the impact of organizational level factors such as staffing level, supervision, and the environmental culture on workplace violence, and while I acknowledge the enormous importance of such factors, here I focus on the experiences of the individual nurses. I sought to understand their perceptions of both the impact workplace violence has on their ability to feel safe, healthy and supported in the workplace and the impact these experiences have on their ability to function effectively at work. Violence in this context is defined as including verbal harassment, sexual harassment, sexual assault and physical assault as well as more subtle forms of abuse such as threatening, bullying and demeaning behavior towards the nurse. I specifically sought information about the types of violent incidents, the perpetrators and the outcomes that nurses had encountered and found most upsetting.

This study was conducted in both community and hospital settings. First, incident reports of violent incidents were reviewed in order to understand the types of incidents that are currently reported and those that are not. Second, nurses were interviewed, both in focus groups and individually, to gain a rich understanding of their experiences and of their perceptions of the impact on their work-life. Lastly, the original intention was to design an intervention and to implement and evaluate it in the study settings. However, system wide anti-violence programming was introduced during the time of data collection. It would have been too confusing to introduce a second new program concurrently in these areas. I therefore chose to respond to the wishes the nurses had expressed regarding areas in which they felt under prepared and I designed an intervention aimed at meeting their stated needs.

The data collected in the interviews showed that nurses felt they lacked sufficient preparation in the area of skills around anticipating aggression and violence, de-escalating

people who become agitated and violent, and keeping themselves safe when a violent incident occurs. Most, but by no means all of them acknowledged having received some education regarding workplace violence in both their original nursing

program and in orientation to their present job. However, none felt that they knew enough to keep themselves safe or that they were confident to act. As well, they were generally lacking in knowledge regarding the current policies or protocols in their workplaces and, as a group, felt that reporting violent incidents was 'generally a waste of time'. Overall several nurses remarked on their reluctance to report a particular patient as 'potentially violent' as they held the believe that the patients would never be able to get the label out of their charts and would thus be stigmatized. Lastly, they were aware that they faced potential violence on a daily basis and they expressed the need for resources to help them prepare to handle incidents as necessary.

In response to these needs I developed a DVD on workplace violence. I discuss the content and intended use of the DVD in some detail later in this report. The DVD will be housed within the school of nursing and will be made available to anyone who wants it. VHG/UBC educators have already expressed interest in using it in their education program and would like to launch it. It will be distributed throughout the hospitals and health units in which data was collected. It will also be made available to WorksafeBC to use as needed.

Conclusions

- Almost nurses have experienced at least one incident of workplace violence
- Resources are sadly lacking in the form of policy and procedure guidelines that nurses feel comfortable using
- Nurses feel unsupported by management and at risk of serious consequences from workplace violence
- Nurses are unclear about what happens to their report if they do make a statement about a violent incident

- Nurses' personal histories can have implications for their experiences of violence at work

- They are clear about what would be helpful

- Education programs are currently not meeting their needs either in their original nursing programs or in their places of work

Recommendations

- The visibility of administration in creating effective workplace violence protocols, implementing them, and evaluating them needs to improve

- Nurses need to be clear on what happens when they report violence. Thus there needs to be someone designated to follow up such reports and to ensure that the individual knows the outcome

- Educational interventions need to be available in several forms and frequent opportunities for practice need to be built in

- Nurses need help in understanding how their personal histories and experiences might have an impact on their experiences of workplace violence. Some of this could occur in nursing educational settings in the form of self-awareness work

- Future inquiry should be conducted into organizational level factors that might have an impact on nurses preparation to avoid &/or handle violent events, as well as on their feelings of being supported and valued, as well as on their willingness to report incidents, when they do occur.

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In the early parts of this report I draw heavily on the proposal submitted for the WorksafeBC Focus on Tomorrow 2006 Competition. I also draw heavily throughout on the extensive and useful feedback from two reviewers of an earlier draft of this report. The rationale for the study and the significance of the topic has not changed. In fact recognition of the scope of the problem of workplace violence continues to grow. Since I began this study, the first International Conference on Workplace Violence in the Health Sector was held in Amsterdam, The Netherlands in October 2008. I presented preliminary findings from this study at that conference and was one of hundreds of international scholars from all over the world coming together for the first time around this important area of mutual concern. In this report I will be referring to some of the themes that were raised repeatedly at that conference and which arose again in this study. I will also be identifying areas where the original focus of the study changed and explaining the reasons for those changes.

Research problem/context

Unfortunately, all the conditions that were present at the beginning of this study continue to be factors today. Workplace abuse and violence in health care settings, and against nurses in particular, is a problem that is increasingly recognized at an internationally level as being of epidemic proportions (Canadian Nurses Association, 1993, 2003; Duncan, 2000; Federation des Infirmiers du Quebec, 1995; International Council of Nurses, 2003; Health and Safety executive, 2001; Kingma, 2001; Workman's Compensation Board of BC, 2004; World Health Organization, 2002). Indeed, recognition of the profound nature of the problem and of its

worldwide relevance led to the first highly successful and widely attended 'International Conference on Workplace Violence in the Health Sector: Together, creating a safe work environment' being held in Amsterdam, The Netherlands in October of 2008. The second one will take place this year.

Workplace violence in health care settings, including hospitals, clinics and patients' homes, is a problem with profound implications for nurses' abilities to provide care effectively (Davidson & Jackson,1985; Findorff-Dennis, McGovern, Bull & Hung, 1999; Hewitt & Levin, 1997; Hislop & Melby, 2003; Williams, 1996). It is also acknowledged to have profound implications for the sense of satisfaction that nurses are able to gain from their work and thus for recruitment and retention: a matter of significance in a period of worldwide nursing shortages (Henderson, 2003; Williams, 1996). At the same time as the overall level of violence against workers in health settings is being acknowledged there continues to be an increase in troubling reports of horizontal violence and bullying between professional groups and between co-workers (Cox, 2001; Duncan et al, 2001; Dunn, 2003; Fitzgerald, 1993; Henderson, 2003; Henry & Ginn, 2002; Lewis, 2001; McKenna, Smith, Poole & Cloverdale, 2003) although this was not a focus of the present study. I also posited in the original proposal that the personal experiences of violence, harassment and abuse that nurses bring to their work from their life experiences could logically be expected to have implications for their ability to handle the violence they experience in the workplace. Lastly, it was clear anecdotally at the time of data collection that nurses were reluctant to use current anti-violence programming. The rationale for this study lay in its potential to produce a deeper understanding of the interrelationships between the various factors detailed above as well as in its significant potential to increase our ability to intervene effectively on behalf of nurses abused at work. At the beginning of the study the intended end goal was to

demonstrate that workplace violence programming, developed with an understanding of the complex interrelationships of experiences that mediate individual responses, could be effective in decreasing workplace violence. As the study evolved, the end goal changed due to a number of factors that will be described later in this report.

Methodology

Research Objectives:

The objectives of this research were:

1. To understand the impact of the workplace environmental culture, including current measures to address workplace violence, on nurses' perceptions of their ability to be safe and healthy at work.

2. To understand the impact of workplace violence on nurses' ability to function effectively in their jobs.

3. To understand the impact of lifetime experiences of abuse and violence on the way nurses respond to and handle workplace violence.

4. To pilot test an intervention addressing workplace violence, developed from nurses' accounts of their experiences

Research Design

The original design broke the study into four distinct phases, which were as follows.

Phase I: Review, summarize and describe incident reports filed using the current anti-violence policy.

Phase II: Conduct focus group and individual interviews using a qualitative approach with nurses in both hospital and community settings.

Phase III: Revise current anti-violence policy. Pilot test a newly revised educational program on two units involved in the study.

Phase IV: Evaluate the educational program.

Participants and Settings:

The participants in this study were all Registered Nurses working in various settings in the Vancouver Coastal Health region of Richmond B.C.. Nurses from a number of different clinical areas were interviewed. These areas were: 4 different adult medical/ surgical units, an inpatient mental health unit, an emergency department, preventative community health and outpatient mental health. We attempted to interview representatives from residential care settings but for a variety of reasons these attempts had to be abandoned.

Inclusion criteria: All RNs working on one of the study units for six months or more were considered eligible to participate.

Exclusion criteria*;* Nurses who had worked on the unit for less than six months will be excluded since they were unlikely to be familiar with many of the subtleties of the unit culture or the antiviolence program. There were no other specific exclusion criteria since, by virtue of functioning as RNs, nurses can be expected to meet all usual criteria of familiarity with English etc. Since all nurses are equally vulnerable to experiences of violence males were equally eligible for the study.

Methodological Approach: Data Collection and Analysis

Phase I of this study involved a review of incident reports that had been compiled since the existing antiviolence program was implemented in 2004. This programming included a process of reporting that, at the beginning of the study, was in the form of a written statement, but, by the

end, was an online process. The research assistants and I were given access of an excel spreadsheet in which all the incidents for the last 2 ½ years was summarizes. No names were included but the specific nature of the incident and the setting and estimations of the severity and outcomes of each incident was specified as were suggestions regarding how the incident could have been avoided (for example 'staff member approached resident from the side without telling him what he was going to do. Corrective action, Care plan adapted so that staff know to approach resident form front and speak to him about…"). The review of the reports helped to generate a clear picture of the use of measures outlined in that program to address incidents as they occurred. We compiled a spreadsheet of the available incident reports with a view to understanding the types of incidents that were currently being reported and, more importantly, those that were not.

Data Collection: All existing incident reports about violent and abusive incidents involving nurses, occurring since the current anti-violence policy was adopted, were reviewed. The interview guides that are designed to direct the qualitative interviews in Phase II were reviewed in the light of this information in order to ensure their relevance to the kinds of incidents being reported. Specific information was collected about: type of incident, location and any action that resulted. The numbers of violent or abusive incidents reported over the period were noted. The intent was to gather further relevant points from them: for example time of day, perpetrator (no identifying data was to be collected – rather the classification of person was to be noted, i.e. visitor, patient, other HC professional etc.). Again, any action taken in response to the incident was also noted to help ensure the relevance of the qualitative interviews. Interestingly, many of the incidents clearly occurred when patients were attempting to avoid some form of care- in most cases a dressing, a treatment or taking of medication. Another major precursor to violence, from

the nurses' perspective, was their inability to met patients' clients' or visitors' needs immediately. These insights are examples of ones that specifically informed the development of a line of questioning in Phase II.

Phase II of the study utilized a qualitative research approach known as Interpretive Description (Thorne, ; Thorne, Kirkham, and MacDonald-Emes , 1997; Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004): This approach was specifically developed to have utility for those in practice professions. Using it, researchers explore human experiences with a view to generating knowledge with practice implications. These authors recognize the importance of the knowledge gained by researchers who used traditional, non-nursing, qualitative research methodologies such as ethnography, grounded theory, and phenomenology in their classic forms, but they contend that these same researchers often had to blend components of these methods to answer the questions that are of interest to the nursing profession.

Thorne et al (1997) point out that one of the foundations of nursing knowledge is that, although there are shared aspects of experience, each person lives that experience from an individual perspective generated by unique life events. They argue that the interpretive descriptive research approach can be used to explore the uniqueness of each person's experience while identifying the aspects of the phenomenon that are common to everyone who live through it. The interpretive descriptive research approach "is grounded in an interpretive orientation that acknowledges the constructed and contextual nature of much of the health-illness experience, yet also allows for shared realities" (Thorne et al, 1997, p.172). In the case of this study interpretive description thus provided parameters regarding the collection of highly personal and potentially sensitive data from participants; only that which is relevant to the practice issue was considered appropriate. Interpretive description is uniquely suited to explore issues like workplace violence

where the experience may be common to all but where the experience, from the perspective of the individual, mediated and shaped as it is by previous personal history, can logically be expected to have a profoundly personal effect on each individual.

Data Collection: Phase II of the study concerned the collection of qualitative data regarding nurses' experiences of workplace violence, previous experiences of violence in their lives and their satisfaction with the current antiviolence programming. Attention was paid to nurses' views of, not only the response when an incident has occurred, but also their opinions regarding the efficacy of violence and abuse prevention programming since these views provide evidence towards an understanding of how nurses see themselves as supported within the workplace and thus their opinions regarding their safety and health at work.

A combination of focus groups and individual interviews was to be utilized as the data-gathering method for this phase of the study. Five focus groups were to be conducted; one from each clinical setting. All focus group were to be audio-taped and each group session was expected to take up to two hours allowing for a social time at the beginning and end of the group, getting consent forms signed and an orienting introduction. We began recruitment for both focus group and individual interviews by conducting information sessions in each of the study settings: a community health unit, two surgical floors, two medical floors, a mental health inpatient unit, a mental health outpatient unit and an emergency department. We attempted to access to several residential care units but were never successful. We discover that many of those we approached had recently taken part in a similar project and therefore might have been saturated with researchers.

The notion behind the use of focus groups is that they can encourage participants to react to and to be stimulated by the ideas and opinions of others in the group who have had similar life

experiences. The use of focus groups is generally acknowledged to be appropriate when the researcher is interested in exploring the generally accepted group wisdom of a population in an area which has previously been unexplored or inadequately described (Carey, 1995; Krueger, 1994; Morgan, 1988). The focus here was intended to be on nurses' views of the environmental climate and on specific aspects of the current policy and procedures regarding the effectiveness of procedures both to prevent violence and to address it once it has occurred. This phase of data collection changed radically once in the field. We began by providing information sessions as a recruiting mechanism. Large groups of nurses attended these sessions and talked freely about their experiences but were declined to be in a focus group. However, clearly they were happy to be individually interviewed. We ended up conducting only two focus groups each with three members. This data collection strategy was only marginally useful. In the end, the utility of the focus group material was questionable – while the small number of both groups and participants in groups rendered the content virtually invalid, the members did all comment on points raised by other participants in the information sessions where people had talked quite openly. Thus, in a sense, many voices were present.

However, the lack of a satisfactory outcome from the groups led to the inclusion of some of the questions focused on the workplace environment being included in the individual interview guide. This meant that we did obtain this content but in a less efficient way and without the type of insights that groups of people with similar experiences can stimulate in each other. One insight I gained from this experience is that I would never again conduct information sessions in the same way. These sessions were composed of both practice leaders and the staff they supervised and yet, in the sessions, everyone seemed to speak openly, comfortably and at length about the types of aspects of workplace violence that were comfortable to share in groups

of people – similar experiences, comments about the physical setting, management issues etc. However, my sense is that generally they felt they had had an opportunity to say what they wanted to say on those topics and no longer felt the need to be interviewed – in fact two nurses specifically made this comment. Thus, although I heard about their experiences and of their concerns, it was not data and was not used except to inform the conduct of the individual interviews.

At the information sessions I did make clear that the individual interviews would concentrate on other aspects of the topic and virtually all of the study volunteers for individual interviews were recruited following the information sessions in the various settings. Three other people heard about the study and volunteered over the phone. Individual in-depth interviews with volunteers were used to access the data that we thought nurses might be unwilling to share in the more public setting of the focus group, for example, the relevance of personal experiences of abuse and violence to their personal responses to incidents in the workplace.

The focus of the interviews was to gain a deeper understanding of that individual, his or her experiences of workplace violence and of the individual influences on the way such incidents are perceived. Thus data about previous personal experiences of violence and/or abuse was collected but only in so far as such content was relevant to the workplace experience. After the failure of the more formal and extended information sessions, which nurses signed up to attend, to recruit focus group members, we began showing up at workplaces to distribute information sheets to whichever individual nurses happened to be present that day. We chose less formal settings such as lunchrooms following the lunch hour. The research assistants would then ask if the nurses were interested. This approach was more successful and roughly 75% of the nurses who attended agreed tom participate. We conducted a total of 30 interviews. Interviews were

conducted in a number of settings, including participants' workplaces, homes, and impersonal

settings like coffee shops. The interviews were transcribed and the interviews cleaned of any

identifying data. They were numbered and kept in a filing cabinet in the research office. The two

research assistants and I all read and analysed all interviews independently. We then met to

discuss our findings and to continue more in depth analysis.

Data Analysis: Thorne et al (1997) discourage the use of overly complex coding systems in the

analysis of data in a study directed by interpretive description. They recommend using

phenomenologically based approaches such as Giorgi's (1985) in which repeated immersion in

the data as a whole precedes any attempt to categorize into themes. Thorne et al claim that:

> From our perspective, struggling to apprehend the overall picture with
> questions such as " what's happening here?" and "what am I learning
> about this?" will typically stimulate more coherent analytic frameworks
> for interpreting descriptions than will sorting, filing and combining vast
> quantities of small data units…(p.174)

Giorgi describes synthesizing data into broader descriptions, theorizing about what those

descriptions might mean and then applying the notion of context to the resulting analysis (Giorgi,

1985). Giorgi outlines a four-step process in which the researcher moves, through a series of

analytic procedures, from a more concrete description of what is being portrayed to a more

abstract conceptualisation of the meaning of the data. First the researcher reads the whole

interview through in order to gain a sense of the whole – what is the tone, the emotion, the

underlying message, for example. Next the researcher reads more closely for specific points that

the participant brings up and tries to label them in language close to the participants – for

example if the participant talks about being anxious, the researcher might label that point

'anxiety'. Next the researcher attempts to move the labels up a level of abstraction to capture

more universal themes – as an example, still using the anxious label in the previous case, the

researcher might have a theme regarding 'emotional responses to violence' and might cluster a number of emotional responses under the umbrella. If there were to be a wide range of emotional responses, it would suggest that the researcher now look at the data for aspects that might help to explain the differences. Lastly, the researcher attempts to write a description that captures the nature of the participants' experience in a way that would read true to all of them.

Phase III; In the last phase of the study we intended to use insights gained in Phases I and II to refine the existing anti-violence programming, and to introduce the new program into the settings used in the study. We were then going to monitor incident reports about violent incidents for six months following the introduction of the new program into the settings in which we had collected data. In the event this phase underwent a radical reorientation with the abandonment of the new program idea and the development of an educational DVD on workplace violence. The specifics will be described fully in the next section of this report. The impetus for the change was that Vancouver Coastal Health introduced a new set of guidelines to address workplace violence at about the same time that we would have been introducing the revised program. It was clearly not feasible to have two new programs being introduced and tested in the same settings at the same time. We therefore revisited the data to provide us with direction to develop a new intervention, in the form of a DVD, based on the stated needs of the research participant.

The decision to develop a DVD was, to some extent determined by the content of the program that was in process of being introduced. It contained a heavy emphasis on training and the influence of the workplace itself in the form of respectful workplace protocols, support between and among staff members and on reporting procedures and specifics of follow up and institutional response. What seemed to be lacking, and what the nurses told us that they wanted, was an emphasis on how to spot the development of potentially dangerous situations, how to

assess situations, defuse and deescalate evolving situations, and how to keep both themselves and their patients safe if it proved impossible to prevent. They also wanted a resource that they could use frequently without it having to involve an organized educational experience. Thus a DVD that could be used by groups OR by individuals seemed to meet their needs.

The DVD is extensively described in the findings section of this report. In summary it contains information about principles guiding workplace violence management, four scenarios-each about 15 minutes in length - illustrating a number of situations evolving in the context of settings in which violence is known to occur quite frequently, and how it might be effectively managed (as well as what might happen when the management of the incident is not so effectively managed). Although violence can occur in any health care setting, and although it can come at the hands of relatives, visitors, colleagues or others in the environment, in the DVD we concentrate on the more generic situations while emphasizing that the scenarios are for the purpose of illustration of approach and can be usefully applied in most situations.

Lastly, the DVD contains an extensive interview with experts in the area of workplace violence education in health care settings. In the interview discussion focuses on such topics as; how such education has evolved and continues to do so in terms of the content of these sessions as well as the best way to conduct them, theories behind best practices and current thinking about teaching skills like breakaway techniques. At the time of this report the DVD is complete and ready for dissemination. Thus Phase IV of the study has not been undertaken and a new evaluation study for the DVD needs to be designed. I next move to a description of the research findings in the next section.

Research findings

I begin here by describing some of the findings and insights from both Phase I and II of the study as well as the intervention developed for Phase III.

In Phase I we reviewed just under 200 incident report summaries. There are several important insights to be gained from them. The majority of reports concerning patients described incidents in which the violence occurred in a situation where the patient was known to have aggressive tendencies - for example a patient with dementia or known contributing medical conditions. Several of these cases resulted in a plan to have two people provide care rather than one alone. The second largest group described incidents of unpredicted aggressive behavior. These were usually described as either lashing out or as attempts to bite or scratch, often in the context of physical care-giving. In community settings there were a surprising number of dog bites, even when the nurse reported calling ahead and requesting that the dog be confined during the visit. This was an interesting finding since these nurses all knew of the 'visiting a home with a dog in it' protocol.

The most critical insights derived from this review however concerned what was not included. There were no reports of family or visitor verbal abuse, threat or aggression. There were no reports of horizontal violence or bullying, no reports of inappropriate sexual harassment and no reports of harassment by other health care professionals. In the interviews several of the nurses told us that they find this type of incident too difficult to report and unsatisfactory in that they rarely hear back about its results and often feel that no-one is interested in hearing about these events.

As well, there were no reports concerning verbal abuse exclusively. In many ways this last one is not surprising. Nurses reported verbal abuse to be an almost daily occurrence. As they describe it, if they reported it all, they would have no time for anything else. However,

considering the huge volume of literature that clearly identifies these types of incidents to be the most troubling for nurses, it is extraordinary that there was not one report of them. Since this omission was so glaring I included a question about it in the interviews.

The Phase II interviews resulted in enormously rich data. I begin by describing the findings concerning the overall topic of workplace violence, its prevalence, severity, impact and nature including some of the more unexpected insights that the nurses provided. Then I describe what the nurses identified as being unmet needs regarding their experiences of workplace violence and the system's (educational institutions, professional associations and workplace administrators) responses, or lack thereof, to those needs.

Nurses' experiences of workplace violence: Many of the overarching themes deriving from the nurses' descriptions of their experiences confirmed other literature on the topic and were not surprising. I, therefore, will identify the major ones but spend little time on them. First, consistent with findings from other studies, it is important to acknowledge that nurses expect a certain level of physical danger to be part of their work. While no one enjoys this aspect of the work, it is seen as inevitable and therefore as needing to be managed. When incidents occur that are perpetrated by patients explained by the nurses as being unable to help themselves they fall into this category. Nurses in this study experienced violence from patients with dementia, mental health and substance abuse issues. They described themselves as expecting to encounter this and as being more or less prepared to deal with it.

> I mean its kind of like what I was telling you earlier, that we kind of take it for granted
> that, you know, oh yeah, well it comes with the, you know, the nurse scope, you know,
> its sort of job description kind of thing.

Most of the nurses in this study expressed this opinion in some form or another. However, they were much less accepting when they felt the attacks to come from a source that should be under

self-control. A main finding of this study is the confirmation of the omnipresence of verbal abuse in the workplace. Nurses confirmed that they experience verbal abuse on a daily basis from patients, relatives and, sometimes, other visitors. As has been reported elsewhere, they find this to be the most troubling form of abuse. The nurses in this study were particularly upset with verbal abuse from relatives and visitors. The following quotes illustrate the paradox of working with this population and the upsetting effects on the nurses:

> The family always - we wanted them to be around but sometimes it doesn't always work because they are the one that makes it even worse

> Who, who might be, you know, instead of working cooperatively with the nurses then they might come in and try and have power over the nurses, they think, they think if they sort of put you down or tell you do this, do this, why isn't this done, why isn't this done so its not a good approach, right, its not working together, its more of a, yeah, an intimidation

> Yeah, I can't - I have a harder time dealing with "acts of violence" either verbal abuse or threatened when I don't know who's talking to me - I don't care that you're related, I don't know anything about you, I don't have a chart to look back to see anything about your, what you're saying is valid…

There was a certain tone of tired, aggrieved yet helpless confusion in the nurses accounts in that, while theoretically, they valued the notion of working in partnership with the patient's family and friends, pragmatically, they often found such involvement made matters harder to deal with. This is the type of paradox that nurses find the most difficult in that they clearly they value being caring people but know that, if they build some form of protective emotional wall, they won't get hurt as much.

Coping: There are various coping mechanism that nurses employ in order to cope – some they employed during the work day and others in their private lives. There were few surprises in the workplace so in the interests of saving space I intend to list them. Overall, the major coping skill

that nurses used at work once they experienced either verbal or physical abuse can be characterized as consciously being more careful and mindful of their safety, both emotional and physical. This overall goal was achieved through a variety of strategies that included such things as; consciously working towards becoming more assertive, being more careful about physical positioning in relation to a patient, consciously cultivation of inner strength, being firm, and, one which several nurses reported as their primary response, avoiding the individual concerned as much as possible. This is a disturbing finding in many ways and illustrates the importance of this topic in relation to implications for basic patient care. If the nurses are avoiding the patient or the patient's family, by definition, they are unlikely to be providing optimum care. This finding, by itself, illustrates the importance of considering the topic of workplace violence when discussing the provision of care to patients.

Nurses were very clear that the repercussions of violence and abuse affected them in their private lives in a number of ways. They were more vigilant, often more fearful, and more irritable and easily frustrated by normal day-to-day life.

> - that I think I'm bringing
> R: You're bringing your work home with you?
> P: I'm bringing my frustrations because I can't voice it out but I feel my anger sometimes and, you know.
> R: So when you get home you take your frustration out on your family?
> P: Yeah, sometimes, yeah.
> R: And how do they react to that?
> P: They're used to it now though but I think its not fair for them, you know, they're used to it but now I'm like trying to control myself now, - so when I'm tired –

With regard to coping mechanisms to handle this issue, nurses reported using many of the same strategies they used at work for example consciously taking control and trying to change. However sometimes, when things became really tough, extreme measures were necessary. The following quote is representative of those who had had extreme experiences and of the responses to those experiences;

> I did take medication for awhile and I did go to my GP, that's right I remember it now and I said I can't do this anymore … medication against, you know, I didn't want to do it but thought well I need something because I was really anxious and uptight and he, you know, gave me some time off work like a medical leave from work and so I did that and then was transferred to a different setting, still within the same company but just a different setting

Overall, the nurses clearly did recognize that the violence and abuse they experienced at work had an effect on their functioning in their private lives. The converse side of this notion concerned the nurses' accounts of how their private lives affected who they were as nurses. In the next section I examine this aspect of the data.

Personal history: Many of the nurses had personal experiences of violence in their private lives, either before they began nursing or ongoing during the time they were interviewed, that they recognized as influencing their work in nursing.

> The man I was married to for twenty-six years had an extremely long rope but when he snapped he really snapped, you know, and our separation was fairly abusive, verbally abusive and deprecating to me, you know, of course that reflected, I learned through that, I learned through that and I remember, I remember a counselor saying to me it might help you to separate because I was separating
> R: Yes, yes.
> P: And that was very good learning for future, for work place issues too.

All in all there was a reciprocal relationship between nurses' experiences of violence and abuse in both their work and private lives that worked both ways.

No matter whether nurses had or had not experienced violence and abuse as private people, when they encountered in the work context, they needed to feel supported by management and most of these nurses did not. Two of the most consistent complaints regarding lack of administrative support were lack of timely and efficient critical incident stress debriefing (CISD) and lack of regular education and practice on de-escalation techniques.

Support, Lack of support: Nurses were very clear that they need timely, effective and professional CISD, available automatically rather than when requested or after a specific incident, and they were equally clear that they were not getting it.

> But having critical stress debriefing in the ER should be routine even though we're not always involved in a critical stress, we should offer it all the time not just offer it we should have it so that every six months or every three or four months, you know, everybody sort of checks in, you know what I mean, have the chance to sort of get whatever is their mind off in a situation where they can actually debrief and get rid of their stress, I don't think it should be something that just we wait until we have a horrendous situation but it should be ongoing all the time sort of to keep them in a healthy sort of frame of mind,

> Almost mandatory, almost mandatory you know, and people may not have anything to say but it should be offered frequently, you know, or they should be having people check in, you know, every three or four months.

As a matter of clarity I want to make plain that nurses' perceptions are that there used to be extremely effective CISD but their perception is that, for a number of reasons, most usually related to budgetary cutbacks, this service had been curtailed. In one case staff felt that the service fell by the wayside because it had only survived as long as one dedicated individual championed it.

> we still had this critical incident stress management team and the social worker [name] who was the champion of that when she retired about 2003, when she retired the program just fell apart, it just wasn't there and so, you know…

Some would say that the overall need being expressed here is a desire for ongoing counseling but it is equally clear that this need is what nurses think of as CISD.

The other area in which nurses felt they were ill prepared was when trying to anticipate, prevent and initiate de-escalation techniques for handling violence and abuse

and, lastly, how to keep themselves safe when an incident became inevitable. I discuss

these areas further in the following section.

Nurses' unmet needs: Several protocols were in place to assist nurses; however, nurse

did not always know that policies existed or how to access them. Recommendations

from the nurses for future education/procedures included: CISD, de-escalation

techniques; the management of aggressive clients with weapons (given by police); and

consistent education on managing violence. I discussed the need for CISD in the

previous section. With regard to overall violence management the nurses felt the need

for preparation in;

> ..dealing with violence in the workplace, definitely how to deal with a violent
> visitor, patient, farther. Some de-escalating terminology, you know, dialogue,
> tactics that may work. Sometimes they're just not going to work but sometimes
> they do work, or ongoing dialogue or education

> …basically I guess on how you can diffuse situations, just de-escalating I guess
> potentially violent situations.

> … have on how to handle the gang members, how to deal with potentially violent
> people like that, you know, if you suspect that they're carrying a weapon because
> they do carry weapons

However, one very important insight offered by these nurses was that several of them recognized

that health care personnel themselves often contributed to the escalation of incidents and that

they felt the need for preparation in how to avoid this;

> I think a lot of times the family members don't know what's going on and the
> family members come here and they're sick and the family members are
> worried and I think I just feel like I think sometimes we don't tell them, the
> family enough, you know and I feel like sometimes we should talk to them a
> little bit more in terms of conferring otherwise the family feels, you know …

I look at the time we spend in front of that computer and the managers, its management by computer now, you know, at times I think sometimes that time would be better spent [with the patient]

It is important to note that general feeling of lack of support from management, in the form of lack of procedures to help nurses prevent, cope with, and handle the effects of workplace violence in all its forms is probably the most robust finding from this report.

As illustrated by the verbatim quotes in all the sections above, these themes that came up again and again in a variety of guises and were: lack of critical incident stress debriefing, the ineffectiveness of personnel charged with providing counseling after an incident, and the perception that there was no follow up and no support after an incident. Nurses felt unprepared to anticipate violence, unprepared to handle it and unsupported by administration when it did occur. Some of them also recognized that the health care context itself, in the form of rushed, apparently uncaring, authoritarian approaches to patients and families in stressful situations, often contributed to the likelihood of such violence developing in the first place. This insight became a focus of the intervention.

Intervention: Development and use of a DVD on workplace violence

The data collected in the interviews showed that nurses felt they lacked sufficient preparation in the area of skills around anticipating aggression and violence, de-escalating people who become agitated and violent, and keeping themselves safe when a violent incident occurs. The sections of the DVD are; an extended introduction discussing the research study, the focus of the DVD and how to use it, four scenarios demonstrating situations that the nurses described as being typical ones in which violence occurs and an interview with two educators responsible for teaching this content to the nurses in the Providence Health Care system and the VGH/UBC system. The interview is quite comprehensive and introduces principles guiding

workplace violence education, a discussion of how such programs have evolved over time and why and how such education should be offered.

The four scenarios comprise a major part of the content. Each one is self-contained and addresses a different root cause of situations with the potential to escalate to violence however, the narration points out similarities between them. The four scenarios are; an emergency room in which a man in pain is kept waiting and becomes angry, a hospital ward in which an elderly lady is in pain and is frightened and the nurse wants to move her, a hospital ward where a young agitated head injured man is being required turn down the volume of his music and a new baby home visit where the husband seems aggressive and abusive to his wife and verbally aggressive to the nurse. In each of the scenarios techniques for de-escalating the situation are demonstrated as are ways in which poor practice might escalate the situation. It is important to emphasize, as we do in the DVD, that each situation could be handled a number of different ways so there is no one right answer. Rather, there are certain underlying principles that should govern any response. Each of the scenarios draws upon the principles introduced at the beginning of the DVD and discussed in the interview.

The DVD will be housed within the school of nursing and will be made available to anyone who wants it. VHG/UBC educators have already expressed interest in using it in their education program and would like to launch it. It will be distributed throughout the hospitals and health units in which data was collected. It will also be made available to WorksafeBC to use as needed.

Discussion

Many of the findings of this research confirm both previous findings and those arising from the literature today. Following the data collection period of this study, and during the development of the DVD, I attended the First International Conference on Workplace Violence in the Health Sector held in Amsterdam in 2008. At that conference I presented the preliminary

findings from the study and attended many presentations from others working in the field. Among the most interesting observations was that administrators, policy-makers and researchers from around the world were reporting on such similar findings. For example, early work postulating that factors such as childhood abuse and level of education "…are unique risk predictors of physical and sexual abuse by patients." (Little, 1999, p. 22) were confirmed by Campbell, Messing, Kub, Fitzgerald, Agnew, Sheridan, Boyland, 2008 and VandeWeerd, Coulter, Estefan & de la Cruz, 2008, as was the importance of understanding the impact of domestic violence on the likelihood of assaults in the workplace (Woodman, Reimer & Ballerman, 2008).

Another important finding that came up again and again was that workplace policy makers around the world are abandoning a reliance on zero tolerance of violence policies and are instead focusing on prevention in the form of the development of best practices in the areas of anticipating violent incidents, de-escalation techniques and improved training in how to manage incidents when they do occur. (Carroll, 2008; Di Martino, 2008) McKenna, 2008; Waddington, 2008). Interestingly, these and other presenters stressed that, while violence is never an acceptable solution, frequently patients and relatives had good reason to be angry – a point reinforced by findings from nurses in this study. In the present climate of increased acuity, nurse shortages and a general feeling that health care systems everywhere are stretched to the limit, people are frequently anxious and that can easily translate into becoming angry. Zero tolerance policies tended to reinforce staff becoming more militant and defining and eventually defining any negative communication as 'violent' (Waddington, 2008). Instead researchers are coming to a consensus that better use of empathetic communication, active listening and improved assessment techniques regarding people's emotional responses to the situations in which they find themselves, might held defuse a lot of incidents before they occur (Carroll; Di Martino; McKenna). Thus this is the area on which the DVD is largely focused.

Implications for future research on occupational health

Overall, there are a number of clear implications from these findings. In the following sections I outline the main implications for future research on this topic, implications for policy and prevention as well as discuss my plans for dissemination this research.

There are four main areas in which I would make recommendations for further research. These are; the foregrounding of the voices of patients, families and nurses in discussions about what precipitates violent incidents; the development and communication of clearer procedures for reporting violence and for supporting nurses once they have experienced a violent incident; exploring the effects of personal history on nurses experiences and interpretations of violence encountered at work and, lastly, evaluation of the effectiveness of the DVD developed in the present study. Next I briefly discuss these areas.

The etiology of violent incidents in health care settings; Research needs to be ongoing in which the voices of those concerned, namely patients, families and nurses, are fore grounded in discussions about factors contributing to the development of violence. Qualitative studies that provide in-depth descriptions of health care conditions and their contribution to the evolution of these situations need to be ongoing as the situation in which healthcare is provided continue to evolve.

Reporting procedures; It became very apparent during the early stages of this study that numerous procedures were already in place to address nurses' experiences of workplace violence. As the study got underway, it became equally apparent that nurses were either unaware of these procedures or were unable or unwilling to use them. Further research needs to be conducted on a) what constitutes a user-friendly policy B) evaluation of the effectiveness of

policies once adopted and c) on how best to encourage nurses to use these policies once implemented.

Nurses' personal histories: A nurse is not just a nurse; he or she is also the individual who is a product of their history to this point. Nurses bring this history to their lives as professionals. Research needs to be conducted exploring the implications of both personal history on the ability to be an effective professional and on how professional experiences have an impact on nurses' personal lives. Research is also needed on how best to prepare nurses to be aware of their own personal triggers, resiliencies and areas of vulnerability in so far as these aspects of their personalities affect their abilities to act as professionals.

Effectiveness of the DVD intervention; In the interviews for this study nurses expressed, over and over again, that they felt unprepared to anticipate, prevent or address workplace violence. A new program was being introduced on just this topic, throughout the research health care district, at just the same time as the data collection phase of this study came to an end. The development and introduction of another program, even though this is what was specified in the original proposal, was therefore clearly inappropriate. As a result a new approach was needed so the product of this study has been the development of a DVD. The DVD will be discussed in more detail in the final section of this report but, in the meantime, there is a clear research implication involved in the development of any such interventions. An evaluation of the effectiveness of the DVD needs to be conducted.

In summary, research needs to be continued in which the voices of patients, families and nurses is sought at the same time as policy and implementation research is conducted on the various strategies to address violence. In the next section I briefly provide policy and prevention implications of this research.

Policy and prevention

In this section I outline policy and prevention implications using the headings requested by WorksafeBC. In the interests of effective space utilization, I present them in point form.

Identification of policy and prevention implications directly arising;

- Clear guidelines must be developed and disseminated regarding reporting procedures.

- Nurses need to be aware of follow up mechanisms once violence is reported.

- Nurses need education on the effects of their own personal experiences on their interpretation of, and response to, violence in the context of work.

- Patients and families need user-friendly avenues through which to communicate dissatisfaction with care and these need to be proactively made clear to them.

Identification of relevant used groups for the research results;

- Educators in health care settings, both hospital and community-based.

- Educators of all health care personnel, particularly nurses.

- Consumer advocacy groups.

- Government and policy-making groups.

Description of any policy-related interactions undertaken by the researcher;

- I met with administrators in the research settings to alert them to the fact that a) a number of nurses either were not aware of or didn't use present reporting procedures and that b) nurses felt that incidents they reported were not being followed up on.

- I, with them, discussed the feasibility of a procedure whereby nurses could track the status of their report.

- They undertook to implement this procedure. I have not followed up on this.

Dissemination/Knowledge Transfer.

No research project is complete until the results have been disseminated. I undertook (and am still in the process of so doing) several activities in this area. I also have continuing plans to continue towards this goal.

First, I presented the findings of the data collection to administrators in both the community and hospital-based study settings. Second, I presented the findings to staff on all the units that participated in the study. I asked for feedback on the findings from both groups. I presented the findings to the educators responsible for violence prevention education in both the Providence Health Care and VGH/UBC health systems and they agreed to be interviewed as part of an educational DVD on nurses and workplace violence.

I presented the study at the First International Conference on Workplace Violence In the Health Sector held in Amsterdam in October 2008. This was an important conference in which it was possible to exchange views and compare directions with a wide variety of international experts on the topic.

I have outlined papers on several different findings from the study. Some arise from the feedback to the paper I presented in Amsterdam and had confirmed by other papers presented, others from the nurses' accounts of their experiences. Of the papers arising from the Amsterdam presentation one concerns the international perception that a zero tolerance for violence policy is not successful and is often actively counter-productive. Another relates to the, again general international, finding that patients and families have few avenues available to them for legitimate complaint and that therefore, the system predisposed to inappropriate expression of frustration. A

third paper will relate to issues arising from the teaching of personal safety techniques. With

regard to the nurses accounts, I think it is important to write a paper about the interaction of the

personal and the professional self when it comes to experiences of workplace violence in all its

forms. I also think a paper on the discrepancy between the level of care nurses say they would

like to provide versus the level they see themselves as being able to provide in the current health

care climate.

The last major product of this research is the educational DVD that is complete. The

school of nursing will disseminate it widely and will take over its distribution. It is intended to be

a practical education tool that will help prepare nurses to anticipate, prevent and or manage

violence effectively and to understand the conditions under which it may occur. It represents the

product of the research that was developed as a specific response to the voices of the nurses.

Evaluation of the DVD needs to be conducted in a future study.

In summary the study will be disseminated and knowledge transfer will occur at the

administrative level, the workplace/care-giving level, in educational settings and, through

WorkplaceBC, in policy-making organizations.

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