An exploration of workplace violence in the Emergency Department: Are emergency nurses safe?

by

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A thesis submitted to the Victoria University of Wellington

in partial fulfilment of the

requirements for the degree of

Master of Arts (Applied)

in Nursing

Victoria University of Wellington

2006

Abstract

This thesis arises from the experience of several years of working in the Emergency Department and being exposed to workplace violence from patients and their families. Emergency nurses in New Zealand experience workplace violence every day. Registered nurses and the institutions in which they work manage workplace violence to varying degrees and in an ad hoc manner. New Zealand has no national consistency, no national guidelines, or consensus on the management of workplace violence in the health sector.

This research explores emergency nurses' encounters during their work when they have experienced workplace violence. The purpose of this study is to demonstrate the experience and the consequences when nurses are confronted with episodes of violence while working in the Emergency Department. The essence of this research is gaining an understanding of how registered nurses have managed workplace violence and the impact of that violence on themselves, their colleagues, and the patients in the Emergency Department.

Recommendations are made regarding nationally consistent guidelines, education on the management of workplace violence, improved security, and Emergency Department design. The discussion will conclude with suggestions for further research on workplace violence in the health sector.

Acknowledgements

Table of Contents

Chapter One

Introduction

A group of New Zealand emergency nurses participated in this study to surface and uncover their views about being confronted with workplace violence in the Emergency Department. While the focus of this study will question the way in which workplace violence in Emergency Department is currently managed, it is anticipated that the emergency nurses in the study will be empowered to challenge not only themselves and their responses with violent patients, but also some of the organisational constraints that influence their behaviour when dealing with violent events.

New Zealand emergency nurses appear to have had little opportunity to explore the impact of workplace violence. There does not appear to be any published research regarding workplace violence in the Emergency Department in a New Zealand context. This research will add to the knowledge about workplace violence in the New Zealand health sector.

It is difficult to explain to others outside of the health sector the complexity and impact of workplace violence. Many health professionals such as registered nurses suffer abuse just because they work in the Emergency Department, (Kuhn, 1999; Lyneham, 2000). International research on workplace violence in the Emergency Department details the impact of workplace violence on emergency nurses. These studies indicate that in many instances employees do not report workplace violence and when it is reported only minimal figures of events are collected. There is consistent under-reporting of violent attacks on registered nurses and the extent of the issue or phenomenon is largely unknown (Crilly, Chaboyer & Creedy 2004; Dimond, 2002; Kuhn, 1999; Lyneham, 2000; Whittington, 2002).

Chapter one will explore the context and environment of the Emergency Department. Registered nurses in New Zealand and the work of the Emergency nurse will be discussed. This chapter will also describe my experience of managing workplace violence in the Emergency Department. This chapter will set the scene for the research question to be explored and give the reader more of an

understanding of the complexity and the uniqueness of the emergency department particularly when confronted with a violent event.

Background to the Research

I am a registered nurse in New Zealand. My nursing experience spans eighteen years, across many different specialty areas. During this nursing experience, I have been exposed to episodes of workplace violence. When I began working in the Emergency Department violence became a significant issue for me. This was due to my increased exposure to workplace violence, and watching my colleagues experience similar episodes. Because of this experience and my role as a senior nurse, I was committed to safeguarding nurses in the Emergency Department. I am now a Professional Nursing Advisor for the New Zealand Nurses Organisation and I continue to have a commitment in advocating for the safety of registered nurses.

Experience and Observations

My experience of violence towards staff in the Emergency Department was from observing nurses being subjected to verbal and physical abuse from patients, their families, and members of the public. Emergency nurses experienced this violence and appeared to accept it as part of the job and part of their environment. As a new emergency nurse, I found this level of violence intimidating and disturbing. I had no education in defusing or de-escalating aggressive patients or family members. I had no education on personal safety techniques.

Upon progression to a Clinical Nurse Co-ordinator[1] role as a requirement of the job I was expected to assume a leadership role in the management of workplace violence. During this progression, again I was exposed to violent experiences and witnessed many forms of violence towards my colleagues and members of the public, patients, and families. The skills and strategies I needed to cope with and manage the workplace violence I experienced were absent in the

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[1] A Clinical Nurse Co-ordinator is a designated senior nursing position within a DHB setting. This role incorporates management and leadership. Clinical Nurse Co-ordinators have clinical management of the department, allocation of resources, appraisals of staff and leading a portfolio such as rosters or disaster management (National Professional Development & Recognition Programmes Working Party, July 2004).

professional development options I had the opportunity to participate in. I acknowledged this problem in an annual appraisal with my manager and was offered the opportunity to attend a one-day workshop facilitated by the mental health service on challenging incidents. This was my first understanding of education programmes specifically identified for managing aggressive incidents or behaviour. This one day course was initially useful as an introduction on managing violence, however there was a great need to have an ongoing education programme specifically designed, available and accessible to the Emergency Department.

On investigation of other educational opportunities, I discovered a programme designed in the USA by the Crisis Prevention Institute [2]. This programme is internationally researched and recognised (Fernandes et al., 2002; Saines, 1999). A licensed Crisis Prevention Institute instructor provides the 'Non-Violent Crisis Intervention' programme. After attending this programme, I became a licensed instructor who assisted with the workplace violence education of registered nurses and others in the Emergency Department. I had a theoretical framework to develop the skills of other emergency nurses and to provide them with the expertise and confidence to de-escalate aggressive or violent events.

The health care environment in New Zealand

To understand workplace violence in the Emergency Department it is important to comprehend the health sector in New Zealand, the people in it and the employers and the employment environment of registered nurses. The New Zealand Health system is determined by an elected government of New Zealand and monitored by the Ministry of Health (MoH). The responsibility of the MoH is to co-ordinate the health and disability system for New Zealand and to implement and enforce relevant legislation and regulations to facilitate co-ordination of these services within and across the health sectors (Ministry of Health, 2005a). Health administration and delivery is divided into 21 regional District Health Boards (DHB). The MoH has a contractual arrangement with

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[2] The Crisis Prevention Institute has educated over 5 million professionals worldwide since 1980 in the management of disruptive and assaultive behaviour via a course designed under four guiding principles of care, welfare, safety and security. A basic course can be delivered by certified instructors in one day. All attendees should do a refresher course on a yearly basis. The instructor course is delivered to educate instructors over four days (Crisis Prevention Institute, 2002).

these DHB's and all designated Emergency Departments in New Zealand are publicly funded, resourced by the DHB and governed under a DHB. Funds are allocated for public hospital and primary care services. The Emergency Department resources are constrained within the overall budget of that particular DHB (Ministry of Health, 2005a). The DHB's are the employers of emergency nurses and will be referred to in this thesis as such.

The people and function of the Emergency Department

In New Zealand Emergency Departments are open to public access 24 hours a day and are staffed by the multi-disciplinary team of health practitioners. Registered nurses and other health professionals who are employed in the Emergency Department, deliver and provide health care to the community. The team includes nurses, doctors, health care assistants, receptionists, and then there are the patients, families and friends and other health professionals, which may visit or contribute to the work of the Emergency Department. This team comprises of 'front line' nursing staff, which have significant patient and public contact while undertaking their duties during the working day.

Who is an emergency nurse?

The College of Emergency Nurses New Zealand - NZNO (CENNZ) [3] describes emergency nurses as:

> Registered nurses who demonstrate the application of speciality knowledge and expertise in the provision, delivery and evaluation of emergency nursing. Decision-making is based upon assessing and prioritising urgency of care in unpredictable, wide ranging and emotional situations. These nurses advise, advocate, implement procedures and care for a diversity of cultures encompassing individuals, families whanau and others across the life span in a safe and trusting environment. (CENNZ, 2005b, p. 38)

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[3]The College of Emergency Nurses New Zealand – NZNO, is a representative body that advocates for emergency nurses throughout New Zealand. They are nationally represented by an elected process and are engaged in national networks. They have collaborative relationships with other emergency clinician groups within New Zealand and Australia (College of Emergency Nurses New Zealand, 2005a).

For registered nurses to fulfil the requirements of this definition by CENNZ, the environment has a major impact on the ability to deliver timely and safe patient care. A 'safe and trusting environment' is essential to fulfil the potential an emergency nurse has to contribute to patient care. Registered nurses who undertake the role of triage[4] work from isolation of other nurses in the Emergency Department environment. They are situated at the front door of the Emergency Department, in view of the people in the waiting room.

Central to emergency nurses' practice are concepts of decision-making, autonomy and rapid assessment of situations and individuals. Excellent communication and time management skills are essential. The co-ordination of resources is also essential to this process. Emergency nurses work collaboratively with other health professionals in the Emergency Department. This collectivism is vital to the smooth running of the Emergency Department; this can often be the only variable in the day that can be controlled. Autonomy of the registered health practitioners in the Emergency Department is most evident in the roles of triage and shift co-ordinator. In these roles, there is the need to prioritise care of the patients in all areas of the Emergency Department and manage the constant demands and hospital issues, such as lack of inpatient beds, which impact upon the flow of patients through the Emergency Department.

Ideally, registered nurses in the Emergency Department are qualified and experienced in emergency nursing. They have had education in triage nursing, prioritising patient care and advanced health assessment. These nurses work various hours of the day dependent upon a rotating 24 hour roster. Effective leadership skills in the Emergency Department are imperative. Leadership skills are required to facilitate patient flow through the Emergency Department and to decrease the factors that lead to violence, such as waiting times and lack of resources to meet the current demand. Identification of areas, which precipitate or cause violence in the Emergency Department, is important.

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[4] Triage means to 'sort or choose' and dates back to the French military who used it as a process to identify the injured who were most likely to return to battle after medical intervention. Today, triage is a way of ensuring those patients assessed as having the most urgent need for care are treated more quickly than those patients with a less urgent need. (Australasian College of Emergency Medicine, 2005a)

Emergency Department work

The work in the Emergency Department is varied, complex and has an energy of expediency. Time is always a factor in the Emergency Department. The Emergency Department receives, stabilises, and processes patients with a variety of urgent and non-urgent problems (Ministry of Health, 2005b). The Emergency Department is unique from all other environments in the hospital. It has an unpredictable workload. There are no appointments or booking systems. Sometimes the unpredictability of the environment is what makes Emergency Departments both interesting and frustrating at the same time.

Patients are 'triaged' or categorised into levels in which they can safely wait for medical attention as determined by the Australasian College of Emergency Medicine (ACEM)[5]. These are called triage categories as outlined in Table 1 on page 7. The Australasian Triage Scale (ATS) is a system to determine the clinical urgency of those needing medical attention first, down to the people who need attention the least (Australasian College of Emergency Medicine, 2005a). Registered nurses who have had education package with mentoring, have undertaken an exam that is based on the Australasian Triage Scale should carry out the triage role in New Zealand (CENNZ - [NZNO], 2005c). This course is nationally recognised and delivered in a consistent manner. Since the introduction of the ATS, Emergency Departments have operated with a model of care that supports the use of the ATS as dictated by the MoH service specifications for Emergency Departments in New Zealand. An experienced emergency nurse must assess all patients presenting to the Emergency Department at their point of arrival (Ministry of Health, 2005b).

A quality manual on the management of violent patients that present to the Emergency Department is part of the quality standards under the Service Specifications for Emergency Departments. There is no instruction upon education or reporting of violent events to the MoH and this is the only instruction by the MoH about violence in the Emergency Department setting in New Zealand (Ministry of Health, 2005b).

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[5] The Australasian College of Emergency Medicine is an incorporated educational institution whose prime objective is the training and examination of specialist emergency physicians for Australia and New Zealand (Australasian College of Emergency Medicine, 2005b).

Table 1: Triage Guidelines - Australian Triage Scale (ATS). *Note.* From "ACEM triage guidelines", 2005 adapted with permission from ACEM.

ATS 1	ATS 2	ATS 3	ATS 4	ATS 5
Immediately seen upon arrival (no waiting)	Assessment and treatment within 10 minutes of arrival	Assessment and treatment within 30 minutes	Assessment and treatment within 60 minutes	Assessment and treatment within 120 minutes
Conditions that are an immediate threat to life.	Time critical intervention needed or threat to life if treatment is not commenced within 10 minutes	Potentially life threatening or situational urgency	Potentially serious or situational urgency	Less urgent or review of previous results.

The triage system is not designed to be used to place a barrier or block patient's access to health care, the triage nurse, and the triage process are key to determining the patient journey in the Emergency Department. Research indicates that patients and their families at times lack the understanding and knowledge of how an Emergency Department works (Cross, Goodacre, O'Cathan & Arnold, 2005; Nystrom, Nyden & Petersson, 2003). They are unsure of what to expect and the reasons and processes that contribute to the journey through the Emergency Department. This triage system is not easily understood by the public and often requires extensive communication from the triage nurse to explain this system to the patients. Research also indicates that waiting in the Emergency Department is a major source of frustration for patients and their families (Bjorvell, 1991; Nairn, Whotton, Marshall, Roberts & Swain, 2004).

Patients are often cared for in cramped environments with a lot of noise and competition for a health professional's attention (Nairn et al., 2004; Nystrom, Dahlberg & Carlsson, 2003). Factors beyond the control of the Emergency Department can influence and affect the dynamics of the Emergency Department environment whether it is physically, structurally or emotionally. Research has

shown that these factors include limited access to inpatient hospital beds, increased community illnesses and changes to outside healthcare services such as closing private after-hours facilities that would have provided an alterative option for some patients that may present to the Emergency Department (Richardson, 2004).

Key Relationships for the Emergency Department

For Emergency Departments to function successfully, they need the staff to establish strong links within the hospital environment and externally with primary care providers and private health operators such as ambulance services and residential care facilities. Internally they need an understanding and appreciation of other environments. Communication between other hospital services and the Emergency Department is essential. Research has shown that hospital bed management significantly influences the Emergency Department workload (Adargh & Richardson, 2004).

The Emergency Department must have a working relationship with the hospital security department. It is important to have an understanding of the level of help available to assist the Emergency Department in times of crisis. The process to summon help and the appropriateness of the assistance a security guard can often differ within organisations. Ensuring the security of the Emergency Department is a high priority within healthcare organisations, as it is one of the only places within the hospital where members of the public have open access to it 24 hours a day. In some violent situations, it is more appropriate to call the police as well as the hospital security. Secure systems within the Emergency Department, which are practised, are required to ensure patient and staff safety. Trust in security protocols is critical when the first step an employee can take is the de-escalation of the aggressive behaviour. However if the incident does move on to more violent behaviour, the assumption that each employee will then carry out their assigned task is essential. Research demonstrates that systematic processes are to be followed when dealing with a potentially violent event (Crilly, Chaboyer & Creedy, 2004). A key external relationship for the Emergency Department is the local police force. Knowing the processes within the hospital to summon assistance from the police is essential. During my career in the Emergency

Department, I had called upon the police multiple times to assist during periods of violent behaviour from members of the public and patients and their families.

In my experience, the staff working in the role of triage and shift co-ordination of the Emergency Department experience the most exposure to violence. Many factors contribute to the escalation of incidents in the Emergency Department. Research indicates that waiting times for treatment, and previous experiences of the Emergency Department processes are significant contributors to workplace violence (Bjorvell, 1991; Nairn et al., 2004). Of equal importance are patients and visitors being unsure of the triage process and high patient expectations (Cross et al., 2005; Nystrom, Nyden & Petersson, 2003). Patients and their families who are stressed by being in the Emergency Department can also contribute to an incidence of violence (Jenkins, Rocke, McNicholl & Hughes, 1998). Over consumption of alcohol and drugs by patients and the public were also found to be contributing factors (Kuhn, 1999). Of more significance, was the staff member's tolerance of violent events and those that had reported the incident perceived that no change in their safety was evident from hospital management or legal action taken against the perpetrator (Jenkins, Rocke, McNicholl & Hughes, 1998; Mayer, Smith & King, 1999).

A major contributor to the ongoing nursing workforce shortage that impacts upon patient care is workplace violence (Robinson, Jagim & Ray, 2004). Overcrowding[6] and increasing patient length of stay in the Emergency Department and the inability to find inpatient hospital beds were also significant indicators for violence (Australasian College of Emergency Medicine, 2005c; Ardagh & Richardson, 2004; Jones & Lyneham, 2000; Stirling, Higgins & Cooke, 2001).

The Research

The purpose of this research is to demonstrate the experience and the consequences for registered nurses in the Emergency Department when confronted with episodes of violence. In many of the international studies, researchers have surveyed staff and expressed the number of episodes of violence perpetrated against nurses (Fernandes et al., 1999; Lyneham, 2000; Peek-Asa,

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[6] Emergency Department overcrowding refers to an extreme excess of patients in the treatment areas exceeding Emergency Department capacity and frequently necessitating medical care to be provided in corridors (Australasian College of Emergency Medicine, 2005c).

Cubbin & Hubbell, 2002). Very few qualitative studies outline the experience of nurses who have experienced violence in the Emergency Department (Hislop & Melby, 2003; Levin, Hewitt & Misner, 1998). The essence of this research is to gain an understanding of how emergency nurses have managed workplace violence and to consider the impact of violence has had on themselves, their colleagues, and patients in the Emergency Department environment.

It is acknowledged in the literature that other registered health professionals experience workplace violence, for example registered nurses employed in mental health settings, and registered nurses who experience abuse from other colleagues in the workplace (Lee & Saeed, 2001; Nolan, Dallender, Soares, Tomsen & Arnetz, 1999; Trenoweth, 2003; Whittington & Wykes, 1994). For the purposes of this research registered nurses employed in the Emergency Department setting and who have experienced violence from patients or their relatives are the sole focus. The research in this thesis uncovers these issues for emergency nurses, and explores solutions to manage workplace violence in the Emergency Department.

This thesis is presented in six chapters. Chapter one has explored the context and environment of the Emergency Department. Registered nurses in New Zealand and the work of the emergency nurse were discussed. Chapter one has also described my experience of managing workplace violence in the Emergency Department. This chapter set the scene for the research question to be explored and gave the reader an understanding of the complexity and the uniqueness of the Emergency Department.

Chapter two will outline the international literature and the limited data on workplace violence in the New Zealand health sector. Legislation and regulation of health professionals will be described and the links to workplace violence will be explored. Education and professional representation with regard to workplace violence will also be considered. The chapter will also explore the various definition of workplace violence and determine the definition that will be used for the purposes of this research.

Chapter three will outline the methodology and approach for this research. A critical theory methodology is used to explore and uncover the issues for registered nurses that are confronted with workplace violence in the Emergency Department. Critical inquiry is valuable when researching issues of oppression, power and emancipation. The use of semi-structured interviews was the method of data collection chosen for this research. The design of the research along with ethical considerations and the process for obtaining ethical approval will be discussed.

Chapter four will examine the data collected in the interview process and describe the themes from the analysis. A thematic analysis of the transcripts exposed recurrent ideas and patterns. The participants provided a insight into the reality of how emergency nurses confront workplace violence.

Chapter five will discuss the findings of the research in depth and compare these findings with themes in the current literature. These discussions will be undertaken using a critical perspective. The management of violent events in the Emergency Department is not consistent and there are no national guidelines to assist clinicians to eliminate or minimise workplace violence in the Emergency Department.

Chapter six will outline recommendations for the management of workplace violence in the Emergency Department and explore future areas of research on workplace violence management in the health sector in New Zealand.

Chapter Two

Introduction

This chapter will outline the international literature and the limited information on workplace violence in the New Zealand health sector. Legislation and regulation of health professionals will be described and the links to workplace violence will be explored. Education and professional representation with regard to workplace violence will also be considered. The chapter will also explore the various definitions of workplace violence and determine the definition to be used for the purposes of this research.

The international literature on workplace violence in Emergency Departments

Published research indicates that there is workplace violence in the Emergency Department (Jones & Lyneham, 2000; Fernandes, et al., 1999) and many authors have recognised that there are precipitating factors that lead to the public and patients assaulting nursing staff. Studies indicate alcohol, drugs, increasing waiting times and a lack of space for patients in the Emergency Department are significant (Australasian College of Emergency Medicine, 2005c; Brown, 2001; Lyneham, 2000; Lyneham, 2001). Crilly, Chaboyer and Creddy, (2004) found that triage three and four patients are more likely to assault staff because of waiting times and the waiting times were above the recommended waiting times for treatment by Australasian College of Emergency Medicine (ACEM) for triage three and four category patients. The researchers found that the average waiting time experienced by patients that were violent towards staff was 66.2 minutes. This is a significant finding as the recommended patient waiting times for treatment for category three and four patients is between 30 and 60 minutes. Many patients in New Zealand Emergency Departments wait longer (Ministry of Health, 2005c; Ministry of Health, 2005d). The majority of violence towards staff was in the hours between 1500-2300 (Crilly, Chaboyer & Creddy, 2004, p. 70).

Jones and Lyneham (2000) considered the demands of the triage role and how triage nurses are often verbally abused face-to-face, in view of a crowded waiting room. Communication is an essential skill for emergency nurses in the triage role, who at times are managing patient needs within the confines of the current Emergency Department capacity. Managing conflict and potential areas of dispute are indispensable skills for nurses undertaking the triage role (College of Emergency Nurses New Zealand, 2005c).

There is a perception by some emergency nurses who experience workplace violence that it is 'just part of the job' when employed in the Emergency Department (Jones & Lyneham, 2000). This has implications for the retention of experienced emergency nurses and the nurturing of new practitioners in the field of emergency nursing. It is acknowledged in international literature that registered nurses are experiencing adverse events because of workplace violence (Atawneh, Zahid, Al-Sahlawi, Shahid & Al-Farrah, 2003; Anderson, 2002; Needham, Abderhalden, Halfens, Fischer & Dassen, 2005). Registered nurses who have been assaulted either verbally or physically are less likely to stay in employment and had impaired performance and took days off after the violent event (Fernandes et al., 1999; Mayer, Smith & King, 1999). The non-physical effects of violence are concealed in feelings of powerlessness, reluctance to go to work, embarrassment, anger, and frustration. These effects have an impact upon registered nurses' ability to interact with patients, produced fear of the perpetrator and precipitated a change in employment (Needham, Abderhalden, Halfens, Fischer & Dassen, 2005).

The reporting of workplace violence towards nurses in the Emergency Department is not consistent with the actual numbers of violent events experienced. Under-reporting of workplace violence is a significant finding in the literature (Duncan et al., 2001; Fernandes et al., 2002; Kuhn, 1999; Lyneham, 2000). Lyneham (2000) argued that 20% of workplace violence experienced in the Emergency Department is never reported in writing and 54% is rarely reported. This lack of consistency with reporting could have a significant impact upon the Emergency Department environment. When there are no supporting data to influence change in an organisation, it can be difficult to stop the cycle of violence against emergency nurses.

A personal account of the experience of workplace violence can be powerful in describing the feelings of the victim effected by workplace violence, and the impact it has upon their lives after the event. Understanding the occurrence of workplace violence and its effects is integral to the findings in the literature and the implementation of the research findings in the practice environment. Hislop and Melby (2003) researched the lived experience of workplace violence on 26 emergency nurses. Their research found three significant themes of 'why me', 'a sense of isolation', and 'a sense of belonging'. The emergency nurses in the study expressed feelings of frustration with organisational responsiveness to workplace violence in the Emergency Department. Informal support from some colleagues in the Emergency Department was the only debriefing of incidents that was useful, and that staff often felt alone in difficult or dangerous situations. Insights of nurses in regards to assault in Emergency Department were examined by Levin, Hewitt and Misner (1998). They interviewed twenty-two registered nurses in a large metropolitan area. Eleven of these nurses were physically assaulted at work and all had experienced verbal assaults and threats. The participants expressed anger towards perpetrators and withdrew from patients. Significantly, violent encounters experienced in the workplace also had effects upon the respondents' personal relationships and they did not tell family members of these events occurring.

Access to education to manage workplace violence is minimal for registered nurses, in both the undergraduate education arena and the availability of continuing education while in the Emergency Department environment (Mayer, Smith & King, 1999). An education programme for staff to manage workplace violence can be a significant tool to reduce the amount of workplace violence experienced (Fernandes, et al. 2002). Fernandes, et al., found that education programmes helped reduce the incidence of violence in the short term, with the need to do refresher education on a yearly basis and suggested that this education should be calendared into the entire staff education programme. The education programme was based upon the 'Non-violent Crisis Intervention' course (the same education programme for which I was an instructor in a New Zealand Emergency Department). Beech and Leather (2003) evaluated an education module for student nurses as part of their undergraduate programme. Questionnaires and surveys of the student nurses were conducted prior to the course and after clinical

placements. Findings concluded that education programmes were useful and are significant in the reduction of violence encountered in clinical practice. Violence occurs at a high frequency and staff were lacking in confidence when dealing with violent individuals (Lee, 2001). Deans (2004) demonstrated the effectiveness of training for emergency nurses in Australia. The research identified that training improves nurses' abilities to manage violent instances.

Education that focuses on managing and addressing workplace violence is not without debate in the international literature. Education alone is not the sole intervention to eliminate violence in the workplace. Many authors cite the need for organisational support, guidelines on the management of workplace violence, robust reporting structures, ongoing educational opportunities, and legislation to protect the safety of the registered health professional (Dimond 2002; Fernandes, et al., 1999; Kuhn, 1999; Lyneham, 2000).

California, USA, has had legislation addressing workplace violence since 1993: the California Hospital Security Act (AB508) (Peek-Asa, Cubbin & Hubbell, 2002). This act requires hospitals to train their employees on the management of workplace violence and to report all violent events. Peek-Asa, Cubbin and Hubbell researched violence in Californian Emergency Departments after the implementation of this act and resurveyed these departments ten years later to measure any changes. The researchers asked the same questions as in the original survey in 1992 by the California Emergency Nurses Association and sent the survey to existing Emergency Departments. The researchers compared their results with the survey undertaken prior to the introduction of the legislation. They found that violence continued to be a problem in the Emergency Department and that security measures still needed to be improved. However, the legislation had been useful in that it supports the employer to provide appropriate security systems and education to protect their staff.

There were common significant themes evident in the literature and under-reporting of violent incidents was common (Duncan et al., 2001; Lyneham, 2000; Mayer, Smith & King 1999). Educational programmes alone cannot reduce the incidence of workplace violence (Fernandes et al., 2002; Lee, 2001). Waiting times in the Emergency Department is a precipitating factor for violent incidents (Crilly, Chaboyer & Creddy, 2004; Lyneham, 2000). Exploration of the experiences of

emergency nurses who had experienced workplace violence, found that emergency nurses expressed frustration with organisational responsiveness to workplace violence in the Emergency Department (Hislop & Melby, 2003; Levin, Hewitt & Misner, 1998). Similar research has demonstrated that education improves nurses abilities to manage violent incidences (Beech & Leather, 2003; Deans, 2004, Fernandes et al., 2002). The implementation of specific legislation in regards to workplace violence can implement a change in practice and improve resources and organisational attitudes (Peek-Asa, Cubbin & Hubbell, 2002).

New Zealand literature on workplace violence

New Zealand research into workplace violence in health settings focusing on registered nurses is limited to two published research studies and one unpublished thesis. McKenna, Poole, Smith, Coverdale and Gale (2003) surveyed registered nurses in their first year of practice and, Wilkinson and Huntington (2004) interviewed district nurses. Burmeister (2003) researched the prevalence of reported violence in one New Zealand DHB.

McKenna et al., (2003) surveyed New Zealand new graduate registered nurses in their first year of nursing practice regarding violence in the workplace. Over half responded to the survey. Survey results reflected the international research with reports of threats of physical violence, incidents of serious assaults and intention to leave the nursing workforce. Twenty-two incidents of assault required medical attention. They also found the management of violence in the workplace was inadequate and that violent events were under reported. Significantly, the researchers commented upon the education on managing violence. In the undergraduate setting seven hours of education was reported by the participants and in the post registration setting 37% of participants said they had twenty- four hours of education on the management of violence in the workplace. The respondents saw this amount of training as inadequate. The research team concluded that registered nurses need effective prevention programmes and support to deal with a violent event. The researchers suggested that undergraduate education of nurses needs to provide more of a focus on the management of violence in a more comprehensive way.

Wilkinson and Huntington (2004) interviewed six New Zealand district nurses employed by one District Health Board (DHB). Their findings concluded that nurses felt unsafe in a number of situations when dealing with clients in the home environment and expressed distress at not having their concerns addressed by the DHB. Their research demonstrated the lack of organisational support for nurses in the community setting who are confronted with workplace violence. For the participants there were no defined policies on the management of violence, and limited opportunity to attend education programmes. Concern was also expressed at the lack of communication devices, security back-up or personal alarms to call for help in an emergency situation.

Burmeister (2003) researched the prevalence of violence in one DHB in New Zealand over a twelve-month period. Of the 670 violent events reported, 59% were of a physical aggression or assault and 20% were verbal aggression. There were incidents of violence between patients; however, 72% of the reported violence was directed towards healthcare personnel. The majority of the people abusing staff were between 20 – 50 years of age and 32% of violent people were involved in more that one violent event at the DHB. Burmeister suggests that not all violence against employees is reported and the research highlighted issues in gathering information regarding staff injury when two or more reporting systems were in use.

These three studies highlight the incidence of workplace violence within health settings in New Zealand. Like the overseas experience, there are concerns regarding inconsistent reporting measures, lack of organisational support, and limited educational opportunities. In my search of the literature, there appears to be no published research on workplace violence in the Emergency Department setting in New Zealand nor any research published on emergency nurses in New Zealand who have experienced workplace violence.

Regulation of Registered Nurses in New Zealand

The regulation of New Zealand nurses has an influence on nursing practice and decision-making. The following section will explore the legislation, the relationship to workplace violence and how this is currently managed in the New Zealand health care sector. The Health Practitioners Competence Assurance Act

(HPCAA) 2003, regulates registered nurses alongside other registered health professionals in New Zealand[7]. The Nursing Council of New Zealand (NCNZ) regulates nurses in New Zealand by enforcing the HPCAA. The principle purpose of the HPCAA is to protect public safety, and to ensure that registered health professionals in practice are competent and work within a legislated scope of practice (HPCAA, 2003).

The Nursing Council of New Zealand (NCNZ) assesses registered nurses against a competency framework[8] and in 2005 the NCNZ revised the competencies for the registered nurse scope of practice. Included in the competencies are references to the safety of patients while in the health care environment and the expected nurses' response to the management of client safety and well-being (outlined in Table 2 on page 19). Registered nurses in New Zealand must be able to demonstrate to the regulatory authority how they would meet competency 2.5 in the practice environment. This competency has indicators requiring registered nurses to provide evidence of competency when they are audited by the NCNZ[9]. As a senior nurse, my educational opportunities regarding the management of workplace violence was not a common occurrence. This competency would be hard to achieve without appropriate and suitable education and support from the employing organisation.

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[7] Under the Health Practitioners Competence Assurance Act 2003 (HPCAA, 2003) there is a list of Registered Health Professionals who are regulated under this act, including registered nurses. They are accountable to their own regulatory authority (Supplement to New Zealand Gazette, Wellington, September , 2004).

[8] This council has a mix of appointed positions by the Minister of Health. The main mandate is to enforce the Health Practitioners Competence Assurance Act 2003 (HPCAA, 2003) by ensuring public safety through the regulation of competency and the four scopes of practice: Registered Nurse, Enrolled Nurse (trained until 2000), Nurse Assistants (trained after 2000), and Nurse Practitioners (Supplement to New Zealand Gazette, Wellington, September, 2004).

[9] Since the introduction of the HPCA Act 2003 the NCNZ has instituted a system to audit nurses in New Zealand. This audit is conducted yearly. Assessments of Registered Nurse's practice against the competencies for the Registered Nurse scope of practice (NCNZ, 2005a) are required to be submitted to NCNZ if required when audited.

Table 2: Competencies for the registered nurse scope of practice June 2005 *Note.*
From "Competencies for the registered nurse scope of practice", NCNZ, 2005a.

Competency 2.5 Acts appropriately to protect oneself and others when faced with unexpected client responses, confrontation, personal threat or other crisis situations.

Indicator: Understands emergency procedures and plans and lines of communication to maximise effectiveness in a crisis situation.

Indicator: Takes action in situations that compromise client safety and wellbeing.

Indicator: Implements nursing responses, procedures and protocols for managing threats to safety within the practice environment.

Education on workplace violence in New Zealand health settings

Registered nurses in New Zealand are educated in tertiary institutions that provide undergraduate education programmes approved by the Nursing Council of New Zealand and clinical placements that are contracted with healthcare providers. The students graduate with a Bachelor degree in Nursing (Supplement to New Zealand Gazette, Wellington, September 2004). During my undergraduate nursing education in the eighties I was not provided the opportunity to learn about the skills of de-escalation or what was required to assure my personal safety. McKenna, et al., (2003) found only seven hours of education on the management of workplace violence for the New Zealand registered nurse undergraduate.

Education on managing workplace violence for registered nurses in the health sector is not consistent across New Zealand. There is no obligation for the DHB to provide this type of education nor is it mandatory to attend a course in managing violence. Registered nurses are currently learning about the management of violence from their experiences in the clinical practice environment and individual DHB policies. Education for emergency nurses to learn to manage violence is determined individually by Emergency Departments. There are no national standards or guidelines in place to direct Emergency Departments in providing education or training for staff in the management of workplace violence. Every registered nurse who works in the Emergency Department must be able to demonstrate their ability to manage a violent event

and keep patients safe in that environment according to the NCNZ Competencies of the Registered Nurse.

Legislation relevant to workplace violence

New Zealand has legislation to protect the rights of patients that have encounters with health professionals and health providers - The Code of Health & Disability Services and Consumers' Rights 1996[10]. The Health and Disability Commissioner was appointed in 1994 to lead any investigations of complaints against the code are undertaken and recommendations are carried out so future patients are safe guarded (Health & Disability Commissioner Act, 1994).

On examining the Code of Health and Disability Services and Consumers' Rights 1996 (Health & Disability Commissioner, 1996) there are multiple references to the safety and dignity of patients. Right 2 states "every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial, or other exploitation" (p. 291). In addition, Right 3 states, "every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual" (p. 291). While Right 4.4 of the code states "every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimise the quality of life of, that consumer" (p. 291). Patients that encounter the health environment in New Zealand have the right to be cared for in a safe environment. These patient rights are an accountability for which the registered nurse is often held responsible. There appears to have been little opportunity for registered nurses to have access to education to address this in the context of ensuring a safe environment. Patients who are cared for by the Emergency Department can be vulnerable to workplace violence if strategies and robust polices are not in place. Research suggests that organisations and health practitioners in a collaborative approach can find useful solutions and approaches to facilitate a safe working environment for

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[10] Health and Disability Commissioners Code of Health and Disability Services and Consumers' Rights 1996 outlines the rights of the individual when they come in contact with the health service. The Code of Rights was determined by legislation in 1996 and since then has been integral to patient care delivery in New Zealand. The "Canterbury Health Ltd – a report by the Health and Disability Commissioner, April 1998" was the first HDC case that investigated multiple patients' deaths in a New Zealand hospital. This report has influenced many health providers since (HDC, 2004).

all (Ardagh & Richardson, 2004; Deans, 2004; Fernandes et al., 2002; Rankins & Hendey, 1999).

In addition to this legislation, is the Health and Safety in Employment (H&SE) Act 1992 and the amendments legislated in 2002 and 2003[11]. The H&SE Act 1992 defines hazard as one that cause harm or serious harm. Section 7 and 8 of the Act demand that all employers must take all practicable steps to identify, eliminate or isolate harm to employees. In the health sector, there are several and potentially harmful pieces of equipment or exposure to events or environments that put individual personal safety at risk. Johnson (2004), uses the example of intoxicated persons coming to the Emergency Department as an illustration of a workplace hazard that needs to be managed to ensure health professionals' safety. Under the H&SE Act 1992, there is an obligation on the employer to provide education to minimise hazards. The H&SE Act 1992 has defined safe as "in relation to a person, means not exposed to any hazards; and in every other case, means free from hazards: - and "unsafe" and "safety" have corresponding meanings." (p. 5). For the purposes of answering the research question to determine the safety of emergency nurses I have adopted the definition as stated in the H&SE Act 1992.

The Department of Labour (DoL) implements and monitors the HS&E Act 1992 and have investigated reports of a number of serious harm to caregivers. Violence in the workplace is an identified hazard. As a direct result of these incidents, the DoL in 2004 disseminated a discussion document on establishing guidelines for employers and employees to minimise the risk of harm in the health care setting (Occupational Safety and Health Service, 2004). The Occupational Safety and Health Service recognises that the environment in which health professionals work in is not always safe. This document remains in discussion and the recommendations made are not finalised nor implemented. Some managers believe they are unable to completely eradicate and eliminate workplace violence, however there are strategies and initiatives that have been in place to minimise the risk of harm to employees in the health sector (Occupational Safety and Health Service, 2004).

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[11]This act is enforced the Department of Labour (DOL). This act is fundamental for employees and employers to ensure workplace safety, to eliminate and minimised harm in New Zealand workplaces. The H&SE Act amendment in 2002 put the primary responsibility on employers to provide a safe working environment (Occupational Safety and Health Service, 2003).

In 2001, the MoH published the New Zealand standard regarding restraint minimisation and safe practice (Ministry of Health & Standards New Zealand, 2001a). These guidelines require that organisational policies and procedures minimise the risk of harm to consumers during restraint, and that adequate and appropriate reporting and recording occurs. These guidelines address only the behaviour of patients who require restraint. The MoH and Standards New Zealand define restraint as:

> the implementation of any forcible control by a service provider that limits the actions of a consumer in circumstances in which the consumer is at risk of injury or of injuring another person; or the intentional removal of their normal right to freedom (p. 42).

These minimisation restraint standards are not designed to be used by health professionals or employing organisations to address workplace violence in the health sector. Currently, the MoH minimisation restraint standards and the DoL discussion document are the only guidelines in the practice environment that are close to a national framework. Nevertheless these documents do not address workplace violence management nor are they able to met the needs of clinicians or employing organisations.

Conviction for assault under the New Zealand Crimes Act of 1961, may result in an imprisonment sentence and a maximum fine of four thousand dollars. Section 2 of the Crimes Act of 1961[12] defines assault as:

> the act of intentionally applying or attempting to apply force to the person of another, directly or indirectly, or threatening by an act or gesture to apply such force to the persons of another if the person the threat has, or causes the others person to believe on reasonable grounds that he has, present ability to effect his purpose. (p. 642)

There are no published statistics of how many perpetrators of workplace violence in the health sector are charged by the police authorities or go through the court system to get a conviction in New Zealand. Lyneham (2000) found that 70% of violent incidents in the Emergency Department were not referred to

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[12] The Crimes Act of 1961 has had many amendments – the most recent at the time of writing this thesis was in 2006 (Statutes of New Zealand)

authorities and respondents lack confidence in the legal system to take any action against perpetrators. In the New Zealand context, the amount of referrals or complaints of assault to authorities by health professionals or DHBs are unknown (Burmeister, 2003).

Section 48 of the Crimes Act of 1961 outlines self-defence against unprovoked assault. This is not an easy defence for health professionals to use, as Registered Health Professionals must weigh up all considerations in the health context or they could face disciplinary action by the regulatory authorities under the HPCAA 2003. A registered nurse in a mental health setting in New Zealand was disciplined by the Health Practitioners Disciplinary Tribunal[13] and was found guilty of professional misconduct for not exercising good judgement and using other methods to control the violent situation instead of self-defence (NCNZ, 2006). These three acts influence registered nurses' practice and employment but I believe that registered nurses are unable to fulfil their legal obligations without education and guidelines to address the management of workplace violence.

Professional representation for violence in the workplace

The International Council of Nurses (ICN) in collaboration with the World Health Organisation (WHO) and the International Labour Organisation (ILO), have conducted case studies in selected countries to identify workplace violence as a hazard in the health sector internationally (Cooper & Swanson, 2002). The ICN in 2000 had an international theme of highlighting workplace violence in the health sector and how it effects nurses across all health sector environments.

In New Zealand there are two prominent organisations that promote nurses' welfare. The College of Nurses – Aotearoa is a professional group of Registered nurses with around 600 members, interested in advancing the nursing profession. On examination of their website and Te Puawai[14] no position on

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[13] The HPCA Act 2003 outlined a new disciplinary process for Registered Health Practitioners in New Zealand. The Health Practitioners Disciplinary Tribunal is chaired by a lawyer, has three health professionals from the occupational group being investigated and a member of the public. These investigations are open for public scrutiny and the decisions of the tribunal are published on a public website www.hpdt.org.nz. The maximum penalties imposed on Registered Health Professionals are fines that can be determined up to a maximum of $30,000.00 and permanent removal from the register (Health Practitioners Disciplinary Tribunal, 2005).

[14] Te Puawai is the official publication of the College of Nurses – Aotearoa. This publication has been in circulation since 2001 (College of Nurses – Aotearoa).

workplace violence was evident. The New Zealand Nurses Organisation (NZNO) is a leading professional nursing organisation and union with membership of over 38,000 nurses, midwives, and healthcare workers. NZNO has published many articles in their official publication Kai Tiaki Nursing New Zealand[15], highlighting the issue of workplace violence and ways in which to manage workplace violence (Brown, 2001; Brown, 2002; Manchester, 2001, McKenna et al., 2004). The NZNO is an affiliate of the ICN and highlighted the theme of workplace violence in 2000 on International Nurses' Day. The NZNO have a national employment agreement[16] for registered nurses in New Zealand DHBs. This document has clauses that address workplace safety and reinforces aspects of the H&SE legislation to minimise violence (District Health Boards & New Zealand Nurses Organisation, 2005). CENNZ is a part of the NZNO structure and has also highlighted workplace violence in the Emergency Department. This has been a continuing topic for discussion within the CENNZ annual conferences and highlighted in the journal Emergency Nurse New Zealand (College of Emergency Nurses New Zealand -- [NZNO] 2005d; Rolls, 2003).

Locating a definition of workplace violence

There is differing opinions in the literature of an agreed and accepted definition of workplace violence (Ferns, 2005). Workplace violence has been defined "as incidents where staff are abused, threatened or assaulted in circumstances related to their work. This includes commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health" (Joint programme on workplace violence in the Health Sector, 2002, p. 3). The Occupational Safety and Health Service (1995) in New Zealand defined workplace violence as "any incident in which an employee is abused, threatened or assaulted by fellow employees or by a member of the public in circumstances arising out of the course of his or her employment" (p. 6). Data on workplace violence events are inconsistent due to the lack of an agreed definition of violence in the workplace (Cooper & Swanson, 2002).

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[15] Kai Tiaki Nursing New Zealand is the official publication of the New Zealand Nurses Organisation. This publication has been in circulation since 1908 (Kai Tiaki Nursing New Zealand, 2005).

[16] District Health Boards and New Zealand Nurses Organisation Multi Employer Collective Agreement 2005.

Waddington, Badger and Bull (2005) argue that an "inclusive definition of workplace violence" can incorporate events that the researchers felt were not violence but episodes of 'conflict' or 'disputes' (p. 152). They compared experiences of emergency nurses, police officers, social workers, and community mental health workers and indicated that the experiences told by the police officer participants were constituted as violence but the experiences of the emergency nurses were seen as episodes of 'conflict'. There were examples given by the emergency nurse participants in this research that I would classify as episodes of violence. For example, the researchers felt the acting out behaviour of patients waiting for treatment in the Emergency Department was not violence but an episode of conflict (p. 154). There are appropriate channels for patients to complain about the health service and the Code of Health & Disability Services and Consumers' Rights 1996 that protects this patient right[17]. Physical or verbal violence towards emergency nurses is unacceptable and should be classified as workplace violence.

A useful classification of workplace violence is that of the California Occupational Safety and Health Administration (cited in Cooper & Swanson, 2002). This classifies workplace violence into three broad types as shown in Table 3 on page 26. The majority of workplace violence in the health sector setting is the type *II* classification and which identifies that violence is perpetrated by patients attending the health service. This definition does not include relatives of patients who also contribute to the violence experienced in the Emergency Department.

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[17] Code of Health & Disability Services and Consumers' Rights 1996 ("Health and Disability Commissioner Act", 1994, p. 292) , Right 10 – Right to Complain. *"Every consumer has the right to complain about a provider in any form appropriate to the consumer"*.

Table 3: California Occupational Safety and Health Administration Classification: Note. From California Occupational Safety and Health Administration, cited in Cooper & Swanson, 2002, p. 14.

Type *I*, where the assailant has no legitimate relationship to the workplace and the main object of the attack is cash or some other valuable commodity.

Type *II*, which involves some form of assault by a person who is either the recipient or the object of the service provided by the affected workplace or victim.

Type *III*, where an assault is perpetrated by another employee or supervisor, or an acquaintance of the worker.

The definition of workplace violence that will be used in this research is from the Joint programme on workplace violence in the Health Sector definition, 2002. The rationale for accepting this definition is that incorporates various types of violence such as physical and non-physical incidences of violence against employees because of their employment and acknowledges the effects of workplace violence has on their 'safety', 'wellbeing' or 'health'. The participants of this research were asked to define their understanding of a definition of workplace violence from their experience or education opportunities.

Significance of this research

Considering the lack of educational opportunities and the regulation of nurses in New Zealand, it is of no surprise that nurses are ill equipped to manage workplace violence in a confident and safe manner. There is an absence in the New Zealand health system of guidelines and a standardised approach to the management of violence in the workplace. The management of workplace violence is inconsistent and there are significant organisational and legal responsibilities on emergency nurses and employers in New Zealand. There is a need for consistency in the health sector on the management of workplace violence to meet these obligations.

Conclusion

Chapter two has described the international literature and the limited data on workplace violence in the New Zealand health sector. Legislation and regulation of health professionals was described and the links to workplace

violence were explored. Education and professional representation with regard to workplace violence were considered. The various definitions of workplace violence and the definition that will be used for the purposes of this research were determined. Chapter three will outline the methodology and approach for this research, along with ethical considerations and the process for obtaining ethical approval will be discussed.

Chapter 3

Introduction

This chapter introduces the methodology that underpins the research and the rationale for its choice. The design of the research is outlined, including describing the participants, the method of data collection and the process of data analysis. The ethical process and the process to ensure quality in this research are outlined. Gillis and Jackson (2002) suggest that it is necessary to describe the methodology in sufficient detail so that it is apparent that all research processes are clear for future replication by other researchers.

Methodology

The methodology used in this research is that of critical theory. Critical theory enables the researcher to examine a problem and take political action. Clare (2003) suggests that "critical theorists accept that the intentions and desires of individuals may be socially constrained or redefined by external agencies" (p. 126). Critical theory attempts to generate knowledge and understanding that is liberating (Jackson, Clare & Mannix, 2003). Gillis and Jackson (2002) suggest that critical theory is "a critique of society and visioning of new possibilities" (p. 22).

Critical theory has its origins in the Frankfurt school that brought together critical social theorists after World War One. This was based on the theories of Marx and Simmel to bring about social change through political action. Individuals such as Horkheimer, Adorno and Marcuse developed critical theories in reaction to the social changes in Europe of that time. Such changes included the defeat of the left-wing working class movement and the rise of Nazism in later years. Critical theorists acknowledged the limitations of a scientific model and believed that their theories could contribute to the understanding of and emancipation from such oppressive social structures (Fontana, 2004; Roberts & Taylor, 2002; Stevens, 1989; Wittmann-Price, 2004). Critical theory has evolved through the contribution by Habermas. He has informed critical theory by arguing that the spoken word adds strength to the argument for critical theory as a methodology. Habermas argued that the spoken word was comprehensible, true, right and sincere (Jackson, Clare & Mannix, 2003).

Gillis and Jackson (2002) suggest a combination of many critical theories have evolved over time and are constantly changing. Despite this there are concepts considered fundamental to critical theory. Fontana (2004) asserts that critical theory research is important to uncover issues in practice and identifies key aspects in critical research to ensure the methodology is reflected in the research. Further, Fontana states the seven concepts that need to be evident in critical research as critique, context, politics, emancipatory intent, democratic structure, dialectic analysis and reflexivity.

The first concept is critique. This process uncovers origins of oppression through the examination of relationships of power within society. The second concept of context refers to the political, social, economic and historical factors that influence the research topic. Politics is the third concept examined in critical theory research. Politics is not removed in critical research as it is in other methodologies. Examination of politics is vital in critical research to expose power imbalances. The fourth concept of emancipatory intent explores the liberation from the present situation to achieving potential improvement through the possibility of change and includes a process of reflection with the aim of improving the status quo. The fifth concept examines the democratic structure in critical theory research. This is vital so that the researcher does not dominate the participants and cause power imbalances over the participants that are experiencing the phenomenon under examination. Dialectic analysis as the sixth concept examines the way things are versus the way things should be. Critical researchers will question and critique contradictory values, scientific, practical and political interpretations of the world (Stevens, 1989). The final concept of reflexivity is essential for the researcher to examine any constraints and bias put on the research by institutional policies or historical influences. These aspects could impair the emancipatory intent of the inquiry and the validity of research processes.

Such themes of emancipation in critical theory have been criticised as idealist. Roberts and Taylor (2002) assert that "the powerful still tend to flourish, even in the centre of the most stringent reasoned reflection and critique" (p. 342). Despite this criticism, these authors state this methodology has the potential to initiate changes in practice over time. This change in practice relates to the concept of empowerment. Empowerment can be defined as the action of providing and

accepting power in order to achieve liberation from an oppressive situation. Nurses can be potentially empowered by critical research activities (Taylor, 2000).

Jackson, Clare and Mannix (2003) suggest four questions that a critical researcher should consider during analysis to challenge the status quo: "whose interests are being served?", "whose reality is being privileged? "whose voices are being excluded?" and "who is gaining from the situation?" (p. 216). The four questions by Jackson, Clare and Mannix (2003) and the key aspects identified by Fontana will develop and will form part of the critical lens that will be used for the discussion in chapter five and provides a framework in research.

In conjunction with critical theory, I have chosen feminisms to approach the research interviews as a way to safeguard the participants. Gillis and Jackson (2002) state that:

> in many ways, feminist theory fits well with the critical perspective and could be considered as a subset of critical social theory even though, methodologically, feminism draws much of its inspiration from the interpretative perspective. Proponents of the critical perspective share a common desire to improve the condition of humanity (p. 22).

Critical inquiry informed by feminisms has been used to explore issues of oppression, power and emancipation. Gillis and Jackson (2002) suggest that there are four basic principles of feminisms as shown in Table 4. By recognising the principles of feminisms, it is acknowledged that the relationship between the researcher and the participants can be affected by power and privilege (Jackson, Clare & Mannix, 2003).

Table 4: Four basic principles of feminisms. Note; From, Jackson, Clare & Mannix (2003).

1. A valuing of women and their experiences, ideas and needs.
2. A seeing of phenomena from the perspective of women.
3. A recognition of the existence of conditions which oppress women.
4. A desire to change these conditions through criticisms and political action.

It was important for me to be able to explore, explain and portray the concerns emergency nurses have with workplace violence in the Emergency Department. Kushner and Morrow (2003) state "feminist and critical theory perspectives are recognised as important to nursing knowledge development because of their emphasis on vulnerable populations, social analysis and critique, and emancipatory action to promote social justice in the context of women's issues" (p. 31).

Design of the research

The participants in the research

The inclusion criteria for participants are registered nurses who carry out the role of triage, or manage complex patients, and or could undertake the role of shift co-ordination or co-ordination of areas in the Emergency Department. These participants are experienced in emergency nursing work and are employed by DHBs with Emergency Departments, which are open twenty-four hours a day.

The role of the researcher

The role of the researcher is to accurately explore and portray the accounts the participants gave in relation to their knowledge and the realities of experiencing workplace violence in the Emergency Department. The researcher has the responsibility to adhere to the ethical processes and approval of the ethics committee to ensure anonymity, confidentiality and informed consent for the participants is robust. Acknowledging the code of conduct (Nursing Council of New Zealand, 2005b), as a nurse researcher I also have a responsibility to take all care with the participants.

The ethical process

Application for ethical approval was made to the Human Ethics Committee of Victoria University of Wellington (see Appendix 1). Ethical approval was obtained prior to engaging and conducting the research with participants. The ethical guidelines of Victoria University of Wellington were adhered to. The importance of ethics within research is to ensure participation in the research is not harmful or detrimental to the participants in the research. As a Registered Nurse and the researcher, I had to determine how I would manage

issues of unsound nursing practice, unethical practice or incompetence that may be divulged during the interview situation. These issues were covered in the application of the ethical approval to undertake this research. In the event, no such situations arose.

Participants' rights to safety in the research were protected by access to Employee Assistance Programmes (EAP). This counselling service is provided to all employees of District Health Boards in New Zealand. The staff can access this service in a self-selected manner. By disclosing experiences and perceptions of workplace violence, potentially this could lead to the need for an opportunity to work through experiences and explore them in a more detailed manner. Murphy and Nightingale (2002) acknowledge that a significant proportion of potential areas of research in the Emergency Department are sensitive topics. I have acknowledged that workplace violence is a sensitive topic to research and that discussing these issues may uncover other feelings for the participants. Therefore, managing the processes for the nurses who might become distressed was essential and each participant at the beginning of the interview was given information on the EAP service.

The founding document of New Zealand is the Treaty of Waitangi Te Tiriti O Waitangi, was signed in 1840 between the British government (the crown) and Maori (Tangata whenua – people of the land). The treaty outlines four articles to protect and honour the rights of the Maori people[18]. Today the Treaty of Waitangi Te Tiriti O Waitangi is evident in the structures and delivery of health care in New Zealand (Ministry of Health & Standards New Zealand, 2001b). Any participants that identified as Maori would have been offered support and this process was outlined in the ethical application.

Anonymity of the participants is essential to this research. Emergency Departments in New Zealand and the nursing staff, who are employed, have strong national networks. Research has to ensure the anonymity of the participants (Tolich, 2001).

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[18] There are two versions of the Treaty of Waitangi. One in English and the other in Maori. The English version has the principles of partnership, protection and participation, whereas the Maori version has four articles of governance, self determination, equity and spiritual freedom (Orange, 2004).

Participant recruitment and consent

Recruitment of participants to this research was by identification of key informants and expressions of interest of others to take part in the research. A call for participant poster was designed (see Appendix 2) and provided to all the participants was an information sheet explaining the research (see Appendix 3). Essential to this process was informed consent of the participants in this research. By the use of the information sheet, the participants had a broad understanding and knowledge of the research project and the intent of the findings of the research. This consent was free from coercion from the researcher (see Appendix 4). At any given time, the participants were able to refuse to participate in the research and withdraw from the project. These participants met the inclusion criteria that had been identified. The number of participants in this research included six registered nurses, and therefore met this research objective and the scope of this research within the context of their experiences. It is not intended to be representative of all emergency nurses in New Zealand.

With the research approvals concluded, I was able to approach some key contacts to facilitate the recruitment of participants for this research. I was able to recruit six participants easily. With negotiation with the participants, the interviews were organised to take place. All of the participants in this research were female[19] and registered nurses. Five had completed their nursing education in New Zealand and one was educated in the United Kingdom. Some of the participants had gained emergency nursing experience in overseas settings.

Data collection – semi-structured interviews

The interview process in this research was semi-structured. Interview prompts were used by the researcher and invited the participants to express their accounts of workplace violence in the Emergency Department. The interview prompts were submitted to the ethics committee with the ethics application (Appendix 5). Interviews were private and individual and were of no more than one-hour's duration. The questions in the interview schedule were designed to answer my research question that examines the safety of emergency nurses who are confronted with workplace violence. After each interview, I wrote participant

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[19] In 2004, 90.9% of the actively practising Registered Nurses and Midwives in New Zealand are female (New Zealand Health Information Service, 2004).

contact notes in order to recall the interviews. A satisfactory rapport was established between the participants and the researcher and the interview schedule was used to prompt only when needed.

The process of data analysis

The data was analysed using a qualitative thematic model. Thematic analysis is a way of looking at the data and grouping the data into themes. Roberts and Taylor (2002) suggest thematic analysis is a method for identifying themes and patterns in the text. They also suggest that although many researchers use thematic analysis, very few are able to articulate exactly what they do to find the themes within the text and that this process is important to ensure quality research. By the merging of the data from all of the transcripts into themes, confidentiality of the informants was protected and anonymity of the participants was assured. All material was considered confidential to the researcher, supervisor, and the transcriber of the interviews. Portions of the audiotapes were not used in the analysis as the participants explained their experiences by using examples of violent events from practice and told patient examples. These were excluded to continue ensuring the rights of the patients and confidentiality of the patients; no names of patients were given or any other identifying factor to the researcher.

The following steps were taken to identify the recurrent themes in the transcripts. Step one involved transcribing the interviews. These were sent to an external transcriber (see Appendix 6). Step two involved sending the transcripts to the participants to ensure accuracy and up to this point the participants have the opportunity to change the content or remove themselves from the study. This step is essential to ensure the concept of democracy in critical theory is achieved. Step three involved reading the transcripts and listening to the audiotapes multiple times. Listening to the audiotapes and reviewing the transcripts was crucial to the analysis of the data in the transcripts to familiarise the researcher to the data.

Step four involved line numbering the transcripts and the transcripts were tidied to remove any extraneous details such as 'ums', 'ahs' and comments not central to the research question. This step is crucial in safeguarding the participants in the research and acknowledges the principles of critical and feminist theories which value the role of the participants. Roberts and Taylor (2002)

suggest that these extraneous details serve no purpose and make the conversation awkward and detract the researcher from the patterns and themes. Step five involved re-reading the transcripts, listening to the audiotapes and reviewing the contact notes. Jennings (2002) suggests that reviewing the contact notes acts as a 'memory jogger'. It was important to reconsider the aims of the research at this point and not be distracted by themes not relevant to the research question. Roberts and Taylor (2002) suggest that by the activity of re-reading the text you gain a refreshed and refocused view prior to grouping the text into themes.

Step six involved manually cutting the transcripts up and grouping them into themes. The data was analysed into themes that were common across the transcripts. This allowed the reality of workplace violence experienced by the emergency nurses to emerge. Roberts and Taylor (2002) suggest that the themes are reduced until the researcher can "no longer move ideas without losing some of their specialness in relation to the research" (p. 430). Step seven involved choosing a participant's comment that best represented that particular theme. These steps have outlined the process to collate the research which are important in ensuring quality.

Trustworthiness in Qualitative Research

The literature describes diverse terminology that describes concepts of trustworthiness and rigor in qualitative research. Koch and Harrington (1998) argue that establishing trustworthiness and rigor in qualitative research has created debate in the literature and those who discuss methodology have yet to reach agreement on how rigor can be achieved. This can be confusing to the novice nurse researcher. For example, Kincheloe and McLaren (1994) state:

> critical researchers award credibility only when the constructions are plausible to those who constructed them, and even then there may be disagreement, for the researcher may see the effects of oppression in the constructs of those researched – effects of those researched may not see. (p. 151).

Burnard (1995) suggests, "any search for real meaning is an illusion" (p. 243). Despite the ongoing debate in the literature regarding trustworthiness and rigor, I will be using the criteria of creditability, dependability, confirmability and

transferability to establish trustworthiness in this research as suggested by Gillis and Jackson (2002).

Jackson, Daly and Chang (2004) define credibility "as truth of findings as judged by the participants and others within the discipline" (p. 149). Other emergency nurses will judge this research and qualitative researchers must clearly represent the ideas, experiences, views and the reflections of the participants in a transparent and consistent manner (Gillis & Jackson, 2002). Dependability can be defined as accountability or the ability to audit the research so it can be replicated by other researchers (Jackson, Daly & Chang ,2003; Gillis & Jackson, 2002). The process of ensuring dependability was outlined earlier in this chapter to show the reader how they can audit the findings of the research or replicate the study. For the purposes of this study, I checked dependability. Transferability or fittingness is a "faithfulness to the everyday reality of the participants described in enough detail so that others in the discipline can evaluate importance for their own practice" (Jackson, Daly & Chang, 2004, p. 149). A critical research report needs to be empowering in style and actions (Roberts & Taylor, 2002). The literature suggests that any match between the research and literature confirms the accuracy of data interpretation (Williams, 1998). Transferability will be addressed in chapter five. Confirmability ensures that credibility, dependability and transferability has been addressed in the research. Returning the transcripts to participants for verification ensured that it validly represented the experience and reality of the participants. Crucial to a critical theory methodology is trustworthiness in the research as outlined in the discussed concepts of creditability, dependability, confirmability and transferability.

Conclusion

Chapter three has outlined the process that was used to undertake the research. A critical theory methodology was chosen underpinned by feminisms for this research. Critical research is a way of exploring the environment, context, and the causes of events of violence in the Emergency Department. This has relevance to this research topic as environmental and contextual factors can often precipitate a violent or aggressive event. This is an important issue that needs to be explored from the perspective of the participants. The design of the research was outlined to provide the reader with a clear and concise approach to the

research process. A thematic analysis was discussed, alongside the concepts of trustworthiness. Chapter 4 will examine the data collected in the research and will provide an analysis of the recurrent themes.

Chapter 4

Introduction

This chapter will examine the data collected in the interview situation. The process of analysis followed the steps outlined in Chapter 3 and elicited clusters of distinctive themes in the transcripts. In a critical methodology approach, it is important in the final report to add participants' excerpts.

Data Analysis

Overall, the participants understood the intent of this research once they had read the information sheet, asked any additional questions and explanations on accessing Employee Assistance Programmes. All participants signed the consent forms prior to the commencement of the interviews. Four of the six interviews were conducted in the Emergency Department environment. One interview was conducted in a public park and the other in the participant's home. On analysis, the interviews conducted in the Emergency Department had closeness to the topic, whereas the interviews conducted outside of the Emergency Department meant the participants had time to relax and contribute to the conversation in a different way. Time away from the Emergency Department is a valuable commodity. To spend that time reflecting upon workplace violence is a contribution that I took very seriously. Once the six transcripts were available, they were provided to the participants for comment. None of the participants contacted the researcher to either pull out of the research or make any comment on the transcripts.

Distinctive themes

The six participants provided an insight into how emergency nurses confront workplace violence in the Emergency Department. Several distinctive themes emerged and will be discussed in detail in this chapter. The themes were grouped and quotes from the transcripts were collated under these headings. The analysis concluded once the themes were identified. Inclusion of participant comments in the analysis are chosen to best illustrate each theme and demonstrates concepts of trustworthiness.

A definition of violence

Each participant could describe a definition of workplace violence in the Emergency Department. This comprised of physical violence, emotional, verbal aggression or intimidation. All the participants indicated verbal, 5 out of 6 stated physical. As previously stated there is no standard definition of workplace violence. Words used to describe a definition included 'verbal', 'non-verbal', 'physical', 'lashing out', 'threatening manner', 'body language', 'intimidation', 'emotional' and 'aggression'.

> I think violence is quite a broad term – there's a lot of different aspects in violence, whether it's non-verbal, verbal or physical aggression, basically violence to me would be anything that's from underlying body language to the verbal aggression to the lashing out, and all of which we see (participant 5, transcript lines 11-15).
> And…
> I would define it as behavior, whether it be verbal or non verbal, that makes me feel uncomfortable, that is unacceptable manner for someone to behave in the workplace (participant 6, transcript lines 7-10).

All of the participants spoke about incidents of violence that occurred that were not precipitated or deliberately directed at them. This violence was a result of an illness of some sort such as a head injury, psychosis, or confusion from infection. These patients were not aware of their behaviour due to the severity of their illness:

> I define that being verbally abused by patients, occasionally being physically hit by patients, whether it's because they're frustrated or confused at times, like confused with drug and alcohol involvement, psychiatric illness. More often the physical violence, because they've got the substances involved. Or the verbal abuse can often just be from when people are frustrated with waiting (participant 1, transcript lines 7-16).

It is evident that these nurses in this research have a clear definition of violence and have experienced workplace violence in many forms. The experience of violence informed the definition of violence the participants constructed alongside specific education received by three of the participants and institutional policies.

The importance of communication

All of the participants expressed communication with patients, families, and members of the public as a crucial component to keep violent incidents or verbal abuse to a minimum. All agreed that to avoid escalation was a better strategy to use. All participants believed they could call upon the security service within the hospital setting and the police. They expressed some views on the reliability of outside help coming to the Emergency Department before escalation of events occurred. One participant felt that effective communication is the most important factor to prevent a violent event occurring:

> You get a little feeling in the waiting room area and that when there's a tension – you get the looks and you daren't even look up at the waiting room at times because you know they're all staring at you. It's just a feeling, you can just sense it and that does make you a bit tense but then again I think it comes down to if you can open the lines of communication with the waiting room and talk to them about what's going on, and why they're waiting, that does tend to have a good effect at times. It does lessen the tension and people do understand. They're quite happy. A lot of them are happy, if they know what's going on. It's when they languish in the waiting room for hours and hours and no one talks to them. That's when the tension starts to bubble over (participant 6, transcript lines 153-165).

All participants agreed it was difficult when the Emergency Department is overcrowded and had long waiting times to communicate effectively. One participant said that people who are waiting put up barriers or intimidated staff. When this occurs the participants believed it was much harder to approach the patient or relative when all they could say is that the wait had to continue. They believed if they could not say the situation had resolved that is was pointless to

approach these people and experience more verbal abuse. This approach could be seen as avoidance of the issue of addressing the communication needs of the public, but it was a self - preservation technique of the staff so further exposure to verbal abuse did not occur to them.

> What they do is intimidate us, and no one wants to go and approach the patient and the relative. So people back off and the communication doesn't come forward to that patient because of the relative's body language at the end of the bed. They block us from wanting to go in there freely and talk because of the feeling of intimidation is enough to not to want to have any interactions with the patient, so it hinders the patient process (participant 5, transcript lines 55-70).

Communication is important to nursing and an essential component in interactions with patients and their relatives. Communication from staff to patients in episodes of violence and aggression is complex and is a skill that is not easily taught. Experience with these complex situations and knowledge of behaviour patterns was believed by the participants as essential skills for emergency nurses.

Education on workplace violence

Three participants had attended a formal education course specific for establishing tools to manage workplace violence. One participant attended this education overseas. One participant believed that education on managing violence is not the sole answer to eliminating violence in the Emergency Department that some of the solutions are in the clinical setting by finding out what will work, but a theoretical framework was useful in the first instance. One participant could recall the undergraduate education they had but since working in the Emergency Department, there was no education designed around the management of workplace violence. All participants believed that the education should occur on an ongoing basis, like refresher courses. Most of the participants identified de-escalation techniques they used to manage a potentially violent event. They could set limits on people's behaviour and activate security measures or call the police to assist. Some of the participants expressed they were out of their depth in

managing the event and called upon others in the team to intervene to de-escalate the behaviour. The participants believed an education programme designed with skills in communication and personal safety would be beneficial:

> I think all Emergency staff should have a course, so that there is clear guidelines on what we can do, what we can't do, guidelines on how we proceed if somebody behaves in a manner, or acts in a manner that is violent. I think it should be compulsory, I think there should be courses that are paid for by the DHB, that nurses at risk should attend these courses that are in work time and it's paid for, for the protection of nurses, so that we know clearly where we stand, what's available to us, and also more resources given to us (participant 2, transcript lines 253-259).

A number of participants believed that education on workplace violence would help clarify each member of staff role in the management of a violent or an aggressive event. A participant made comment on the role of the senior nurse in when an incidence of workplace violence occurs. They felt they could stand back and not get involved like the senior nurse that needed to take charge of the situation. Conversely, one participant told of how vulnerable it felt when others did not show support or actually distanced themselves from the incidence. They felt their own personal safety was at risk. Three of the participants acknowledged the amount of workplace violence experienced by reception staff and that the triage nurse or shift co-ordinator had to intervene or support the reception staff when this occurs:

> I'm sometimes a co-ordinator here and quite often you'll step in to someone else's problem to sort out. The triage nurse or a member of staff is caught up with somebody who's being aggressive and you are called to assist. You could say "I'm the nurse in charge" and the violent person thinks here's someone who will sort my problem out. You may say exactly the same as the last person who said it, but you are a different face, a different name, a different voice. It makes a difference (participant 4, transcript lines 411-418).

Emergency nurses reporting violence

A participant indicated how having reported all incidences of violence they encountered they never received feedback from quality improvement units or managers. Some of the participants felt it was worthless to report all incidents as no changes were evident in the Emergency Department environment. There were comments upon how reporting is time consuming using the official forms and some of the participants recorded it only in the patients' notes. There was a lack of communication back to the person reporting the event and of the actions that have occurred by managers or a collation of data reported to the staff in the Emergency Department. There was a perception that no actions were taking place because there was no visible communication back to the person reporting the complaint. One participant felt uncomfortable reporting verbal abuse because it was seen as "she said – he said" situation and that physical abuse was easier to report because of the damage that is evident:

> I think the only barrier would be the time constraint. Nurses don't feel they've got the time to sit down and write them because they do take a while. Do we get any results from it? What's changed? We report it, we don't hear any feedback and still go on doing the same things. I think for a lot of people they want to see physical change. They want to see the security guard permanently based at the Department and that is not happening. I think it [violence] always rears its head. The night staff especially feels vulnerable with the staffing mix, there is often only female staff on that shift (participant 5, transcript lines 468-475).

One participant told of an event of violence that occurred and at the time, the hospital was supportive of nurses pressing charges against patients that destroyed hospital property but not supportive of registered nurses pressing charges against the patients for a challenge against their safety. Hospital management encouraged the nurse not to actively pursue this action. Nevertheless, the police that attended the Emergency Department laid charges against this patient. The case went to court and there was a monetary penalty awarded against the patient. This policy of inaction has now transformed itself into a zero tolerance of workplace violence and now pressing charges is considered

for every case in that environment. The effect upon staff that experience this coercion by hospital managers can lead to a sense of betrayal or lack of acknowledgment that workplace violence is a serious issue for clinicians in the Emergency Department. All participants spoke of a zero tolerance strategy to manage workplace violence with posters on walls informing patients and members of the public of this strategy. Participants believed more targeted resources was required such as education, increased security, appropriate numbers of emergency personnel and a more rapid response of the local police force:

> I'd definitely report it through an incident form. I don't know whether I'd lodge a police complaint, depending on the harm and depending on I guess my perception of the patient's judgment. I don't usually hear back what's happened. It just goes through the quality control system – I've never heard any feedback from incident reports (participant 1, transcript lines 80-88).

Contributing factors leading to violence: the participants' perceptions

All participants identified precipitating factors leading to a violent event in the Emergency Department. These causes may be grouped into 'aspects' under the control of the Emergency Department, such as waiting times for treatment, communication difficulties between staff and the patients, the Emergency Department environment (overcrowding). Other aspects include causes outside of the Emergency Department's control, for example, the use of illegal drugs and over consumption of alcohol. Violence in the community is brought into the Emergency Department. A patient's aggressive behaviour may be linked to their illness, for example, head injury, where their judgement is impaired. People presenting to the Emergency Department with mental health problems were commented on by all participants and there was a need to improve the care of those patients so a delay in treatment did not precipitate an aggressive event. The participants acknowledged the differences in the capabilities of a patient's state of mind when a violent event is occurring. Finally, patients and their relatives act out in an abusive manner because of the situations that have brought them to the Emergency Department and the staff were caught in the middle.

I guess it can be really frustrating at times waiting. It's usually when you're really busy that the violence tends to occur because people aren't kind of seen as quickly as they could be and people are left in the corner kind of thing for a while and it can be really stressful and hard to deal with because you've just got too much else on your plate to have to stop everything and deal with someone who's been really physically or verbally abusive. And I find it quite hard (participant 1, transcript lines 231-237). And…

In our waiting room, you can't see what's going in the rest of the department. So people think, "oh - there's no-one here and why am I waiting". If they've come in all churned up it just gets worse (participant 3, transcript lines 372-376).

Effects on other patients in the Emergency Department

Participants identified the difficulties in managing the other responsibilities and accountabilities to other patients in the Emergency Department. Issues surrounding privacy, dignity and keeping other patients in a safe environment were also significant. They expressed a real conflict in balancing all of these responsibilities and not having any guidance to manage these priorities or rights for nurses. One participant felt that there was protection for patients in the health system but not for nursing staff. There were multiple challenges in ensuring that nurses kept other patients safe. One participant talked about other patients in the Emergency Department 'stepping in' and assisting the nursing staff when a violent event occurs. This adds to the complexity of managing the environment and the participants implied that the environment was inadequately resourced to handle the violent event, or had a strategy in place to activate in this type of emergency:

It's very disturbing to other patients, especially in the Emergency Department, you don't have walls, you've got curtains dividing a patient's bed to another patient's bed and if you have an elderly person that maybe has been given some bad news and then you've got a violent person right next to them that's verbally abusive – that can be quite detrimental to somebody. They're having to deal with their own crisis and then hearing other people within the Department that are verbally aggressive towards

the other staff. It's very hard for these other patients to cope with and it becomes quite unfair to them to hear all of that. We try our best to shuffle people around, do things like that and try to protect to the best of our ability, other patients from that kind of abuse but that's not always possible, especially with it being so busy (participant 2, transcript lines 131-144).

Emergency Department design

All of the participants commented upon the design of the Emergency Department and how these designs do not adequately provide a secure or safe environment. People can walk freely around all areas of an Emergency Department and have the ability to gain access to the electronic entry door buttons by putting their arms through a wire barrier. They believed that the electronic doors can be forced open easily. Participants wanted security personnel present and visible in the Emergency Department at all times. They needed to be easily accessed, to walk around the Emergency Department and assist with patients that the registered nurse felt needed to be watched for safety reasons. Some of the participants believe that the triage area was a potentially unsafe place to work. This was because of the isolation from other nursing staff in the Emergency Department and the poor communication devices to activate help or seek attention.

> You do have physical barriers. There is wire, there is netting, but you do have to retreat back from that, because people can put their hands through. There's the phone and usually other people around that you can get assistance and we do have duress alarms. We don't have one out at the front desk that I'm aware of. I think they're all in the office, (participant 6, transcript lines 69-76).
>
> And…
>
> Design is worse at the triage area. You are in such an isolated spot. Because maybe people aren't more likely to mouth off to you if there's two other people on either side of you, (participant 3, transcript lines 480-485)

Effects upon Registered Nurses and their families.

Workplace violence had many influences on registered nurses that participated in this research. Three of the participants had significant violent encounters with patients ranging from being seriously physically assaulted, threatened with a knife and furniture thrown at them. Two of the participants commented upon the need for formal counselling or clinical supervision[20] sessions for nurses in high stressed areas. Other participants believed that these strategies might reduce the effects of workplace violence on an individual and improve the retention of emergency nurses. Interestingly, one participant acknowledged that they do not inform their partner of these violent events that occur in the Emergency Department as this would most certainly lead to her partner advising her to leave the Emergency Department because of the danger. One participant expressed a frustration with rehabilitation back into the workforce after a violent event and injury. They believed that they were financially disadvantaged and caught between the Accident Compensation Corporation and the DHB rules on sick leave and working. There is no rehabilitation process to support nurses to return to work gradually. All of the participants found informal strategies to cope with violence they have endured. Fortunately, none of the participants felt that they wished to leave the Emergency Department because of their experiences but felt that working in the Emergency Department would be more enjoyable and manageable if the violence was eliminated:

> It just does something to you unconsciously, it does something to your emotions, it makes you more fragile maybe because you are dealing with something that the ordinary public don't see. I guess it has to be something detrimental – it's never anything positive (participant 3, transcript lines 437-444).
> And…
> I need to debrief and I don't take any work home. I won't go home and say to my husband "oh this happened to me at work today". If I went home and told him half the things that were said to me, he'd probably ban

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[20] Clinical supervision is a debatable term that can be defined as support that enables nurses to reflect on their practice in a supportive way, to develop expertise and to enhance care to consumers. It is not a performance management tool (Royal College of Nurses, 2002).

me from coming to work. And say, "why do you work there?" You get so much of people's problems and you do become hardened to it, and I don't like that side of it, that you feel like all day you're dealing with conflict management. The nicest thing is that if the staff have seen you being abused, some of them will come up and go, you handled that really well. And that makes me feel better. It is tiring and part of me thinks we don't warn the new staff when they come here that they're in for this. I think that you definitely would find that a few of them would leave because of the stress, and the pressure that the type of work Emergency does puts on them, would encourage them to leave. We've had about five that have left and gone to different areas, and feel better for leaving (participant 5, transcript lines 652-684).

Conclusion

This chapter undertook to outline the analysis of the transcripts to uncover the themes from the participants' interviews. Themes that emerged were a personal definition of workplace violence, how they managed a violent event and the differences in education and the place of guidelines in the practice setting. Other themes were communication and how workplace violence effected the participants and their families and the other patients in the Emergency Department. In the next chapter, the understanding from this analysis will be considered using a critical perspective to inform the discussion.

Chapter 5

Introduction

This chapter will discuss the themes that emerged in chapter four in relation to the current literature regarding workplace violence in the Emergency Department. Implications that emerged in the research themes that may verify or be in conflict with the literature will be identified and discussed from a critical perspective. Critical researchers look at the status quo of a situation and look deeper to determine what is happening and compare it with what should be happening. The participants in this research identified common themes of the importance of communication in the Emergency Department environment, and the management of workplace violence without guidelines and education. With reflection on the themes presented in this research I attempt to breakdown the perceived barriers and offer plausible solutions for future management of workplace violence in the emergency setting in New Zealand.

Discussion

The status quo

A range of beliefs were evident from the participants in the research regarding reporting of violence in the Emergency Department. Reluctance in reporting a violent incident was linked to poor feedback and lack of organisational change. Participants were dissatisfied with the organisational response to the workplace violence they had experienced. The participants analysed each occurrence of violence and determined if they should report it to official authorities such as the police. Equally noteworthy in the literature is evidence suggesting that violence in health care settings has a history of being seriously under-reported (Australasian College of Emergency Medicine, 2004; Burmeister, 2003; Deans, 2004; Fernandes, et al., 1999 & Fernandes, et al, 2002; Fulde, 2005; OSH, 2004; Holmes, 2006; Houry, Feldhaus, Nyquist, Abbott & Pons, 1999; Jenkins, Rocke, McNicholl & Hughes, 1998; Lee, 2001; Luck, Jackson & Usher, 2006; Lyneham, 2000; Peek-Asa, Cubbin & Hubbell, 2002; Saines, 1999; Senuzun Ergun & Karadakovan, 2005; Schnieden & Marren-Bell, 1995). Holmes (2006) estimates that 80% of violent incidents remain un-reported to hospital authorities. There is an urgent need to report all violence experienced by emergency nurses to

demonstrate the scale of this issue and to report to hospital structures and to advocate for improved systems, conditions and increasing security measures in the Emergency Department. Employers must actively encourage emergency nurses to report all events of workplace violence and analyse the data to improve systems and offer regular feedback to staff.

Participants in the research described how the designs of Emergency Departments inadequately provide a secure or safe environment. Participants wished to have security personnel present and visible in the Emergency Department. Participants believed that the triage area was a potentially unsafe place to work because of being isolated and geographically removed from the rest of the team. There were poor communication devices to activate help or seek attention. Literature suggests that controlled access to the Emergency Department is essential with a electronic card entry, should include adequate lighting to all areas, with surveillance systems and adequate exit routes for staff to escape and the triage area could be made secure with clever design (Anderson, 2002; ACEM, 2004; Keep & Glibert, 1995; Kuhn, 1999; Jenkins, Rocke, McNicholl & Hughes, 1998; Jones & Lyneham, 2001; Robinson, Jagim & Ray, 2004). In contrast to the New Zealand experience, international Emergency Departments have had to design triage areas to eliminate the risk of the use of guns against emergency personnel or suggest how to handle weapons brought into the Emergency Department (Keep & Gilbert, 1995; May, 2006; Rankins & Hendey, 1999). Implications for future redesign of the Emergency Department in New Zealand are the need to address significant issues to increase the personal safety of emergency nurses. Any Emergency Department that is redesigning should consult with the Department of Labour to ensure that all practicable steps are taken in the design phase and consultation with emergency nurses should inform these discussions. Emergency Departments should look at their current configurations and undertake an assessment that can identify any areas of potential risk especially at the triage area and the need for permanent security personnel based in the Emergency Department.

Current management of workplace violence is inconsistent in the Emergency Department setting. The participants in the research acknowledge multiple ways in which they perceived workplace violence was managed. There

were inconsistencies with the actions taken after events. Participants in the research acknowledged that workplace violence had many influences upon them from experiencing adverse outcomes to acknowledging the long-term effects upon themselves and their families. They found informal strategies to cope with these effects but felt that structures that were more formal were required and a supportive rehabilitation programme to return to work was essential. Evidence suggests that workplace violence has lasting physical and psychological effects upon nurses and their families. These effects ranged from absences from work, expressing the intention to leave the Emergency Department, to feelings of isolation, fear of patients and powerlessness (Atawneh, Zahid, Al-Sahlawi, Shahid & Al-Farrah, 2003; Crilly, Chaboyer, Creedy, 2004; Fernandes et al., 1999; Ferns, 2005; Hislop & Melby, 2003; Jones & Lyneham, 2001; Keoug, Schlomer & Bollenberg, 2003; Levin, Hewitt & Misner, 1998; Mayer, Smith & King, 1999; Racette, 2001; Smith, 1998; Sofield & Salmond, 2003). Implications are that clinicians in the Emergency Department do not readily access clinical supervision and Employee Assistance Programmes. These two programmes need to be embedded into a healthy workforce environment. Individual nurses must factor in these 'self caring' activities to maintain their own wellbeing in the workplace. These activities should include good rosters to allow for adequate recovery, seeking assistance such as counselling and mentoring programmes including the provision of clinical supervision.

Participants identified varied responses when they encountered a violent event and acknowledged that the whole Emergency Department team is vulnerable to workplace violence. They argued that consistency in managing workplace violence is imperative and useful strategies would ensure a cohesive team response to a violent encounter. There was a reliance on the senior nurse to be involved in the management of a violent event. These nurses were sometimes brought into a situation at a late stage and early warning signs of an aggressive incident occurring are often missed by the original staff. Evidence suggests that hospital managers need to increase their support of staff that experience violence by putting into place plans and policies to manage violence that all staff are aware of, using a team approach (ACEM, 2004; Deans 2004; Dickson, Price, McClaren, & Stern, 2004; Jenkins, Rocke, McNicholl & Hughes, 1998; Kuhn, 1999; Robinson, Jagim & Ray, 2004; Rodger, Hills, & Kristjanson, 2004; Senuzun &

Karadakovan, 2005; Strawser, 1994). It is noteworthy that Lee (2001) suggests senior nurses had experienced copious episodes of violence in their careers and felt they were more competent to handle violent episodes. There are implications for all emergency personnel to be aware of their role when a violent event occurs. Senior nurses in the Emergency Department will need additional education and resources to assist other staff when an event occurs. It is of no surprise that there are inconsistencies as there is no national guideline to assist employing organisations. Currently the Emergency Department have only one instruction to address workplace violence from the MoH (MoH, 2005a).

Participants in the research all indicated that an education programme, which includes communication techniques and personal safety, would be beneficial. A suggestion was made that an education programme should be paid for by the DHB. Evidence in the literature suggests that education on workplace violence is a significant staff education requirement in the Emergency Department (ACEM, 2004; Deans, 2004; Fernandes et al., 1999; Fernandes et al., 2002; OSH, 2004; Holmes, 2006; Lee, 2001; Luck, Jackson & Usher, 2006; Lyneham, 2000; Peek-Asa, Cubbin & Hubbell, 2002; Saines, 1999; Senuzun & Karadakovan, 2005; Schnieden & Marren-Bell, 1995). Implications for education on workplace violence in the Emergency Department are the costs of providing this education to all staff, releasing staff to attend education programmes and prioritising workplace violence education with other competing education requirements, for example, paediatric resuscitation. This education need can ensure employers are complying with their obligations under the H&SE Act 1992 and acknowledges that education can reduce the events of violence against emergency nurses. A strong theme evident throughout the interviews with the participants was communication strategies. How the nurses interacted with the patients, families and the public was significant. Issues that appeared to cause concern included when the nurses were telling people about delays to treatment, long waiting times or moving people into less satisfactory conditions in the Emergency Department such as the corridor instead of a cubicle with curtains or a door. Effective communication is highly valued by patients and the overall perception of their stay in the Emergency Department. It was perceived as better for those who received regular updates than those who did not receive any communication by staff. Poor communication

often leads to complaints (Cross, Goodacre, O'Cathain & Arnold, 2005; Nystrom, Dahlberg & Carlsson, 2003; Nystrom, Nyden & Petersson, 2003).

The initiatives identified are improvements on the status quo and improvements on the structures and processes are currently available in the practice setting. The initiatives can be achieved if employing organisations and registered nurses wish to improve the safety of the existing practice environment. There are real opportunities to challenge the status quo and make lasting improvements.

Challenging the status quo – new initiatives

Looking at the themes from a critical perspective it is evident that solutions rely on actions from a spectrum of people with a common aim to eliminate workplace violence. Challenging the status quo requires a collaborative approach with local initiatives and nationally consistent guidelines. There may be obstacles which require that changes are made. Hegemony means that the oppressed within those systems have the impression that the dominant force is unassailable (Roberts & Taylor, 2002). Nurses, employers and society are interlinked in solving this issue. These participants have given voice to the issue of workplace violence from their perspective. Currently, the reality of workplace violence is detrimental to the safety of patient and staff in the Emergency Department. By not determining a strategy to manage workplace violence people in higher positions have a privileged reality. Workplace violence does not enter their work environment, in contrast to the experiences of the research participants.

In the diagram I have conceptualised (see Figure 1 overleaf) indicates six solutions to manage workplace violence, none of which can occur in isolation. So often, only two or three of these interrelated solutions occur simultaneously leading to barriers or imbalances in resolving workplace violence or empowering the emergency nurses. Nurses need to be involved in the construction of national guidelines. This ensures that their voice is not being excluded.

Figure 1: Solutions to manage workplace violence.
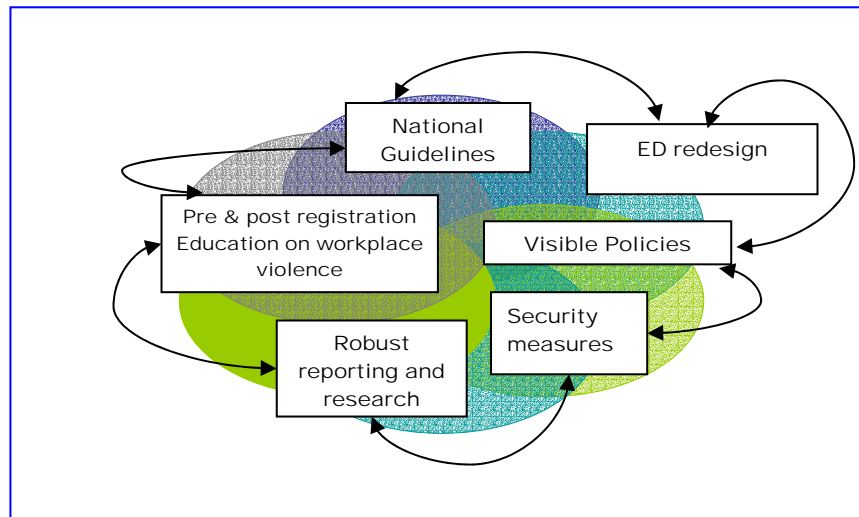
Solutions to manage workplace violence can be broken down into aspects of what managers and staff in Emergency Department could do now. It would be useful for these departments to form a group of interested participants to review the safety of the setting. Inclusive of this would be registered nurses and managers that could approve any necessary changes. This group could review past data available on workplace violence and analyse them. Once they have scoped the issue locally they could initiate visible policies, introduce education on workplace violence to the education programme for all staff and review their security measures. These groups can identify causes of workplace violence in their environment and look at ways to address each factor.

The participants in the research had their own perceptions of the contributing factors that lead to workplace violence they experienced. Similarly, the literature suggests that waiting times in the Emergency Department contributed to workplace violence alongside the use of drugs, alcohol, illness, overcrowding of the Emergency Department and the increasing use of weapons (Brown, 2001; Jenkins, Rocke, McNicholl & Hughes, 1998; Luck, Jackson & Usher, 2006; Stirling, Higgins & Cooke, 2001). Increased public expectations of the Emergency Department is significant and the ability to deliver a timely and appropriate service is limited by resources allocated and the amount of staff available (ACEM, 2005c; McKerras, 2005). In terms of managing workplace violence, the length of time in which patients are in the Emergency Department is often the trigger point of a violent event (ACEM, 2004, Jones & Lyneham, 2000; Lyneham, 2001). Patients that present with mental health problems to the

Emergency Department often wait long periods of time before their needs are addressed. Due to the very nature of the Emergency Department, these patients are seen within the whole context of the overall workload. Clinicians need to access appropriate services in a timely fashion so these patients are not left feeling neglected or ignored (Thompson, 2005). In contrast to the themes that emerged from my research, the literature reports that nursing staff employed in other areas of the hospital can also be a source of verbal abuse and aggression, with one study (Lyneham, 2000) suggesting that 20% of emergency nurses surveyed identified this. Implications for Emergency Departments are that eliminating these contributing factors is difficult in the short term. There are factors that the Emergency Department can address and factors that are outside the control of the Emergency Department for the Ministry of Health (MoH) to address. For example, the Emergency Department could implement an improved patient flow system through the Emergency Department to decrease waiting times but the resource implications of this would need additional funding from the MoH.

An example of such a collaborative approach is from the United Kingdom (UK). In 2005, the Royal College of Nursing (RCN) released a study on workplace violence. Its findings show that emergency nurses are at most risk of being a victim of workplace violence (RCN, 2006). In the UK, the National Health Service (NHS) has made a serious commitment to address the issue of workplace violence in the health sector. The NHS developed a special unit to implement a management plan for eliminating workplace violence. This plan included education of staff to recognise and defuse a potentially violent event, and encouraged staff to prosecute people who assaulted healthcare workers. In the first year of implementation in 2004, the NHS prosecuted 51 people for attacking healthcare workers; however in 2005 they prosecuted 759. The NHS has since educated over 250,000 workers out of 750,000 and plans to have all health workers educated in recognising and defusing workplace violence by 2008.

In 2004, Scotland introduced legislation that protected the rights of emergency workers. "Any person caught assaulting, obstructing, or hindering emergency workers" was liable to a nine-month prison sentence and or a fine of five thousand pounds (Donnelly, 2006, p. 5). This is a significant deterrent to stop people being violent towards emergency workers. England and Wales will have a similar piece of legislation through their Parliament in 2006. (RCN, 2006).

Currently in New Zealand, there is no such commitment from the New Zealand government, the Ministry of Health or District Health Boards to eliminate workplace violence in the New Zealand health sector in such a comprehensive and co-ordinated way.

Research, analysis and reporting of workplace violence data is not consistent. There is a strong rationale for a starting point to adopt one language or data tool so that a common understanding of workplace violence can express the enormity of the situation, accepting one definition of workplace violence in the health sector, and one definition to identify hazards and to make positive changes in reporting structures, management guidelines and education. Significantly, the participants in this research articulated a common definition of workplace violence and could express the aspects which construct a definition. Their understanding of a definition sits within the definition located in chapter 2 which underpinned this research. I have conceptualised the participants' definition of workplace violence in Figure 2.

Figure 2: Definition of violence: Concepts of violence
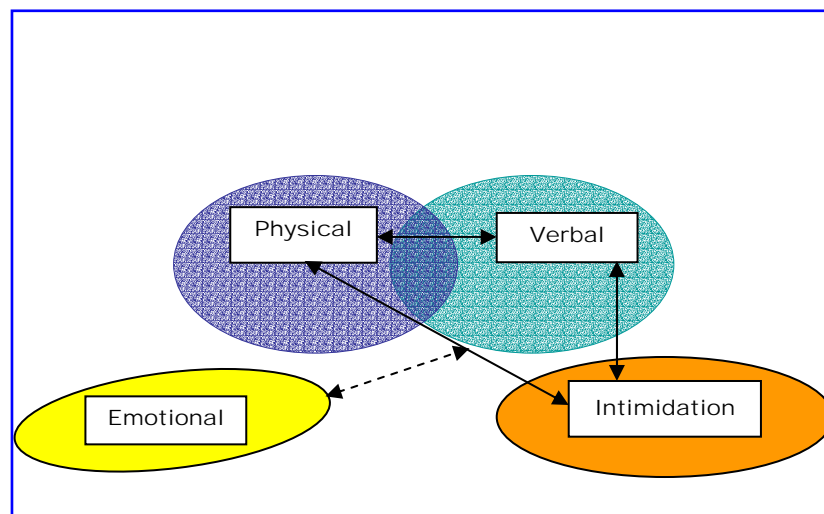
This diagram shows a relationship between intimidation, physical and verbal violence. A reaction to this type of violence leads to an emotional response, which may not be seen by others or may not be perceived to sit within the definition of violence. The emotional relationship to violence sits alongside the definition of workplace violence used in this research. Without a definition of workplace violence that includes the emotional cost upon nurses, solutions to manage workplace violence in the Emergency Department will have no starting

point (Anderson, 2001; Armstrong, 2006; Emergency Nurses Association, 2001; Crilly, Chaboyer & Creedy, 2004; Fernandes et al., 1999; Hislop & Melby, 2003; OSH, 2004; McPhaul & Lippsomb, 2004; Speedy, 2006; Waddington, Badger & Bull, 2005). Failure to reach agreement on what workplace violence is has an impact upon statistical collection, analysis and research. I believe an inclusive definition of workplace violence is warranted in New Zealand. A comprehensive discussion paper commissioned by Occupational Safety and Health Service in 2004 does not have a definition of workplace violence despite an extensive literature review, management of violence and causative factors in the workplace (Occupational Safety and Health Service, 2004). There is a need for a nationally consistent definition of workplace violence and the definition should be the definition developed by International Council of Nurses, World Health Organisation, International Labour Organisation and the Public Services International (Joint programme on workplace violence in the health sector, 2002).

It is evident from the findings of this study that a co-ordinated strategy is needed to research and inform workplace violence management and education in the Emergency Department. Ferns, Stacey and Cork (2006) rightfully assert the need to generate research and understanding on workplace violence in the Emergency Department. A key element they identified was the lack of emergency nurses in practice conducting this research. The writers identified only 15 authors internationally researching workplace violence in the emergency setting who are emergency nurses. The unique perspective and voice of the emergency nurse is limited in the international dialogue on workplace violence in the Emergency Department. Robust research on workplace violence and the multiple collection methods and interpretations should align to uncover the complexity surrounding workplace violence in the health sector (Lau & Magarey, 2006).

Research studies of other occupational groups in New Zealand have been published since the completion of the fieldwork in this research. For example, Gale, Arroll and Coverdale (2006), surveyed New Zealand general practitioners to ascertain the amount of violent events that general practitioners have experienced. Of the 1205 respondents, male general practitioners were at greater risk of being verbally threatened, while female general practitioners were at greater risk of sexual harassment. A key discussion point raised was that this research did not explore

the meaning or impact of workplace violence on general practitioners so better management of workplace violence could occur. The researchers found that front line staff such as the receptionists and nurses, were at more risk of a violent event occurring. Gale, Arroll and Coverdale's research findings validate this research project's methodology and aims of trying to discover the impact of workplace violence on emergency nurses and to inform better management of workplace violence in the health sector.

Violent crime in New Zealand is increasing in our communities (New Zealand Police, 2006). This research has found the Emergency Department staff does encounter these violent events and now is the time to undertake a collaborative approach to address workplace violence in New Zealand Emergency Departments.

Conclusion

The purpose of this research was to highlight that workplace violence occurs in New Zealand Emergency Departments. The management of violent events at a local level is not consistent across New Zealand and there are no national consistency or guidelines to assist clinicians or department managers to eliminate or minimise workplace violence in the Emergency Department. In 2006, there is yet to be a guideline published or implemented in health settings. There is a continuation of an absence of guidelines, education or nationwide approach to eliminating violence in the health care setting. With a collaborative approach to manage workplace violence in the Emergency Department there is an opportunity to improve the safety of emergency nurses. This chapter discussed the findings of the research within New Zealand and compared the findings with the literature. The final chapter will conclude with recommendations for the New Zealand health setting, employers and healthcare workers.

Chapter 6

Introduction

Recommendations from this research involve the engagement of government agencies, employers, and healthcare workers. To eliminate workplace violence in the health sector there is a need for a collective understanding that workplace violence should be eliminated from the health environment. Once this understanding is established the key recommendations for the education of healthcare workers, guidelines to manage workplace violence, the physical environment of the Emergency Department and other clinical issues that influence the Emergency Department work that lead to workplace violence occurring, can collectively eliminate workplace violence in the Emergency Department.

I chose a critical theory methodology to explore and uncover the issues for registered nurses that are confronted with workplace violence in the Emergency Department. Critical theory is an inquiry that looks critically at an issue. Critical researchers see their research as the first step in a political action and are not satisfied with just increasing knowledge (Kincheloe & McLaren, 2005). Workplace violence is an issue that requires collaborative action to address the problem. Without collaborative action, there will be no changes to the management of workplace violence in New Zealand. Uniformity in Emergency Departments to address workplace violence management and the lack of educational preparedness of registered nurses needs to be addressed. These changes need to come from the Ministry of Health (MoH) and the Department of Labour (DoL). The management of workplace violence in the Emergency Department now requires critical and significant attention.

Recommendations

A guideline to manage the risk of violence in the Emergency Department and the wider health care setting is a serious and significant gap in policy for health care workers in New Zealand. Urgent agreement, dissemination, and implementation of these guidelines is needed. The DoL and MoH need to provide key leadership in developing workplace violence solutions to help reduce the risk and support staff exposed to potential workplace violence in clinical settings like

the Emergency Department. This guidance would allow managers to better support staff in the Emergency Department and encourage the reporting of incidents that staff might experience. Nurses who work in New Zealand Emergency Departments need to have access to education in dealing with and eliminating workplace violence. Access to this education will enable nurses to look at ways they deal with workplace violence in their practice. The competencies for the registered nurse scope of practice highlighted during this research, demonstrates the need for specific education in the New Zealand setting.

Knowledge of workplace violence is crucial for all clinicians working in the Emergency Department. There is a need for action plans for workplaces to implement when a violent event occurs. Action plans will need to be designed for the local context based upon nationally consistent criteria. This plan should be practised and is easily used no matter what time of day or day of the week. At each workplace a 'champion' could lead the management, reduction, reporting and highlighting the issue of workplace violence in the Emergency Department. A useful solution is a person designated a portfolio to manage and to report on this issue to all staff and feedback to the staff member that has filled out incident forms that report violence.

Environmental issues in the Emergency Departments are in need of transformation to address the lack of privacy and security for clinicians and patients. For patients to feel secure in the Emergency Department many factors can reduce the possibility of violence and warrant attention when buildings are being redesigned. Seeking ways to reduce the noise, decreasing 'bottle necks' at entrance points; safe exits and entries to Emergency Departments can reduce the risk of a violent or aggressive incident occurring. Special attention is required for the design of triage areas. There may be a need to install alarms, recording devices such as video surveillance and appropriately placed communication devices. Physical barriers at the triage area can ensure staff safety however this can present difficulties in gaining knowledge from the patient at the triage area. Solutions are needed to overcome inappropriate installation of barriers and to ensure that any barriers (wires, glass etc) do not inhibit the work of the triage nurse. Poorly designed triage areas could lead to triage nurses stepping outside the barrier and potentially putting themselves at risk, if they make the wrong decision. A triage

nurse should be equipped with a personal communication device that has an emergency calling system.

A streamlined reporting system within each District Health Board is required. Each violent incident needs to be reported within organisations. The data needs to be collected in a central reporting system. Each clinical area that submits reports on violence needs to have regular report backs to the clinicians that have reported the violent event. With open discussions on the actual causes of violent events and then focusing on solutions to eliminate workplace violence in each clinical area a reduction in the incidence of violence could occur. The provision of security and the enforcement of policies that relate to violence elimination are required to be addressed by organisations. Education of the public's behaviour in the Emergency Department needs to occur from each District Health Board. Improved security of Emergency Departments is needed. Security measures such as wide triage desks, escape areas for staff and patients inside both the department and the waiting room are necessary. Police availability to the Emergency Department is a priority for any DHB.

Support of nurses who have experienced events of workplace violence needs to occur in conjunction with the Accident Compensation Corporation and Department of Labour. This partnership would help in achieving the best outcome of returning to the workforce for the registered nurse. Significant injuries can alter people's lives and remove them from the workforce if employers and other government agencies cannot ensure that nurses can return to the workforce in a supported way that does not disadvantage them financially. District Health Boards need to adopt a supportive rehabilitation approach. Retention of emergency nurses is an issue for the health sector. Minimising, reducing or eliminating workplace violence in the Emergency Department will assist in the retention of nurses and support those who have not reported events they have experienced in the past.

A financial commitment from the MoH is required to construct and implement a strategy to manage workplace violence in New Zealand. This commitment must cover educational needs of registered nurses; improve the environmental issues in the Emergency Department that lead to workplace

violence and ensuring that all Emergency Departments are addressing this issue seriously. Further research of nurses in all areas of practice is needed in New Zealand to gather the significant findings to change the practice environment and the culture in which nurses are looking after patients. There needs to be a common understanding in the health sector of the management of workplace violence and a person nominated in each workplace to lead the discussion on eliminating clinicians' exposure to workplace violence.

Reflections on the research

This research was conducted to fill the requirements to complete a Masters thesis. It included interviews with six nurses in Emergency Departments; however a quantitative study or survey of all Emergency Departments and emergency nurses in New Zealand could inform this topic and provide further evidence to support the conclusions in this research. This research has focused upon the individual's knowledge of workplace violence and the experience these participants have reflected on when faced with workplace violence. Other registered health professionals are faced with workplace violence whilst in the health sector; however this research does not include their experience or explain the impact of the issue on them. Various common themes could be similar for them and the ability to handle the experience and its effects could be the same, however their account is not included in, or part of this research.

Concluding Statement

This research has added to the knowledge on workplace violence in Emergency Departments in New Zealand. Findings of this research confirm that skills to manage incidents of workplace violence and education alone are unable to fix this problem. What is needed are sound policies, procedures, and enhanced security for Emergency Departments that limit the impact of workplace violence on nurses and ensure that employers are taking practicable steps to ensure violence in the workplace is reduced and eliminated.

Although the removal of workplace violence in the health sector is a priority for me, other health professionals are dealing with workplace violence by addressing some of the root causes of workplace violence in the Emergency

Department. These are addressing overcrowding in the Emergency Department, patient pathways, reducing waiting times, and advancing nursing practice in the Emergency Department, recognising the contribution nurses have to the overall management of the Emergency Department. With a collaborative effort to address these factors, Emergency Departments will be able to minimise if not eliminate the degree of workplace violence that is currently experienced by nurses in New Zealand. Emergency Department nurses deserve a safe workplace and need to be reassured that the Emergency Department will be safe for all. As more nursing research is based in New Zealand changes in practice will be more effective for registered nurses in the Emergency Department. My response to workplace violence has fuelled a passion to understand the issue and create an awareness of the problem in the clinical context - to not only create awareness but to change attitudes to eliminate workplace violence. Education on de-escalation, defusing and recognising violence is essential for all Registered nurses in all settings, along with robust guidelines in the management of workplace violence, so patients and health care workers are not at risk.

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Appendix 1: Ethics Approval

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI

VICTORIA
UNIVERSITY OF WELLINGTON

MEMORANDUM

Phone	0-4-463 5676
Fax	0-4-463 5209
Email	Allison.kirkman@vuw.ac.nz

TO	Suzanne Rolls
COPY TO	
FROM	Dr Allison Kirkman, Convener, Human Ethics Committee
DATE	November 1, 2005
PAGES	1
SUBJECT	**Approval: No129/2005, Workplace violence in the emergency department: are emergency nurses safe?**

Thank you for your application for ethical approval, which has now been considered by the Standing Committee of the Human Ethics Committee.

Your application has been approved and this approval continues until 30 March 2006. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Allison Kirkman
Convener

Appendix 2: poster

Call for Participants

My name is Suzanne Rolls. I am a registered nurse with a background in Emergency Nursing. Currently I am enrolled in the Master of Nursing (Applied) at Victoria University of Wellington in the Graduate School of Nursing and Midwifery. As part of this degree I am undertaking a research project leading to a thesis.

I am interested to hear from Emergency Nurses who have experienced workplace violence.

Emergency departments are not alone in experiencing workplace violence. However little is known about the New Zealand experience. Emergency Nurses have exposure to workplace violence have had little opportunity to explore the complex issues that arise from incidents of violence.

Your participation is called for to be part of this research and is voluntary. Interviews with participants will occur on an individual basis, with an interview schedule as a guide. The interview will be probably one hour in duration and will be at a venue agreeable to the participant.

See information sheet for more details

Appendix 3: Participant Information sheet

Participant information sheet

"Workplace violence in the emergency department: are emergency nurses safe?"

RESEARCHER

My name is Suzanne Rolls. I am a registered nurse with a background in Emergency Nursing. Currently I am enrolled in the Master of Nursing (Applied) at Victoria University of Wellington in the Graduate School of Nursing and Midwifery. As part of this degree I am undertaking a research project leading to a thesis and completion of the Masters of Nursing (Applied).

RESEARCH TOPIC

I am interested to hear from Emergency Nurses who have experienced workplace violence. Emergency departments are not alone in experiencing workplace violence. Little is known about workplace violence in the New Zealand context. Emergency nurses have exposure to workplace violence and have not had the opportunity to explore the complex issues that arise from incidents of violence.

I have received ethical approval from the Victoria University of Wellington, Human Ethics Committee. I am employed by the New Zealand Nurses Organisation. However, I am under the supervision and direction of the Graduate School of Nursing and Midwifery Victoria University of Wellington for the research.

WHAT WOULD PARTICIPATION MEAN TO YOU?

I would welcome your participation in this research and your participation is voluntary. Individual interviews with participants will be audiotaped and the interview will probably be one hour long and will be at a place agreeable to us both. Should any participants wish to withdraw from the project, they may do so without question at any time until I begin the analysis of the research material. At the time of the interview, participants will be given an indication of when this is likely to be.

CONFIDENTIALITY

All care will be taken not to identify you personally. Only themes will be presented in this report. All material collected will be kept confidential and stored securely. No other person besides me, my supervisor, Denise Blanchard and a transcriber, will see the transcripts of the interviews. The thesis will be lodged in the Victoria University of Wellington library and the New Zealand Nurses Organisation library.

FINALLY

It is intended that one or more articles will be submitted for publication in scholarly journals*.* Presentations at conferences to disseminate the findings of the research will also be undertaken. The transcripts will be stored in a secure manner and kept for a period of one year after the end of the project. Destruction of the transcripts will occur after this specified time.

I look forward to your participation.

CONTACT

If you would like to receive further information about the project, or if you would like to take part in the research please contact me:

Researcher

Suzanne Rolls – Masters Candidate
C/O Graduate School of Nursing and Midwifery at Victoria University of Wellington,
PO Box 600
Wellington

If you have any other questions you could contact my supervisors:

Supervisors

Associate Professor Pamela Wood	Denise Blanchard
Graduate School of Nursing and Midwifery at Victoria University of Wellington,	Graduate School of Nursing and Midwifery at Victoria University of Wellington,
PO Box 600	PO Box 600
Wellington	Wellington

Appendix 4: Participant consent form

VICTORIA UNIVERSITY OF WELLINGTON
CONSENT TO PARTICIPATION IN RESEARCH

Title of project: **"Workplace violence in the emergency department: are emergency nurses safe?"**

☐ I have been given and have understood an explanation of this research project. I have had an opportunity to ask questions and have them answered to my satisfaction. I understand that I may withdraw myself (or any information I have provided) from this project (before data collection and analysis is complete) without having to give reasons.

☐ I understand that any information I provide will be kept confidential to the researcher, the supervisor and the person who transcribes the tape recordings of our interview, the published results will not use my name, and that no opinions will be attributed to me in any way that will identify me.

☐ I understand that I will have an opportunity to check the transcripts of the interview before publication.

☐ I understand that the data I provide will not be used for any other purpose or released to others without my written consent. It is intended that one or more articles will be submitted for publication in scholarly journals. Presentations at a conference to disseminate the findings of the research will be undertaken. The transcripts will be stored in a secure manner and kept for a period of 1 year after the end of the project. Destruction of the transcripts will occur after this specified time.

☐ I agree to take part in this research

Signed: _____

Name of participant: _____
(Please print clearly)

Date: _____

Appendix 5: Semi-structured Interview Question

<u>Key Research Question:</u>

- How do you define violence in the Emergency Department?

<u>Prompts for the interviews:</u>

- Strategies you use to manage violence

- Coping with an incident of violence

- Mechanisms for support in the Emergency Department

- Reporting

- Barriers to reporting

- Guidelines or protocols in the Emergency Department

- Training or education to explore workplace violence

- Observed workplace violence

- What impact has workplace violence had on you?

Appendix 6: Transcriber's consent form

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI

VICTORIA
UNIVERSITY OF WELLINGTON

Transcribers Consent Form

Research Project:
"Workplace violence in the emergency department:
are emergency nurses safe?"

- The information I have heard and transcribed is confidential to this research project.

- I will not disclose or discuss the content of the audiotapes to others.

- I will keep all information confidential.

- I will store the audiotapes and transcripts in a safe and secure place.

Signed: _____

Name of Transcriber: _____
(Please print clearly)

Date: _____

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