Registered Nurses' Experiences of Patient Violence on Acute Care Psychiatric Inpatient Units

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ABSTRACT

Nurses working in acute care psychiatry experience high rates of violence perpetrated by patients and their perspectives on these experiences are essential to understand this phenomenon. The purpose of this study was to explore psychiatric nurses' experiences of patient violence in acute care inpatient psychiatric settings. In this interpretive descriptive study, a purposeful sample of 12 nurses were interviewed to understand how they define patient violence and understand their experiences of abuse within the workplace. Using thematic content analysis, a problem, needs and practice analysis was also conducted. Experiencing patient violence had many perceived negative impacts on nurses, patients and the organization. It was often considered to be part of the job and some nurses struggled with the role conflict between one's duty to care and one's duty to self when needing to provide care following a critical incident. Power, control and stigma also influenced nurses' perceptions and responses to patient violence. In their practice, nurses used a wide variety of interventions to stay safe as well as prevent and manage patient violence. Nurses recommended increased education, support and debriefing, and an improved working environment. Future research should explore a consistent definition of violence, barriers to incident reporting and the creation of best practice guidelines specifically related to patient violence. Understanding the perspectives and experiences of nurses in acute inpatient psychiatry leads to greater knowledge of the phenomenon of patient violence and helps to inform the development of future nursing interventions to prevent and to respond to patient violence, as well as support nurses working within the acute care setting.

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Most unforgettable of all are the registered nurses who took the time out of their busy lives to participate in this study. Their experiences were both integral to my research and awe-inspiring. I hope that these stories will contribute to awareness of patient violence and the role of psychiatric nursing, future research for successful interventions, safety measures, better patient care and better care for nurses who pour their heart and soul into their roles.

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LIST OF ABBREVIATIONS

ATAS	Attitudes Towards Aggression Scale
BHA	Behavioural Health Associate
BPG	Best practice guideline
CIHI	Canadian Institute for Health Information
CNO	College of Nurses of Ontario
HiREB	Hamilton Integrated Research Ethics Board
HRQol	Health-related quality of life
ICN	International Council of Nurses
IES-R	Impact of Events Scale-Revised
ILO	International Labour Organization
IPV	Intimate partner violence
MAVAS	Management of Aggression and Violence Attitude Scale
MHA	Mental Health Act
POPAS	Perceptions of Prevalence of Aggression Scale
ProQOL	Professional quality of life
PTSD	Post-traumatic stress disorder
RNAO	Registered Nurses Association of Ontario
RN	Registered Nurse
RPN	Registered Practical Nurse
WHO	World Health Organization

CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

Background

Registered nurses (RNs), compared to other healthcare providers and auxiliary staff, are at a higher risk of experiencing violence in the workplace (Nolan, Dallender, Soares, Thomsen, & Arnetz, 1999) including violence initiated by patients or their families (Hesketh, et al., 2003; International Council of Nurses [ICN], 1999; Registered Nurses Association of Ontario, 2009). There are three general categories of workplace violence classified according to perpetrator. Violence can be perpetrated by: (1) an individual from outside the workplace; (2) clients or patients of the workplace; or (3) internal staff members (Herath, Forrest, McRae, & Parker, 2011). Within the context of nursing, violence in the workplace is any "incident of aggression that is physical, sexual, verbal, emotional or psychological that occurs when nurses are abused, threatened or assaulted in circumstances related to their work" (Registered Nurses' Association of Ontario, 2009, pp. 30).

Among employed nurses, there is a significantly high prevalence rate of experiencing workplace violence. Between 25 and 80 percent of nurses working in acute care hospitals reported experiencing violence in one form or another from patients (Campbell, et al., 2011; International Labour Organization, 2002; Moylan & Cullinan, 2011; Nolan, Dallender, Soares, Thomsen, & Arnetz, 1999) with most studies hypothesizing that these events are vastly underreported, possibly due to a lack of conceptual clarity on what constitutes psychological or emotional violence (Gates, Gillespie, & Succop, 2011; Hesketh, et al., 2003; Owen, Tarantello, Jones & Tennant, 1998). In Canada, Shields and Wilkins (2009) reported that almost one third (29 percent) of nurses working in direct care hospitals or long term care facilities reported physical assault by a patient in the last 12 months, and more than 40 percent (44 percent) of the

study population reported emotional abuse. Both physical assault and emotional abuse were not defined in the study.

Hesketh and colleagues (2003) surveyed a large sample (n= 9, 174) of RNs working in hospitals in Alberta and British Columbia about their experiences of violence in the workplace over the last five shifts. Their study included definitions of violence against nurses as follows: (1) physical assault (e.g. being spit on, bitten, hit, pushed); (2) threat of assault (either verbal or written threats intending harm); (3) emotional abuse (such as hurtful remarks or attitudes, gestures, insults, coercion, humiliation); (4) verbal sexual harassment (repeated, unwanted remarks or questions of a sexual nature, and (5) sexual assault (any forced physical sexual contact or forced sexual acts). Their results suggested that RNs experience many incidences of violence within a short period of time, especially those nurses working in psychiatry, emergency and medical-surgical areas. More specifically, they reported that 55 percent of their sample of Canadian psychiatric nurses were victims of verbal or emotional abuse, 19.5 percent experienced sexual abuse, and 20.3 percent reported experiencing physical abuse *in their last five shifts.* Psychiatric nurses reported among the highest violence victimization rates of all types of nurses (Campbell, et al., 2011; Hesketh, et al., 2003; Shields & Wilkins, 2009). This may be due to the nature of patient pathologies and the cultures and environments of acute psychiatry (Lanza, 1996 as cited in Soares, Lawoko, & Nolan, 2000).

The short-or long-term exposure to any type of violence can result in significant negative outcomes for nurses, patients and organizations. For nurses, there may be both physical and psychological consequences. The psychological outcomes include feelings of anger, fear or anxiety, post-traumatic stress disorder (PTSD) symptoms, guilt, self-blame and shame (Nolan, Dallender, Soares, Thomsen, & Arnetz, 1999), decreased job satisfaction and increased

expressions of intent to leave the organization (Sofield & Salmond, 2003), lowered health related quality of life (HRQoL) (Chen, Huang, Hwang, & Chen, 2010), and in some cases, physical outcomes including temporary or permanent disability (Pai & Lee, 2011).

For patients, outcomes of both verbal and physical patient violence have been found to include higher incidences of medication errors, falls, late administration of medications, decreased perceptions of nursing productivity as well as decreased patient satisfaction and perceived quality of care (Arnetz & Arnetz, 2001; Gates, Gillespie, & Succop, 2011; Kisa, 2008; Roche, Diers, Duffield, & Catling-Paull, 2009).

The impact of workplace violence for organizations is also significant, and negative outcomes may include: higher staff turnover and difficulty with nurse retention (Ito, Eisen, Sederer, Yamada, & Tachimori, 2001; Sofield & Salmond, 2003), decreased morale, the development of hostile work environments (Kisa, 2008), absenteeism, higher frequencies of medical errors following the event, greater costs associated with short or long-term disability leaves, increases in workplace injury claims (Hoel, Sparks & Cooper, 2001; Liss & McCaskell, 1994), and reduced quality of patient care and productivity (Gates, Gillespie & Succop, 2011; Kisa, 2008).

The costs associated with both short and long term disability leaves and workplace injury claims have been found to be significant for organizations. Hoel, Sparks and Cooper (2001), researchers for the International Labour Organization (a division of the World Health Organization[WHO]), reported that workplace violence has been estimated to account for approximately 30 percent of the overall costs of ill-health and accidents. Statistics Canada reported that 33 percent of workplace violence incidents occur in health care and social service settings compared to 14 percent occurring in accommodation or food services, and 11 percent

occurring in educational services, and in Ontario, it has been reported that the health care sector has the highest incidence of workplace violence with 8 percent of lost time injuries caused by violence and aggression (Léséleuc, 2004). Liss and McCaskell (1994) examined Ontario Worker's Compensation Board claims of injuries due to workplace violence with data from 1987 to 1991. The authors reported that the number of days lost averaged about 2, 500 per year with costs estimated at $300, 000 per year. Their data did not include any claims that were denied which may have involved injuries that were treated, but allowed the worker to continue working. Thus, their results may have underestimated the burden and cost of illness (Liss & McCaskell, 1994).

The WHO identifies workplace violence as both an individual problem as well as a "structural, strategic problem rooted in social, economic, organizational and cultural factors" (International Council of Nurses, 2002, pp. 9). The prevalence of patient violence has a widespread impact on not only nurses, but on patients and the organization itself. This leads to a greater need for understanding the experience of this phenomenon. It is especially important to further understand patient violence from the perspectives of RNs working in one of the most highly reported areas for violence, namely acute care psychiatric inpatient units. This specific population of RNs can inform the need for further research and, ultimately, this research may lead to the prevention of violence and lessen the impact of violence on individuals, organizations and communities.

Literature Review

The goal of a literature review is to provide context to the research topic of interest based on the available empirical literature. Literature reviews also encompass discussions about methodological decisions that inform study design features and important results (Bourner,

1996). The purpose of this literature review was to explore the existing quantitative and qualitative evidence surrounding patient violence as experienced by psychiatric nurses, and to critically appraise the extent, quality and rigor of this literature.

To structure the overview of the literature on patient violence in the workplace, an electronic search of multiple databases was conducted, including: Ovid, the Cumulative Index to Nursing and Allied Health Literature [CINAHL], EMBASE, PsycINFO, Web of Science and PubMed, and the grey literature (via Google® Scholar).

Grey literature is defined as "that which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers" (Grey Literature Conference Program, 1999 as cited in Grey Literature Report, n.d.). This may include materials such as various types of reports, theses, conference proceedings, bibliographies, technical standards, official documents not yet commercially available, amongst others (Grey Literature Report, n.d.). The method to search the grey literature involved using Google® Scholar which is a search engine for scholarly research including articles, theses, books, abstracts and court opinions, from academic publishers, professional societies, online repositories, universities and other web sites (Google.ca, 2013).

This search utilized the following key search terms (including combinations of each): violence, assault, abuse, aggression, workplace, patient-initiated, psychiatr*, mental health, and nurs* and was limited to adult populations, aged 19 and older. Each database was searched for English-language articles pertaining to the study topic and citations from key studies were also analyzed and reviewed. See Appendix A for Ovid interface search dates. CINAHL was searched from 1982 to present. PubMed was searched from 1980 to present. These databases were searched from the beginning of their publications in order to explore historical reports

available relating to patient violence and psychiatric nursing. Once data were obtained within the initial searches, the data bases, including Web of Science, were searched from year 2000 to present for subsequent searches exploring newer reports. A summary table of the literature search is also presented in Appendix A. A second literature search was conducted 10 months later using the same databases and search terms to identify any newly published material. The result of this secondary search was the inclusion of four new additional articles. Each of these studies were categorized by thematic content and analyzed for their strengths and limitations using either Critical Appraisal Skills Programme (CASP) checklists for appropriate study types or the Health Evidence Bulletins (HEB) Wales checklist for cross-sectional and other observational studies. These tools were chosen based on a systematic review by Sanderson, Tatt, and Higgins (1997) which evaluated evidence-based, reliable, valid and easy to use assessment tools for observational epidemiological studies. The final literature review was completed by March 1, 2014.

Types of Violence

There are different ways to categorize the phenomenon of workplace violence. Typically, it is categorized by the type of violence as defined by different behaviours or categorized by perpetrator characteristics. Violence can be physical, psychological or involve sexual abuse, harassment, bullying, or aggression that may occur intentionally or unintentionally (Registered Nurses Association of Ontario, 2009). The Joint Program on Workplace Violence in the Health Sector has further defined three categories of violence (International Council of Nurses, 2002). Physical violence may include actions using force against another person (for example, hitting, stabbing, pushing, or any other forms of physical assault). Sexual violence is defined as any verbal or physical behaviours based on gender or sexuality. Lastly, psychological violence may

include verbal or physical threats, or repeated intimidation or demeaning behaviours (for example, criticism, insults, yelling, passive aggressive behaviour, and lack of acknowledgement).

Workplace violence is also categorized according to who constitutes the perpetrator. There have been various attempts made to define types of perpetrators. Herath, Forrest, McRae, & Parker (2011) defined three categories of perpetrators. The first is Type 1, or criminal intent, where the perpetrator has no relationship to the workplace. The second is Type 2, or client/customer/patient, where the perpetrator is a client/patient at the workplace who becomes violent towards a staff member or fellow client/patient. Patient violence which is the focus of this study falls under the Type 2 category of violence. Type 3, or worker-to-worker violence, is where the perpetrator is a staff member of the workplace including physicians, managers, volunteers and any other workers. The Ontario Safety Association for Community and Healthcare (OSACH) has expanded this three-category definition to include a fourth type of perpetrator. This additional category is referred to as personal relationship violence, where the perpetrator is a person with a relationship to a staff member who then becomes violent towards the staff member at the workplace (College of Nurses of Ontario, 2009a). Due to the number of ways to classify violence, conceptual clarity is lacking and thus remains variably defined and poorly understood.

Nurses are subject to multiple forms of violence in their day-to-day practice. They are at higher risk of violence in the workplace compared to all other healthcare providers; and in particular, at higher risk of experiencing violence perpetuated by patients or their families (International Council of Nurses, 2002; Gerberich, et al., 2004; Hesketh, et al., 2003). This may be due to the nature of their work and having frequent, direct contact with people in distress (di Martino, 2002). Current research also suggests that nurses working in psychiatry have an

increased risk of experiencing violence (Duncan, et al., 2001; Hesketh, et al., 2003). For example, Hesketh et al. (2003) found that the threat of assault was double for nurses working in psychiatry than medical-surgical nursing, as well, psychiatric nurses were 1.4 times more likely to be physically assaulted and 1.8 times more likely to be emotionally abused compared to nurses working in all other types of units (excluding emergency, medical/surgical, critical care). One reason for this may be that violence in the community is a universal criterion for involuntary admission of an individual suffering from serious mental illness requiring hospitalization (Monahan, et al., 2001) and thus the workplace itself poses a high risk for the continuation of violence in hospital (Lanza, Zeiss, & Rierdan, 2006; Owen, Tarantello, Jones, & Tennant, 1998).

Prevalence and Incidence of Patient Violence

Reported rates of patient violence may vary across international and national reports. As previously stated, the prevalence of violent events against nurses in acute care hospitals by patients is reported to fall anywhere between 25 and 80 percent (Campbell, et al., 2011; Duncan, et al. (2001); Gerberich, et al. (2004); Shields & Wilkins, 2006) and it has been hypothesized that these events are immensely underreported (Gates, Gillespie, & Succop, 2011; Hesketh, et al., 2003; Owen, Tarantello, Jones & Tennant, 1998). This section will review several studies to provide a more in-depth discussion regarding prevalence and incidence of patient violence.

Campbell et al. (2011) studied workplace violence in four health care institutions in one U.S. metropolitan area. They surveyed RNs, and nursing assistants (n= 2, 166) to determine the prevalence of workplace violence and demographic, work-related, and adult and childhood abuse histories as risk factors for violence. Overall, 30 percent of their respondents reported some form of violence during the previous 12 month period which was higher amongst nurses than nursing assistants, with the greatest prevalence in emergency and psychiatry departments.

Ninety percent (90.2 percent) of all workplace physical violence was perpetrated by patients. This study clearly identified definitions of the different types of violence as well as provided an electronic and paper means of completing their survey tool. Limitations of this study included a low response rate (52 percent), and the biases inherent in self-report methods and recall.

Gerberich and colleagues (2004) conducted a nested case-control study to explore the prevalence and risk factors of work-related assaults on nurses. In their sample of 6, 300 registered and practical nurses in Minnesota, they reported the rate of physical assault to be 13.2 incidents per 100 persons per year. They also reported that nurses who worked in nursing homes or long-term care facilities, emergency and psychiatric departments to be at increased risk of violence. Strengths of their study include the randomization of study participants as well as the control for response bias by the weighting observed probabilities of response. However the risk of recall bias remains and the transferability of findings have limited generalizability as the data were collected from Minnesota, United States.

Most of the evidence supports that nurses working on psychiatry units have an increased risk for violence. More specifically, incidence rates of patient violence towards nurses working in inpatient psychiatry is reported anywhere between 34 to 81 percent (Foster, Bowers, & Nijman, 2007; Moylan & Cullinan, 2011; Nolan, Dallender, Soares, Thomsen, & Arnetz, 1999; Shields & Wilkins, 2006).

Foster, Bowers and Nijman (2006) also studied patient violence on acute psychiatric inpatient wards in the United Kingdom using a cross-sectional design. The purpose of their study was to investigate the nature and prevalence of inpatient aggressive behaviour directed at staff, co-patients and the patients themselves via self-harm behaviour. Aggression was defined as “any verbal, non-verbal or physical behaviour that was threatening to the self, others or

property, or physical behaviour that actually harmed self, others or property" (Foster, Bowers, & Nijman, 2007, p. 142). RNs and nursing assistants on five acute inpatient wards reported aggressive incidents using the Staff Observation Aggression Scale – Revised during a 10 month period. Staff were involved in 57.1 percent of aggressive incidents, with the most frequent means reported as verbal violence (60 percent of incidents) or feeling threatened (59 percent). The authors estimated that based on their data, nurses working in psychiatry have a one in 10 chance per year of receiving any kind of injury as a result of patient violence. Due to the location (United Kingdom) of this study the results may be less transferable, and there remains a potential for unreliability of the data due to the limitations of cross-sectional survey designs, however the authors made an attempt to include descriptors of the context and settings to improve rigour.

Moylan & Cullinan (2011) reported that 80 percent of RNs working in psychiatry had been physically assaulted in the course of their careers. Their study utilized a mixed methods study design to provide updated, in depth information about the nature, frequency and severity of assaults and injuries among psychiatric nurses. This study also examined assault and injury in relation to the nurse's decision to restrain patients. Their sample included 110 RNs working in five institutions (two designated psychiatric hospitals, three general hospitals with acute psychiatry units) in the New York City metropolitan area. The mixed method nature of the study provides some rigour and depth to the study however a potential for recall, self-report bias and nonresponse bias still remains. The use of convenience sampling may also affect the representativeness of the sample.

Nolan, Dallendar, Soares, Thomsen and Arnetz (1999) conducted a cross-sectional study in the United Kingdom aimed to identify the extent and nature of violence against mental health

nurses and psychiatrists, and to identify what support, if any, they received following their experiences of violence. Their sample included psychiatrists (n=74) and RNs (n=301) from five West Midland Trusts with an overall response rate of 47 percent. Violence was operationalized within their study as "displaying aggressive behaviour, including spitting, scratching, deploying physical force, or using an object as a weapon, either to threaten or physically assault" (Nolan, Dallender, Soares, Thomsen, & Arnetz, 1999, p. 936). They reported the incidence of violence among hospital-based nurses to be 81 percent which was significantly higher than the incidence among community-based nurses (50 percent) and psychiatrists. Of their sample, 96 percent of nurses and 95 percent of psychiatrists reported the violence to be perpetrated by patients. The low response rate of this study may lend itself to volunteer bias and nonresponse bias, and affects the generalizability of the results and geographically confined to a specific region in the United Kingdom and thus limited the generalizability of the results as well.

As evidenced by these cumulative findings, the variation in prevalence rates may be due to the source of data; for example, there may be a reduced prevalence rate if the data were collected from official reports rather than from self-report (Lanza, Zeiss, & Rierdan, 2006), the length of time measured, as well as the lack of conceptual clarity on the definition of violence for each study. Despite these limitations, research clearly indicates that nurses are at high risk for violence.

Within a Canadian context, the rates of patient violence have been explored in a couple of large, relatively representative studies. The 2005 *National Survey of the Work and Health of Nurses*, a large Canadian study involving almost 19, 000 nurses, was conducted jointly by Statistics Canada, the Canadian Institute for Health Information (CIHI) and Health Canada in order to examine links between nurses' work environments and their health. The authors reported

that 29 percent of nurses (both registered and registered practical nurses) who provide direct care reported being physically assaulted by a patient in the previous year, and 44 percent of nurses reported emotional abuse. For nurses working on acute psychiatry units, 44 percent reported physical assault and 70 percent reported emotional abuse (Shields & Wilkins, 2006). Definitions of physical assault and emotional abuse were not provided to participants in this study which may have affected the reported results. For example, participants may not have reported incidences if they were unsure of what could be classified as violence. This study was representative of employed Canadian nurses, and each nursing body (i.e. Registered Nurses, Registered Practical Nurses and Registered Psychiatric Nurses) was weighted for representative estimates. The response rates amongst each nursing body were satisfactory (>65 percent) with an overall response rate average of 80 percent improving study validity and generalizability.

Similarly, a cross-sectional Canadian study of 8,780 registered nurses from Alberta and British Columbia measured a range of hospital and patient outcomes, including measures of workplace violence (Duncan, et al., 2001). This study is part of a large international research project across Canada, the United States, England, Scotland and Germany aimed at exploring the relationships amongst hospital restructuring, the organization of professional nursing practice and patient care outcomes. Data were collected through the use of anonymous surveys and questionnaires in 210 hospitals in both Alberta and British Columbia. Violence against nurses or nurse abuse was defined as any incident where a nurse experienced:

> physical assault (i.e. Being spit on, bitten, hit, pushed), threat of assault (i.e. verbal or written threats intending harm), emotional abuse such as hurtful attitudes of remarks (i.e. Insults, gestures…), verbal sexual harassment (repeated, unwanted intimate questions or remarks of a sexual nature) or sexual assault (any forced physical contact…). (Duncan, et al., p. 313)

In terms of violence prevalence, it was identified that 46 percent of nurses (self-report) experienced one or more types of violence (physical assault, threat of assault, emotional abuse,

verbal sexual harassment or sexual assault) during their last five shifts. Additional findings indicated that 70 percent of nurses did not report the abuse to anyone at the time of occurrence and that emergency and psychiatry departments were at greater risk for violence which concurs with prior reports (Duncan, et al.). These findings may not be representative of all provinces in Canada, but does suggest a high prevalence of violence and strikingly low reporting practices among nurses. While the data may be fairly transferable, and they lowered their risk of response bias by adjusting the time frame to the last five shifts, the response rate was low at 48.6 percent (British Columbia) and 52.8 percent (Alberta) which may lead to volunteer and nonresponse bias. Due to the cross-sectional nature of the study, self-report bias may also inhibit the accuracy of results.

The literature reviewed suggests a prominent trend regarding the magnitude of violence for nurses working in psychiatry. Lanza, Zeiss, and Rierdan (2006) exemplify this issue with their published literature review on violence against nurses. They based their review on a search of English language articles from 1995 to 2004 accessed through MedLine. Search terms included: 'nurse or nursing' in connection with 'violence or assault or aggression or sexual harassment or PTSD' and from additional searches through reference lists of the included publications. Most research studies included in the review focused largely on nurses from Europe and North America. They cited research samples of psychiatric nurses and nurses in general, but not any other nursing specialty representatives. The number of articles searched was not provided, nor their criteria for inclusion or exclusion of studies selected for their review. Their review explored the prevalence of verbal, physical and sexual violence, the disparity between the incidence of violence and that which gets formally reported, and the impact of violence on nurses. Through their review, they concluded that the "magnitude of workplace

violence of all types is so great in the experience of psychiatric nurses as to be virtually normative internationally" (Lanza, Zeiss, & Rierdan, 2006, p. 75). This suggests that violence in nursing has become accepted in the psychiatric nursing culture as merely part of the job and may play a role in explaining why so few incidents are reported as nurses may have become desensitized to violence over time. Lanza, Zeiss and Rierdan (2006) also described other potential explanations for why violence is underreported and found that nurses typically only report the most severe forms of physical violence, which is often only a small subset of violence, and that nurses are uncertain as to what the definition of violence encompasses. However some caution should be used with this published review as there are several key methodological elements that are not described including the number and descriptions of the studies included. The scope of the search was limited to only MedLine and English language articles which may affect the accuracy of their findings and interpretations.

Anderson (2002) also remarked that workplace violence is a "reality" (p. 351) as nurses will experience at least one event of patient violence in their careers with many experiencing numerous events and of multiple different types of abuse, such as both verbal and physical abuse. This demonstrates a clear need to take action against patient violence and change the growing idea within the culture of nursing that exposure to violence is a normative component of the workplace environment.

Violence and Mental Illness

The link between violence and mental illness is often disputed in the literature. For example, Stuart (2003) published an overview on the link between mental health and violence. Her review was conducted to answer three key questions: (1) are the mentally ill violent? (2) are the mentally ill at increased risk of violence? and (3) are the public at risk? As part of her

review, she discussed the results of the *MacArthur Violence Risk Assessment Study* (Monahan, et al., 2001) that has been described as one of the most comprehensive studies on violence amongst the psychiatric population (both in hospital and the community) to date. Monahan and colleagues' study reported that the prevalence of violence among those with a major mental illness who do not abuse substances was indistinguishable from the control group (also non-substance abusing). It is important to note that Monahan and colleagues (2001) also reported that a concurrent substance abuse disorder doubled the risk of violence which is a common diagnosis found in acute inpatient psychiatry settings. Stuart's conclusions included that (1) mental illness is neither a necessary nor sufficient cause of violence and that the major determinants of violence continue to be socioeconomic factors such as being young, male and of lower socio-economic status; (2) that the public exaggerates the strength of the relationship between violence and mental illness as well as their personal own risk and, (3) that substance abuse appears to be a major determinant in violence whether it occurs alongside mental illness or not (Stuart). The author's search strategy, criteria for inclusion and exclusion of journals and critical appraisals of the included journals were not reported and therefore may limit the accuracy of her findings within the review.

Similarly, Mullen (1997) also conducted a literature review which investigated the association between mental illness and rates of violent behaviours as well as the implications for clinical and public policy. Mullen concluded that recent research had established a modest association only between mental illness and an increased propensity to violence and that the increased risk of violence is mediated, at least in part, by the active symptoms of mental illness. Similar to Stuart (2003), the author's search strategy, criteria for inclusion and exclusion of

journals and critical appraisals of the included journals were not reported and therefore may limit the accuracy of his findings within the review.

Mullen's (1997) conclusion that the increased risk of violence is mediated by symptoms of mental illness is also substantiated by earlier research by Link, Andrews and Cullen (1992). Their study aimed to evaluate alternative explanations for the association between mental patient status and violent/illegal behaviour and concluded that only the presence of psychotic symptoms explained the differences between their patient and community samples. They also concluded that while there was an elevated risk of violence/illegal behaviour among current and former mental health patients, the magnitude of the effect was not relatively large. Compared to other risks like age, gender and education, the risk associated with mental illness was modest (Link, Andrews, & Cullen). Whilst their study aimed to explore alternative views of violence and mental health patients, generalizability may be affected as their data were exclusively from the United States. However both countries use the same gold standard criteria for diagnosing mental illness.

Arboleda-Florez, Holley and Chrisanti (1996) conducted a critical appraisal of the literature on the link between mental illness and violence in Canada. This extensive review was commissioned by the Mental Health Division of Health Canada and involved agency participation by the Mental Health Division of Health Canada, the Canadian Mental Health Association, Canadian Psychiatric Association, John Howard Society of Canada, National Network for Mental Health, and the Schizophrenia Society of Canada. This review explored primarily Canadian and American sources to increase the generalizability of their findings. A number of key findings and statistical relationships were found throughout the literature review. First, the strongest predictor of violence and criminality is a past history of violence and

criminality regardless of diagnostic group (i.e. whether schizophrenia or substance abuse). Second, whether persons with schizophrenia are at risk for violence depends, in part, on the context and the presence of psychotic symptoms. For example, people with schizophrenia have been found to be at somewhat increased risk of committing violent acts, especially when they are experiencing psychotic symptoms. However, violent behaviour has been found to be low among patients with schizophrenia who are receiving appropriate neuroleptic treatment. Third, the occurrence of violent incidents among persons hospitalized with a mental illness may be increasing. Their fourth conclusion is that when released into the community, individuals with mental illness disorders are at high risk of subsequent arrests and violence especially if they are experiencing psychotic symptoms or have a previous history of arrests and violence. Similar to Stuart's (2003) conclusion, Arboleda-Florez, Holley and Crisanti (1996) also reported that substance abuse appears to be a significant risk factor for violence and criminality among community, hospitalized, and offender populations. Finally, very broadly, individuals who are younger are at higher risk of violence and criminality. This review shows evidence that violence among the treated mentally ill population due to the presence of psychotic or residual symptoms leads to higher levels of criminality and violent criminality compared to the general population, and a high incidence of violence while in hospital. Furthermore, studies of mental illness among incarcerated offenders have shown a high prevalence of serious mental disorders and substance abuse disorders. The authors caution that this evidence does not prove that mental illness *causes* violence due to several methodological limitations.

Each of these literature reviews has described significant methodological challenges that prevent researchers from determining a definitive, causal relationship between mental illness and

violence. Mullen (1997) summarizes:

> Each…is bedevilled by methodological problems, not in the least among which are the definitions of dangerousness and the ascertainment. Some studies, for example, conflate criminal convictions with violence, others rely on self report and yet others place heavy reliance on the perceptions of staff and/or relatives in estimating levels of violent and fear-inducing behaviours. In evaluating such literature we are thrown back on looking for overall trends and congruences emerging from methodologically diverse studies, and on a heavy reliance on a few studies which seem to come closest to transcending the methodological difficulties. These latter studies are unfortunately often of a scale and type which make replication, let alone refutation, difficult. (p. 4)

Rippon (2000) published a literature review directly in keeping with Mullen's (1997) observation that there are no clear definitions in relation to terms about danger (i.e. aggression, violence). He stated that this lack of clear definitions has hindered efforts to address the problem of violence in the workplace making current report data less reliable and often skewed (Rippon). He outlined several varying interpretations of both aggression and violence in which all definitions varied in their inclusion of intent and emotions. Ultimately, he concluded that both violence and aggression are essentially synonymous and explored the belief that there are so many interpretations and contextual meanings of these words that they have become useless for the purpose of scientific research (Rippon).

Another challenge that Mullen (1997) describes is that violence cannot be measured directly and thus requires self-report or incident documentation as well as the prevalence of multiple confounders. Arboleda-Florez, Holley, & Chrisanti (1996) also described these methodological challenges in their literature review. First, they stated that it is not always evident how comparisons across study groups should be adjusted to account for factors such as age, sex, socio-economic status, prior arrests, or prior institutionalizations and that it is not possible to diagnose mental illness independently from violence due to how many diagnoses in the current psychiatric manual are defined. Second, that many psychiatric medications have been reported to cause aggression and that the extent that these reactions could account for

violence among the mentally ill is not known. Third, that many studies to date have based their results on treated populations of people with mental illness or incarcerated offenders and these groups are often not representative of all people with mental illness who are recently admitted to hospital and as such are biased towards those people with mental illness who are at greater risk of perpetuating violence. Because of legislation surrounding admission to hospital, results based on treated populations may lead to exaggerated estimates of the relationship between mental illness and violence. Lastly, many studies have relied on institutional records (admission or arrest reports) which may reflect political and social biases and trends and thus not be representative of the true data (Arboleda-Florez, Holley, & Chrisanti, 1996).

From these comprehensive reviews, it is apparent that there is a lack of a strong association among mental illness and violence propensities, however these overviews do not speak directly to the phenomenon of violence in acute hospital settings as many have examined both inpatient and community settings in combination in order to determine a general relationship between violence and mental illness. Other authors (for example, Lanza, 1996 as cited in Soares, Lawoko, & Nolan, 2000) examined the hospital setting more specifically and described that environment as being more strongly associated with violence than psychopathology due to risk factors such as overcrowding, budget cuts and unsuitable conditions.

Risk Factors

Several studies were reviewed to identify risk indicators associated with patient violence towards health care providers. To structure the review of risk factors, Cutcliffe and Riahi's (2013) *Systemic Model of Aggression and Violence in Mental Health Care* was used. This systemic model is based on the empiric evidence of phenomena to date and consists of four

thematic categories. The four categories include: (1) intrapersonal, client-related phenomena; (2) clinician-related phenomena; (3) environmental-related phenomena and; (4) mental healthcare system-related phenomena (Cutcliffe & Riahi, 2013).

Intrapersonal, client-related phenomena.

There have been many risk factors identified for patients which put them at an increased risk for engaging in violence. Owen, Tarantello, Jones and Tennant (1998) conducted a prospective cohort study designed to examine the frequency of violence and aggression on psychiatric units as well as explore potential interactions between staffing, patient mix and rates of behaviours. In this study, 1, 289 violent and aggressive incidents were reported over a period of 105 weeks. In terms of risk factors for patients, relative risk was found to increase with a greater number of involuntary patients on the unit as well as having a diagnosis of psychosis or unstable personality. At the time of their study, on average 50 percent of the population on the units were detained involuntarily and each week more than half of the patients had a diagnosis of schizophrenia or bipolar affective disorder which highlights how psychosis or being a danger to self or others can increase the risk of violence among professionals caring for these types of patients.

Several other studies have identified that being male (Monahan, et al., 2001), being a young adult (Sturup, Monahan, & Kristiansson, 2013), having a prior history of violence, anger or violent thoughts (Monahan, et al., 2001; Sturup, Monahan, & Kristiansson, 2013), having a history of substance use or abuse and withdrawal (Bowers, Allan, Simpson, Jones, & Van Der Merwe, 2009; Lin & Liu, 2005; Monahan, et al., 2001; Steadman, et al., 1998) or personality disorder (Owen, Tarantello, Jones, & Tennant, 1998) increased the risk of being a perpetrator of violence. This finding is directly related to Stuart's (2003) report that concurrent substance

abuse doubles the risk of violence, as those under the influence are less able to control or manage their impulses.

Clinician-related phenomena.

Many studies have also identified risk factors that put staff at risk of being a victim of patient violence; however findings across studies are inconsistent.

Chen and colleagues (2010) reported that being married, having a pre-existing higher anxiety level and shorter employment duration increased a nurse's risk of experiencing workplace violence. One major limitation of this study is that it did not explore other risk factors that may have an impact, such as aggressors' profiles or environmental factors (Chen, Huang, Hwang & Chen). However Pai and Lee (2011) also reported that pre-existing high anxiety levels in their sample of RNs in Taiwan was associated with greater risk for experiencing patient violence. Shields and Wilkins (2009), in their large Canadian study, described less experienced nurses as more likely to report all types of abuse which may explain why less experienced nurses appear to be more likely victims of patient violence versus those with longer employment duration.

Another risk factor that Campbell et al. (2011) reported is that nurses with a past history of childhood sexual abuse or intimate partner violence have an increased risk for workplace physical violence. It is important to note that this study did not limit the perpetrator to patients, but included patient's relatives, coworkers, supervisors and physicians which may have exaggerated the risk for violence by patients (Campbell, et al., 2011). Early violence experiences may be risk factors for later violence (Anderson, 2002). Nurses who have a past history of abuse may suffer from Post-Traumatic Stress Disorder (PTSD) and be unable to provide calm direction when a patient is escalating due to hyper-arousal and fear. Other symptoms of PTSD, such as

numbing or hyper-arousal, may also inhibit risk recognition (Krause, Kaltman, Goodman, & Dutton, 2006) and thus increase their risk of patient violence.

Gender and age are two risk factors that are often disputed in the literature. McKenna, Poole, Smith, Coverdale and Gale (2003) as well as Pai and Lee (2011) reported that being younger increases one's risk of experiencing patient violence, whereas Shoghi et al. (2008) in a study of 1, 317 nurses in Iran, found that nurses age 31-43 years in their study were exposed to more verbal abuse than others, and nurses age 44-58 years were exposed to more physical violence. These authors also reported that male nurses were more exposed to both verbal and physical violence than female nurses (Shoghi, et al.). A limitation of this study may be the generalizability of the findings due to cultural and religious differences in Iran compared to North American settings; however this finding was corroborated by Campbell et al. (2011) in their *Safe at Work* study as well as Shields and Wilkins (2009) in their *Factors Related to On-the-job Abuse of Nurses by Patients* study. These results were contradicted by Ayranci, Yenilmez, Balci and Kaptanoglu (2006) who reported that women experienced a higher percentage of verbal and physical violence compared with men, but that the difference was not significant. Again, a limitation of this study is the generalizability of the results due to cultural and religious differences as this study was based out of Turkey. It is difficult to hypothesize why there are differing results due to the limited generalizability of the study settings, but one hypothesis may be that male nurses are exposed to more violence as they tend to act as protectors of female staff, and another is by Berman et al. (2000 as cited in Lanza, Zeiss, & Rierdan, 2006) who speculates that females are socialized to accept certain types of violence, for example sexual harrassment, as "normal" and thus do not report these events to the same extent as males.

Environmental-related phenomena and mental healthcare system-related phenomena.

The environment in which patients receive, and nurses provide, care has been found to also influence patient violence. Psychiatry and emergency departments reported the highest rates of workplace violence; consequently staff employed in these areas are at higher risk of being a victim of violence (Campbell, et al., 2011; Gerberich, et al., 2005; Shields & Wilkins, 2009). Other risk factors include a lack of presence of security and surveillance, poor teamwork and role ambiguity (Liss & McCaskell, 1994), frequent interruptions, time pressures, high turnover of patients (Bowers, Allan, Simpson, Jones, & Van Der Merwe, 2009) and high levels of physical strain at work, as well as nursing shortages and poor staffing or absenteeism (Owen, Tarantello, Jones, & Tennant, 1998). The time of day has also been reported to have an impact on the risk of violence. It has been reported that evening and night shifts carry the highest risk (Kisa, 2008; Lin & Liu, 2005; Pai & Lee, 2011; Shields & Wilkins, 2006; Shoghi, et al., 2008). This coincides with typically having fewer staff and supports during these shifts.

A Canadian study by Shields and Wilkins (2009) explored four workplace environmental factors: (1) staffing/resource adequacy; (2) nurse-physician working relations; (3) supervisor support and; (4) co-worker support. This study was one of the first Canadian studies to use a nationally-representative sample to study risk factors of abuse in the workplace. The authors reported that all of these factors were significantly associated with both physical and emotional abuse. The risk of assault by patients was reported to be highest among nurses who perceived staffing or resources to be inadequate, and lowest among those who thought they were adequate. A similar result was found between abuse and nurse-physician relations. Those that perceived favourable relations reported a lower abuse rate, and inversely those that perceived poor relations

reported a higher abuse rate. Nurses who identified having low supervisor support were more likely to report physical assault or emotional abuse by patients. This finding was similar to the level of co-worker support. Nurses who perceived low co-worker support were more likely to report physical assault or emotional abuse by patients. One limitation of this study is that it did not assess the frequency or severity of abuse which could have provided a more complete picture of the predictors and factors for violence. These results appear to indicate that a negative work environment for the staff reflects and transfers negatively onto patients and thus increases their risk of perpetuating violence.

Outcomes

Exposure to patient violence within the health care setting has an impact on a range of nurse-related outcomes at both personal and organizational levels. Engagement in acts of violence also impacts patient-related outcomes.

Personal outcomes associated with patient violence.

There are substantial, and mostly negative, consequences for staff following a violent event by patients. Needham, Abderhalden, Halfens, Fischer and Dassen (2005) published a systematic review of studies that were published from 1983 to 2003 to determine non-somatic effects of patient aggression. They included 25 reports from eight different countries and four domains of nursing, including psychiatry, emergency, residential and gerontology, and general/mixed nursing settings. They found that the predominant responses to these incidents included anger, fear or anxiety, PTSD symptoms, guilt, self-blame and shame. These responses occurred across all countries and all nursing domains. This indicates that the responses to violence are a relatively universal experience and significant for those exposed. One of the main

limitations for this systematic review is the lack of standardization amongst definitions of violence as well as the measures used to obtain data on violence exposure.

Sofield and Salmond (2003) also reported that verbal abuse by patients contributes to increased turnover of staff, lower job satisfaction and intent to leave work. They also reported similar negative, non-somatic impacts as Needham, Abderhalden, Halfens, Fischer and Dassen (2005). The specific care environment (e.g. psychiatry, medicine etc) in which these outcomes were evaluated are not identified. The authors also considered verbal abuse from multiple sources in addition to patients, including physicians, patient's families, peers, supervisors and subordinates making it difficult to determine the degree to which patient's as perpetrators of violence singlehandedly contributes to these negative outcomes. However, Ito, Eisen, Sederer, Yamada, & Tachimori (2001) found similar results and report that perceived risk of assault is a significant predictor of intention to leave one's current job. This can be a significant consequence for the organization in retainment of staff. Fewer staff may also lead to staff shortages and the continuation of the feedback cycle of patient violence.

Meanwhile Chen, Huang, Hwang and Chen (2010) found nurses as having significantly lower health-related quality of life (HRQoL) as a result of experiencing physical violence by a patient. Their web-based study did not explore other risk factors, such as environment, and thus these potential confounders could not be controlled for, however this study still provides evidence regarding the relationship between HRQoL and workplace violence.

Not only are there psychological outcomes, but there is also high risk of physical consequences including physical injuries, and temporary or permanent disability (Pai & Lee, 2011).

Organizational outcomes associated with patient violence.

Patient violence towards health care providers results not only in negative health outcomes for the individual, but also influences outcomes at an organizational level. Patient violence has been associated with decreased morale and hostile work environments (Kisa, 2008). A cross-sectional study conducted by Roche, Diers, Duffield and Catling-Paull (2009) across 21 hospitals in Australia found that organizations have difficulty with nursing retention due to nurses' perceptions of emotional violence being present in their workplace resulting in a higher staff turnover, and intent to leave their current positions. Sofield and Salmond (2003) also found similar results in their cross-sectional study in a three hospital health system. They reported that 13.6 percent of participants had left a nursing position because of verbal abuse, 62.2 percent believed it caused increased turnover, and 67 percent of participants believed it contributed to an increased shortage of nurses (Sofield & Salmond, 2003). Another important finding in Roche, Diers, Duffield and Catling-Paull's study was that there was a higher incidence of medical errors following the event and reduced quality of patient care and productivity. This result was also corroborated in studies by both Gates, Gillespie and Succop (2011) as well as Kisa (2008). These studies were based on both self-report and incident reports from a wide variety of nursing units internationally which may affect the generalizability of their findings.

Hoel, Sparks and Cooper (2001) wrote a report commissioned by the International Labour Organization (ILO) Geneva entitled *The Cost of Violence/Stress at Work and the Benefits of a Violence/Stress-free Working Environment*. Through their extensive review of international literature, they reported that, in addition to the above outcomes, violence in the workplace is also associated with absenteeism, as well as high costs associated with leave and workplace injury claims (Hoel, Sparks & Cooper, 2001). A local study by Liss and McCaskell (1994) examined

Worker's Compensation claims in Ontario and corroborated similar findings as Hoel, Sparks and Cooper's international report as did Yassi, Gilbert and Cvitkovich (2005) that reported in Ontario, 58 percent of all stress-related claims were related to violence, with a steady increase in post-traumatic stress from 1996 to 2002. These studies' results may in fact underestimate the burden on organizations in terms of Worker's Compensation claims, especially lost time-injury claims as Liss and McCaskell found that only five percent of nurses who reported they had been assaulted filed claims with the Ontario Worker's Compensation Board, as well the data does not include rejected claims, those with no lost time or incidents with long-term sequelae (i.e. posttraumatic stress disorder).

Patient outcomes associated with patient violence.

Another important consideration is that patient violence may impact patients themselves. Both verbal and physical violence has been associated with adverse outcomes for patient care, such as higher incidences of medication errors, falls, late administration of medications, decreased perceptions of nursing productivity as well as patient satisfaction and perceived quality of care (Arnetz & Arnetz, 2001; Gates, Gillespie, & Succop, 2011; Kisa, 2008; Roche, Diers, Duffield, & Catling-Paull, 2009). It is important to note that the studies conducted by Arnetz and Arnetz, and Gates, Gillespie and Succop utilized cross-sectional research designs and thus cannot confirm causation between the relationship of violence, quality of care and productivity, but merely infer a relationship. All of these studies explored different settings or a mix of multiple nursing domains, as well as were conducted in various locations in the United States and Turkey which may affect generalizability of the study results.

Nurses' Perceptions and Experiences of Workplace Violence

Despite the increasing awareness about patient violence and the impact of this exposure on a range of outcomes, little is known about nurses' descriptions and lived experiences of violence in the workplace. Lack of knowledge about how violence is experienced by nurses makes it difficult to develop effective supports, interventions and workplace guidelines. The next section highlights some of the research findings on nurses' experiences with patient violence.

Catlette (2005) conducted a qualitative descriptive study in Mississippi on the perceptions of workplace violence and safety strategies. It consisted of a sample size of eight RNs employed in level one trauma centres. Participants identified two consistent themes of vulnerability amongst the emergency department nurses and identified inadequate safety measures in the environment (Catlette, 2005). This identification of safety concerns gives insight that the environment can play a significant role in the feelings of vulnerability and experience of patient violence amongst nursing staff. However, these findings may be limited in their transferability to nurses working in acute care psychiatry due to the variation in ward environments. For example, one concern identified was that emergency department doors have a delay upon closing and thus can allow people to slide into the department unnoticed, whereas in psychiatry, often the doors are locked and do not have a time delay to close.

Kisa (2008) conducted a descriptive study examining the phenomenon of verbal abuse towards hospital nurses in Turkey. In this cross-sectional survey study, a sample of 339 female nurses completed questionnaires measuring the incidence of verbal abuse in the hospital work setting, severity of abuse, sources of verbal abuse, behavioural responses and affective feelings after the experience, and where verbal abuse occurred. About 80 percent of participants reported experiencing verbal abuse in the last 12 months with nurses on in-patient units experiencing

verbal abuse most frequently (55.4 percent), followed by 21.9 percent of nurses working on special units (intensive care, operating rooms, or emergency departments) reporting and 18.9 percent of nurses working in outpatient departments. Nurses who reported being verbally abused indicated that they experienced feelings of anger (65.4 percent), sadness/hurt (42.4 percent), shock/surprise (52.8 percent), embarrassment/humiliation (9.3 percent), powerlessness (15.2 percent), fear (17.8 percent), shame (10 percent), hostility (4.5 percent), intimidation (3.7 percent) and other (2.2 percent). The nurses in this study also reported that verbal abuse negatively affected their morale (88.1 percent), caused emotional exhaustion (89.6 percent), decrease in perceived productivity (70.3 percent), and affected the delivery of nursing care (61 percent). Verbal abuse was found to be a nearly universal experience and has serious negative effects for nurses with a range of emotional reactions that also impacted their ability to function within their role as a nurse. Unlike Catlette's qualitative descriptive study, Kisa did not report feelings of vulnerability.

Chapman, Styles, Perry and Combs (2010) conducted a qualitative study to examine whether Taylor's (1983) theory of cognitive adaptation could be used as a framework to understand nurses' perceptions of being a victim of workplace violence. Their study explored the experiences of nurses working in several areas of the hospital (including emergency departments and psychiatry). The perpetrators of workplace violence were not specified. They found that the three cognitive processes that comprised the conceptual framework were identified in the data (*finding meaning, gaining mastery, self-enhancement*). *Finding meaning* involved nurses seeking meaning by describing the event in a logical, step by step process in order to make sense of why the event happened. *Gaining mastery* involved nurses using strategies to gain control of their situation, such as attending counselling, reporting the event, initiating

physical and chemical restraint and avoiding similar situations. *Self-enhancement* involved the use of three strategies to boost self-esteem: (1) comparing themselves favourably with their colleagues; (2) evaluating themselves positively; and (3) finding benefit to themselves, others and the organization. This study identifies that, within the context of experiencing violence, some nurses may be able to cognitively adapt to these intense and stressful situations. This challenges many studies that have explored only the negative outcomes and experiences of patient violence. One limitation of their study was that the authors did not interview nurses who had left the profession as a result of violence, and therefore they hypothesized that their sample may include unusually well-adjusted participants (Chapman, Styles, Perry, & Combs, 2010).

Luck, Jackson and Usher (2008) explored the meanings that emergency department nurses attributed to violent incidents. They conducted a rigorous instrumental case study of 20 RNs who worked in an Australian Emergency Department. They reported that these nurses made judgments about the meaning of violent events according to three factors: perceived personalization of the violence, presence of mitigating factors (such as comorbid or presenting health problems), and lastly the reason for presentation to the emergency department. These results showed that the experience of violence is quite complex and that the meanings nurses attributed to violence was contextually constructed. These judgements affected the ways in which the nurses responded to violence.

Jonker, Goossens, Steenhuis, and Oud (2008) conducted a cross-sectional study measuring the perceptions of and attitudes towards patient aggression by mental health nurses. This study took place on six inpatient wards in one healthcare institution in the Netherlands with a sample size of 85 nurses completing the questionnaires (response rate of 75 percent). Their questionnaire was comprised of two existing instruments: (1) Attitudes Towards Aggression

Scale (ATAS), and (2) Perceptions of the Prevalence of Aggression Scale (POPAS) as well as incorporating questions based on the Theory of Planned Behaviour. Nurses reported being confronted with non-threatening verbal aggression most often (60 percent), followed by passive-aggressive behaviour (31.8 percent), splitting aggressive behaviour (29.5 percent), threatening physical aggression (23.5 percent) and only 9.4 percent reporting physical violence. In terms of attitudes of nurses towards patient aggression, highest scores were found for the view that patient aggression is destructive and offensive and the lowest scores were found for the view that patient aggression is protective or communicative. The strengths of this study include using validated tools to measure attitudes and perceptions.

Cutcliffe (1999) conducted a hermeneutic (phenomenological) study within an East Midlands psychiatric hospital. No further location details were provided. He interviewed six full time RNs who worked on an inpatient unit within the hospital that was previously identified as having the highest incidence of violence. Data were collected through semi-structured "conversations." The researcher stated he used the word "conversation" to avoid a one-way interaction. Cutcliffe (1999) identified 14 categories of data which he then synthesized into three key themes: *(1) personal construct of violence; (2) feeling equipped;* and *(3) feeling supported. Personal construct of violence* refers to individual perceptions of violence, individual responses to violence, defining a violent incident, factors involved in determining that an incident is violent, attitudes towards physical restraints, violence as an expression of malevolence, ambiguity of the madness/badness divide, and the focus of the incident (Cutcliffe). *Feeling equipped* refers to the relationship between repeated exposure to incidents and the nurse's ability to manage the incident, experience or training as a means to equip nurses to be able to manage incidents more effectively, the incident as a chance for learning, and the range of interventions

used to manage the incident. Lastly, *Feeling supported* refers to the opportunity to deal with feelings produced by the incident and the range of feelings produced by the incident (Cutcliffe). From this data, the author constructed an integrated theory where the three themes all overlapped into the lived experience of violence. While the study is representative of the unit the sample was obtained from, it is less generalizable to other populations due to the relatively homogenous sample. It was also not clear precisely where the study took place with few details given making it more difficult to gauge its transferability. Sample size was also limited and may not have reached complete data saturation.

Similarly, Kindy, Petersen and Parkhurst (2005) explored the lived experience of nurses working on psychiatric units with high risks of assaults in Northern California. They utilized a rigorous phenomenological approach and describe four major categories: *safety fortifications, catalysts for violence*, *perplexing aftermath* and *pervasive invasive sequelae*. *Safety fortifications* referred to the preparation staff undertook when faced with a potentially assaultive event. Nurses described instituting the use of tangible safety devices as well as personal preparation, such as drawing on prior training and education, physical positioning, observation of patterned behaviour and the use of medications. *Catalysts for violence* were factors perceived to increase the risk for violence, such as low staffing levels, broken promises to improve environmental safety, slow responses to emergency situations, professional elitism and more. This is similar to Catlette's (2008) theme of identifying inadequate safety measures. The theme of *Perplexing aftermath* refers to nurses' responses and feelings after violent incidents. Participants reported feelings of hypervigilance, fear, and often weighed the risks and benefits of returning to work. They also reported a lack of debriefing following the incident. The last theme is *Pervasive invasive sequelae* which explored the emotional burdens associated with

patient violence, such as the evaluation of one's worth as a nurse, and changes in personal behaviours outside of work. Participants identified negative personal behaviours outside of work which contrasts what participants described in Chapman, Styles, Perry, & Combs' (2010) study such as feeling like they are better parents after the incident of patient violence. The authors self-identified that their small sample size of 10 participants may be a limitation, though they did describe reaching data saturation (Kindy, Petersen, & Parkhurst).

A very recent qualitative study conducted by Zuzelo, Curran and Zeserman (2012) explored RNs' and behavioural health associates' (BHA) responses to violent inpatient interactions, more specifically to physical interactions. The authors conducted focus groups to identify nurse-patient behaviours likely to be categorized as physically violent, explore thoughts and feelings in response to patient violence, and describe team responses to the incidents. Several major themes were discovered such as sharing information about episodes of violence to colleagues through different communication methods, protecting self and others (e.g. keeping one's distance, identifying antecedents to the event, recognizing patient behaviours), intervening non-therapeutically (e.g. directing patients to other staff, requesting apologies, caring mechanically), intervening therapeutically (e.g. exercising restraint, therapeutic consensus, treating patients with dignity and respect), recognizing team influences (e.g. supporting each other, valuing teamwork, establishing group rules), experiencing emotions after violence (e.g. fear, empathy, losing self-control, staying positive, depersonalization) and understanding the work environment (e.g. accepting unpredictability, knowing patients will change with treatment). There are a few major limitations of this study. The first is that it does not specify which qualitative methodology it follows. Another limitation is the use of focus groups may not elicit as rich and indepth of information on this sensitive topic as would other data collection methods.

And lastly, the transferability of the findings from this study may be limited given the small sample (eight RNs and 11 BHAs) from a single health network in the United States.

Nurses' experience with patient violence has thus been studied both qualitatively and measured quantitatively. Research has shown that the frequency of patient violence towards nurses in psychiatry is high, and overall, nurses' experiences with patient violence have significant impact on those involved. The research shows that nurses describe feeling fearful and vulnerable, as well as identify the role that the environment plays in contributing to this feeling of vulnerability. It can be concluded that nurses use a variety of methods to cope after an incident of patient violence, including distancing themselves, becoming more self-prepared to deal with patient violence, speaking with colleagues, and trying to make sense of the incident. However, many published qualitative studies are small in size, with blurred methodologies and conducted mainly within the United States and Europe which may affect generalizability and transferability of the results to other populations and contexts. This highlights the need to conduct high-quality qualitative research focussed on the dimensions of psychiatric nursing and patient violence in inpatient settings and specific to the local context.

Violence Towards Psychiatric Nurses

Few studies have explored violence towards psychiatric nurses in inpatient settings specifically. Many studies have examined violence towards nurses and accounted for various hospital units within each study, or explored community samples. A few others studies (for example, Nolan, Dallender, Soares, Thomsen, & Arnetz, 1999) explored psychiatric nursing accounting for both community and hospital-based nurses. Lanza, Zeiss, & Rierdan (2006) studied the available research on violence towards psychiatric nurses and synthesized research

findings regarding the prevalence, perpetrators and impact that patient violence has on nurses. The authors viewed violence against psychiatric nurses to be part of a:

> series of increasingly broader contexts. It is a special case of violence against nurses, which is a special case of violence against healthcare providers, which is a special case of violence in the workplace, which is, of course, a special case of violence in contemporary global society and culture. (p. 72-73)

Overall, they divided their results into three general findings: (1) psychiatric nurses typically report the highest (or among the highest) levels of violence among all other types of nursing; (2) nurses (as a whole) are typically found to report the highest level of violence amongst all other types of healthcare providers, and (3) internationally, nurses experience more nonfatal violence than any other occupational group.

One potential reason for the high incidence of patient violence towards psychiatric nurses is that these nurses work in an acute environment and often have to make the decision to seclude or restrain escalating patients. Having physical interactions can increase the risk of violent events, but Moylan and Cullinan (2011) also reported that decreasing the use of restrictive measures, such as seclusion or restraints, have increased injury and assaults towards mental health nurses as well which has become a major focus by management in today's psychiatric nursing culture.

Another reason was suggested by Owen, Tarantello, Jones and Tennant (1998). These authors reported that psychiatric nursing staff are the most prominent group to respond to incidents of escalating patient violence. They hypothesized that this may be due to their expertise, availability and the greater proportion of nurses to other staff and thus accounts for the increased incidence of violent events.

Lastly, Papadopoulos et al. (2012) conducted a meta-analysis of the antecedents to patient violence and found that the primary antecedent to patient violence is staff-patient interactions.

Upon examining this, the authors found the main theme of limiting patients' freedoms, such as denying requests or placing some sort of restriction, was the most frequent precursor to patient violence. Often acute inpatient wards have locked-door policies and patients are given privileges to leave the unit. Denial of privileges like these by primarily nursing staff may partially explain the increased patient violence on psychiatric units.

While there is an increasing amount of research exploring patient violence, there is a deficit of research on the topic of patient violence in acute inpatient psychiatry and thus some background and contextual information on this topic, for the purpose of this proposal, has been explored from other sources.

Summary of Evidence and Problem Statement

Not only is patient violence an occupational hazard, but it has severe consequences for the physical and mental health of RNs. Psychiatric nurses are especially at risk (Hesketh, et al., 2003). Despite the prevalence of violence in the workplace and the growing research on this topic, there are still many gaps in our knowledge. While there is a significant amount of research on the topic of workplace violence, including the identification of risk factors for violent behaviours, there are considerably fewer Canadian studies that have explored this topic using qualitative designs to describe and understand the experience of patient violence from the nurses' perspective in the context of acute care inpatient psychiatry despite the increasing magnitude of the phenomenon and the identification of it as an occupational hazard within hospitals around the world (National Institute for Occupational Safety and Health (NIOSH), 2004). It appears that the majority of violence research is quantitative with a focus on epidemiology, risk factors and outcomes of the event in various settings both nationally and internationally. This literature inadequately describes the experiences of patient violence through the lens of psychiatric nurses

working in inpatient hospital settings who are at greater risk of experiencing this phenomenon. Another important concern within the current research is the reliability of the information, and lack of clarity on the definition of what constitutes patient violence. Exploring this identified research gap leads to a more holistic picture of the phenomenon of patient violence and to a more in depth understanding of this clinical issue for nurses that is necessary to advance disciplinary knowledge. More specifically, this information provides a deeper understanding of the problems experienced by nurses within this context, as well as what knowledge and skills they require to address the problem and insight into current practices being implemented to counter patient violence at the clinical level.

Chapter 2: Research Methods

This chapter addresses the research methods for the study. It provides the research purpose, questions and definitions. Next, the principles of interpretive description (Thorne, 2008) as they relate to recruitment, sampling, data collection and data analysis procedures are described. Lastly, strategies to promote overall trustworthiness of the findings and a review of ethical considerations are explored and presented.

Purpose Statement

The purpose of this study was to describe psychiatric nurses' personal experiences of patient violence within the context of acute care inpatient psychiatric settings and the perceived short and long term impacts of patient violence. The findings from this study are intended to create awareness and understanding of the experiences of patient violence to key stakeholders, including nurses, nurse managers and other hospital personnel responsible for staff health and safety, hospital and other nursing organizations and other researchers. Understanding how nurses experience and perceive their exposure to patient violence is critical to designing appropriate interventions to prevent, reduce and manage violence in the acute inpatient psychiatric workplace. It may also decrease stigma and enhance formal and informal support by giving a greater understanding of violence in psychiatry and the perspectives of those who work within the field.

Research Questions

In this study, the following overarching research questions were explored:

1. How do nurses describe their experiences of patient violence in acute care psychiatric hospital settings?

2. How do nurses describe the professional and personal outcomes they associate with their personal exposure to patient violence?
3. What practice strategies do nurses describe as influencing current responses to patient violence (before, during and following an exposure to violence)?

Definition of Terms

This study utilizes the RNAO's definition of violence against nurses. Violence is defined as an "incident of aggression that is physical, verbal, or emotional that occurs when nurses are abused, threatened or assaulted in circumstances related to their work" (Registered Nurses' Association of Ontario, 2009, p. 30). More specifically, *patient violence* is any act of violence towards nurses (as defined above) by patients.

Study Design

Qualitative research is used to explore and develop complex, holistic and detailed understanding of a human or social phenomenon, specifically from the perspectives of the individuals who have experienced the phenomenon (Creswell, 2007). As the current research questions aimed to explore patient violence based on the nurses' experiences with this phenomenon, a qualitative approach was considered appropriate.

Within the qualitative paradigm, an interpretive descriptive approach was selected as the study design and is most suitable for advancing knowledge and documenting subjective as well as experiential elements that have not been previously or adequately reported (Thorne, 2008). Interpretive description arose as a methodology that is congruent with the specific requirements for knowledge within nursing and healthcare. It is a qualitative research approach whose purpose stems from two sources: (1) an actual practice goal, and (2) an understanding of what is or is not known from the empirical evidence from all sources (Thorne, 2008). Interpretive

description is an inductive method of research that involves the formation of a description, but then takes it beyond the self-evident to further discover "associations, relationships and patterns within the phenomenon that has been described" (Thorne, 2008, p. 50) with a focus on bringing the analysis back into the context of the practice field. The goal of interpretive description is to create understanding that is of practical importance to the applied disciplines, such as nursing (Thorne, 2008). The principles of interpretive description (Thorne, 2008) guided all of the current study decisions with regards to sampling, data collection and data analysis. The present study explored the subjective experiences of patient violence by nurses who were employed in acute care inpatient psychiatric units and thus was a useful methodology to achieve the study goals. The primary study purpose, utilizing an interpretive description, was to capture themes and patterns from the subjective experiences of nurses encountering patient violence to inform subsequent clinical practice. This understanding will aid future researchers and clinicians in creating appropriate supports and interventions for nurses.

Approval was granted by the Hamilton Integrated Research Ethics Board (HiREB) to conduct this study (see Appendix B) on December 2012; an amendment to expand advertising and recruitment to an additional hospital in South Central Ontario was subsequently submitted and approved in February 2013.

Setting

This study is set within the Canadian healthcare system and was not limited by geography within Canada. Each province or territory within Canada has a health insurance plan that interlocks together to form the national system known as Medicare. The provision of hospital care falls under the jurisdiction of the provincial and territorial governments and thus can differ by province or territory (Canadian Institute of Health Information, 2001). There are both general

acute care hospitals with acute inpatient mental health services as well as specialized psychiatric hospitals within Canada however there is no standardized criteria for what is considered to be a psychiatric hospital (Canadian Institute for Health Information, 2008).

In general, acute psychiatry units consist of a varied adult patient population including patients with primary diagnoses of schizophrenia, bipolar disorder, depression, personality disorders, substance abuse and addictions as well as other concurrent disorders. The Canadian Institute for Health Information (2008) reported that general hospitals had slightly higher percentages of patients with diagnoses of organic disorders, mood disorders, anxiety disorders, personality disorders and other, whereas psychiatric facilities across Canada tended to have a higher percentage of patients with schizophrenia and other psychotic disorders as well as substance-related disorders. Within general hospitals, it was specified that the diagnosis of mental illness was not always the initial most responsible diagnosis for their admission.

The purposes of hospital admissions are to stabilize acutely ill patients, and provide a safe environment for recovery, resume pharmacological treatments and connect with social and community supports (Canadian Institute for Health Information, 2008; Canadian Mental Health Association of Ontario, 2012).

Staffing, in regards to nursing, within acute psychiatry varies across Canada and often involves a mix of regulated professional nurses including RNs, registered psychiatric nurses as well registered or licensed practical nurses, clinical nurse specialists and more recently nurse practitioners (Health Canada, 2006). Other interdisciplinary team members can include psychiatrists, psychologists, social workers, occupational therapists, recreational therapists, vocational rehabilitation specialists and pharmacists (Videbeck, 2011).

Within the broader context of the Canadian health care system, acute care inpatient psychiatry was chosen as the focus of the exploration of the phenomenon of patient violence. This environment was specifically chosen because it has been consistently identified within the literature as a high-risk area for violence with limited qualitative exploration, and is a context most familiar to the Principal Investigator.

Sample

A purposeful sample of nurses working within acute care psychiatry who self-reported an exposure to patient violence was invited to participate. Purposeful sampling is the selection of individuals based on their ability to provide a rich and detailed description of the research phenomenon being studied (Creswell, 2007).

Nurses were purposively selected to participate in the study if they met the designated inclusion criteria: (1) licensed as a RN in his/her province or territory; (2) fluent in English; (3) were currently, or previously employed within the last 10 years, as an RN in psychiatric adult inpatient acute care; and (4) experienced any single type (or combination of types) of patient violence. Potential participants who were currently engaged in any legal proceedings related to their incidents of patient violence were excluded, as they were legally bound to abstain from discussing their alleged experiences.

Within purposeful sampling, one can sample homogenous or heterogeneous groups. Homogenous sampling is used to ensure that the sample is chosen because of a similar trait or factor that they possess (Cottrell & McKenzie, 2011). This method of sampling was appropriate as this study sought to explore an explicit, in-depth phenomenon occurring within a specific homogenous subgroup of psychiatric nurses (Patton, 2002). More specifically within homogenous sampling, one can sample homogenous groups of typical, intense or extreme cases

(Patton, 2002). Due to the high incidence of patient violence amongst psychiatric nurses, it was hypothesized that within a typical sample of nurses, most will have experienced some degree of violence. To best understand this phenomenon, in-depth, intensity sampling was attempted initially.

The strategy of intensity sampling consists of seeking "information-rich cases that manifest the phenomenon of interest intensely, but not extremely" (Patton, 2002, p. 234). For this study, "intense" cases were defined as RNs who self-reported a) physical abuse or assault where the nurse experienced an injury or no obvious injury; b) verbal or emotional abuse, including harassment; or c) exposure to intimidation or threats of harm from a patient (Mayhew, 2000). Intensity sampling was chosen as it had the potential to provide a more accessible sampling population than extreme cases. It is likely that extreme cases would involve nurses who had moved out of the health care system and were potentially on long-term disability or deceased and thus have limited accessibility for the researcher as a sampling population. Alternatively, intensity samples are more information-rich than "typical cases". By using relatively unusual cases in intensity sampling, it may highlight both the unusual and typical cases, but not distort the phenomenon of interest by being too extreme (Patton, 2002). Due to the use of snowball sampling as a method of recruitment, in order to identify the full range of experiences and the varying dimensions of patient violence, a result was the subsequent recruitment of both extreme and more typical cases.

Only RNs were chosen to participate in this study to enable greater depth and transferability of the study findings as there is some preliminary evidence suggesting that education may play a role in influencing the frequency and intensity of violence (Kisa, 2008; Nachreiner, et al., 2007; Pai & Lee, 2011).

Sample size.

Thorne (2008) suggests that the more common a phenomenon, the smaller the sample size that is needed. While it is difficult to determine a qualitative sample size *a priori*, given that the phenomenon of patient violence, as variously defined, is relatively common within the context of inpatient psychiatry, the estimated sample size for this study was 15 participants. However, the goal of sampling and recruitment was that it would continue until data saturation was achieved for the most significant themes that emerged.

Recruitment

To acquire a purposeful sample of nurses who had experienced patient violence at some degree of intensity, a range of recruitment strategies were used and included: (1) convenience sampling of RNs in one acute care psychiatric inpatient unit located in South Central Ontario; (2) snowball sampling; and (3) study advertisements in the newsletters of relevant provincial and international professional nursing organizations, specifically those with a focus on mental health.

The convenience sampling strategy for recruiting participants involved approaching RNs working on an acute adult inpatient unit in a community hospital in South Central Ontario. Posters (Appendix C) and study information were provided on the unit, and the Principal Investigator held an information session on the unit in which six RNs were in attendance. Permission to present this research project to the nurses had been obtained from the manager and nursing professional practice leader of the unit. At the end of the session, nurses were provided with a summary of the study and the inclusion criteria, and asked to contact the investigator if they met the criteria. One RN contacted the investigator and met criteria and subsequently consented to participate in the study through this recruitment method.

Given the requirement to locate an intensity sample, snowball sampling was also used as a recruitment strategy. Snowball sampling is a method of sampling in which each research participant is asked to recommend additional prospective participants, often when participants are difficult to reach (Boswell & Cannon, 2011). Snowball sampling also involves utilizing experts in the field to identify potential participants (Patton, 2002). For this study, nine key psychiatric clinical nursing leaders identified in Ontario and Alberta that were employed in psychiatry were contacted to identify potential participants and to share study information with interested nurses via a study flyer and information sheet. Interested nurses were then asked to contact the Principal Investigator directly for more study information. This recruitment strategy resulted in identifying 10 registered nurses who subsequently consented to participate in the study.

The last method for recruitment was advertising information about the study on the Mental Health Nursing Interest Group (MHNIG) website, an interest group of the Registered Nurses' Association of Ontario as well as the Nursing Network for Violence Against Women International (NNVAWI) website. A post on the News board regarding a second call for participants was also requested of the MHNIG. Interested group members who met the study inclusion criteria were asked to contact the Principal Investigator to learn more about the study. Advertising through the MHNIG resulted in identifying one RN who subsequently consented to participate in the study.

Data Collection

The primary method of data collection was the use of individual, semi-structured interviews conducted by the Principal Investigator to ensure consistency of the delivery of the interviews. Semi-structured interviews are commonly used in qualitative research to allow the

researcher to explore more deeply the social and personal phenomena under study and to create meaning with participants by exploring their individual perceptions of their experiences (DiCiccio-Bloom & Crabtree, 2006). The semi-structured technique ensures that the researcher will obtain all of the information required, but at the same time, allow the participant freedom of responses and description to illustrate concepts (Morse & Field, 1996). Semi-structured interviewing begins with several pre-determined questions and probes with follow-up questions to elicit more information (DiCiccio-Bloom & Crabtree; Morse & Field, 1996; Walker, 2011). Interviews were conducted in-person for local participants and by telephone for those located outside of the Golden Horseshoe region of Ontario or by participant request.

Prior to the interview, participants were asked to complete a short demographic questionnaire which focused on key areas such as age, gender, work role and years of nursing experience and information related to their shift schedule (Appendix D). The focus of the semi-structured interview was to gain an understanding of how nurses define patient violence and to capture their narrative experiences (stories) of violence in the workplace. The remainder of the interview involved collecting data for the purpose of defining the problem, conducting a needs analysis and completing a thorough practice analysis. This latter section of the interview used a theoretical scaffolding, or structure, to guide the interview questions which were based primarily on the *second stage* of Van Meijel, Gamel, van Swieten-Duijfjes and Grypdonck's framework for *Developing Evidence-based Nursing Interventions* (2002). Van Meijel, Gamel, van Swieten-Duijfjes and Grypdonck's entire model consists of four stages: (1) problem definition; (2) accumulation of building blocks for intervention design; (3) intervention, and (4) intervention validation. The second stage, accumulation of building blocks for intervention design, involves a literature review followed by conducting a problem analysis, a needs analysis and thorough

practice analysis to allow for the creation of an optimal future intervention. This model was chosen for its simplicity, its specific design for evidence-based nursing as opposed to a related field, its emphasis on the importance of qualitative findings and its successful use in the literature (for example, Van Hecke, Verhaeghe, Grypdonck, Beele, Flour & Defloor, 2011). A copy of the semi-structured interview guide is located in Appendix E.

A hallmark of qualitative research is the concurrent collection and analysis of data. As new concepts or practice patterns emerged during the interviews, the properties and dimensions of these concepts were explored in subsequent interviews. As such, the interview guide was revised to include new questions as these themes emerged. A pre-test of these interview questions was conducted with two RN volunteers in order to ensure the information collected provided useful answers to the research questions (Morse & Field, 1996). Revisions to the interview guide were made as necessary.

Each participant was contacted via the initial contact method (either by phone or email) and provided with further information about the study (See Appendix F). They were also contacted by either telephone or email to arrange a mutually convenient date and time for the interviews to take place either face-to-face (n=6) or via telephone (n=6) depending on location and accessibility for participants. This study chose to use both methods to collect data due to feasibility of recruitment and accessibility for participants. Telephone interviews have been reported to decrease cost and travel time for participants, increase the ability to reach geographically dispersed participants, allow the ability to oversee the interviewers, and enhance interviewer safety (Aday, 1996). Chapple (1999) also reported that qualitative telephone data is rich, detailed and of high quality. Participants were screened for study criteria prior to the interview commencing. Initial interview data were collected from March 2013 to December

2013. The interviews were 60-90 minutes in length. When more time was needed to richly explore the data, the participants were invited to a second interview lasting approximately 30-45 minutes. All 12 participants were invited, however only five participants responded and agreed to engage in a second interview. A sixth participant had initially responded stating interest in participating in a second interview, however never responded to additional emails attempting to confirm a date for the interview to be held. All seven participants who had not responded to the initial request for participation in second interviews were contacted once more via the initial contact method, but no responses were obtained. The second interviews were conducted between February 2014 and April 2014. Each participant was sent, in advance, a table of emerging themes from the study and a summary of the transcript from their initial interview. Following all interviews, each participant was provided with a Tim Horton's gift card in the amount of $5.00 as a small token of acknowledgement for their participation in the study. In the event that a telephone interview occurred, the gift card was mailed to the participant at their preferred location.

With the consent of the study participant, each interview was digitally recorded. Only one participant declined to be digitally recorded for reasons unspecified, but consented to the investigator taking detailed notes throughout the interview. During and following each interview, field notes were maintained. Documented in these notes were records of vocal intonations, physical expressions and gestures (when conducting a face to face interview) that were not necessarily audible on the tape to ensure accuracy (Crist & Tanner, 2003). All digital recordings were transcribed verbatim for data analysis, including notes and observations, and secured through encryption and passwords available only to the research team. An anonymization protocol was used to remove any proper nouns/words or identifying data.

Electronic data were backed up on USB drives. Physical notes and papers, as well as backed up USB drives were stored in a locked cabinet for protection and safety by the lead researcher.

Following Thorne's interpretive description methodology, interpreted data that was synthesized underwent the "thoughtful clinician test," where the findings were taken to researchers and educators with expert knowledge of patient violence in psychiatry, as well as the supervisory team, to determine whether the results were plausible (Thorne, Reimer Kirkham & O'Flynn Magee, 2004). The emerging results were discussed with nurse educators who work in the field of psychiatry as well as a researcher with experience in psychiatry. Emerging results were confirmed through this test. Interviews were completed until no new significant themes emerged, known as data saturation (Sandelowski, 1995).

Data Analysis

Data analysis in qualitative research is an iterative process in which data are collected and analyzed concurrently (Creswell, 2007; Hewitt-Taylor, 2001). For this research study, data were analyzed inductively using a conventional content analysis approach (Hsieh & Shannon, 2005). This type of analysis is appropriate for a study design where the objective is to describe a multifaceted phenomenon, such as the phenomenon of patient violence (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). The data were analyzed inductively as there was limited former knowledge and theory about the experience of patient violence within the psychiatric nursing setting. With a conventional content analysis, data are collected primarily through interviews with the use of open-ended questions and non-specific probes. The analysis began by reviewing all of the collected data (transcripts) repeatedly to become immersed within it and to identify areas needed for further exploration in subsequent interviews and sampling (Jacelon & O'Dell, 2005). Following this initial review, data were then read a few words at a time to derive

potential and relevant codes from the text to highlight the key concepts while the researcher made notes of their initial thoughts and analysis. As this process continued, the labels for these codes began to emerge. These codes were then then grouped into similar, or linked, categories. These categories were further collapsed and organized into meaningful clusters. This process of abstraction continued for as long as it was still logical and possible. During the coding process, a constant comparative approach was used in which the data was gathered and then coded into emergent themes. This thematic data is then constantly revisited after initial coding to ensure that there are no new themes emerging. All data gathered from the interviews were coded and revisited for the entirety of the study until no new themes emerged (Creswell, 2007; Hewitt-Taylor, 2001). Next, definitions for each category, subcategory and code were created using content-characteristic words. For example, the code *Part of the Job* was defined as descriptions of the beliefs that violence may (or may not) be part of the job for (psychiatric) nurses. In order to prepare for reporting the results of the study, ideal examples for each code and category were selected from the data (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). Using a conventional content analysis allowed for the ability to gain direct information from study participants without creating bias from preconceived categories or theoretical perspectives (Hsieh & Shannon, 2005). Data coding and analysis for this study was aided by the use of computer assisted qualitative data software (CAQDS), more specifically N-VIVO 10. CAQDS offer the greater ability to store, manage, as well as code-and-retrieve higher volumes of data with less risk of losing or overlooking segments of data (Richards & Richards, 1991; St John & Johnson, 2004).

Trustworthiness and Rigor

Assessment of rigor differs amongst both quantitative and qualitative research, and rightfully so as there are significant conceptual and methodological differences between them.

Qualitative research is assessed for trustworthiness, the confidence that the reader has that your findings are "worth paying attention to" (Lincoln & Guba, 1985, p. 290) as opposed to concepts of reliability and validity (Krefting, 1991). However the purpose and methodology of qualitative research can also have significant differences and thus diverse ways of determining trustworthiness based on what is appropriate for the given research purpose (Krefting). There are four qualitative criteria for determining trustworthiness, and thus rigor of qualitative research that this study followed. The criteria are: (1) credibility; (2) transferability; (3) dependability, and (4) confirmability (Lincoln & Guba).

Credibility

Credibility refers to the confidence in the truth of the findings (Krefting, 1991; Tobin & Begley, 2004). Credibility was strengthened using several strategies. Analysis of the collected data was completed with the assistance of the research team, as opposed to a sole researcher to enhance credibility. The Local Principal Investigator (thesis supervisor) double coded three transcripts and the remaining two committee members also coded another transcript. Analysis with the Local Principal Investigator and other committee members was completed at the beginning of data analysis in order to obtain consensus around the type and range of codes that may be achieved. This occurred again midway through data collection with the Local Principal Investigator as well as the other remaining committee members to continue to obtain consensus surrounding thematic content and coding. This process acted as a form of triangulation which adds dependability, credibility and confirmability to the process (Krefting). Peer debriefing through ongoing discussions with the Local Principal Investigator and other committee members allowed for challenging ideas and insights throughout the research process (Lincoln & Guba, 1985) and also improved credibility. Member checking, a strategy of revealing research findings

to participants in order to ensure the accuracy of data, is often used in qualitative research to decrease the chances of misrepresentation (Lincoln & Guba). In interpretive description, this strategy is not strongly encouraged, however a synthesis of ideas from multiple participants may be shared in order to clarify concepts and consider if the synthesis has adequately captured their experience (Thorne, 2008). Member checking was conducted by sharing a written synthesis of the study data with the participants and inviting them to comment on the accuracy of findings, as well as to explore and clarify the emerging concepts further during a second interview. Credibility was also enhanced by the use of the "thoughtful clinician test," (Thorne) as described previously, which was employed throughout the data collection and analysis process. A reflexive journal was also kept by the primary researcher to improve credibility which included comments on methodological issues as well as acted as a forum to allow the researcher to challenge and account for personal biases (Lincoln & Guba) as well as to reflect on interpretations, new insights or questions brought to the analysis and thus may be contributing to the outcome (Krefting). Krefting also discusses credibility within the idea of the authority of the researcher and the importance of assessing investigative skills or technical competence as well as the interviewing process itself. The Principal Investigator conducted all interviews, enhancing consistency and thus credibility, and has an expertise in acute care inpatient psychiatric nursing thus having a familiarity with the setting and phenomenon as well as investigative and interviewing experience. All interviews fulfilled the maximum time limit and several participants were willing to continue past the allotted time for the interviews. This speaks to both the interviewer's skills to have participants share their truths and experiences as well as the needs for participants to be able to talk in a safe environment. Lastly, theoretical triangulation,

comparing concepts and ideas from diverse or competing literature (Krefting), was also used to enhance credibility throughout the data analysis process.

Transferability

This is the representativeness of the participants for that particular group or more simply the degree to which the findings can apply or be transferred beyond the research. This is comparable to the concept of external validity in quantitative research, however the purpose of qualitative research is not to generalize to a large population and thus the concept of external validity is not appropriate (Krefting, 1991; Lincoln & Guba, 1985; Tobin & Begley, 2004). Transferability was supported by restricting the sample to RNs only, as opposed to including a variety of other nursing levels which enabled a depth and transferability of the study findings to make the results more generalizable and therefore more applicable to RN practice, and to future research (Tobin & Begley). According to Thorne, Reimer Kirkham and O'Flynn-Magee (2004), avoiding common errors in analysis such as premature closure (prematurely attributing a structure to findings in the process) and of going native (an assumption that you as the researcher understand the phenomenon on the same level as a participant) further strengthened the rigor of the study. Open coding of main themes followed by more selective coding relevant to the research purpose was used to avoid premature closure. Transferability was also enhanced by providing in-depth descriptions of the study population and context so that readers may make their own decisions about the transferability of the findings to other settings (Krefting; Lincoln & Guba).

Dependability

Dependability refers to consistency of the data and the quality of the data collection and analysis (Krefting, 1991; Lincoln & Guba, 1985; Tobin & Begley, 2004). Inter-coder reliability

was not applicable as only the Principal Investigator conducted the coding, however as previously mentioned, the Local Principal Investigator (thesis supervisor) and other committee members coded some transcripts to obtain consensus around thematic content and coding.

Confirmability

Confirmability, or neutrality, is the freedom from bias in the research process (Krefting, 1991; Tobin & Begley, 2004). The minutes from team meetings, which outlined all decisions made throughout the study, were recorded as part of a research log and as an audit trail in order to enhance the auditability and confirmability of the study findings (Lincoln & Guba, 1985). This refers to the degree to which research procedures are documented and clarifies and outlines the decision trail of the study (Lincoln & Guba), thus allowing the researcher to better assess the quality of the study (Thorne, Reimer Kirkham & O'Flynn-Magee, 2004) and allow other researchers to follow the decisions made in order to repeat the study and obtain similar results (Krefting) . NViVO 10.0 software, used to manage, store, code and search the data, aided in the auditability of the study by making the analysis process more visible and reduced the risk of having segments of data lost or overlooked (St John & Johnson, 2004).

Ethical Considerations

This research was considered non-invasive, involving minimal risk and included no vulnerable populations. The ethical principles of Respect for Persons, Concern for Welfare and Justice were exercised throughout this study.

Respect for Persons

According to The Tri-Council Policy Statement [TCPS], authored by the Canadian Institutes of Health Research [CIHR], the Natural Sciences and Engineering Research Council of Canada [NSERC] and the Social Sciences and Humanities Research Council of Canada

[SSHRC], *Respect for Persons* is a core ethical principle that must be exercised in research. They describe autonomy as the primary method through which a researcher demonstrates respect for persons. Autonomy is defined as "the ability to deliberate about a decision and to act based on that deliberation" (CIHR, NSERC, SSHRC, 2010, p. 8). This study demonstrated autonomy by ensuring that all participants were aware that participation was voluntary and that there were no consequences associated with withdrawing at any point in time throughout the study. Both paper and electronic copies of the Letter of Information and Consent (Appendix F) containing comprehensive study details were provided to potential participants to better inform their decisions to participate. Furthermore, all participants were given the opportunity to ask questions of the researcher. Written, informed consent was obtained prior to the interview.

Concern for Welfare

Concern for Welfare is another core principle that is best demonstrated by researchers through efforts to minimize risk and protect participants (CIHR, NSERC, SSHRC, 2010). In order to demonstrate concern for welfare, any potential risks to participants were anticipated and strategies to mitigate them were generated. For example, in this study one potential risk was of exploring a distressing topic for participants. This risk was minimized by ensuring that the interview location was in a comfortable environment, participants were made aware of the voluntary nature of the study and that the interview could be terminated at any time and the researcher could have provided information for further assistance should participants have required or requested it.

Another potential risk was that of inconvenience and this risk was minimized again by ensuring participants were aware that their participation was voluntary and may be terminated at

any time with no consequence. Interviews were conducted at both a mutually agreeable time and location of the participants' choosing.

The last potential risk was that of a breach of privacy or confidentiality. This risk falls under the element of Respect for Privacy and Confidentiality within the ethical principle *Concern for Welfare*. Confidentiality is defined as "the obligation of an individual or organization to safeguard entrusted information" (CIHR, NSERC, SSHRC, 2010, p. 56). This risk was minimized by creating an anonymization protocol for all study materials and ensuring proper storage of data through encryption of electronic files and key lock storage for paper data. Participants were also made aware of the confidential nature of all interactions and study data collection. This data will be stored for the recommended 10 years by the HiREB and will subsequently be destroyed through confidential waste after that time.

Justice

The last ethical principle, *Justice*, is defined as a researcher's "obligation to treat people fairly and equitably" (CIHR, NSERC, SSHRC, 2010, p. 10). Recruitment and the potential power imbalance between researcher and participant are areas where the consideration of justice is important (CIHR, NSERC, SSHRC). To demonstrate awareness of justice, the sample inclusion criteria developed for this study did not exclude any participant arbitrarily.

Chapter Summary

This chapter provided an overview of interpretive description methodology and the rationale for its appropriateness for this study, as well as presented a comprehensive description of this study's design, recruitment, sampling, data collection and analysis procedures. Ethical considerations related to this study were also explored.

Chapter 3: Findings

Findings from individual interviews were explored and synthesized using the principles of interpretive description and conventional content analytic strategies to generate thematic patterns. This chapter begins by exploring the characteristics of the purposeful sample of the RNs who participated in this study, followed by an in-depth description and interpretation of their experiences with patient violence. The presentation of the findings starts with the identification of factors as perceived by nurses that contributed to the specific incidents of patient violence and the processes that nurses engage in to prevent and manage patient violence. Following this, a description and interpretation of the impacts that patient violence had on the RN are presented as well as meta-themes that emerged from the data. These meta-themes include power and control, stigma, violence as "part of the job" and the balance between nurses' safety versus patient care. Finally, nurses' perceptions of their needs relating to patient violence are explored.

Using the three unique recruitment strategies previously described, a total of 33 RNs were contacted and invited to participate in this study. A total of 18 individuals responded to requests for participation. However only 12 consented to participate in an interview and six other individuals declined further participation due to time limitations and/or became unresponsive to attempts to schedule interviews. Of the remaining individuals contacted, 15 did not respond to the initial contact (see Figure 1). With an overall sample size of 12 nurses, 17 interviews were conducted (12 primary interviews and second interviews with 5 of the 12 participants). Study participants described a total of 33 unique exposures to patient violence within the acute care psychiatric environment. These 33 exposures were considered as unique units of analysis and the characteristics of each exposure were compared and contrasted within the content analysis

process. Quotes by various RNs are used throughout the chapter to support, illustrate and clarify concepts (Thorne, Reimer Kirkham, & O'Flynn Magee, 2004) and illuminate experiences of participants (Sandelowski, 1994).

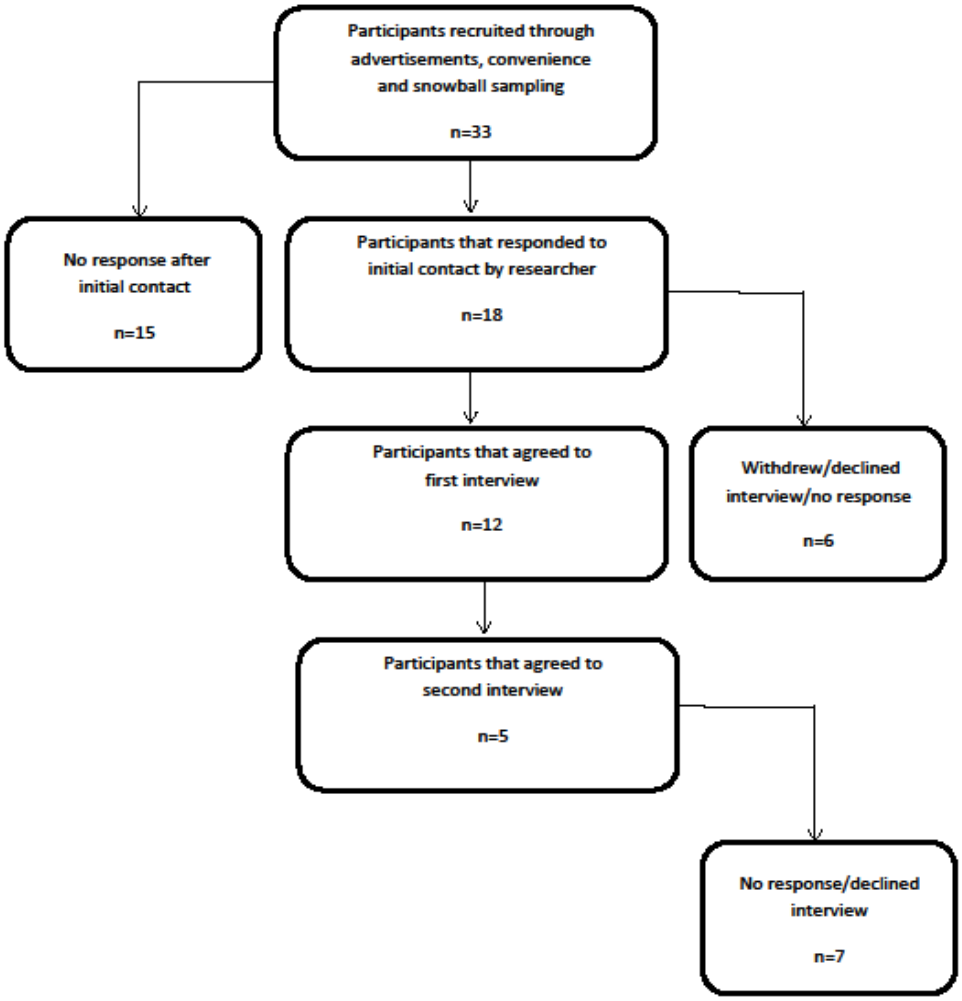

Figure 1. Recruitment process and resulting sample

Demographics and Context

In 2013, when the initial interviews were conducted, the average age of study participants was 39 years (range 27-57 years). Eight participants were female, four participants were male. Participants in this sample had worked an average of nine years in acute inpatient psychiatry (range 5-23 years). All participants worked in a general hospital on acute inpatient psychiatry

units as opposed to within specially designated psychiatric hospitals. Participants worked in hospitals located in South-Central Ontario, Alberta and New Brunswick. One RN had a college diploma in nursing, five RNs held a baccalaureate degree in nursing, five RNs held Master's degrees and one RN was completing a doctoral degree. At the time of data collection, seven participants were currently staff nurses in acute inpatient psychiatry, one was an Admissions nurse, two were Clinical Nurse Specialists, one participant was a nurse manager in acute inpatient psychiatry and one was a psychiatric nurse educator. All had worked as staff nurses in acute inpatient psychiatry within five years of data collection. Nine participants were or had been employed full time, and two participants worked part-time. One participant worked both full and part time throughout their career working in acute psychiatry. Three participants worked at multiple hospital locations within the five years preceding these interviews.

The unit environments employing the study participants varied by context and location as well. Two participants described that, throughout the course of the study, their hospitals had relocated to new buildings with a third organization in the planning stages of a major renovation. The number of beds on each unit ranged from 16 to 36 which were often divided into ward beds and beds in sections of the unit that were lower stimulation with the sections having the ability to be locked for patients considered more unwell and higher risk (i.e. in terms of harm to self or others, or elopement risk). This was sometimes referred to as the psychiatric intensive care area. Among the participants, they all confirmed working on units that had at least one room designated for seclusion. However, it was observed that on some units there were specifically designed seclusion rooms and in other unit contexts, staff took it upon themselves to locate space within the unit that could be used for locked seclusion. As one RN explained, "technically it was not a legal seclusion room but we called it a seclusion room because we could lock the door"

(RN05). Room layouts also differed by organization with some participants (two RNs initially, a third RN post-hospital move) described having private rooms throughout the ward, while other participants described shared rooms with up to four patients per room. All participants described staffing primarily as a mix of RNs and registered practical nurses (RPN) at differing ratios. Several RNs described that the ratio fluctuated during their course of working as a staff nurse, anywhere from being an RN only staffing model to ratios such as three RPNs to one RN and this mix also varied depending on the specific shift. The workload ranged from three to eight patients per nurse depending on staffing availability, acuity (i.e. higher acuity often meant fewer patients per nurse), and the specific shift (i.e. night shift tended to have a higher patient to staff nurse ratio). RNs described working with patients in crisis with a variety of diagnoses including mood disorders, substance use disorders, schizophrenia and other psychotic disorders, concurrent disorders (developmental disorder plus a co-occurring psychiatric disorder), personality disorders, behavioural problems and patients without formal diagnoses.

Security services were present regardless of the workplace for all participants; however their scope and training differed significantly. For example, two participants from Alberta described having a mix of both hospital security guards and Peace Officers that received specialized mental health training. The Public Security Peace Officer Program is unique in Canada and gives different levels of government the opportunity to employ peace officers for community safety or specialized law enforcement needs (Government of Alberta, 2012). Others described their hospitals as employing hospital security staff or contracted security staff and these RNs described having varying confidence in the security staff's skills and abilities.

Types of Patient Violence Experienced

RNs participating in this study described a number of different events of patient violence in their workplaces including physical and verbal violence.

Physical Violence

Within the context of the interviews, the participants described a total of 25 violent events that could be described as physical violence initiated by a patient and directed towards the RN. More specifically, the types of physical violence expressed included: being chased and cornered, being hit, punched or grabbed, kicked, spit at, strangled, as well as using a weapon or the environment, such as breaking a window, to illicit violence. Four incidents included a combination of these, such as being hit and kicked simultaneously. The most commonly described type of physical violence was being hit (for example, punched) (n=5 incidents) followed closely by being grabbed (for example, hair pulled) (n=4) and being kicked (n=4). These experiences were not necessarily exclusive to only physical violence with many events also involving simultaneous verbal violence (n=4) in the form of threats, swearing or demeaning comments.

Verbal Violence

Experiences of verbal violence, encompassing verbal abuse, as well as emotional and psychological violence, were somewhat more difficult to elucidate for most RNs. Many participants were only able to describe verbal violence in a general sense as there was consensus that being on the receiving end of verbal violence was a very common occurrence. One RN explained "…that [verbal violence] happens all the time right up until this morning!" (RN04). However there were eight exclusive, more detailed, verbally violent incidents described. These events ranged from swearing, to threats, intimidation and gestures, to sexually inappropriate

comments to mean, spiteful, confrontational or demeaning incidents. The most commonly described experience was that of threats, intimidation or gestures (n=7 incidents) with the content relating to physical harm or rape.

Nurses' Perceptions of Violence

How Nurses Defined Violence

Defining patient violence was complex. No one participant had the same definition of patient violence. Participants very readily included physical violence in their personal definitions of patient violence. RNs tended to include those types of violence that were most threatening or dangerous to their personal well-being in their definitions of violence over types of violence that were seen as more benign, such as swearing. For example, many participants initially remarked that verbal violence was such a common occurrence and thus not always considered to be a form of violence, as stated by this participant:

> I guess because we work on psychiatry we assume and forget that verbal violence is violence and so we take it serious [sic] to a certain extent, but where other units would do incident reports for something like that, that is our everyday. (RN03)

Four participants chose to specify that they only considered threats or intimidation as violence. One RN conceded that verbal violence was not worthy of being included in their definition of violence, but when asked to describe experiences with violence, freely discussed situations involving verbal violence.

After exploring participants' stories of patient violence, several participants chose to expand their initial personal definitions to include more broad types of verbal violence as this RN highlighted:

> I didn't really think of verbal threatening as violence, however after seeing my transcript [summary] in black and white, it's *really* traumatizing to see that someone yelling and screaming is the most disturbing thing to read and it's almost re-traumatizing to read it

> again which, no one has ever written this down and had it sort of read back to me, so *yes*, I do think that the yelling, verbal aggression would be classified as violence. (RN05)

Did They Mean To Do It?

More complex however was the relationship between a patient's intention and their expression of violent behaviour according to the nurses interviewed in this sample. If the act, verbal, physical or other was perceived by the nurse as intentional, or the patient was viewed as doing it purposefully and not as a symptom of their illness, participants defined those actions as a form of patient violence. However if the actions were viewed as unintentional, or a component of the patients' illness, three other nurse participants stated that it could still be classified as violence depending on many factors including the situation, relationship with the patient, specific actions, and whether it was bothersome or had noticeable impacts on the individual nurse regardless of the type or intent of the action. For the remaining participants, when violence was considered unintentional, it was legitimized as part of their illness and thus decreased their perceived level of threat and harm leading them to consider it as something other than violence, such as self-defence.

Understanding the Context of Care

Within the acute psychiatric inpatient unit, there were many pre-existing factors that nurses perceived as having influence over whether or not violence occurs, and that within this context, nurses already have strategies that they routinely use in their practice to prevent or manage violence. Despite these strategies, there are also other conditions that can contribute to the experience of patient violence and nurses identified that there are multiple contributing factors that create an environment for this to occur. Existing strategies to support nurses who have experienced violence within the contexts of the organizations are also explored.

Contributing Factors to Patient Violence

RNs in this study identified several patient-related, nursing-related and environmental factors that they perceived as contributing to patient violence. The patient-related factors identified were: (1) type of psychiatric diagnosis; (2) history of patient's previous violent behaviour, and (3) substance use. Nursing-related factors were: (1) communication amongst nursing staff; (2) engagement in debriefing, and (3) the quality of patient assessment. Finally, unit-related attributes of the inpatient psychiatric unit that were also perceived to play a role in patient violence were: (1) the availability of nursing staff; (2) physical space; and (3) availability of activities for patients.

In terms of patient-related factors, often a patient's diagnosis was considered to be a contributing factor to the violence the participants experienced. In the analysis of the 33 narratives of nurses' experiences, what emerged was that for physical violence, seven RNs described that patients who are diagnosed with psychosis or a personality disorder contributed to the experience of violence, and participants further explained that this was due to the symptoms often exhibited with these illnesses such as impulsivity or experiencing perceptual disturbances and disturbed responses to involuntary stimuli. The specific patient diagnoses that this sample of nurses identified as being associated with an increase risk of violent behaviours included: schizophrenia, schizoaffective disorder, psychosis not otherwise specified, bipolar affective disorder, major depressive disorder, borderline personality disorder, antisocial personality disorder and substance use. Meanwhile participants attributed not necessarily a specific diagnosis of a disorder to the experience of verbal violence, but to a patient's personality and ability to cope. RNs believed that a patient's ability to cope with stress, or anxiety or anything

else that forced them to lose control could impact their propensity for violence regardless of a specific psychiatric diagnosis. As this participant explained:

> Everyone brings things that they become out of control in…maybe they become so distraught because they can't cope in a situation…Maybe they haven't learned a better way of coping, maybe these individuals have experienced trauma and maybe what they experienced was violent, maybe they experienced their parents being violent towards each other and that's how they learned to cope and de-stress. (RN12)

Regarding patients' personalities, general malevolence was also perceived as contributing to violence as one RN pointed out that "…there's [sic] people that are mentally ill, but there's also some very vile people who are mentally ill…" (RN06). A history of violence and/or substance use was also considered to contribute to verbal violence in a small number of participants' experiences. As RN02 points out, "There's [sic] dangerous people at times with long criminal histories of violent behaviour so it's not surprising that they may regress and be violent in hospital or violent in every other aspect of their life." If a patient was brought to hospital because of violence in the community, it was also perceived by some RNs as contributing to violence in the hospital. For one participant, substance use was ascribed to be a direct contributing factor to the experience of verbal violence as the patient had ingested substances prior to the abuse. For another RN, one of their narrated experiences involved a patient who had a long history of substance abuse and this may be an indicator of the patient's inability to cope with stress and thus be a contributing factor to the experience of patient violence.

Communication, specifically poor communication, amongst nursing staff in the study was seen as nursing-related factor contributing to patient violence when it put nurses into unsafe situations. Specifically RNs described poor communication around passing on risks or safety issues to colleagues or not having a well communicated plan to prevent and manage violence.

For example, for one participant, it directly contributed to the violence that he/she experienced. The RN was told by nursing colleagues that the patient wanted to speak with the RN, but they failed to communicate the patient's high level of agitation and subsequently when the RN went to speak with the patient the RN was physically assaulted. Throughout data analysis it was also apparent that a lack of debriefing had several negative effects on both RNs and patients, and was perceived by nurses as contributing to violence when they did not have the opportunity to provide or receive feedback, plan for other prevention measures or debrief with the patient to gain an understanding of their triggers and coping skills.

For some participants, the quality of the emergency department assessment and at times subsequent appropriateness for admission to the unit were factors that contributed to the experience of patient violence. How well the emergency department staff performed an assessment and communicated risks influenced the preparedness of the nurses for the admission to the unit and often meant that the needs of the patient were met appropriately. For example, this participant described the experience of receiving a new admission without a thorough assessment:

> The patient was deemed a stable, depressed patient…I had to call the resident who kept saying, "but she was calm down in emerg [sic] so I didn't give her any meds" and we said "well, we need meds" and he just kept saying "but she was calm" and I just held the phone up and said "*this* is your calm patient now!" and he could hear her screaming in the background and I said we need something so we were finally able to get some meds and get them into her and calm her down. (RN01)

Unit-related factors included physical space, availability of activities for patients, and the availability of nursing staff. Throughout RNs narratives of their experiences with patient violence, the availability of staff on the unit played a role in contributing to violence. In most accounts, the nursing staff complement was normal for the particular units, however often the nurses were on breaks, or distracted by other tasks such as admissions and discharges, their own

patient care or assisting with recreational activities when the events occurred and thus not as attuned to other events on the unit. These reasons were also seen as causing a delayed response time of colleagues and having staff available to assist during a situation which was described as contributing to the experience of physical violence. Other than nursing staff, one participant directly contributed the experience of patient violence to the unavailability of the psychiatrist as the psychiatrist did not see the patient until the 72 hour assessment hold was almost expiring as this RN described:

> His doctor had not seen him since admission and quite a few hours had passed. I'm talking like 70 hours of a 72 hour hold had passed without a psychiatrist seeing him and he was *well* aware of this and this man, not a very large man, was able to make his bed (while in five point restraints) hop across the room because he was so angry and so agitated and screaming that I can *still* hear him screaming in my head…and all he kept screaming was the doctor's name and I still hear him screaming. (RN05)

This demonstrates a lack of consistent access to care and assessment by physicians and other members of the healthcare team which puts RNs in a difficult and unsafe position to manage situations in which they have little control. Lack of physical space and crowding was another unit-related factor that was often alluded to in regards to contributing to violence. When space was limited, RNs described the possibility for interpersonal friction amongst patients. They also considered that space and crowding may impact patients' feelings of safety and have a ripple effect amongst the unit population as RN08 described:

> You have all these different types of people with different types of problems and different manifestations in different psychopathology all within this confined space where people don't necessarily feel safe…And that actually has this kind of ripple effect. People kind of peak off each other and…that can increase the risk of violence.

Two RNs in the study perceived that boredom from a lack of patient-focused activities was another unit-related factor that contributed to patient violence. The level of programming varied from organization to organization, and could even vary in amount offered within an organization

as this RN described, “Some units are better than others and here at this organization it all comes down to each individual program how much funding goes into programming and activities” (RN08).

Staying Safe – Nurses’ Strategies to Ensure Their Own Personal Safety

General strategies to protect one’s own personal safety while at work held high importance with most nurses in the study. These strategies were used routinely while at work, regardless of the risk of violence, and often these strategies were all within the realm of the nurses’ control and abilities. Some of the strategies, or the frequency to which certain strategies were used, depended on the culture and influence of other colleagues on the unit.

Awareness of surroundings and colleagues’ whereabouts.

RNs made a point of knowing where exits were located in their immediate vicinities, knowing who else was around and where people were relative to themselves to ensure their own safety. They paid attention to the sounds and milieu of the unit at any given time, as well as being aware of what objects on the units could potentially be used as weapons and taking steps to reduce these risks, such as removing sharp objects or specific furniture from the unit. This was consistent for all participants. They described the need to “have eyes on the back of your head in terms of where people are positioned, where your colleagues are” (RN01) and that this safety measure becomes “second nature” (RN01). For some participants, it was also perceived as something important to teach to new nurses that gets passed down from more experienced colleagues.

Similarly, all RNs described the importance of telling their coworkers where and with whom they were going so that coworkers would know to look for them or keep an eye out for them in case of trouble, as well as when they were going on break to know how many staff were

left on the unit. For example, this RN explained, "I'll notify the other nurses…I'll notify them of where I am kind of thing when I'm not in the nursing station especially if there is someone who has a history of aggression or violence" (RN11). Participants viewed this practice as both a courtesy and a necessity for themselves regardless of whether other coworkers engaged in this practice. Knowing where colleagues were was perceived to help to ensure the safety and security of the unit and subsequently ensure that there was sufficient power available in case a situation evolved. Sometimes it was a strategy not only used by individual nurses, but adopted by the unit as a whole as described by an RN, "It's kind of a part and parcel of how this unit operated to make sure we were safe. So I think those [strategies] just become ingrained" (RN01).

Personal alarm devices.

Some participants wore personal alarms, or other devices such as whistles, as a method of calling for help and preventing escalating violence, however this varied. Whether a participant wore a personal alarm or other device seemed to depend on: (1) whether such device was accessible and available to staff, and (2) what the prevailing culture on the unit was relating to personal alarm devices. Some RNs described the culture of their units to disregard using personal alarm devices, regardless of whether it was mandated or not, because they were an annoyance either due to their size or bulkiness, intermittent functioning, or felt they would disrupt coworkers on their breaks and thus would not wear them while others valued their use. This participant described the culture of wearing personal alarm devices on their unit:

> It's the culture, right? If I don't like this or if I don't think this is necessary…I think some of it had something to with the fact that some of these people, not all of the nurses, but some of the ones that had a lot of pull or strong personalities basically just said "you're on your break and you don't want to be bothered…so I'm not going to wear it". It was reinforced over and over that you have to do this, its policy and these people just set their own policy, their own rules and that's the way it was. (RN06)

For those participants that viewed the personal alarms as necessary, they described them as important so that they could call for help as well as respond to others in need. Many of these RNs explained that personal alarms were the only method to call for help on their units due to size and the lack of other emergency call bell systems. This was a method of ensuring the safety and security of the unit, but also that sufficient staff and power could be available to prevent patient violence if the need arose.

Safety of self.

Other individual safety measures involved one's own person. Especially used in prevention of physical violence, RNs ensured that they had unobstructed vision, tied their hair back if it was long, and did not wear anything around their necks nor had anything dangling, such as earrings, that could be grabbed. One participant went as far as to explain that he refuses to have antiglare coating put on his glasses:

> It sounds weird but I've never got that antiglare coating on my glasses so I can see people coming up behind me…I always get asked "do you want the antiglare?" No, I'd prefer to be able to see who's coming up behind me. (RN12)

The focus of these actions was on controlling their own personal safety unrelated to the security of the patient or the unit.

Existing Organizational Safety Supports

All participants reported working with and being supported by security personnel within their organization, however the perceived degree of support and confidence in their skills and abilities varied. Three RNs (two of whom worked at the same organization) identified that their security personnel were not trained to have any physical interactions with patients, which then limited their ability to assist and support RNs during a time of physical crisis, and subsequently lowered the nurses' confidence in security personnel's skills and abilities to manage the crisis.

RNs' confidence in the skills and capacity of local security to assist and support them was also based on their physical appearance, as this participant described:

> All our security staff are not very good …They're seniors, or they're basically frail. They're not helpful. They show up, but I've never seen them do anything, but they're there so I mean it's good to have a couple pairs of hands but I think they're pretty scared when they come. (RN10)

Nurses' opinions about security personnels' value tended to impact how well they perceived working together and being supported.

Experiences of Patient Violence in Acute Care Inpatient Psychiatry

Despite the routine practices that nurses already have in place and the identification of contributing factors, patient violence towards nurses still occurs. Often, violence is preceded by some form of a trigger, or antecedent. Once nurses are aware of the triggers, there are a number of strategies RNs use in practice to prevent and manage escalating patient violence at an individual and team level.

Antecedents of Patient Violence

Antecedents, also known in the literature as precursors or triggers, are events and/or conditions nurses perceive that immediately precede and are responsible for initiating patient violence. Throughout the analysis of the 33 narrative experiences, the antecedents reflected mostly interpersonal interactions, with some incidents reflecting intrapersonal, client-related precursors. Within the interpersonal interactions it can be further categorized into nurse-patient or patient-patient interactions.

The RNs in this study described their roles as being care providers to patients to assist in treatment and recovery, but within their role, they are also responsible for the safety and welfare of their patients, co-patients and colleagues on the unit which often required very different approaches. They were also responsible to uphold legislation including the Mental Health Act

(Canadian Federation for Mental Health Nursing, 2006). Maintaining safety on the unit for both staff and patients required that there be rules in place to mitigate the risk and nurses were often tasked with being the enforcers more so than other disciplines which highlighted the power differential between patients and nurses. Often these were rules limiting freedoms such as being able to leave the hospital or have privileges to leave the unit, which many times were also supported by the Mental Health Act if a patient were being held based on an involuntary status.

Leading up to the experience of violence, the loss of power stemming from a patient being denied something by an RN or an RN "placing boundaries" (RN04) and restrictions on a patient was the most significantly identified trigger to both verbal and physical violence. As participant RN07 explained, "It could be as simple as they want to go off for their cigarette and you're saying no, you can't go off." This finding is supported by Foster, Bowers and Nijman (2007) that found that being denied something was the most common trigger to patient violence. Similarly, if patients felt their rights were being disregarded, often when they were being held in hospital involuntarily, then this was seen as a common antecedent to patient violence. An example of this is described by RN12:

> Me and the doctor [sic] were interviewing him, and twenty minutes before the incident, he started to get agitated. You know, saying he had the right to leave, that he wanted to be with his family and he started getting agitated.

Within the nurse-patient interaction spectrum, there was one incident that could be classified into a sub-category referred to in this study as nurse-patient-nurse interaction. In this narrative, the RN's patient had a tendency to target another staff member, but was physically violent towards the RN and this interaction was perceived by the RN to have triggered the ensuing violence. Intrapersonal, client-related factors were also believed to play a part in why the one staff member was a target.

As RN08 explained:

> A staff member who she [the patient] tended to target was on staff that day and that was actually part of what was happening prior to, like she was getting revved up and saying "this person's [other staff member] doing this to me" which was not real because….the stuff was just completely bizarre.

In other situations, the trigger was a result of a patient-patient interaction. Patients on the psychiatric inpatient units interacted in a number of identified ways such as during unit-led recreational or therapeutic activities or groups and in common areas of the unit. One participant described altercations between the patient and other patients on the unit preceding the patient directing their aggression on the RN. The RN acknowledged, "What had also triggered him was he was getting aggressive with other patients" (RN02) prior to the incident of patient violence with the participant.

Nurses' perceptions of patients actively experiencing perceptual disturbances, such as hallucinations or delusions, was also seen as a preceding event for violence and can be categorized as an intrapersonal, client-related antecedent. In several narratives, RNs believed their patients were experiencing active hallucinations or delusions as this participant demonstrates:

> I had a patient who was quite psychotic. He was in his early forties, quite docile, nothing indicated that he would have reacted in a certain way after the day I had him…but this guy had actually switched gears on me when I was talking to him and he went into just a completely different realm of talking. Like…his eyes went black and I didn't know what he was thinking and I was actually in a position where he had me cornered in a part of the unit that I couldn't really get away from him and…he started actually chasing me on the unit. (RN06)

Another participant described the experience of a patient who was delusional at the time of the incident:

> He believed he was a martial arts expert. We were able to de-escalate him and actually get him down to our seclusion area and…get him to take medications, but he was under

> the belief that he was an expert in martial arts. He had to show us…and he first started to physically attack the environment, but then he broke a window in my face. (RN12)

In these examples, the participants attributed the patients to having psychotic experiences which directly preceded and led to the experience of violence. There were also several narratives that the nurses in the study described in which the RNs could not determine what the antecedent to violence was.

Through exploring the antecedents and triggers to violent events it is apparent that RNs do not see themselves as being responsible for violence, but place emphasis on interpersonal interactions and client-related triggers.

Individual Violence Prevention Strategies

Nurses spoke of the prevention of exposure to violence on a continuum from primary prevention strategies through to attempting to prevent further levels of escalation and violence (secondary and tertiary prevention). Primary prevention strategies are proactive. They are aimed at stopping violence before it occurs, and attempt to reduce the factors that put people at risk for experiencing violence. Secondary prevention focuses on the immediate responses to violence and tertiary prevention involves long term approaches that occur in the aftermath of violence which also include lessening the emotional trauma to the victim (Centers for Disease Control and Prevention (CDC), n.d.). This section is outlined following this framework. Participants identified similar current individual practice strategies for both physical as well as verbal violence. Several strategies were consistently used regardless of an individual RN's background, workplace or experience level however which strategies used depended on the level of existing escalation of the patient. As prevention measures moved throughout the continuum from primary to secondary prevention, the focus became less on the individual strategies and more towards a team approach to prevention. The movement along the prevention continuum

also demonstrated a shift from patient-centred strategies intended to keep the patient's best interest and needs in focus to more nurse-centred strategies. The nurse-centred strategies aimed at controlling the situation, self-preservation and one's own safety and back to patient-centred strategies after the event occurred to prevent any further incidents. Despite the shift to more nursing-focused strategies, RNs believed they were acting within the patients' best interests.

While there were many strategies discussed and implemented while exploring RNs' narratives, many participants described these strategies as being ineffective at the time or not being able to implement anything in time before an event happened and the majority of RNs had difficulty in identifying strategies that they perceived to have been successfully implemented in their workplaces.

Patient-centred strategies to prevent violence.

Along with knowing their surroundings, RNs made sure they used safe body positioning techniques such as allowing adequate personal space for patients, watching how their back was turned, and knowing how to enter a room safely. In terms of body language, four participants from four different organizations, ensured that their body language, including tone of voice, and position maintained an appearance of openness, respect and was nonthreatening as this participant described, "I think the number one thing is to watch your body language and your tone of voice so that you maintain a respectful approach with the patient" (RN02). Body positioning and body language are supported by concepts of de-escalation (Richmond, et al., 2012) as well as maintain one's own safety all the while signalling a caring approach.

In terms of communication and engagement with patients, four RNs described the importance of using empathy, and respect with their patients to prevent violence as well as engaging with the patient to discuss their needs and concerns before situations escalate. These

four RNs also felt it important to allow patients to feel included in their own care and described it as being pertinent to not bring oneself to the patient's level of violence or engage in a power struggle to prevent violence. As RN04 highlighted:

> Empathy is the first thing that I see works…It's my golden nugget...Other strategies to back that more would be to make sure that I'm letting them know I'm there for them…allowing them to feel included and not excluded, treating them like human beings.

Three of the four participants identified being employed by an organization that was either in the process of or had adopted a Tidal Model approach to psychiatric patient care which focuses on recovery, the person's story and highlights the importance of the person/patient being a partner in their own care (Barker & Buchanan-Barker, 2010) and thus the culture of these organizations and approaches to care may positively influence the response to prevent violence. As well, three of these participants held a Master's degree and the remaining participant had specialized training as a Crisis Prevention Institute (CPI) instructor responsible for teaching CPI's Nonviolent Crisis Intervention program. These additional educational accomplishments may impact their therapeutic communication skills and increase their confidence to use these skills in practice.

Along with communicating and engaging with patients, many RNs expressed that knowing your patient, including knowing their triggers for anxiety or agitation, what helps them relax, their body language, and their past history was important in building and improving the therapeutic relationship thus preventing violence as this participant summarizes:

> I think knowing strong histories and knowing triggers for clients, knowing your client is probably the best sign, getting to know what escalates [them], getting to know what calms them, really helps you predict what chances are taking away. Building up and building a rapport with individuals no matter what. (RN12)

One deviation from very patient-centred strategies relating to primary prevention was that of creating and enforcing ground rules and limit setting. Informing patients of the ground rules

that violence is not acceptable, outlining what unacceptable behaviour constituted, and the potential consequences of the behaviour were identified by several participants as being part of their practice as a method of primary prevention to prevent violence, ensure safety on the unit and promote a respectful environment. One participant described that this information was routinely communicated to patients as part of their weekly community meeting on the unit, and many other RNs used this approach to remind patients of their unacceptable behaviour when it was displayed. Another participant described her thoughts around communicating ground rules:

> I think it's important to have that…conversation around expectations. Laying out what those expectations are so that they're knowledgeable coming in that that [violence] isn't tolerated. For instance, we have had patients that…have done damage on the unit, you can't damage property in the mall or you're charged, but suddenly you can come into a mental health unit and you can tear it apart and that's okay. So I think sometimes laying out what expectations are…(RN07)

Limit setting is a similar concept that is further down the prevention continuum used to prevent violence. This involves the RNs setting boundaries, perhaps in line with or in addition to the ground rules, but also giving some realistic, but limited choices. These methods ensured knowledge and compliance with the rules to maintain order and control of the unit, but by offering choices, through limit setting, still maintained a small degree of focus that was patient-centred.

Listening and de-escalation techniques, including the use of empathy, problem solving, allowing clients to vent their frustrations and concerns and be heard, were considered to be first-line, patient-centred strategies to prevent both physical and verbal violence however there was some skepticism around their effectiveness. Some participants believed that while this practice should always be attempted, some violent situations happened too suddenly for it to be effective or else felt that it would not always work despite their best attempts and other methods of

prevention needed to be implemented instead, such as medication administration as this participant explained:

> A lot of the time people will calm down when you try to address what the problem is with them. Sometimes they just want to be heard. There's something that's problematic that they don't see a solution to and that sometimes we can so to sometimes sit down and talk with the patient can help. So yes…de-escalation is used and sometimes it's not either, sometimes you can't talk people down and it's a lost cause. (RN06)

This demonstrates that while initially participants are willing to use these techniques to convey a respectful, caring approach, some RNs in this study resorted back to more coercive approaches when order was not quickly obtained and individual safety was further threatened, and they remained skeptical of the usefulness and effectiveness of less coercive approaches.

Leaving the area when violence was anticipated was identified by participants as another strategy that they implemented. However, participants indicated that the reason for leaving the area differed by situation. This action occurred particularly with verbal violence as a means to signal the end of the conversation and the nurses' willingness to be part of the violence as RN03 described, "If you're going to talk to me that way, I'm not going to listen and the conversation is terminated and you are to leave the nursing station or I will walk out of the room."
It was also used when RNs were not sure how to handle the situation or were feeling emotionally affected by the violence:

> I kind of leave it alone and understand that they're just feeling very angry and impulsive, just kind of walk away…I don't do a great job with the verbal stuff…sometimes I feel too weak to really address it because I don't want to embarrass myself or them. I just feel so on my own… sometimes I just feel like I don't know how to stop the small stuff like the sexual harassment. (RN04)

Another participant described that when he did not know how to handle the situation, "that sometimes leaving the situation is helpful just to diffuse it. Approaching it from a different standpoint like 'hey, can we start this over again', maybe just try a different approach" (RN06)

was helpful or he would use that opportunity to reflect on his approach and seek feedback from peers and then re-approach the patient.

For both verbal and physical violence, leaving the area was also a means to "give them [the patient] space" (RN02, RN04) to cool off or for the nurse to get out of what could become a dangerous situation. If the reason for leaving the area was to give the patient space to gain control of themselves or reduce stimulation, this could be viewed as demonstrating a caring, patient-centred approach and empowering the patient to gain their own control. If, however, the reason for leaving the area was to ensure their own safety, to signal intolerance to violence, or because their feelings have been allowed to affect the interaction, it coincides with a more nurse-centred approach for self-preservation.

Two participants believed that in order to prevent patient violence, it is important to teach patients coping skills in order for them to learn how to be able to remain in control. This individual tertiary prevention strategy focuses on empowering the patient, not controlling the unit environment. RN08 described the use of:

> …therapy or meaningful discussion with them around distress tolerance… and adaptive coping strategies…Cause some people act out or threaten because that's all they know, or because it's what's worked in the past. Squeaky wheel gets the grease, you know?

Nurse-centred prevention strategies.

All participants described being required to take a nonviolent crisis education course annually which involved crisis and de-escalation theory as well as a hands-on component. RNs felt that knowing the background theory and knowledge was valuable to prevent violence; however it varied in relation to the hands-on component. Some participants felt confident in their ability to use hands-on techniques learned during the nonviolent crisis interventions

courses, though other participants were less confident and described being less likely to use proper hands-on techniques endorsed by their training.

Knowledge of the assessment for and use of medications, knowledge of legalities surrounding patient care, ability to recognize agitation and assess risk, ensuring novice nurses with less knowledge or training were not put into potentially violent situations alone, and knowledge of de-escalation techniques were all described as important practice strategies for the prevention of patient violence.

RNs referred to using medications as a method of prevention and containment. They justified the use of medications to calm patients in that they may prevent violence or harm to the patient or others and was thus in the patient's best interest. Medications, such as PRN (as needed) medications, were used to keep patients settled and lessen any risk of violence as well as aid in their treatment. This RN explained the use of medications:

> If we have a patient who has a violent history…our mode of taking care of that is to medicate. Myself personally, I PRN people as much as I can to avoid that [violence]. Usually when people are ill, and this is the biggest risk when they come on the unit, and as they get better, the chance of this kind of violence happening usually lessens. In that case, it's about medicating and containing them with medication. (RN06)

Medications were also used as chemical restraints when a patient's behaviour was escalating and nurses needed to intervene before a more serious event happened. This form of chemical restraint was viewed as the least coercive measure and attempted before any other more physical strategies were used such as seclusion or physical restraints as RN04 explained, "…making sure, in terms of least restraint, I would use medication before seclusion and use seclusion before four point restraints." When situations reached this intensity, medications were no longer an individual nurse's response, but conducted as a team to enact this intervention. Principles of de-escalation include offering medication, but encourage clinicians to broach the subject as a

discussion and a choice, and only forcefully as last resort when there is no other alternative (Richmond, et al., 2012).

Another strategy is that of working as a team and getting help. RNs viewed that to ensure the safety of the unit and the staff members, secondary prevention was often not done alone. It also allowed the RNs to gain power by shifting the focus away from the patient to that of the team. Colleagues, including nurses, physicians and security personnel, were used as back up in a situation that had the potential to escalate, as well as when the nurse viewed their skills as inadequate to prevent a situation on their own. This is also supported by de-escalation principles (Richmond, et al., 2012) that clinicians must be able to recognize their limits and know when to seek assistance. Participants also valued their colleagues' feedback and input on decisions related to preventing violence, once again focussing on the team and not the individual patient. When RNs felt they could trust their colleagues or when there was more effective communication amongst the team, they felt they were better able to prevent violence because they would all be on the "same page" (RN02) and aware of what was going on with all of the patients on the unit.

Unit and Team Violence Prevention Strategies

Similarly to individual-focused prevention strategies, nurses in this study described strategies to prevent violence on a unit and organizational level on a continuum focusing largely on primary and secondary prevention. These strategies were used for both physical and verbal violence. Unit and team prevention strategies focussed on addressing and understanding: (1) the unit's physical layout and structure or elements of the unit; (2) the team's dynamics and; (3) specific management strategies.

Physical elements of the unit.

There were many elements of the units' physical layouts and structures that were viewed as aiding in violence prevention. Visibility on the unit was perceived as being a very important factor for preventing violence by giving nurses the ability to observe the unit and the milieu and thus intervene proactively. How well visibility on the unit was achieved varied significantly based on the participants' workplaces. Some RNs prided their unit for having a central nursing station, few hidden areas, surveillance systems and good lighting where others described the complete opposite with units that were dark, a nursing station removed from the central hub of the unit and many "blind spots" (RN05). The location within the hospital was also a factor as it impacted the physical layout as well as the ability for colleagues from other areas of the hospital to respond and assist to prevent violence. Two participants working for the same organization described their unit as being a separate building never intended for inpatient use:

> This building that our unit was located on is physically not part of the original hospital so this was a nursing residence that had been renovated for an interim inpatient unit during the building of the unit that took 15 years so they are still in their interim location. This was never designed to be a patient care area. (RN05)

Two other participants similarly described their units as initially being designated for other use. For example, RN06 explained that the unit "…is supposed to be a neurology unit. We are having a mental health pavilion built in front of the hospital that won't be open for another two years" and the other participant's unit was originally an office area converted to an inpatient unit. Thus these units were not built for the purpose of psychiatry or safety.

Another important consideration is that of physical space for patients. As previously discussed, the lack of physical space can be an antecedent to violence, but having therapeutic space can have the opposite effect by giving patients somewhere quiet to go to settle and increase the likelihood they will have privacy. Several participants described having private rooms and

encouraged patients to use this private space as a strategy to prevent patient violence as RN05 highlighted:

> Patients could go to their own room to get away from other patients that were irritating them, agitating them, get away from the nurses that had been irritating or agitating them. It gave them a quiet place to say "this is my space." We didn't have a visitation room so they visited in patient's rooms and patients started to take ownership...and I think that helped immensely in decreasing violence because it was their own space and they didn't have to share with anybody and it gave us a quiet place to talk if we needed to go in and talk to a patient.

Other nurses in the study described having designated comfort rooms or low stimulation areas that they could encourage patients to access when feeling anxious or agitated and these were perceived as helpful strategies to prevent violence. Some nurses spoke about the unit layout being designed with safety in mind and thus did not have glass in picture frames or had non-breakable glass in the windows, some furniture or decoration were bolted to the wall and could not be used as a means of violence as RN01 described, "Even things like pictures on the walls, right? Pictures had no glass and were secured to the walls so they couldn't be lifted off and smashed over a patient's head or a nurse's head."

Several units were equipped with Code White buttons designed to be pushed when a nurse required assistance with a patient when attempting to prevent patient violence or was feeling unsafe. Nurses perceived these buttons as being important in preventing violence and provided reassurance to the nurses that they had a means to call for help. This was also similar for those RNs whose organizations supplied personal alarm devices. Some of the personal alarm devices and Code White buttons were connected directly to security services while other units were described as triggering an overhead page throughout the hospital.

Three RNs described their units as adopting a more person-centred nursing care model, such as the Tidal Model previously described, which was felt on a unit-level to reduce patient

violence. In particular, one participant who had been part of a hospital move throughout the course of the study described the new environment being designed to optimize a patient's freedom which coincides with the Tidal Model the unit supports. The entire organization was designed to support this by dispensing individual key cards to patients to give them "freedom to open and close doors as they see fit… more freedom to wander the hospital and go to groups outside of the unit" (RN12) while still maintaining their safety and provide them opportunity to de-escalate themselves.

Finally, being denied the ability to go off unit to smoke was perceived as a significant contributor to patient violence. The availability of nicotine replacement therapy (NRT) throughout the organization was seen as an important strategy to preventing patient violence as NRT reduces withdrawal symptoms. Despite this, some RNs felt that while NRT could be beneficial, often their patients refused it and it did not help to prevent violence as one RN highlighted:

> The number of power struggles that we have about smoking and when you say to a person "I really regret that you can't smoke right now because you aren't able to leave the unit, would you prefer this to this choice of smoking cessation"…People don't like that. (RN08)

One participant's unit had access to a mezzanine that functioned as a smoking shelter for patients which did not require them to have to leave the unit's vicinity to smoke. As this RN explained, "We have a smoking shelter… and no one else is allowed to smoke in the whole hospital except for us…if someone's really having a hard time they can always go for a smoke" (RN04). This area was attributed to prevent patient violence by allowing patient's to engage in an activity that was stress-relieving to them.

Just as the lack of recreational programming was perceived as a contributing factor to violence, the provision of recreational activities by unit staff was used as a strategy to prevent

patient violence by some RNs like this participant explained, “I think a huge part of it is occupying their time and when people get bored they can act up” (RN11). Recreational activities and programming were also not limited to solely nursing staff. Participants described the availability of recreational and music therapists, as well as social workers to assist with these strategies, while others found that programming on their individual units was limited and thus felt they were unable to successfully utilize this strategy to prevent patient violence.

A small number of RNs in the study perceived that the routine visibility of security services helped to prevent patient violence. These participants described that the organization encouraged security services to do routine walk-throughs on the unit and check in with nursing staff to be aware of what was happening on the unit related to safety. If there was a higher potential for violence, security services would increase their presence on the unit. The increased presence of security services also assisted to form a more collaborative relationship between the nurses and security services and they were viewed by one participant as “a more integral part of the team instead of just calling them when something happened and would run into a code and not know who it is” (RN01).

One participant described their organization as implementing a Patient Safety Committee, Code White Committee, and a Safety and Security Committee as well as regionally there was a patient safety consultant. The patient safety consultant “regularly does visits with the unit and talks to staff about how to make the unit more safe…She would be open to hearing that stuff and she tries to follow up with those things to help the staff out” (RN04). The patient safety consultant’s role explored all patient safety issues, not just those that are violence-related. Because the patient safety consultant was responsible for all hospitals within the specified region and the role was fairly newly established, this intervention was perceived as having the potential

to be beneficial to assist nurses in preventing violence, but had not been successful at the time of the study.

All participants described being required by their organizations to take mandatory nonviolent crisis intervention training programs. While each program differed by organization, they were all described as an educational training program aimed at teaching nurses how to safely prevent and manage violent behaviour through verbal and physical interventions. The ability to review theory and knowledge around violence was valuable for the nurses in the study to help to understand the patients' perspectives and prevent patient violence as this participant highlighted:

> If you don't have all that knowledge, if you don't have all that theory…it's really easy to forget in that moment and to take things personally so it's really important to review all that so you remember it's not a personal attack and that the patients are feeling trapped, and their feelings are that their rights are being taken away, like they can't wear their own clothes, they can't leave the unit, like how would you feel? It really works upon and teaches you different ways of talking to the patients and validating their frustrations instead of saying "this is the way it is so you have to deal with it", you know? …I think it really reinforces and reminds the nurses because it's so easy to get jaded experiencing this every day. It reminds us what the patient is going through is completely unpleasant. (RN03)

However putting the training into practice was less consistent. Several RNs described the team using "most of" (RN11) the nonviolent crisis intervention techniques, especially related to the verbal interventions such as de-escalation, or isolating the area when violence was occurring to protect other patients. Contrary to this, two participants from the same organization identified that nonviolent crisis intervention techniques were not consistently used within their team as this RN described:

> I can tell you confidently that there was no CPI [nonviolent crisis intervention program] actually implemented on the floor. It was a strategy that would *never* be able to handle the situations that we were faced with. We didn't often have people go through that nice cycle. It often escalated so fast that you didn't have the beauty of time to intervene with

> this de-escalation strategy that was supposed to be in place… and when we did need to do certain CPI strategies, the team didn't know them so they were not used. (RN05)

In this particular organization, there was little confidence in their skills and their team's knowledge and abilities to prevent or manage violent situations. One of these two RNs also pointed out that the course they were required to take had specifically endorsed strategies, but did not always have solutions to common situations that they supported, such as how to manage a patient spitting at you as she described, "If it means we have to you know, cover this person's face with a mask, well CPI doesn't support the use of that, but that's what we're going to have to do…" (RN05). This could hinder the nurses' buy-in to the training and their willingness to use the recommended strategies.

For other participants, while they described using most of the nonviolent crisis intervention strategies in practice, their confidence in their ability to use these techniques varied. RNs that strongly believed in the theory of de-escalation and the nonviolent crisis intervention programs, or had seen or used these strategies successfully in practice seemed to have more confidence in their skills and abilities to use these interventions and techniques than those who had not. For example:

> Oh quite [confident]. I've used them [nonviolent crisis intervention techniques] a lot…you end up using them for sure and I think the use of them, you think and realize "okay, I can actually do this" and I've seen colleagues…I'm thinking one particular colleague, she's probably five foot, maybe 110 pounds soaking wet, but that woman can grab your arm and pretty much steer you anywhere and I think "*wow* if she can do that, *I* can do that". (RN01)

Knowledge of organizational policies relating to patient violence as a secondary prevention measure varied by participant with some participants being unaware of policies at all, some participants superficially aware and others having a more in-depth knowledge of the organization's policies. The most common policy identified across the various organizations

were least restraint policies outlining the organization's beliefs to use the least restrictive methods of managing patient violence first, and most coercive measures, such as seclusion and restraints, as last resorts. As this RN highlighted, "The big one is definitely least restraints and that's within all aspects – chemical, physical, environmental, that is definitely a big one within our organization in terms of preventing violence" (RN03). Regardless of how well regarded the specific organizational policy was, participants identified with this philosophy for managing patient violence and followed these principles when enacting strategies to prevent and manage violence.

Several RNs were also able to identify that their organization had a policy outlining the procedure for Code White situations, including who is required to respond when a code is called and what their roles are. Even fewer participants identified policies around seclusion and restraints which outlined the procedures for using these techniques, such as "how often you can chemically restrain someone…" (RN06).

Organizational policies were often perceived as guidelines and how efficacious the policy was varied by participant. Some participants felt that the policies they identified were beneficial and provided nurses with more knowledge and assisted them in making decisions about managing patient violence, while others saw policies as being vague:

> Within the protocols and policies…a lot of it is discretion. And you follow certain guidelines that are put forward by the unit and [government] health services on how you deal with certain situations, but a lot of it is the discretion of the nurse that's working with that patient…(RN06)

For those participants wanting more direction, these policies were perceived as being unsupportive:

> We have *very* poor rules on our use of seclusion, *very* poor rules on the use of restraints…they don't necessarily meet the best practice guidelines that are out there…we don't have a whole lot of guidance. (RN04)

Another policy described by some RNs in the study was the presence of a Zero Tolerance for Violence policy. This policy was in place to outline the hospitals' stands on tolerating violence. This was perceived by some participants as a step in the right direction to support the staff in preventing and managing patient violence; however some nurses expressed the opinion that their organizations, while endorsing the policy, did not enact and enforce the guidelines or recommendations within the policy. As one nurse explained,

> I don't know how that would roll out in terms of what would actually take place. Certainly on another unit…outside of acute psychiatry, if you had a patient or family member abusive to a staff member, the family would be escorted off the unit and may not be allowed to visit again, and the patient would be spoken to. In acute psychiatry I've never seen it come into play, the policy is there but…I don't know how it would actually roll out as a policy in terms of any precedence. I've never seen it come into play. (RN01)

On the contrary, one participant felt that a Zero Tolerance policy would not be beneficial in preventing or managing patient violence. This RN perceived this policy as a barrier to forming a therapeutic relationship and that violence should be tolerated by nurses within psychiatry as explained further:

> I don't think zero tolerance policies are useful or beneficial…Are they in a state to make the appropriate decision?…These are individuals who aren't always in control, misinterpret and change things, but by having a zero tolerance and saying "no you cannot do that"…it builds a barrier, destroys rapport. We should have some tolerance for it [patient violence] just being the nature of the beast. (RN12)

Unit and team dynamics.

Nurses placed a lot of emphasis on working as a collaborative team in psychiatry to prevent patient violence. Participants often referred to their nursing team members' as "having each other's backs" (RN04). This RN explained the importance of collaboration:

> I really feel like it helps. Collaboration is a huge key in reducing the incidence of patient violence…We're all on board with a common goal, using our assessment skills, reporting to each other, using de-escalation skills or anxiety antecedent management skills, then we can prevent violence from happening and…the team approach is great because we are

> working as a team, we can draw on the resources each of us has to offer. When there's poor collaboration…I've seen patients get hurt, I've seen coworkers get hurt. (RN08)

This same RN went on to describe the importance of collaboration for maintaining a calm unit milieu:

> Your assessment doesn't just occur in the moment that you are talking to your patient. You are *constantly* assessing everyone you see all the time and if you notice something else is happening with someone else's patient you let them know…We are all responsible for maintaining…the most therapeutic milieu possible and so I think that's part of the team approach too. (RN08)

RNs perceived that when the entire team, including non-nursing disciplines, all assessed and worked to maintain a therapeutic milieu, patient violence was more likely to be prevented.

Communication amongst the healthcare team was considered by the RNs to be highly important to the prevention of patient violence especially when this communication was about a patient's risk for violence, their known triggers or antecedents and specifics about their plans of care. Participants shared that information around violence is communicated in the transfer of accountability amongst nurses, through violence risk assessment tools that are documented on the patient's record, team meetings and informal collaborative discussions. RNs described the importance of communicating with colleagues about observations they have made about their colleagues' patients to ensure they are aware of what may be going on with a patient, and sharing with them any information which may help to assist their colleague in preventing patient violence as this RN further explained the importance of communication in nursing:

> It's a strange profession because people are kind of their own entity with their own patient loads which affects everybody else's patient loads. We are kind of like our own little islands, but we are also affecting how other nurses' are dealing with their patients so it's important to communicate with other staff (RN06).

Not only was communication among the unit staff important, but the communication of information from the emergency department prior to a patient's admission to the unit staff was

valued so that they could be prepared on how best to meet the needs of that particular patient and prevent patient violence as this participant outlines:

> From a unit perspective, it was increasing communication right from day one. So we get the call [from the emergency department] that the patient is coming in and right off the bat, figuring out who's doing what…this is our management plan and having everything laid out so people knew what to do and we were ready to go. Prior to that evolving…there was no courtesy call from emerg [sic] prior to the patient being dumped on the unit, there was no way to plan for it. (RN05)

Plans of care were viewed by participants as either a strategy nurses could use to determine a plan to manage a particularly "challenging" (RN06) patient and through the plan of care more formally determine boundaries and limits or, alternatively, care plans were seen as tools for the nurses to use to document and communicate successful strategies to use for patients who are in crisis. This RN further highlighted their use in practice:

> [Care plans help] to get to know the client better…what the client looks like when they're escalating, what the client needs to calm down in those situations, what strategies they think they could use, other things like music therapy, helping the client to re-orientate or de-stimulate in those kinds of situations, what's preference for them. (RN12)

Both ways of viewing plans of care were believed to prevent patient violence primarily because they acted as a more formal method of communicating the information with colleagues and, for particularly "challenging" patients, creating a plan of care acted as a collaborative team exercise. However, as one participant pointed out, plans of care are only beneficial when they are "really active and everybody has to know it, everybody has to sign up and it has to be a living document where people address it explicitly every shift" (RN02).

Two participants felt that sometimes it was not just the special prevention measures put in place, but the routine, proper treatment by the interdisciplinary team of a patient that could prevent patient violence. Essentially, meeting their health needs in a timely manner.

This RN highlighted:

> I think some of the prevention…might lie in the way that we do psychiatry. You know, we are going to medicate people, try to help people, try to get people their sleep, and try to get their illness under control so they don't end up feeling terrible and striking out at you. (RN04)

On a unit level, some RNs felt that awareness of violence and safety is present through actions such as introducing violence assessment scales and tools or minimizing risk, but on an organizational level, awareness and emphasis on nurses' safety were limited. Two participants identified that their organizations demonstrated some awareness and showed this by hanging posters throughout the organization describing the workplace as an abuse-free environment, but this intervention was felt to be of limited value because:

> You have to have an organizational *culture* that is intolerant of abuse of their employees. You need public education campaigns that may be province wide or national to remind people what appropriate behaviour is. If they can do it in hockey and soccer they can do it in healthcare. (RN02)

Advertising the organization's standpoint on violence gave nurses the ability to use the signs as evidence and remind patients and families of the rules and acceptable behaviour within the organization; however it was felt that this was the extent of the value of this intervention.

Managing patient violence was felt to be most effective when participants were able to co-ordinate and plan the unit response as a team before rushing to respond to the situation. One participant explained, "You should have a plan A, and a plan B at least and have it coherent…you *need* to have a plan" (RN02). This involved staff knowing their roles within the team approach, what needed to happen as well as, ideally, the number of staff needed to be present in the situation for the plan to be effective. One RN described their organization as implementing a one page document requiring staff to create an organized plan for entering into riskier situations such as entering a seclusion room with an agitated patient. She further

explained, “It really is a plan sheet. There’s fill in the blank. Like, ideally, we’re going to have X number of people, so and so is going to get the medication, this person is going to do blank” (RN08).

Specific strategies to manage escalating patient violence.

Similarly to an individual nurse’s response to violence, when the situation escalated to the point where it became a team response, de-escalation was continued by the team in an effort to manage the situation whether it was verbal or physical patient violence prior to attempting more coercive team strategies such as medications, seclusion or restraints. In congruence with de-escalation principles, participants consistently isolated the area where violence was occurring on the unit. This involved clearing the area of items that could be used as weapons such as furniture or other objects, items that could get in the way if space was needed to properly perform hands-on techniques, as well as most importantly, removing other co-patients to maintain their own safety and reducing the audience for the patient who is engaging in violence. An RN explained:

> One of the first things they have driven in our heads over and over again for safety is to isolate the violence, to not involve other staff or others…so we make sure the other patients are isolated from this particular potential or ongoing threat of violence from a certain patient. (RN06)

In extreme cases, the team even removed themselves from the situation when their safety was perceived as being severely compromised and sought alternate assistance to manage the situation.

When the team felt they were unable to prevent or manage the verbal or physical situation on their own, security services were often called to assist. Depending primarily on the organization, as well as the situation, security services were used on the unit as physical “manpower” (RN03) to assist with physically containing a patient or applying restraints, but

other times having another discipline other than nursing listen to the patient and assist with de-escalation "as they have excellent negotiating and de-escalation skills usually" (RN08) was viewed as beneficial in preventing and managing patient violence. Nurses in the study also perceived the presence of their uniform as having power and that security services were more effectively able to enforce the rules as this RN described "Sometimes we just need security to talk to them. You know, someone in that type of uniform to be firm and say that's not tolerated" (RN03). Perhaps this sense of power and protection from security services also acted as a comfort for nursing staff that felt powerless, or fearful, and perceived their own skills as being ineffective.

When a situation escalated, especially if a nurse had been physically attacked or injured, the team intervened using physical control techniques such as grabs or holds. This participant described the team intervening to physically restrain the patient to prevent further violence:

> A couple people were there right away and they held her arms to her body and I just got away…and they just held her in place and told her what was going on that they were going to hold her until she was calm and they were going to take her to her room. (RN08)

As a last resort when less coercive interventions were perceived to fail, seclusion and restraints, including physical and chemical restraints, were used to manage patient violence. Chemical restraint, which is the administration of medications when needed and often by force with the intention to restrain, was often given for both verbal and physical violence when other interventions failed and was the first, more coercive, intervention used. RNs in the study were confident in their assessment for using chemical restraints, their knowledge of medico-legalities and knowledge of the use of these medications as this participant described:

> In terms of chemical restraints, I feel very comfortable in my assessment and when to give medication, when to force medication and when not to and I'm very aware of legally how I can do that and legally how I cannot do that and of course the patient's rights in

> terms of that. If the patient is in imminent danger or if they're causing someone else to be in imminent danger I know that I can force a medication no questions asked. (RN03)

If chemical restraint was not perceived as being effective on its own, it was often given in combination with seclusion (a form of environmental restraint) or more restrictive physical restraints. Physical restraints were most often used when situations involved physical violence. These interventions were perceived as being the safest method at that point in time to balance preventing and managing further violence, as well as protecting other patients and staff as this RN explained, "You have to protect yourself, the patient from themselves, and potentially from other patients, so in those situations we use restraints unfortunately. It's not the best, but it's the safest…It's a last resort" (RN10). Through exploring responses to violence, it is evident that participants believed they followed a least restraint philosophy when preventing and managing patient violence.

A Code White was called when participants perceived that more help or resources were needed, beyond what the unit could manage on its own. A Code White was called primarily for physical patient violence. Depending on the organization, this would signal either security services, extra staff (nursing, physicians, allied health) or both to respond to the unit calling for assistance. Three participants, two of whom worked for the same organization, described that while they would still call a Code White as a strategy to manage patient violence, often these situations were poorly attended by extra staff or security regardless of whether there was a Code White policy outlining who is required to respond. One other RN had a very good response to calling a Code White, however she described, "we just got bodies, kind of thing, to help us out and it was *completely* out of control" (RN04). This participant was a relatively new RN at the time and this strategy had limited effectiveness to prevent and manage the circumstances because

the staff who responded were unsure of how to handle the escalating situation as was the RN herself.

Three participants described seeking the assistance of law enforcement to manage an escalating physically violent situation. Two of these RNs worked at the same organization, both described having little confidence in their or their team's ability to manage physically escalating situations, and felt most comfortable seeking the assistance of police. One of these RNs felt that while police were used "far too often" (RN05), it was still necessary because they needed their support to manage escalating violence in the absence of their own skills and came to depend on them as part of the team. Another participant in this study agreed that police involvement could be helpful or necessary with very high risk or violent events, but explained:

> It also creates a barrier between us and trying to build rapport with our client so I think the biggest thing is taking the responsibility, the…role of interacting with them because even in that state, we're still building and supporting a rapport because we're showing that we're taking ownership, we're taking that relationship and that need and the understanding of supporting their needs as important to us. (RN12)

This RN stressed the importance of continuing to interact with the patient with police presence instead of allowing the police to take control of the situation in order to support the therapeutic relationship and ultimately influence tertiary prevention of patient violence for the future.

Debriefing "any type of critical incident is very helpful" (RN06) and was identified as being imperative for both staff involved in patient violence as well as the patients themselves in order to examine the situation, explore what worked or did not and collaborate to determine strategies to prevent future violence. Despite identifying the importance of engaging in debriefing for tertiary prevention, often participants did not participate in debriefing with their peers or their patients. This was especially true when incidents involved verbal violence. Debriefing was identified by many participants as either not happening at all or, when it did, was

relatively informal. Alternatively, "when it does happen, it tends to happen quickly and not everyone gets to be there because people come in from everywhere else to assist and they just want to rush off right away" (RN12) and thus not occur very effectively.

Impacts of Patient Violence on Registered Nurses and Patients

Patient violence, whether it is verbal or physical violence, had many perceived impacts on both RNs as well as on patients themselves. For nurses, there were emotional and physical impacts as well as various impacts affecting nurses' abilities to carry out their role as an RN on the unit. The effects of violence also varied depending on the type of violence, whether it was verbal or physical. The participants in this study also discussed their perceptions of how patients were emotionally or physically impacted after perpetrating a violent event.

Impacts of physical patient violence on Registered Nurses.

There were a wide range of emotions expressed after incidents of physical patient violence. In the moment, as the incident took place, RNs described remembering feeling fearful, in shock or numb, or alternatively, feeling nothing including sometimes not feeling pain arising as a result of physical violence. One RN, describing an incident of physical violence that she experienced, explained:

> I don't know that I was feeling anything. Adrenaline just takes over, you know? I don't think in that moment I really felt much of anything. I was really beat up and my arm was swollen and black and blue and I didn't feel that. (RN01)

Nurses in the study went into "the mode of do what you need to do" (RN01) as the situation unfolded in order to continue to be able to be effective in managing the violence. In the moment, when other staff or patients were involved in the situation, some participants described focusing their emotions and energy on protecting the other staff members, or even for two participants, protecting the patient. In both instances, these two RNs felt their patients were unwell, that they

could not control what they had done, and that their violent actions placed the patients at imminent risk of being in danger. One example of this was when a patient, in a highly psychotic state, enacted physical violence, injuring several nurses, and eloped from the unit as this participant described:

> I was more scared for his safety when he ran away and you go into your crisis mode because he's not safe, someone's going to hurt him, he's going to hurt somebody, but it's not his fault, and be very protective of him. (RN05)

It was quickly after the event had taken place that nurses were often most able to reflect on their feelings and the emotional impact of the incident. It was at this point that participants expressed that they felt fear, as exemplified by such statements as, "we were terrified" (RN07), "it scared me" (RN01), or "that guy scared the living bejeezes [sic] out of me" (RN06). Not only were participants afraid for their immediate safety, but they feared what could have happened if the situation had ended differently, and for future violence as this participant explained:

> What happens if I can't go home? I don't go home one day because something's happened on the unit or what happens if I can't any longer do my job because I've been physically injured? Or I can't take care of my son? What happens if, you know, I am permanently disabled? (RN07)

Fear was most intensely described when nurses felt there was a chance they could not manage the situation, in situations that were perceived as being highly dangerous, and when the physical violence was directed primarily at them. It was less intensely felt when violence was directed at colleagues or unit staff as a whole, or the participant was stepping in to assist and protect other colleagues. The fear of what could have happened if the situation had ended differently was prevalent regardless of whether nurses involved in the situation were physically injured or not.

In situations that involved body fluids, such as when participants were spit on, there were fears and worries of contracting illnesses from the patient as this RN described, "I was worried…I checked her [the patient's] chart to be doubly sure that she didn't have anything like

hepatitis…because she spat in my face and I got a little in my eye. I just needed to know" (RN08).

RNs were also fearful of being blamed by their team, administration or even more formally by the courts or governing professional body for what had happened. At the same time, participants did in fact blame themselves, and feel at least partly responsible, for what had happened as this participant highlighted:

> There was some fear that I would be judged. The fact that this guy is acting out in the first place and that I hadn't managed him well in the first place…I was just concerned how this would be interpreted by superiors and physician leadership and even though he [the patient] was known to be somewhat aggressive, it felt like I was kind of taking on responsibility and blaming myself for the way it happened in the first place. (RN02)

And similarly by this RN:

> You sometimes get judged…because you shouldn't have been there or you shouldn't have crouched down or you shouldn't have been talking to them or you shouldn't have given a shit or something. You always feel like it was your fault which is so parallel to how people feel in society when they're raped. (RN04)

Along with fear was the feeling of helplessness for some participants. This occurred when nurses perceived not being able to connect with the patient and when interventions seemed to fail. This experienced nurse explained, "No matter what we did, it was almost like a helplessness [sic], because no matter what approach we used, it didn't seem to be effective" (RN07).

Anger towards patients was commonly expressed following physical incidents of patient violence. This was especially prevalent when RNs perceived patients as being able to control their behaviour as demonstrated by this participant:

> I was *angry*. This patient in particular…because I had already re-directed her numerous times during her stay…and we had already done so many instructions on transfers and safety and falls risk and because of her cognitive impairment she was not able to comprehend these things and she kept acting independently or unsafely and I couldn't understand why she wasn't listening so then when she hurt me I was *very* angry at her

> and it was *her* I was mad at. I was mad at her. I wasn't accepting this as an illness…it took me a long time to get through that because she looked physically ill so I didn't equate mental illness with her physical illness. (RN05)

Anger was often also directed at colleagues, such as co-nurses and physicians. Some RNs were angry with their nursing colleagues when they perceived they were not engaging in team work and contributed to the experience of patient violence:

> I became *very* angry at the rest of the nurses that were there that day because they were, in my opinion, slacking off and they could have been there and this was not my patient for the day and I'm being courteous by doing the extra round and making sure the other people were okay and to come and see one of them chatting and one of them eating. I was *really* mad at them and they felt nothing. (RN05)

Another participant described her anger being directed at the physician as she had previously asked for orders to be written for medications to help settle the patient. Her request was denied, and directly following this instance violence occurred and staff were hurt. This RN explained further, "with that incident, I was very, *very* angry at the doctor because we had been telling him that we were concerned" (RN03). Anger was also directed towards management and administration when they felt they had not been listened to and administration's decisions had impacted the safety of the nursing staff and contributed to the experience of patient violence. One RN described the experience of having glass shattered by a patient into his face after he had previously brought the safety issue to administration's attention:

> I was mad at administration. When it got down to it, the environment that the person broke the glass and stuff, I'd actually made Health and Safety [department] aware that this was *not* a safe environment at that point in time. The glass was breakable and if it shattered into small pieces it was a risk to staff and clients. So in my head, I was cursing my manager at the time and the people that had just rebuilt our unit and not listened to the staff about that aspect. (RN12)

RNs described feeling "violated" (RN11) with certain acts of physical patient violence. These feelings were most often identified with incidents that caused very little physical harm as

this participant described:

> A glass of water splashed in your face…that sounds *so* small and it was from an older lady who…you wouldn't be afraid of, but I remember feeling really violated when that happened to me which is so strange…Sometimes it's the smallest things versus the big, tough guys throwing a table in your direction, I don't know why. (RN04)

Perhaps the feelings with these less serious incidents were due to participants not being mentally prepared for the violence and had underestimated a patient's risk.

Immediately after events occurred, and lasting for several days, to even months after, all participants described feeling a "heightened sense of awareness" (RN05) and hyper vigilance. These feelings of heightened awareness and hyper vigilance were not exclusive to occurring only in the workplace, but RNs described this as occurring outside of work as well:

> I found I was a lot more sensitive to other patients…Just a little more aware of what was going on or what could go on with the patients that were acute, but just the best way to describe it is a lot more sensitive to the environment at work and outside of work as well (RN06).

After several incidents of patient violence, heightened awareness and hyper vigilance became part of everyday life as this participant explained, "I don't even think you are aware you're doing it anymore – scanning a room or you know, where people are, or you're listening, that kind of thing…It almost becomes second nature" (RN01).

Throughout the experiences explored in this study, RNs described several physical impacts. Injuries described included bites, bruises, lacerations, hair loss, and musculoskeletal shoulder and knee injuries. Other physical impacts of patient violence included being spit at, having water thrown at RNs, headaches, muscle tension, difficulty sleeping and nightmares. Some participants also described poor food and substance use choices, including alcohol and smoking, as a result of experiencing patient violence, as further explained by one participant,

"I…made poor dietary and alcohol use choices as a result of a bad day, you know, where things went bad on a unit and there was violence" (RN08).

Whether the experience impacted the ability to carry out one's role as a nurse after physical patient violence depended on the perceived seriousness of the incident. Some RNs described difficulty concentrating on nursing tasks and thinking clearly after incidents, also being less trusting of the aggressor resulted in nurses keeping "a little more distance" (RN11). This may impact a nurse's ability to pick up on future cues of patient distress or agitation and therefore their ability to proactively prevent violence. Participants expressed feeling less empathetic for their patients as this RN further explained, "It makes you not be as skillful or compassionate with other patients" (RN04). It also affected their level of confidence in being able to prevent and manage patient violence. Many RNs expressed being less confident in their skills after suffering patient violence, but for a very small number of participants, they described patient violence as providing them with beneficial experience and thus greater confidence in their ability to intervene to prevent or manage patient violence as this one nurse described, "I'm more confident in addressing things whereas before I might have avoided situations…now I feel that the avoidance piece doesn't work" (RN07). Similarly, another RN felt she became more proactive in preventing violence as a result of experiencing violence and thus better able to carry out her role as a nurse. For these RNs, they used their experiences as learning opportunities which motivated them to improve their skills at violence prevention.

Impacts of verbal patient violence on Registered Nurses.

Similarly with physical violence, verbal violence predominantly evoked feelings of fear. Much of the fear was driven by nurses in the study feeling ill-prepared to manage verbal violence and thus feel helpless, vulnerable and afraid of the potential of what further violence could occur.

RN01 explained:

> Where do you take the verbal violence? It can feel *as* assaultive and make you feel *as* vulnerable as the physical violence and in some ways more scared. There's that grey area of what do you do with it? Where do you go, and how do you then react?

The more fear a participant felt around patient violence, the more distressing they perceived the incident to be as this RN described, "The man screaming, where I could hear him, that's the most distressing to me because…I was the most afraid with him" (RN05).

RNs described feeling angry and hurt when verbal violence was perceived as a personal attack about themselves as a person, their body or their role as a nurse. This participant described one experience with verbal violence:

> Usually I can take it as a grain of salt and rub it off…but he [the patient] said something about, he's going to sleep with my wife...As a newlywed, it really affected me and I kind of walked away from it a little shaken up. That's one incident where someone's words actually stirred in me an anger, other than me just brushing it off…(RN11).

Again, similar to physical violence, participants described feeling a heightened sense of awareness and anxiety after experiencing verbal violence and it especially "increases your anxiety level around that particular patient" (RN02) who was the aggressor.

Several of the female participants described feeling "belittled" (RN04) when verbal violence was sexually inappropriate in nature or were comments regarding their bodies or attire. One participant described that experiencing verbal violence caused re-traumatization related to her past experiences as she explained, "I'm in recovery from an eating disorder…that level of stress affects past trauma, flashbacks and that's totally related to the eating disorder and depression…especially the sexual innuendos" (RN04).

With verbal patient violence, the most common impact on the ability to carry out the role of a nurse was the ability to maintain the nurse-patient relationship with the patient that was the aggressor. As the perceived severity of the verbal violence increased, so did the RNs desire to

not want to work with the patient anymore, to avoid engaging with them and this often resulted in RNs requesting to change the patient assignment to avoid working with them. One participant described feeling distracted and had difficulty carrying out her role due to anxiety after the verbally violent situation as she explained:

> It just kind of stops me…you feel hot, unwell, physically anxious…immediately following it [the verbal violence]…if I heard it ringing in my ears I *had* to stop everything I was doing and not kind of carry on as if nothing was the matter. I just had to play it out and get rid of it. It was *really* distracting. (RN05)

Impacts of patient violence on patients as perceived by Registered Nurses.

Physical impacts on patients related primarily to when patients engaged in physical violence. RNs perceived most of these impacts as physical injuries to the patient such as bruises, head injuries "from trying to head-butt people" (RN08), potential fractures and bleeding noses. In many of the explored incidents, participants perceived the patients to not have experienced any injuries.

Non-physical impacts of patient violence were related to the nurse-patient relationship, emotional experience, loss of privileges, discharge and follow-up services difficulty, and legal complications. Nurses in the study frequently perceived that patient violence negatively affected the nurse-patient relationship with the aggressor and thus impacted the patient's quality of care that they received. This participant highlighted the common reasons why patient care and the relationship were negatively impacted:

> Because I'm not going to be as therapeutic to someone who has been physically violent or verbally aggressive and I'm probably going to avoid that nurse-client relationship with that person because I don't trust them. And if I don't trust them, how can I engage in that really therapeutic relationship?…so I think it really negatively affects patient care and quite often we, in an acute setting, treat them and street them…and its hope to God they don't come back for a while and that's *really* poor care. (RN05)

After several incidents of patient violence, RNs described patients who were the aggressors as being distraught and remorseful over what they had done, and concerned for the nurses' well-being when their mental status was beginning to improve. Participants also perceived that the experience may be traumatizing for patients due to the measures taken by the nurses to manage violence such as, "when it ends in seclusion, restraints, having just been injected, that's traumatic for them" (RN12).

For some patients, physically and verbally violent incidents led to privileges to leave the unit being revoked, longer length of admission, or oppositely, discharge from the hospital with subsequent difficulty finding appropriate follow-up services due to the violence displayed in hospital, and even involvement with the police and charges being laid. One participant perceived that legal charges could, in fact, be beneficial for some patients as he explained:

> There are some cases where somebody acts out and they get charged and they get convicted and they go the forensic route and they do much better than when they were bopping around the acute psychiatry route so sometimes legal charges are actually therapeutic for the patient. (RN02)

For other patients that were not the aggressors, patient violence was perceived to interfere with their treatment by taking time and resources away from their care. One RN described patient violence as also having the ability to:

> …derail some of the therapeutic interventions that you've done for other people. If you've been doing a lot of work with people to help them feel comfortable…if you're working with people with anxiety disorders…with PTSD and you've done all this work, an act of violence on the unit can traumatize them and take away from the work that you've done. (RN08)

Short-Term Responses to Patient Violence

The reactions and responses to verbal and physical violence in the short term are explored from the patient, RN, colleagues, management and organizational perspectives.

Patient.

After incidents of patient violence, verbal or physical, patients calmed down and some patients were perceived to be remorseful and apologized for their behaviour as demonstrated by this RN:

> The minute he broke the window, he…sat in the corner, and said "I'm sorry" and then waited for staff to come and actually move him out of the room, and went very quietly and carefully with the staff after that incident. (RN12)

By some participants, it was also perceived that patients' behaviour changed, as described by one RN, "where they are more considerate of other patients or other staff…when it's turned out that the patient gains significant insight by their acting out and…they're actually better behaved" (RN02). This may also be influenced by the patients' overall improvements in mental status.

Registered Nurse.

Immediately following the experience of patient violence, RNs sought out support from both formal and informal supports. Management was most often identified as providing formal support as follow-up to the incident however participants more consistently identified seeking out informal supports through colleagues, family, and friends after the incidents regardless of whether it was verbal or physical violence.

Incident reports were also required to be completed soon after the incident, but hospital safety incident reports were not consistently reported by the nurses as being completed. Participants most often identified filling out reports for incidents involving physical violence resulting in injury, but often disregarded completing reports for physical violence that did not result in injury or verbal violence despite acknowledging their understanding of it being an organizational obligation. One participant explained that "violence was probably the one [incident report] that would be least filled out because how do we define it?" (RN05)

demonstrating some of the difficulties staff nurses have relating to reporting violence. Other identified barriers to completing incident reports were described as workload, time, and seeing the benefits of filling out incident reports.

After the incident occurred, many nurses in the study still needed to provide some level of care to their patient despite being the victim of their aggression. This occurred most often when participants remained at work after the incident and the following shifts afterwards. RNs distanced themselves from the patient physically when they remained their most responsible nurse to ensure their own safety. Other RNs requested to not work with the aggressors for at least a few shifts to provide distance and slowly regain some rapport with the patient as well as their own confidence. For one participant who had to continue to work with the patient, she described:

> I feel like I kind of went more automatic. I did what I felt was ethically and legally appropriate for care, but I can tell you for sure I did *nothing* that was extra for this person. I did not want to spend time with this person. I feared for my own safety and I was upset about what had happened…(RN08)

This was a similar response for both physical and verbal violence. With verbal violence, some participants felt that the more times you interacted with a patient, the more opportunities that were given to them to be verbally violent as this RN explained, "Sometimes you do spend less time with the patient because spending more time with them gives them more opportunities for verbal violence and nobody really should be exposed to that" (RN02). Often these interactions became less person-centred and more task-oriented perhaps as a self-preservation tactic for the nurses as they had to continue to carry out their role.

Some RNs refused to work with the aggressor all together after the incident and their colleagues took over the patient's care and for other participants, the incident happened right before they were scheduled for time off and working with the patient in the short term was

avoided. Even though participants felt that they needed the distance from the aggressors for their own safety and mental health, they recognized that it negatively impacted the nurse-patient relationship and subsequently the quality of care the patients received.

> I think rapport was…diminished because, on my end, I was more weary of her…I was less trusting…At other times [after the incident] when I needed to intervene I was always an arm's length distance away whereas previously I would have offered, and she would have accepted, physical comfort. (RN08)

There were some RNs that were offered and accepted time off from work after the incident while others refused to take time off work. One participant was motivated to return to work the next day as she explained:

> I'm the type of person where I don't let anything take me down so if something happens, I need to face it head on and beat it. I was determined that I was going back to work and I was going to walk into that room and by the end of my shift that I'd be able to stand beside him…and have a conversation and tell him how I felt…I *needed* to be able to walk into that secured area again…I *needed* to be able to not freeze, not be scared every time he was around me or said something to me and I was able to do that. (RN03)

Another RN felt similarly motivated and described having a desire to help patients even more after violent incidents because he recognized that this was the time when they were most in need of support, and recognized that often the nurse-patient relationship is affected as he explained:

> As soon as they [patients] have one incidence of aggression…people don't want to care for them, people don't want to interact with them and it's not fair to them. They're not in their right mind, they're not in a place where they are making appropriate decisions and it's not fair. What if I was in that situation? I wouldn't want someone to just give up on me. I would say it makes me want to work with these individuals more because there is a need…(RN12)

Whether the participant had taken extra time off after the incident, was returning from regularly scheduled time off, or was even just returning the next day, RNs had similar feelings and concerns. They were worried and had fears about how the situation was perceived by their colleagues, whether or not the patient was still on the unit and how their safety would be impacted. RNs expressed feeling vulnerable on the unit for several days after the incidents.

Several RNs in the study involved the legal system and either pressed charges or were granted restraining orders against their patients, regardless of whether it was verbal or physical violence. This occurred most often when there were significant injuries or emotional impacts to the RN, and when the RN perceived the patient knew right from wrong and had control over their actions. Some participants described being encouraged by police or their colleagues to charge their patients, but others were equally discouraged by their supervisors, or the amount of work, and time that was required.

As a result of incidents with patient violence, nurses in the study described changing their own behaviour, such as being more likely to resort to using medications, and other more coercive measures as a way to contain violence and maintain their own safety, or oppositely being less likely to use hands-on approaches to try to avoid violence, being more cautious around patients and for verbal violence, trying to think logically and be more objective of the situation to avoid taking the violence personally. One participant began exploring her options to change shifts to avoid working night shifts when she felt most vulnerable as a result of patient violence she had experienced. She further described, "I didn't want to work nights anymore…I began to look for a day line and as soon as a day line came up, I took that" (RN01). Meanwhile other participants described checking the hospital computer system out of fear that the patient might be re-admitted.

For five participants, they did see their patients again in the very near future and were afraid for their safety away from the security of the unit. One RN described that after an incident where her patient threatened to rape her and subject her to various physical violence, a week after he was discharged she saw him while out walking with her husband. She explained:

> I was afraid for my safety a week later when my husband and I were walking down the street together and there's that guy. *Seriously!* There's that guy! I went, "oh my God"

> and I had sunglasses on and I thought "what do I *do*?" I don't know what to do! My husband was talking about something, I have no idea what he was talking about. I just tuned him out. We're just holding hands and walking along and I'm like "okay, just keep walking," right? So what I did was walk right past that guy, but I tell you what, in that moment… I was *really* scared. What do you say to your husband? "Oh this guy is a scary guy…" I can't tell my husband *anything*! I can't! What am I supposed to say? (RN08).

The second participant described charging the patient after a violent physical incident, and the patient receiving the notice with the RN's personal address on it. She described:

> When the letters began to show up at my house I felt really violated and really vulnerable and when the police incident report showed up at my house I realized then and…I felt even more distressed because I felt sort of let down by not even the police services, but then also by my employer…It wasn't as if it was a threatening letter but still, it was like "how does she have my last name and how does she know where I live?"…She came and left flowers on my doorstep!…I just thought for one, she doesn't know what's appropriate or not…and it made me realize just how vulnerable I was and how lucky I was that it wasn't a different situation or that it wasn't a different patient…(RN01)

While the participant did not have face-to-face contact, the fear for her safety and of future violence outside of the workplace was still prevalent. The third participant was threatened by a patient, and described that immediately after the event he had fears of seeing the patient again and of experiencing future violence and has since had several interactions with the patient as the patient is now a volunteer at the hospital as the RN explained:

> I still feel uncomfortable and he's part of the peer support group of the hospital and every time I see him I still feel very uncomfortable. I feel like he is eyeing me every time I see him and whether that's rationale or not it's still at the back of my mind. This is a person who threatened me, threatened my life. I don't think I'll truly ever feel safe around him again whether he's well or not...(RN12)

The last two participants saw the patients when they were re-admitted to their units again. One participant refused to work with the patient again explaining, "I just thought, no, this is not somebody I can *ever* engage with in a therapeutic manner…" (RN05). The other RN did work with the patient, but felt she had to make a conscious effort not to let fear and her past experience influence her care for subsequent admissions.

Colleagues.

Colleagues responded by assisting with patient violence and sometimes even taking over the care of the patient or providing first aid measures to the RN experiencing patient violence. Most often, however, they provided informal emotional support to the RN. Regardless of where the participant worked, or what the situation was that occurred, nurses in the study sought out colleagues for support after an event. This participant explained, "we turned to each other to find that safe place to vent and comfort each other" (RN05).

Management.

Management was most often identified as providing formal support in the workplace particularly after a more serious violent event, such as when a staff member was injured, charges were being laid or the participant needed to leave work. There were some RNs that described having a good relationship with their managers or supervisors, and thus had found them to be very supportive following an incident, but more importantly nurses in the study felt most supported when the manager acknowledged and did not minimize the event as this RN explained, "just having the event recognized as something that was critical and you know, it was traumatic and …they weren't minimizing it and actually embracing it as something that was not acceptable" (RN06). On the other hand, many others described feeling very angry, unsupported and blamed by their managers. Some RNs never even heard from their managers following events of patient violence, while others described receiving a phone call or a brief conversation, which was felt to be thoughtful, but not supportive enough. Others felt blamed by their managers when being questioned about the events that occurred as this RN described:

> I know in a reflective sense…[we] are the best tools for preventing situations, but that form of questioning comes to me as so blame-driven. "*You* just were assaulted, *you* just were hurt", now suddenly you're asking "what could have *you* done differently". Not

> "what could the system have done differently", it's what could *you* have done differently…and its always the first question that always comes up…(RN12)

Organization.

The most common response from the organization was to ensure that staff could access the hospital's Employee Assistance Program (EAP). No nurse in this study accepted EAP support. Often RNs felt the experience did not warrant accessing EAP support, or alternatively felt EAP could not understand the experience as this participant described, "You can talk to other counsellors or whatever outside the unit, but I don't think a lot of people understand the dynamics of what has gone on unless you've been part of the situation" (RN06).

Long-Term Responses to Patient Violence

Long term responses were not very easily or often elicited by participants and these focused solely on the RN themselves. Longer term responses to patient violence involved legal decisions, emotional components and job decisions.

Registered Nurse.

While often legal decisions, such as choosing to charge patients or invoke restraining orders initially were made fairly soon after patient violence occurred, the legal proceedings and associated events lasted years for some participants as often RNs were contacted by the legal system when the case had gone to court or if a patient needed admission to the unit where the RN worked and had a restraining order.

In the longer term, many participants identified feeling desensitized to patient violence which was seen as both a negative side effect of the job as well as a protective mechanism for RNs against patient violence. Three participants described becoming more cynical, "hardened" (RN07) and negative as a result of cumulative verbal violence. Two RNs described feeling "emotional exhaustion" (RN08) and "burn out" (RN04) involving apathy towards their patients

as a result of verbal and physical violence experienced in acute inpatient psychiatry. These two RNs also believed that patient violence lead to leaving their jobs in acute inpatient psychiatry to pursue other roles, however both still stayed within the field of psychiatry. Many nurses in the study felt that over time they became more tolerant of verbal violence because of the high frequency that it occurred in their workplace, and initially felt that verbal violence had less overall impact than physical violence. However, after exploring their narratives of patient violence in this study several RNs questioned the cumulative and long term effects that patient violence has had on them as this participant highlighted:

> I wonder if we are *really* letting things roll off our back because there's *so* much dark humor and burn out and we end up getting cold attitudes so I wonder if those things don't really roll off our backs. Psychiatric inpatient staff are known to be, you know like [sic], dark humour and vent a lot and get burnt out, and we have negative attitudes towards the patients…(RN04)

Meta-Themes

The findings presented above are intended to provide a rich description of how nurses understand violence, the process to prevent and manage patient violence and the impacts that violence can have on not only RNs, but their patients and the organization. To further understand the experience of patient violence, four thematic patterns have been interpreted from the findings.

Power and Control

The concept of power and control was weaved throughout the narratives of the participants. In current practice, participants saw themselves as being responsible for controlling patients and the environment. Several participants identified that engaging in power struggles and the loss of power and control for the patients were often contributing factors to violence and knowing this, strategized to prevent violence by giving control back to the patients. This was

demonstrated when participants offered choices, and implemented recovery-focused nursing models, such as the Tidal Model, that promoted putting patients in the "driver's seat" (RN04), but many RNs had difficulty relinquishing this sense of power and control driven by their own fears of ensuing violence. Oppositely, a small number of participants from the same organization felt the need to have more power and more control over the environment as they perceived it would improve safety, such as having more surveillance, more control over doors and elevators, more physical barriers between nurses and patients. Perhaps this could be attributed to their need to take more power and control to compensate for their identified lack of other skills in preventing and managing patient violence.

A current and common response by RNs was to react more harshly to violence that was presumed to come from someone who was in control, meanwhile nurses in the study ascribed to being more "understanding" (RN11) of violence perpetrated by someone who was perceived to have a total loss of control, often when due to symptoms of severe mental illness.

The problem with current practice lies in whether or not the nurses thought the patient was in control as it affected how they responded to the violence and were impacted by the violence. When patients were seen as being in control, RNs felt the violence was intentional, and they became angrier, and often blamed the patient for the incident. Participants often felt a loss of control, resulting in helplessness and disempowerment when they perceived being unable to prevent and manage patient violence which in turn affected many participants' ability to care for and empower their patients.

Needs identified by participants related to power and control included education on the concepts and effects of power and control, the imbalance of power between patients and nursing,

as well as the need to create a culture of support, respect and empowerment for staff with the hope that this may in turn translate to the patients.

Stigma

Stigma was evident throughout the narratives of patient violence for all participants. Stigma was seen when nurses held the view that when working in psychiatry, violence should be expected and some nurses struggled with this concept. While they expressed that violence could not be discounted with the population, they also felt that those suffering from mental illness should not always be labelled as violent or should not always be assumed they are more violent. One participant highlighted her perspective of the organization promoting a culture of stigma and acceptance due to the fact that, in the mental health program, on the computerized incident reporting system there was no option to report verbal violence:

> What is perceived as normal behaviour and what is normal? Like you work in a mental health facility attitude versus what if that behaviour had happened on a surgical floor? They probably would have been allowed to fill out every report they could because that behaviour is not tolerated there, but in our setting, it was "*that's what you do*" and it wasn't a concern by anybody else. Almost ranking, we're not going to count verbal threats as warranting a risk report. (RN05)

Stigma also impacted how the nurse experienced violence. Many felt that patient violence exhibited by someone with a diagnosis of a personality disorder was more intentional and they saw the patient as having more control over their behaviour. Some nurses used phrases such as "they're doing it to get a rise out of you" (RN03) or "they should know better" (RN04). Personality disorders and substance use issues were seen only as controllable "behaviours" (RN02) and not as truly "serious and persistent mental illnesses" (RN05). Nurses tended to be much angrier, frustrated, less tolerant and more affected by patient violence when it involved a patient with a personality disorder or substance use.

On some level with many of the participants, while they described being more affected by violence perpetrated by someone with a personality disorder, they had insight into the fact that their thoughts and feelings held elements of stigmatization. Yet no participant identified the need for more understanding and education about personality disorders and stigma which perhaps should be considered, however three participants expressed the need to have improved emotional intelligence and ability to manage countertransference as previously described.

"Part of the Job"

Participants in the study perceived the culture of nursing as one where patient violence should be accepted as part of the job and many felt this belief was unavoidable. This was especially true of verbal violence and many RNs in the study identified the routine nature of violence as not only part of the job, but something no longer worthy of reporting. At the same time they did not want to accept that reality nor accept that violence was tolerable. This had a negative impact on the RNs perceptions of nursing as this participant highlighted:

> I *never* thought I would sign up to be…assaulted as a career path. That was something that I never realized that happened so frequently and that it was almost okay for nurses to be beat up all the time or verbally or physically assaulted and I guess that's normal practice and it's going to take a lot longer to change that. (RN05)

Several RNs felt it was not simply the culture within nursing, but stemmed from a larger, societal culture that violence has roots within, as further explained by this participant:

> I think the sad reality is that…anyone who goes into nursing should expect to encounter patient violence…I think violence is innate to our culture and there are certain types of jobs that you are more at risk for it, but I think nursing is definitely one. I think that people should expect [violence], and I don't want that. I don't think nursing students should expect to be hit at least once. (RN08)

The Balance: Nurses' Health and Safety Versus Patient Care

Throughout the narratives, nurses were often conflicted between their role of acting as the health care provider who needed to deliver care in the best interest of their patients versus acting

in a way that would protect their own health and safety. The RNs in the study often struggled to balance the decision to carry out their role in providing therapeutic care with the idea that "it's not part of my job to be hurt" (RN05) and engaging in self-preservation activities which caused internal stress. One RN described the impact this has had on her perceptions of her nursing career:

> Sometimes there's been times where I have felt more like a warden than I have felt like a caregiver and so that left me pretty disillusioned and I don't regret my choice of nursing as a career but it's not what I thought…(RN08)

Nurses also had to fight their natural fight and flight responses in order to respond therapeutically within their role as the healthcare provider as this participant highlighted, "You're in this environment, it's a weird situation, your natural reaction is *get out*, and you can't! Its work so you put it aside and you keep going" (RN08).

In physical situations driven primarily by fear and low confidence in their ability to prevent and manage patient violence, participants most often chose to preserve their own health and safety at the expense of patient care. For verbal violence, if it was unrelenting, threatening or were personal attacks, RNs again chose to protect their own health and safety. When situations involved patients deemed to be out of control due to illness, often nurses chose to put the patients' needs first above theirs. Putting the patient first was also more consistently done for the staff who embraced the principles of the recovery model, but all nurses in the study had their own individual cut off points of when the patients' needs no longer came first. The role conflict experienced when nurses had to decide between their patients' needs over their own safety may add to the impact of the experience for nurses.

Moving Forward: Nurses' Perceptions of Their Needs Relating to Patient Violence

Perceived needs by nurses' in the study are categorized into (1) needs for prevention (primary and secondary), and (2) needs for follow-up and tertiary prevention. Within the needs for prevention, it was further broken down into needs related specifically to the individual, unit and team, as well as the organization. For follow-up and tertiary prevention, perceived needs were explored for both nurses as well as patients

Needs for Prevention

Individual needs.

In terms of primary prevention, further education related to preventing violence was the most commonly identified need. Participants described wanting further education around a wide variety of topics including mental health diagnoses, symptomatology and treatments, identifying triggers, learning more strategies to prevent violence, learning awareness of self within relationships, emotional intelligence along with how to self-regulate and then how this can impact the therapeutic relationship, awareness of the power imbalance between nurses and patients, what the definition of violence (including verbal violence) is, and "nurses need to know that violence shouldn't be expected just because you work on psychiatry" (RN09). Participants also identified the need to have knowledge of the team approach and roles as well as the need for colleagues to know these roles, and to have better knowledge and understanding of the policies related to managing patient violence. Three RNs proposed similar strategies that simply involved having routine discussions about patient violence, regardless of whether it was occurring on the unit at the time, to explore "violence and what does that mean and how do you respond and what is the meaning behind the violence" (RN08) as an avenue for nurses to learn about patient violence. Incorporating evidence-based violence education into orientation for new

nurses to avoid RNs learning skills entirely from colleagues was also a suggested strategy. As well, the need to have both support and funding for nurses to seek out additional education and training opportunities was identified for all levels of violence prevention. Difficulties in being able to attend educational opportunities due to shift work often occurred as this RN demonstrated, "I think in-services would be good, but…because I work 3-11 it makes it difficult for me…I *want* to go, but once again because of my hours I am never part of that" (RN10). Thus support was identified to include not only encouraging nurses to attend, but the ability to get the time off from work to go to educational opportunities.

Unit needs.

Nurses in the study perceived a variety of needs at the unit level for prevention of patient violence. In terms of the unit environment itself, participants described the unit needing to limit access to doors and elevators which promoted power struggles as nurses felt they needed to "have control over those elevators" (RN10), have more accessible means of calling for help as often the personal alarms were "big, bulky and inconvenient" (RN09), and for some RNs, needing more physical space for patients including the availability of therapeutic spaces such as quiet or comfort rooms with equipment and supplies as well as offering increased programming and activities. Throughout nurses' descriptions of their unit contexts, the availability of these spaces as well as access to programming and supplies varied and were often limited. For secondary intervention, RNs also included the need to be able have somewhere to go to get space and a break from violence, especially frequent verbal violence, as this RN explained:

> There's *no* escape and…I don't have the mental capacity to do that for long periods…if you're one on one or you're watching someone in seclusion you *really* should be switching every couple of hours and have a lot more breaks and a lot more support. (RN04)

Some participants also wanted areas on the unit that could be used as a safety retreat for their own protection, such as having an "enclosed nursing station" (RN03, RN05, RN10). These participants also felt it was necessary to have an enclosed nursing station to act as a barrier because patients would "jump the desk" (RN05) or "reach over the counter at us…[or] come down with a bucket of water and pour it all over us and the computers" (RN03).

Related to unit staffing, regardless of the organization where RNs were employed, participants routinely described wanting more staffing which would assist with a lower staff to patient ratio, as well as a safe ratio of experienced and novice nurses. Participants felt the lower staff to patient ratio would assist in preventing violence by allowing nurses time to meaningfully engage with their patients and colleagues as this RN further described:

> So we can actually spend more time really getting to know our patients and understand what is going on with them, to know what their triggers are, what their comfort is and all those types of things. With that, we would also be able to have more time to be able to collaborate together to develop a team mentality and to be able to manage the unit together. (RN08)

RNs in the study also identified the need to improve team communication, collaboration and support for each other to help prevent patient violence. While the existing culture of support and teamwork on the units where study participants were employed varied, all participants identified this as a need to continually work to improve. One participant explained her perception of the impact of team collaboration and cohesion on her unit which highlighted the need for improving team functioning:

> When the team isn't happy, when the team isn't a well-oiled machine, we don't know each other's innuendos; we don't know how to back each other up…and what I feel on the unit is this lack of cohesion…there seems to be a lot of staff unhappiness. People end up complaining, they end up in the nursing station not wanting to do their work and not wanting to be down with the patients…you kind of turn on each other and…if we're going to have that anxiety and unrest and feeling of disempowerment then how are we supposed to empower the patients…which will affect their level of anxiety and agitation and therefore their level and risk for violence? (RN04).

Physicians and residents were also considered part of the team, and RNs perceived the need for physicians and residents to be available to assist in violence prevention as well as provide adequate and appropriate medication orders.

From unit managers or supervisors, some RNs felt it was necessary that they encourage nursing staff to follow policies, best practice guidelines and know how to safely use equipment, such as restraints. Three participants identified the need for the team, including the managers, to evaluate the appropriateness of some patients for admission to the acute inpatient psychiatry unit as this RN explained, "Sometimes we get folks who are here for reasons other than mental illness, sometimes secondary gain is…their primary gain for being here" (RN08).

For some nurses in the study that identified that their unit does not use a standardized violence risk assessment tool, this was perceived as necessary and could empower the nurses to take more responsibility in assessing risk and aid in communication of risks to colleagues in order to prevent violence.

Organizational needs.

A small number of RNs in the study identified the need for an increased presence of security personnel and surveillance on the unit and throughout the hospital which was believed to enable better observation of patients, increase the relationship between nurses and security services, and improve the feeling of safety and security for nurses and potentially patients. Alternatively, some participants did not fully agree with this idea stating they felt the presence of security could have a negative impact for patients such as feeling "incarcerated" (RN08). Needs for secondary prevention of patient violence at the organizational level also related to security services, but focused on the need to have better trained security personnel. One RN suggested having "workshops and training for acute nursing staff and security personnel together to

enhance communication" (RN09), team cohesion, and better define the role of security personnel. The desire to have security services more involved in preventing and managing patient violence may indicate the nurses' limited skill and confidence level in themselves to manage escalating situations.

Consistent amongst several nurses in this study was the perceived need to have improved hospital policies related to managing patient violence as well as clear expectations for patient behaviour. Most participants were unable to identify hospital policies addressing management of verbal violence, and within some organizations, policies relating to patient violence were considered either vague, or "out of date and they weren't really enforced" (RN05). Alternatively, a small number of participants were able to identify their organization as having a Least Restraint policy or Code White policy and thus felt the need was improved knowledge of the policy over improving the actual policy itself.

Needs for Follow-up and Tertiary Prevention

For Registered Nurses.

Nurses in the study consistently identified the need to have the event acknowledged, especially by managers or supervisors, and the perception that managers or colleagues did not minimize the experience of the event regardless of whether it was a verbally or physically violent event. Along with acknowledgement of the event, participants stressed the importance of needing the managers or supervisors to recognize the risk inherent in the situation, recognize trauma, to support them in acknowledging that violence "is *not* part of their jobs. It is not okay for anyone to go to work and get hurt as part of their job regardless of the diagnosis" (RN05), and to support RNs to not feel that money or budget concerns outweighed their own safety. This need for support by managers or supervisors was felt to be crucial by all participants and the lack

of support impacted the experience of violence for the RNs in relation to how they viewed the response from the organization as this participant highlighted:

> They [managers] have to be supportive of their staff or staff feel devalued; like they don't care you are injured as long as you can show up to work for your next shift… Acknowledging that this had happened would have spoken *volumes*…[it] would have alleviated some of the anger and stress…(RN05)

Participants expressed the need to be emotionally supported by both colleagues and managers in a blame-free and judgment-free environment regardless of whether they were the direct victim of the violence, a responder to the violence or a witness because "it's traumatizing" (RN12) and may impact job satisfaction. This support was also identified by two participants as being important to extend to when a nurse chooses to seek legal action against a patient. Support, in the way of encouraging and assisting the individual involved in the violence to complete safety incident reports was also perceived as necessary for four participants.

Options for counselling or further help after "*any* incident a nurse identifies as being a violent incident" (RN05), not just physical violence, were also perceived to be essential for RNs. While many did not identify using supports such as EAP when describing their narratives, the need to have the option available was important to the nurses in the study. One participant further explained the perceived importance of offering counselling to nurses affected by patient violence, "I think *a lot* more emphasis now needs to be on that whole mental health well-being of your staff because how effective are you at your job if you are traumatized by something that has happened to you?" (RN05).

For one participant, after charging a patient and having her home address sent on a notification to her patient from the court, she highlighted the need for hospitals to protect the

personal information of its employees:

> I wasn't out on the street attacked as a person; I was attacked as an […] Health Services employee. That should have been the *hospital* standing behind me and the *hospital* on that incident report, rather than my name…I think there needs to be a system of protection if you choose to press charges. (RN01)

The need to engage in a debriefing process after each incident of patient violence was consistently identified as fundamentally important by all participants regardless of whether the situation involved verbal or physical violence as one RN explained, "the debrief *has* to be baseline. It has to happen for *everyone"* (RN05). Not only was debriefing essential in planning for preventing future violence, but also allowed nurses' concerns to be heard and provided a forum for support and learning.

For patients.

For all patients on the unit, some nurses in the study identified the need to provide a sense of safety and security on the unit as this RN described, "When a situation like that happens on the unit, it affects *everybody*…we have to have those conversations to say 'the unit is settled, it's okay, you're safe'…" (RN07). Participants described needing to not only engage in a debriefing with staff, but needing to recognize the equal importance of engaging in a debriefing with the patient who was the aggressor as this RN emphasized, "I think they [RNs] really need to debrief…and to make the plan that they are going to debrief with the patient as soon as possible. I think that's something that they *really* need" (RN08). This was also felt by some participants to be a necessary and optimal time for nurses to either create or update plans of care for the patient and thus aim to prevent future violence as well as mitigate the risk of lasting trauma to the patient.

Chapter Summary

This chapter provided a description of the study findings including the RNs' perceptions and experiences of patient violence. It also explored primary, secondary and tertiary prevention strategies at the individual, unit and organizational levels. As well, the findings described the emotional and physical impacts of the event, short and long term responses of the RNs and patients as well as the four overarching thematic patterns labelled *Power and Control, Stigma, Part of the Job* and the last exploring role conflict, titled *The Balance: Nurses' Health and Safety Versus Patient Care.* Finally, nurses' perceptions of their needs for each level of prevention as well as follow-up from the perspectives of the RNs and patients were elicited.

Chapter 4: Discussion

Patient violence has been a recognized problem for several decades (Richter & Whittington, 2006) and yet still remains unresolved despite some progress in the area. What is of concern, however, is that workplace violence is a significant public health issue. In particular, exposure to violence, including aggression initiated by patients, impacts the health of nurses (Chen, Huang, Hwang, & Chen, 2010; Gates, Gillespie, & Succop, 2011; Nolan, Dallender, Soares, Thomsen, & Arnetz, 1999; Pai & Lee, 2011), quality of work life (Arnetz & Arnetz, 2001; Sofield & Salmond, 2003) and human resources issues such as staff retention (Ito, Eisen, Sederer, Yamada, & Tachimori, 2001; Sofield & Salmond, 2003). Part of the difficulty in examining and addressing this very sensitive issue of patient violence, within the context of mental health, lies in balancing the well-being of both, nurses, and patients. It is not about placing blame on either group, but finding a solution for the safety of both equally important stakeholders in this contentious, emotionally driven issue.

The purpose of the current study was to conduct an in-depth qualitative exploration using a problem, needs and practice analysis to develop a contemporary and comprehensive description of how psychiatric nurses perceive and experience this phenomenon within acute inpatient psychiatry.

In this chapter, I provide a discussion about the study's major findings including the perceptions and experiences of patient violence, including exploring contributing factors and antecedents to patient violence, prevention and management strategies, as well as the perceived impacts of patient violence on RNs, patients and the organization. I then discuss the influence of power and control, stigma, the perception of violence as "part of the job" and the role conflict

nurses experience when balancing the duty to care for patients and the duty to one's self. The chapter ends with the provision of recommendations for practice, education and future research.

Perceptions of Patient Violence

Significant variation was found amongst participants' individual definitions of patient violence. Variation existed amongst the types of violence to include, for example, initially several RNs did not include verbal violence within their personal definitions. Often verbally violent or abusive acts were considered normative experiences and not violence at all while physical acts were almost always categorized as violent. Variation also existed around the inclusion of intent along with a patient's diagnosis. Some RNs felt that acts were violent irrespective of whether the aggressor was perceived to purposefully cause harm, while others felt that intent played a significant role in whether they perceived the act as violence. This variation in nurses' definitions of patient violence is supported by research by Cutcliffe (1999). He described that all nurses' have their own "personal construct of violence" (p. 108). This in itself contributes to the difficulty of creating a standard definition for patient violence and thus the challenges of accurately measuring the scope of the phenomenon and understanding nurses' experiences (Sofield & Salmond, 2003). It may also impact the interventions that nurses choose to implement when managing patient violence. If a patient's aggressive behaviours are not perceived and then identified as a violent act, then there is the potential that RNs may be less likely to intervene quickly or it may impact the consistency of responses to violence. This further highlights the importance of a standardized definition for patient violence (Cutcliffe, 1999; Rippon, 2000).

In this study, RNs most often determined acts to be "violent" when they perceived the patient was intentionally intending to cause harm. Violence perceived as coming from general

malevolence versus true illness affected how participants managed and were impacted by the violence. This division between attributing violence to either 'madness' or 'badness' is a common finding throughout existing literature known as the madness/badness divide (Crichton, 1995; Cutcliffe, 1999). When RNs in this study believed the violence to be a manifestation of a patient's illness, often they attributed it a patient's need to protect themselves, and thus decreased the RNs perceived level of threat and harm leading them to consider the act as something other than violence. Previous research by Smith and Hart (1994) is comparable. They reported that seriously ill patients were given a wider scope of acceptability for anger expression because patients could not control their behaviour and it helped to intellectually explain the patient's behaviour for the nurses. This contradicts Jonker, Goossens, Steenhuis and Oud's (2008) finding that nurses perceived patient violence as being destructive or offensive and not serving a protective or communicative function. While Jonker and colleagues used a questionnaire approach in their research, their chosen tool, the ATAS, still assessed and captured attitudes towards aggression, such as intent to cause harm (intrusive attitude) and viewing patient aggression as a result of powerlessness (communicative attitude), but these findings were not consistent with the current study.

How RNs perceive the patient engaging in violence may also be influenced by transference and countertransference as supported by Cutcliffe (1999) and Maier (1993). Transference is the phenomenon where one unconsciously transfers feelings and attitudes from a person or situation in the past on to a person or situation in the present, whereas countertransference is the response to significant transference within the therapeutic relationship. It is the response, including both feelings and associated thoughts that are elicited in the recipient by the other person's unconscious transference communications (Hughes & Kerr, 2000). Maier

postulated that nurses' responses to violence start with empathy, and move to anxiety, fear, anger, counteraggression, and end with frustration. According to Maier, nurses who experience this process consistently may develop chronic countertransference, and any countertransference experienced by nurses may influence their perception of the violence and the patient. Some of the RNs in the current study described having a similar response process as Maier proposed, but not all did, and it is possible that the deviation in response is in part due to stigma as well as transference and countertransference. Again, this response relates to the stigma that nurses attribute to certain diagnoses and their perceptions of intent to harm. When violence involved certain stigmatized groups, such as patients with personality disorders, or when RNs felt that violence was intentional, or they had significant transference and countertransference reactions to their patients, RNs rarely described feeling initial empathy for the patient. They did however describe feelings of fear, anger and frustration and often responded with coercive countermeasures in an effort to manage the situations of escalating violence. Any counteraggression described by RNs was in the form of more coercive management strategies, such as the use of seclusion or restraints, but was considered to be necessary and in the best interest of both staff and patients to maintain safety. While transference, counterstransference and stigma played a role in the experience of patient violence, Maier's proposed theoretical process does not fully support the experiences that RNs described in the current study.

Experiences of Patient Violence in Acute Inpatient Psychiatry

RNs in the current study identified several patient, nurse and environmental factors that they perceived contributed to the onset of patient violence. These perceptions of contributing factors were all moderately supported by existing research and literature.

Patient-related factors identified by study participants included (1) type of psychiatric diagnosis; (2) history of patient's previous violent behaviour, and (3) current substance use, as well as a history of past substance use by the patient. In the current study, participants identified certain psychiatric diagnoses and related symptoms of such diagnoses, such as psychotic or impulse-control symptoms, as being contributing factors to the violence they experienced. This is supported by Duxbury and Whittington (2005) whose study participants described that a patient's mental illness and pathology are key internal factors that contribute to patient violence. Kindy, Petersen and Parkhurst's (2005) study participants also perceived characteristics of patient diagnoses as contributing to violence and explored this perception even further. They described that patients contributed to an unpredictable and uncontrollable environment due to symptoms of psychiatric and developmental disorders, such as impulsiveness, explosiveness, and feeling superior to and antagonistic toward staff. Meanwhile the quantitative evidence is mixed and controversial. Krakowski, Czobar and Chou (1999) explored persistence and resolution of violence in relation to psychotic symptoms, ward behaviours and neurological impairments. They found that violent patients presented with more severe positive psychotic symptoms, and were considered more irritable than the nonviolent control group indicating patients with positive symptoms of schizophrenia and schizoaffective disorder are more likely to be violent. Schizophrenia and other psychotic disorders have symptoms that are generally organized into two types: positive and negative symptoms. Positive symptoms are those which are considered above and beyond normal behaviour causing someone to lose touch with reality, such as hallucinations and delusions (National Institute of Mental Health, 2009). This evidence supports RNs' perceptions in the current study that psychotic symptoms can be a contributing factor to patient violence. This is further supported by a more recent literature review by Walsh,

Buchanan, and Fahy (2002). These researchers explored the relationship between mental state, specifically with schizophrenia, and the propensity for violence. They also described the considerable increase in violence risk associated with comorbid substance abuse. Again, this supports the findings in the current study relating to psychotic symptoms as contributing factors to patient violence as well as substance use and abuse. However some (for example, Pescolido, Monahan, Link, Stueve, & Kikuzawa, 1999; Stuart, 2003) suggest this perception may in fact be a manifestation of a stigma towards certain diagnoses rather than a true correlation. RNs in the current study perceived that the history of the patient's behaviour (in relation to violence) also contributed to patient violence while in hospital, such as aggression with other patients. This factor is also supported within the quantitative literature as an indicator for potential future patient violence (Owen, Tarantello, Jones, & Tennant, 1998). RNs in the study perceived patients' substance use contributed to their experiences of patient violence because of its ability to cause disinhibition and it may also be an indicator of the patient's inability to cope with stress. Substance use and its connection to violence has been significantly studied in the quantitative literature, and supports the nurses' perceptions (Cornaggia, Beghi, Pavone, & Barale, 2011; Walsh, Buchanan, & Fahy). Current substance use by a patient can act as a catalyst for violence due to unpleasant symptoms, such as anxiety and agitation, coupled with decreased inhibitory control. Nonetheless even a history of substance use has been shown to increase the probability of patient violence (Bowers, Allan, Simpson, Jones, & Van Der Merwe, 2009; Owen, Tarantello, Jones, & Tennant).

Nursing-related factors identified in the current study are: (1) communication amongst nursing staff (2) engagement in debriefing and (3) patient assessment skills. Lack of effective communication amongst nurses was perceived by RNs in the current study as contributing to

patient violence. This finding is directly supported by other qualitative studies conducted by Catlette (2005) and Kindy, Petersen, and Parkhurst (2005). Kindy, Petersen and Parkhurst also explored communication amongst nurses and other members of the healthcare team and described that nurses felt physicians and allied health did not listen to their concerns about patients which in turn contributed to patient violence. For some RNs in the current study, they described similar perceptions and experiences of physician and nurse communication where they had tried to tell physicians their concerns, the issues were subsequently not addressed and the nurse was the victim of patient violence.

Not engaging in debriefing after an incident of patient violence was also perceived to contribute to patient violence by not allowing time to create a team plan to prevent future violence as well as time for staff support after an incident occurred. Whittington and Wykes (1994b) proposed a cyclical model of violence where staff behavours, including their interaction patterns, were associated with an increase in patient violence. Within this model, the stress experienced by nursing staff is an important factor and may be influenced by an absence of engaging in debriefing and this may result in nursing behaviour that increases the risk of patient violence, however further exploration from a quantitative perspective is needed to confirm these interpretations.

In terms of patient assessment skills and the quality of patient assessments, RNs perceived that the clinician's skills and subsequent quality of a violence risk assessment contributed to patient violence. They highlighted the importance of having a thorough patient assessment completed in the emergency department and any risks communicated to the nursing staff prior to admission of the patient to the inpatient unit. While studies of skills and quality of risk assessments are not common within the discipline of nursing, it has been explored in relation

to physicians. Wong, Morgan, Wilkie, and Barbaree (2012) found that psychiatric residents identified and assessed significantly fewer violence risk factors than more experienced staff psychiatrists. This finding supported the notion of increased experience and education, and also demonstrated the complexity and variation of the significant factors involved in a violence risk assessment which may place nurses and other healthcare providers at risk.

Unit-related attributes of the inpatient psychiatric unit that were also perceived to play a role in patient violence are: (1) physical space and environment; (2) availability of activities and (3) the availability of nursing staff. Physical space and overcrowding are well supported by the literature, both quantitatively and qualitatively, as significant contributors to patient violence (Catlette, 2005; Cutcliffe, 1999; Cutcliffe & Riahi, 2013; Duxbury & Whittington, 2005; Owen, Tarantello, Jones, & Tennant, 1998; Virtanen, et al., 2011). Lighting and visibility were also strongly perceived as impacting the safety of RNs in the present study as supported by prior research. Gerberich et al. (2005) found that of all the environmental factors that they studied, the amount of lighting was most strongly associated with risk of violence. The odds of assault were doubled when lighting was less bright than daylight.

Boredom and lack of activities on the unit for patients were also perceived by the RNs in this study as contributing to their experiences of patient violence. This perception, shared by nurses and patients, is common amongst other study findings (Bensley, Nelson, Kaufman, Silverstein, & Walker Shields, 1995; Chaplin, McGeorge, & Lelliott, 2006; Meehan, McIntosh, & Bergen, 2006; Shepherd & Lavender, 1999). Shields and Wilkins (2009) found that nurses who perceived to have fewer resources were associated with a higher prevalence of violence.

Nurses in the study perceived having fewer staff present to assist were contributors to patient violence whether due to low staffing levels overall or simply nurses being on break or

occupied somewhere else on the unit. Interestingly, while nurses in the study perceived that a higher nursing ratio lowered the risk of violence, a common finding amongst the quantitative literature is that higher staffing levels, as well as more time spent with patients, has a positive relationship with patient violence (Bowers, Allan, Simpson, Jones, & Van Der Merwe, 2009; Gerberich, et al., 2005). However this may be due to the fact that a higher volume of nurses may mean they are more likely to observe and report violence, and similarly more time spent with patients increases the opportunity to experience violence though this contradictory evidence requires further exploration.

Antecedents, or triggers, to the event of patient violence reflected primarily interpersonal interactions, with some incidents reflecting intrapersonal, client-related precursors, such as the experience of psychotic symptoms. According to a systematic review by Papadopoulos et al. (2012), antecedents leading up to violence are complex, however nurse-patient interactions were the most frequent type of antecedent precipitating approximately 39 percent of violence and they further described that limiting patients' freedoms by either placing some sort of restriction, or denying a patient request, was the most frequent precursor of incidents. This was also supported by Bowers, Allan, Simpson, Jones, and Van Der Merwe (2009), and Duxbury and Whittington (2005). Papadopoulos and fellow researchers suggested that this demonstrates that most violent incidents are preceded by staff exercising their power over the patient. Following nurse-patient interactions, patients' behavioural cues and no clear cause were also found to be common antecedents to patient violence (Papadopoulos, et al.). These described results closely reflect the perceptions of the nurses in the current study. While RNs in this study also perceived patients' symptoms to be precursors to violence, this is inconclusive in the literature as there are many studies both in support of and against this perception (Stuart, 2003).

Even if contributing factors and triggers were not assessed as present, RNs still enacted specific strategies to protect their own safety. The subject of staying safe involved nurses in the study identifying their routine, individual-level strategies in which they regularly implemented to protect their personal safety. These strategies included: (1) being aware of their personal space and their surroundings; (2) informing colleagues of their location; (3) wearing personal alarm devices (when available) and (4) selecting work attire that minimizes potential choking or grabbing hazards. Kindy, Petersen, and Parkhurst (2005), in a study of nurses' experiences of working in psychiatric units with high risks of assaults, confirmed that nurses create and institute safety fortifications through two primary elements: (1) personal preparation, and (2) tangible devices. Personal preparation included such things as engagement in therapeutic patient communication, being attuned to one's body language, one's physical positioning, the quality of unit teamwork, knowledge of current methods of managing assaultive behavior, noting client histories, observing patterns of behavior, and the use of medications. Tangible devices used for safety measures included walkie-talkies, cameras, seclusion rooms, restraints, mirrors, and medications, however participants in this study noted that these measures were only as good as the person using them (Kindy, Petersen, & Parkhurst). Gerberich, et al.'s (2005) study partially supported these themes and found that the risk of violence decreased when nurses carried personal cell phones or personal alarms, but offered no difference when they were supplied by their employers perhaps indicating a lack of comfort, knowledge, or training on how to use employer-provided devices. Other elements of environmental protection, such as video monitors and security personnel, had little apparent effect and did not support perceptions of enhancing safety and preventing patient violence by the RNs in the current study. This correlation between nurses' perceptions of safety and actual risk has also come into question in existing empirical

research. Blando, O'Hagan, Casteel, Nocera, and Peek-Asa (2013) found that nurses' perceptions of safety risks were not always correlated with actual risk, however despite this, nurses' perceptions of risk for violence were considered to be equally as important as they are key factors that influence the retention and recruitment of nurses.

Participants described a wide range of strategies currently utilized in practice to prevent patient violence which were categorized into primary, secondary and tertiary prevention approaches. Individual and team approaches using de-escalation principles identified by RNs in this study is well supported within the literature. Often these interventions were used to prevent and manage violence (Finnema, Dassen, & Halfens, 1994). Richmond and fellow researchers (2012) described a three-step process where the patient is first verbally engaged, a collaborative relationship is then established, and finally the patient is verbally de-escalated out of an agitated state. They describe that there are four main objectives when working with agitated patients: (1) ensure the safety of the patient, staff and others in the area; (2) help the patient manage their emotions and distress, and aim to maintain and regain control of their behaviour; (3) avoid the use of restraint when at all possible, and (4) avoid other coercive measures that can cause further agitation (Richmond, et al.). These researchers also recognized the importance of using nonverbal approaches for the prevention of patient violence, such as medication use and environment planning. All participants in this study identified with these goals of de-escalation and described using these skills in their practice to prevent both verbal and physical patient violence though at times RNs struggled with wanting to gain control of the situation instead of empowering the patient to gain their own control. This may also influence the effectiveness of de-escalation. Elements of de-escalation, such as limit setting, have been reported in some previous research as precursors to violence if conducted in authoritarian or unempathic styles

(Duxbury & Whittington, 2005; Lancee, Gallop, McCay, & Toner, 1995). At other times, RNs described situations as occurring too rapidly to successfully use de-escalation. Cutcliffe (1999) identified in his study that nurses who felt most equipped and prepared to manage violence did not view violence as an entirely negative or destructive activity than those nurses who felt less capable to deal with violence. They described experiencing a state of readiness, and a sense of being prepared to handle violence. However this was not always the experience for RNs in this study. Even for some nurses who felt prepared and capable to manage violence, they still perceived it negatively as many perceived violence differently based on patients' diagnoses and behaviours over their appraised abilities. In a small number of instances, when RNs felt unprepared and unable to manage the situation, regardless of the diagnosis or behaviours, they described feeling completely out of control and viewed the violence as a very threatening and negative experience with significant impacts on the RN. This is supported by Cutcliffe's research as well as by further work from Smith and Hart (1994). Smith and Hart described how the nurses' responses to expressed anger differed according to the nurses' appraised ability to manage the situations. Those nurses who felt they had the skills, knowledge and experience of dealing with violence perceived violence in a less threatening way relative to the nurses who did not feel equipped (Smith & Hart). For RNs in the current study, this was especially true for verbal abuse or violence. Many RNs felt they did not have the skills or confidence to successfully manage this form of violence and often described it as being just as threatening and intimidating as more dangerous forms of physical violence.

Avoiding restraints and coercive measures was also explored by RNs in relation to organizational "least restraint" philosophies and policies. This philosophy acknowledges that the quality of life and preservation of dignity are important values guiding nurses' practices. It

encourages nurses to find and use alternatives to restraint measures, and when necessary as a last resort, use the least restraint method possible that still maintains safety (College of Nurses of Ontario, 2009d). However a study conducted by Moylan and Cullinan (2011) found that nurses who had sustained injuries as a result of an incident of patient violence had in fact decided to restrain later in the progression of that incident of aggression.

RNs in the current study also felt that previous experience and anecdotal evidence from their peers provided resources that they could utilize in practice to prevent violence and thus enhanced their ability to manage incidents of violence. Research by Cutcliffe (1999), as well as Smith and Hart (1994) support this finding. However there is opposing evidence that suggests that exposure to violent incidents reduces the nurses' ability to effectively manage future the violence (Whittington & Wykes, 1994) and calls into question the validity of the information that nurses receive from their peers.

RNs had varying perceptions of how effective or appropriate zero or no tolerance policies for violence were in the context of psychiatric care. Several organizations had these policies in place, but RNs described never witnessing them being enforced within the hospital except in different areas, such as medicine. The existing literature is also divided, or contradictory, with some best practices, such as the International Council of Nurses, the Irish Health Service and the Registered Nurses Association of Ontario (RNAO), recommending hospitals implement a zero tolerance policy and approach to violence (International Council of Nurses, 1999; McKenna K. , 2008; Registered Nurses Association of Ontario, 2009). Lanza, Zeiss, & Rierdan (2006) postulate that if an organization is willing to promote zero tolerance, they are accepting of the idea that violence against nurses is unacceptable in any capacity or circumstance. Meanwhile other researchers are cautioning against this approach as it is felt to place blame primarily on the

patient without exploring the other factors that may influence the incidents of patient violence (Cutcliffe & Riahi, 2013). While some RNs in the current study echoed this sentiment, they also acknowledged that there are some patients with whom this policy would be appropriate such as those enacting violence purposefully and maliciously. The lack of a consistent definition of violence adds another layer of complexity to being able to enforce a policy such as this. To address this, the International Council of Nurses suggests each organization define violence for the purpose of enforcing these policies, as well as standardizing and supporting the reporting of violent incidents.

In terms of tertiary prevention, a small number of RNs in the study, who worked for the same organization which had implemented elements and the philosophy of the Tidal Model, stressed the need to teach patients coping skills more often in practice in order to prevent future violence. The Tidal Model was developed as a model for acute mental health nursing care. It is a person-centred approach to psychiatric patient care which focuses on recovery, the person's story and highlights the importance of the person/patient being a partner in their own care. Recovery in this specific sense of the word means to get going again (Barker & Buchanan-Barker, 2010). Barker and Buchanan-Barker reviewed studies evaluating the implementation of a Tidal Model into various practices and found that, despite significant national and cultural disparities as well as variations in the use of the Tidal Model processes, the studies showed similar results with no reports of negative outcomes or negative responses from staff. Their review demonstrated that several studies have shown reductions in the frequency of self-harm and suicide attempts, aggressive verbal and physical acts towards staff, incidents requiring physical control and restraint interventions, and the times staff needed to use PRN and chemical restraint medications (Barker & Buchanan-Barker). The recommendation for de-escalation also

supports the RN's decisions to empower patients and is similar in that it describes the clinician's role (in part) as coaching the patient in how to remain in control once a relationship has been established (Richmond, et al., 2012). This is also in keeping with principles of client-centred care by empowering patients to be involved and active participants in their own care (Registered Nurses Association of Ontario, 2002).

Patient violence, whether verbal or physical, had many perceived impacts on both RNs and patients themselves. For nurses, there were emotional and physical impacts as well as various impacts affecting nurses' abilities to carry out their role as an RN on the unit. Many RNs described experiencing an immediate fight or flight stress response in reaction to escalating violence. This fight or flight response evolved as an automatic survival mechanism to assist humans to react quickly to perceived life-threatening situations (Harvard Health Publications, 2011). However RNs expressed the difficulties of having to mentally push those responses aside, going against their natural instinct to protect themselves, in order to continue to manage escalating violent situations as part of their therapeutic and professional roles when working with acutely ill psychiatric patients. If the stressor remains after the initial stress response occurs, the human body adapts by activating the hypothalamic-pituitary-adrenal (HPA) axis which uses hormonal signals to maintain the stress response. This stress response is likely often maintained since patient violence has been demonstrated to be a significant stressor for nurses (di Martino, 2002; Gates, Gillespie, & Succop, 2011; Needham, Abderhalden, Halfens, Fischer, & Dassen, 2005). If the HPA axis is activated for too long, it has been linked to serious health conditions (Harvard Health Publications) such as heart disease, cancer, stroke, headaches, irritable bowel syndrome, depression and post-traumatic stress disorder (Cohen, Janicki-Deverts, & Miller,

2007). RNs in the current study described headaches, muscle tension, anxiety and exacerbation of existing mental health symptoms.

Other impacts included feelings of anger, shock, and fear, as well as physical injuries and changes in their levels of confidence, vigilance, trust and anxiety. These described impacts by the nurses in this study are both serious and distressing. They have been supported through various research exploring both verbal and physical violence (Catlette, 2005; Inoue, Tsukano, Muraoka, Kaneko, & Okamura, 2006; Kindy, Petersen, & Parkhurst, 2005; Kisa, 2008; Needham, Abderhalden, Halfens, Fischer, & Dassen, 2005; Zuzelo, Curran, & Zeserman, 2012). With the significant consistency amongst existing and the current research, despite numerous differences in research methodologies, settings and assessment tools, it conceivably demonstrates that many of these impacts are a universal experience of patient violence.

Many of these emotional impacts can also be related to symptoms of post-traumatic stress. Post-traumatic stress and the subsequent disorder is often brought on by actual harm or threat of harm to ones' self. Symptoms can be categorized into three themes: (1) re-experiencing symptoms such as flashbacks, bad dreams or frightening thoughts; (2) avoidance symptoms, such as staying away from places that are reminders of the experience, emotional numbness, guilt, depression or anxiety, anhedonia, and difficulty remembering the traumatic event as well as (3) hyperarousal symptoms such as being easily startled, feeling tense or hypervigilant, and having difficulty sleeping or angry outbursts (National Institute of Mental Heath (NIHM), n.d.). Researchers, such as Gates, Gillespie, and Succop (2011), Inoue, Tsukano, Muraoka, Kaneko, and Okamura (2006), Wildgoose, Briscoe, and Lloyd (2003) as well as Richter & Berger (2006), have explored the relationship between patient violence and post-traumatic stress disorder (PTSD). Gates, Gillespie and Succop reported that 94 percent of nurses in their study

experienced at least one symptom of post-traumatic stress PTSD, and 17 percent having scores on the Impact of Events Scale-Revised (IES-R) indicating a probable risk of PTSD. The IES-R is a screen that may implicate the risk for PTSD. Similarly, Inoue, Tsukano, Muraoka, Kaneko, and Okamura found that 21 percent of nurses in their study exceeded the cut off point on the IES-R to suggest probable PTSD after experiencing verbal violence. Wildgoose, Briscoe and Lloyd reported 61 percent of the overall sample reported PTSD symptoms with 10 percent meeting criteria for a diagnosis and Richter and Berger described similar results in their longitudinal study whereby 17 percent of their small sample met criteria for PTSD and four subjects continued to meet criteria six months after the reported incidents. The existing quantitative and qualitative data, along with the findings from the current study, suggest that nurses are highly affected by patient violence in the workplace and a small amount of research reports that previous exposure to trauma may indicate a greater risk of PTSD from subsequent trauma (Anderson, 2002; Breslau, Chilcoat, Kessler, Davis, 1999). There has been fewer studies exploring the impact of violence on nurses' ability to carry out their roles and subsequently their quality of care following incidents of patient violence. The findings in the current study suggest that nurses perceive patient violence to impact the quality of care they are able to provide. This perception is supported by evidence that productivity and quality of care tends to decrease which can have significant impacts on patients, families and organizations (Arnetz & Arnetz, 2001; Gates, Gillespie, & Succop). However there were a small number of participants who stated that, at times, violence garnered much needed attention for patients and improved their quality of care which is contradictory to existing research.

RNs also reported feeling judged, guilty, and they blamed themselves for the incident of patient violence. One participant even likened the feeling to how women feel when they have

experienced rape. These impacts have consistently been demonstrated throughout the existing literature as evidenced by a thorough systematic review conducted by Needham, Abderhalden, Halfens, Fischer, and Dassen (2005). These expressions of self-blame, guilt and feeling judged also parallels the experience by other victims of violence such as those experiencing intimate partner violence (IPV) (Barnett, 2001; Barnett, Martinez, & Keyson, 1996). This highlights that perhaps experiences of violence, despite differing contexts, have a relatively universal experience for the victim. It also demonstrates the need to further explore the significant emotional and physical impacts of patient violence on nurses and the need to support nurses in their understanding that it is not their fault, that they cannot fully control the behaviour of patients at all times, and thus, the outcomes of violence. They must also feel supported and learn from their expereinces do what is recommended as best clinical practices from the evidence addressing the prevention of risk for violence among psychiatric patients.

Not only does violence affect the quality of care for patients, but RNs also perceived various other impacts for patients, such as physical injuries, feelings of remorse, loss of privileges, difficulty with follow-up services and possibly legal consequences. The finding of patients expressing remorse similarly mimics other literature around interpersonal violence, such as intimate partner violence once again. The cycle of abuse begins with tension build up, the assault or abuse occurs and following this there is a period of remorse and attempts to make up for the violent event (Newman & Newman, 2008). Interestingly, Carrlson, Dahlberg, Ekebergh, and Dahlberg (2006) conducted a phenomenological study exploring patients' perceptions of violent encounters in psychiatry. Patients in their study confirmed losing their privileges as a result of violence, but felt this was used as a punishment by staff attempting to control their behaviour. They also did not describe feelings of remorse; instead patients justified their actions

based on how they perceived the nurses' caring styles and actions. This is also similar to Duxbury & Whittington (2005) where patients attributed their violence to the environment and attitudes of staff. However a more recent study by Pulsford et al. (2013) found nursing and patient attitudes to be quite similar. These differing viewpoints both need to be considered when exploring patient violence and further research is needed to explore these perceptions.

RNs' long-term responses to patient violence were more difficult for participants in this study to describe, however they involved legal decisions, such as choosing to charge a patient, emotional components such as feeling cynical or hardened over time and job decisions involving the desire to leave their position or actually changing positions. RNs in the study often struggled with the decision of whether to charge a patient and many described being influenced by colleagues, supervisors, and law enforcement. While some participants in this study felt encouraged and supported to charge their patients, not all did and they spoke of being discouraged by supervisors, psychiatrists, and the police. There are very few empirical studies on the prosecution of violent psychiatric patients as explored in a systematic review by van Leeuwen and Harte (2011). Their recommendations based on the existing literature were to report and investigate cases when the incident resulted in severe injury, the incident was a sexual Offence, or when a patient repetitively caused violent incidents. This may explain why Henderson (2003) reported nurses feeling unsupported by their colleagues with their decisions to charge clients if their decisions were not in keeping with these recommendations. In Henderson's study, nurses almost always described relationships with their colleagues as negative and unsupportive, which also differed from the current study. In the current study, the majority of RNs felt they had supportive colleagues whom they could seek out for assistance and who encouraged the RN to look out for themselves. A small number of nurses identified that, at

times, certain colleagues were less supportive to them and they felt blamed by these colleagues after an incident of patient violence. The RNs whom identified their colleagues as unsupportive described that the culture amongst that group of nurses was negative towards themselves and patients, and not team-oriented.

Research into the long-term emotional impacts of patient violence is also limited. Present study participants described feeling more cynical, jaded and some RNs even remarked upon psychiatric nurses' use of "dark humour." It is possible these experiences are long lasting symptoms of PTSD, negative coping strategies or perhaps play a role in chronic work stress and subsequently burnout. Burnout is characterised by three general categories: emotional exhaustion, depersonalization and personal accomplishment (Maslach & Jackson, 1984). One study of emergency department nurses credited their built up, pervasive anger towards patients as causing them to withdraw and become callous towards patients (Levin, Hewitt, & Misner, 2008). The development of these negative, cynical attitudes and feelings about patients is a cardinal factor in burnout, known as depersonalization (Maslach & Jackson). Melchior, Bours, Schmitz and Wittich (1996) described nurses working with certain patient groups, such as those that are aggressive or suicidal, are at increased risk of burnout. A key aspect in terms of the development of burnout is the amount and degree of contact with patients and if patients give negative feedback (i.e. aggression). It was hypothesized that nurses who continuously focus on the negative aspects of patients developed a more cynical view of human nature.

Another important consideration in terms of long-term effects of patient violence, which not only impacts the individual nurse involved but the entire organization, is that of recruitment and retention. Several nurses in the current study expressed a desire to look for other work soon after the experience of patient violence, with two participants actually leaving their positions for

another citing violence as a major motivation for the change. Kindy, Petersen, and Parkhurst (2005) reported similar findings where several of their participants experienced a desire to leave after weighing the risks and benefits of the job and perceiving that there was minimal hope for change. Ito, Eisen, Sederer, Yamada, and Tachimori (2001) demonstrated that the risk of assault was a significant predictor of nurses' intention to leave their job. Exploring this further, Roche, Diers, Duffield, and Catling-Paull (2009) found that intent to leave the present nursing position was associated with perceptions of emotional violence, but not with threat or actual assault. The current literature establishes that violence plays a role in retention of nursing staff, however the difficulty is that it is impossible to determine if the study sample is capturing the magnitude of the problem including capturing those nurses who have already left the position, organization or occupation as a result of patient violence.

Follow-up after the experienced violent events was provided in the period immediately after the event by both formal (management, or supervisors) and informal (friends, family, and colleagues) supports and the consistency with how much participants felt supported varied. Cutcliffe (1999) described a similar theme which highlighted the relationship between the nurse's level of support and how this support enables them to carry on dealing with violent incidents. Throughout the existing literature, feeling supported by both colleagues and management has been perceived as fundamentally important to the nurses experiencing patient violence and has been found to reduce the negative physical and psychological symptoms as well as negative attitude toward the workplace following violent events (Gillespie, Gates, Miller, & Howard, 2010; Schat & Kelloway, 2003). However there are existing reports of nurses feeling very unsupported, blamed or punished by their colleagues or managers and thus do not seek out additional necessary supports (Kindy, Petersen, & Parkhurst, 2005; Nolan, Dallender, Soares,

Thomsen, & Arnetz, 1999). Part of the follow-up identified by participants was holding a debriefing session after the incident in order to reflect on what happened, how staff were feeling and learn from what occurred. This occurred inconsistently throughout the RNs' descriptions of the experience of violence, often only occurring for incidents perceived to be critical and when coercive measures were used such as seclusion or restraints. Debriefing is supported and encouraged by organizations such as the College of Nurses of Ontario, RNAO as well as incorporated into de-escalation and crisis intervention principles (College of Nurses of Ontario, 2009; Registered Nurses Association of Ontario, 2006; Richmond, et al., 2012) and yet does not appear to be consistently practiced (Needham & Sands, 2010; Pich, Hazelton, Sundin, & Kable, 2011).

Incident reporting after the event was not consistently completed due to difficulties defining and recognizing incidents of violence, workload, and available time to complete the report as well as the seeing the benefit of reporting. Several RNs perceived that filling out incident reports was discouraged within psychiatry due to the frequent nature of the phenomenon. It is also likely that some forms of violence have become so normalized that RNs may not even recognize their exposure to violence or the impact this may have on their health. This is consistent with the existing literature that violence is often underreported (Lanza & Campbell, 1991; Levin, Hewitt, & Misner, 2008; Liss & McCaskell, 1994; Gates, Gillespie, & Succop, 2011). The International Council of Nurses (1999) estimates that only 20 percent of violent incidents are reported by nurses. Participants in the current study described filling out the reports only for incidents perceived to be more critical in nature which is again consistent with existing literature (Lanza & Campbell) however there is a paucity of exploration regarding the

barriers to reporting. It is imperative that nurses are aware that just because violence occurs in psychiatry does not mean it should not be reported.

Meta-Themes

Power and Control

RNs in the current study saw themselves as being responsible for controlling and maintaining order on the unit, but many participants also recognized that power struggles and taking control from patients often contributed to violence, and existing literature supports this as an antecedent to violence (Hoel, Sparks, & Cooper, 2001). A small number of RNs accepted the idea of giving patients back power and control to prevent violence, but had difficulty actually relinquishing this power and control despite identifying the benefit of it. This is not unlike Henderson's (2003) findings where nurses viewed involving patients in their care as requiring them to give patients information and to share decision-making powers with them; however with the exception of a few participants, the majority of nurses were unwilling to share their decision-making powers with their patients thereby creating a power imbalance between the nurse and patient with little patient input. Henderson identified factors including nurses' beliefs that they know best, the view that patients lack medical knowledge and the perceived need for nurses to hold on to their power and maintain control. While participants in the current study did not explicitly identify that patients lacked medical knowledge, they did perceive that their actions to take control of situations were acting within the best interest of patients and thus removing their ability to be a part of their own care while maintaining the nurses' power and control. Another complexity to this issue is that of the overriding demands of the Mental Health Act (MHA). The MHA has significant influence over nursing care which in turn affects partnerships and patients' perceptions of nurses' power (Cleary, 2003) thus adding to the difficulty of nurses to relinquish

their power when the MHA has little or no bearing. It also has the potential to be discouraging for patients to engage with nurses when they are being offered choices and input into their care at one moment to later be relinquished of all control by nurses who are attempting to gain control over an escalating situation (Cleary). This was evident when nurses in the current study moved through the prevention continuum from primarily patient-centred strategies to more nurse-focussed strategies aimed at taking control when they perceived patients to be losing control. The complexity of balancing safety and patients' interests was evident.

Comparing the findings to the Karasek model of work stress may also shed light onto why nurses have difficulty relinquishing power and control. The Karasek model is based on three variables: (1) demands (psychological) which are the pressures put on individuals by the work environment itself; (2) control (decision latitude) which is the individual's ability to respond to work demands and pressures, and; (3) support (social) which refers to the characteristics of the social environment in which working activities are performed (Karasek & Theorell, 1990). According to the model, stress increases when control declines in combination with rising psychological demands or stressors, and alternatively stress decreases when control is gained in combination with decreasing psychological demands or stressors. Lastly, social support operates as a facilitator to reduce stress at work and when social support increases, stress will decrease (Karasek & Theorell). Thus when nurses have high demands placed on them, with limited perception of their abilities, their stress may increase uncomfortably causing them to want to gain back control.

In the current study, nurses often felt disempowered when they were felt they were unable to prevent or manage escalating violence and often tended to blame themselves, at least in part, after the situation occurred. This is supported by findings from Lanza and Carifo (1991)

and can be likened to the behaviour of victims of IPV. There is also evidence that disempowered and oppressed groups, such as nurses, attempt to rise from their current status by gaining control over others (Kuokkanen & Leino-Kilpi, 2008) and thus a possible explanation could be that when nurses feel disempowered and have limited self-efficacy, the desire to exert more power and control over patients is stronger and thus have more difficulty relinquishing this power to gain partnerships with their patients.

Whilst patient violence is not an uncommon phenomenon in healthcare, it has not garnered the same attention as other forms of violence, even within workplace violence. A Workplace Power and Control Wheel (Duthie, 2012) was developed related to violence and abuse in the workplace. It parallels the original wheel created for domestic abuse (Domestic Abuse Intervention Programs, 2011) and the power processes it describes. At the centre of the behaviours is the desire to maintain power and control over somebody else and the relationship. The wheel model provides a visual depiction of the power and control dynamics in relationships. The findings in the current study add to the existing literature on power and control within nursing and a model similar to the Power and Control wheel relating to the relationship between nursing and patient violence may be beneficial to further investigate to assist nurses in understanding these dynamics.

A shift to a more recovery-focused approach may also be beneficial in reducing the imbalance of power and control as Cutcliffe and Happell (2009) suggest. A recovery paradigm focuses on incorporating patients' experiences on their own terms as well as nurses acting as empowering facilitators for patients' recovery. A small number of participants in the current study also supported this idea and identified the beginning shift in culture recently within their

workplaces and were more open to the idea of giving back power to patients, however this did not always translate into practice.

Stigma

It is difficult to find a solution to patient violence until one can understand the stigma that healthcare workers have towards their patients. Healthcare workers, including nurses, are the people that have the most knowledge of psychiatry, and yet are still displaying prejudice and stigma. Stigma was evident in the current study when nurses held the view that when working in psychiatry violence should be expected implying that patients suffering from mental health issues are more likely to be violent. While this perception may exist for many nurses, this is a much contested issue in the existing literature and there has been no firm evidence that patients experiencing mental illness are any more or less likely to engage in violence (Monahan, et al., 2001; Rippon, 2000; Stuart, 2003).

Stigma also impacted how nurses experienced violence. RNs were more angry, frustrated and less tolerant when they viewed violence as intentional and perpetrated by someone with a personality disorder. Within psychiatry, it is much harder to differentiate mental illness from the person (Goldbloom, personal communication, June 5, 2014) and nurses in the current study struggled with this. In the study, RNs often did not consider personality disorders as mental illnesses due to their perceived amount of control over their behaviour, and actions. Thus they were less empathetic, and tolerant which is in line with the majority of existing literature (Ross & Goldner, 2009); however much of the existing literature focuses primarily on Borderline Personality Disorder (BPD). Alternatively, James and Cowman (2007) described the general theme of the responses in their study as reflecting a reasonably positive attitude towards BPD which was not evident in the current study. Markham (2003) reported that nurses were also

more likely to perceive patients with BPD as being more dangerous than those with depression or even schizophrenia; however the results of the current study do not support this existing finding as RNs appeared to perceive both symptoms of psychosis and personality disorders as being contributing factors to patient violence.

RNs' stigma towards patients suffering from personality disorders may also be due to the difficult nature of managing the illness as there are limited evidence-based treatments, therapies or resources available (Schatzberg & Nemeroff, 2009).

"Part of the Job"

RNs perceived the culture of nursing as one where patient violence is accepted as part of the job and many felt this belief was unavoidable. At the same time they were conflicted as the RNs did not want to accept that reality nor accept that violence was tolerable. A number of other researchers have explored this theme and this is found to be a fairly consistent experience of nurses working in psychiatry. Moylan and Cullinan (2011) reported nurses in their study indicated multiple reasons why injuries were not officially documented. One of these reasons was that violence in psychiatry was just an expectation and considered a routine occurrence thus not warranting reporting. Whereas Atkinson (2005) described that management in healthcare treats violence against nurses as an expected job risk. Lanza, Zeiss, and Rierdan (2006) explored the desensitization of nurses to violence and their acceptance of it as part of the job. Repeated exposure to violence may in fact increase the likelihood of desensitization (Zuzelo, Curran, & Zeserman, 2012). An interesting finding by Jonker, Goossens, Steenhuis and Oud (2008) was that despite the research that mental health nurses are confronted with aggression and violence on a regular basis, the majority of nurses in their study reported their perceptions that they were rarely, or only sometimes confronted with aggression, yet the mean perceived number of

incidents was 181 times a year. They questioned whether patient aggression had become such a part of nurses' daily practices that it was no longer perceived as a major problem anymore indicating that perhaps nurses and management in healthcare are accepting violence as tolerable. This perception is not exclusive to nurses working in psychiatry, but has been found to be a common perception amongst nurses working in other clinical areas and across several countries (Gerberich, et al., 2005; Jackson, Clare, & Mannix, 2002; Roche, Diers, Duffield, & Catling-Paull, 2009). However a significant difference was the statements by nurses in this study that they do not want to accept violence as tolerable or part of their reality which may indicate a shift towards the realization that violence in the workplace is not acceptable and nurses are becoming more empowered to take a stand.

Considering patient violence as part of the job also had a negative impact on how the RNs viewed nursing as a career. While the majority of nurses in this study did not regret being a nurse, many felt disillusioned about violence and that students and anyone considering a career in nursing needed to know what they were going to face in their careers. This could have significant implications for recruitment and retention of future nurses.

Although nurses see verbal and physical violence as part of the job, it has been demonstrated throughout numerous accounts in this study and within existing literature as not being reported. Knowing the impacts that patient violence has on nurses, it is imperative that violence, especially the lesser reported verbal violence, is recognized and addressed within organizations and the community.

A Complex Balance: Nurses' Health and Safety Versus Patient Care

RNs had to balance between their role of acting as the health care provider and in the best interest of their patients versus acting in a way that would protect their own health and safety.

This balance also included nurses' role in caring for their patients after an event occurred as well. There is very little guidance available for nurses regarding their duty to care in times of threats to their own safety. Most existing publications relate to pandemics and large-scale disasters (i.e. Ruderman, et al., 2006; Shroeter, 2008). The College of Nurses of Ontario publishes governing provincial practice standards and throughout several standards, including *Ethics* (2009b) and *Professional Standards* (2009c), it is stated that it is a nurse's duty to put clients' needs first and foremost. Another relatable practice standard is *Conflict Prevention and Management* (2009a) which simply outlines in one sentence that nurses have the right to protect themselves in abusive situations by withdrawing from services however that is only if (according to their published decision tree) the imminent risk to self is greater than the risk to the client if you withdraw care. This decision must then be discussed with the employer, documented explaining the reasons for withdrawal of care and then the nurse must be involved in advocating for developing strategies to effectively manage patients who exhibit violent behaviours intending harm (College of Nurses of Ontario, 2009). One argument that could be made is how can a nurse know, in that moment, what the risk to self and what the lasting effects of violence will be when weighing it against the risk to patient care?

Ultimately, this balance creates a conflict in one's role between the duty to care for patients and the duty to one's self and own safety. Role conflict, a form of job stressor, refers to the perception of incompatible demands being placed on the organizational member (Abdel-Halim, 1982). Lanza (1985) described a similar role conflict in her research relating to nursing and patient violence. Her findings indicated that victimized nurses were inclined to want to attend to their own needs and and not care for the aggressor. Similarly, Smith and Hart (1994) reported that when threats were perceived as high, nurses often disconnected from their

aggressive patient by means of withdrawal, transferring blame, shielding, or seeking peer support which was evident amongst the nurses in this study. Lanza also described that nurses are often hesitant about sharing their personal feelings because it conflicts with their professional goals and that nurses were reluctant to press charges or acknowledge feelings of revenge despite this conflict which was also evident in the current study.

While this particular form of role conflict relating to violence has not been well explored, role conflict in nursing more generally has. Role conflict can be a major cause of stress for nurses and has been linked as a risk factor to burnout, particularly relating to personal accomplishments (Levert, Lucas, & Ortlepp, 2000), and job stress (Melchior, Bours, Schmitz, & Wittich, 1997; Stout & Posner, 1984). Unsurprisingly, role conflict has also been linked to a variety of organizationally and personally dysfunctional outcomes such as job dissatisfaction, turnover, lowered productivity, job-related tension, and anxiety (Vansell, Brief, & Shuler, 1981). It is possible that role conflict leads to greater job stress, and greater job stress then leads to feelings of burnout and depersonalization and therefore acts as an antecedent to patient violence thus continuing a positive feedback cycle.

Nurses' Perceptions of their Needs Relating to Patient Violence

Participants' perceptions of their needs were categorized into perceived needs related specifically to the individual, unit and team, as well as the organization. Identified needs included changes to the environment, programming, communication and collaboration, security services, policies, and education. These are the basis for the implications for practice, education and research as well as recommendations for each highlighted throughout the next section of this chapter.

Implications for Practice, Education and Research

A summary of recommendations is provided in Table 1.

Table 1: Summary of Recommendations

Practice Recommendations:

- Individual RN Level:
  - Promote early recognition and assessment of violence risk, along with the promotion of empathic, therapeutic relationships and communication as a universal therapeutic approach to all patients
  - Implement use of a standardized violence risk assessment tool
  - Implement consistent use of substance management strategies

- Unit or Team Level:
  - Maintain appropriate staffing levels and staffing mix including being mindful of the ratio of new to experienced staff
  - Make improvements to unit layout and unit milieu, including the culture of the unit
  - Implement consistent low-impact disclosure debriefing processes based on best practice for staff and patients
  - Promote reflective supervision and discussions about patient violence in the workplace
  - Engage nurses in follow-up procedures and incident reporting

- Organizational Level:
  - Recognize RNs are impacted by violence and the culture of violence as "part of the job"
  - Promote an organizational culture of safety and support for hospital staff against violence
  - Make time for team building with nursing, allied staff and security services
  - Support managers to support their staff with reflective supervision
  - Evaluate current organizational violence prevention and management policies, dissemination of policies and best practice guidelines, creation of BPG specifically relating to patient violence

Education Recommendations

- Required content for undergraduate nursing education:
  - Incorporate patient violence, stigma, awareness of self and emotional intelligence as well as the influence of power and control into undergraduate nursing education
  - Teach strategies to prevent and manage violence, including nonviolent crisis intervention training in undergraduate education

- Recommendations for professional development:
  - Support staff to attend educational opportunities
  - Ongoing specialty education related to patient violence, de-escalation, stigma, awareness of self and emotional intelligence, therapeutic relationships, as well as the influence of power and control

Research Recommendations

- Identify a consistent definition of patient violence

• Explore barriers and proposed solutions to incident reporting and debriefing
• Investigate factors that promote engagement and team collaboration in the workplace
• Explore and validate newer debriefing methods and supportive processes to determine best practices for supporting RNs
• Further investigate long term impacts of patient violence within a psychiatric nursing population. In order to do this, conduct larger scale studies of patient violence to capture extreme cases of nurses who have left their positions in psychiatry or in healthcare altogether
• Research the short and long term impacts of patient violence on patients

Practice Recommendations

Individual RN level.

Therapeutic relationships are the hallmark of mental health care and have been identified as the most crucial element of psychiatric care through which diagnoses are made, treatment plans created and most interventions are delivered (Priebe & McCabe, 2006). Early recognition and assessment of violence risk, along with the promotion of empathic, therapeutic relationships and communication should be a universal therapeutic approach to all patients by RNs (Duxbury & Whittington, 2005; Richmond, et al., 2012) to reduce the risk of escalation and violence.

A standardized risk assessment tool is recommended to support and enhance violence risk assessments and communication. The Brøset Violence Checklist (BVC) is a simple, well tested and suitable tool for short-term prediction of violence in acute psychiatry (Abderhalden, et al., 2004; Abderhalden, Needham, Dassen, Halfens, Haug, & Fischer, 2008). It assesses the presence or absence of six behaviours frequently observed before a violent incident and its implementation into clinical practice should be encouraged. As substance use is also positively correlated to patient violence (Owen, Tarantello, Jones, & Tennant, 1998), consistent use of substance management and withdrawal strategies must be implemented. Assessment tools, such

as the Clinical Institute Withdrawal Assessment (CIWA), warrant investigation and promotion of their use in clinical practice.

Unit or team level.

Reducing contributing factors to patient violence in the workplace should be a priority within clinical practice. Managers need to strive to maintain optimal staffing levels and staffing mix, including being mindful of the ratio of new and experienced nurses. Skill levels of staff and their ability to engage in therapeutic relationships influences the incidence of patient violence (Cutcliffe & Riahi, 2013) and thus should be optimized. Making improvements to the unit layout and milieu are equally important, such as ensuring adequate lighting, visibility and availability of therapeutic space for patients (Gerberich, et al., 2005; Virtanen, et al., 2011). The milieu, including the culture of the unit is also important as it influences job satisfaction, retention (Ito, Eisen, Sederer, Yamada, & Tachimori, 2001; Roche, Diers, Duffield, & Catling-Paull, 2009) and most importantly patient violence (Kindy, Petersen, & Parkhurst, 2005). Improvements in communication, collaboration (Hamrin, Ienneco, & Olsen, 2009) and support (Kangas, Kee, & McKee-Waddle, 1999) should be promoted to enhance quality of work life and prevent patient violence.

RNs routinely described needing support following an incident of patient violence. They consistently sought out informal supports such as family, friends and colleagues immediately after the event as well as occasionally formal support such as managers or supervisors. They often expressed that they did not receive the support they needed or were not engaged by their managers in the follow-up process. Many times this contributed to the described reasons for not completing incident reports for future events as they felt there was no support or follow-up and thus no reason to report an incident. A supportive team is essential to safe nursing practice as

well as the preferred source of support for RNs therefore interventions to engage, and increase support, merit investigation (Schat & Kelloway, 2003). Organizations, with managers taking the lead, must ensure they allow time and space for both formal and informal gatherings for debriefing as well as set time aside for team building activities to promote workplace cohesion. Immediate discussion and feedback after the incident has been shown to increase incident reporting, awareness of the risks of violence, and management of the event (Arnetz & Arnetz, 2000). During debriefings, utilizing the strategy of low-impact disclosure (Mathieu, 2012) may be beneficial. The process of low-impact disclosure involves four steps: (1) increased self-awareness; (2) fair warning; (3) consent and; (4) limited disclosure. It involves RNs having self-awareness to determine what type of debriefing will be beneficial for them, as well as what level of detail is necessary and comfortable to discuss. Giving the support person fair warning of the details they are about to hear ensures that both parties are agreeable to the discussion that is about to take place. This strategy aims to limit colleagues' exposures to additionally traumatizing information and experiences therefore lessening the potential for emotional burden while supporting each other. Unit managers, and the organization as a whole, must also understand the dynamic nature of support and that different types of support may be necessary following exposure to varying manifestations of patient violence (McKenna, 2008) and this must be assessed on an individual basis. Study participants recommended that managers and supervisors need to engage nurse-victims in the follow-up to the incident to encourage nurse empowerment, as well as refrain from engaging in blaming or judgment (Paterson, Leadbetter, & Bowie, 1999).

Organizational level.

While organizations must balance the needs of both patients and nurses when exploring violence, all levels of the organization must acknowledge the significant impact that patient violence has on the well-being of their employees. This must not be limited to understanding the impacts of only physical violence. Patient violence not only affects nurses personally, but impairs the therapeutic relationship with their patients and the quality of care that patients receive (Arnetz & Arnetz, 2001; Registered Nurses Association of Ontario, 2002). They must also recognize the stress that role conflict causes upon nurses who are required to balance their own safety while continuing to provide patient care. This should be of particular importance for organizations as job stress has not only been linked to several personal outcomes (Levert, Lucas, & Ortlepp, 2000; Melchior, Bours, Schmitz, & Wittich, 1997; Stout & Posner, 1984), but has also been connected to various negative organizational outcomes (Vansell, Brief, & Shuler, 1981). As well, organizations must understand the common belief nurses hold relating to violence being part of the job which impacts their reporting of violent events and thus fosters an environment that supports violent behaviour (Jackson, Clare, & Mannix, 2002).

Organizations must strive towards changing the culture from one of blame to one that fosters support for all staff. Blaming reactions may in fact cause a sense of professional failure and enhance the trauma response of the victim through the key principal cognitive response of self-blame and resulting performance guilt which may be experienced by the nurse (Paterson, Leadbetter, & Bowie, 1999). Paterson and colleagues report that the nature of the organizational response to the traumatized nurse can play a fundamental role in the process of recovery if the organizational response fails to recognize or understand the needs of the nurse victim. This in itself may constitute a source of secondary injury or trauma.

The limited knowledge of participants around organizational policies and best practice guidelines suggests that uptake of this information is poor. Currently, Canada does not have a national practice guideline relating to patient violence, unlike other countries such as Ireland and England. However, at a provincial level, Ontario, through the work of the RNAO, has published the *Preventing and Managing Violence in the Workplace* (1999) best practice guideline which incorporates some basic information and recommendations for patient violence, amongst other types of workplace violence. Additionally, the College of Nurses of Ontario has also released practice standards relating to restraint use (2009d) for managing patient violence as well as *Conflict Prevention and Management* which briefly outlines the right of nurses to protect themselves in abusive situations by withdrawing from services (College of Nurses of Ontario, 2009a). Organizations must therefore ensure organizational violence prevention and management policies are in place (Registered Nurses Association of Ontario, 2009) as well as evaluate the dissemination and uptake of these policies, governing college practice standards, and relevant, available best practice guidelines (Woolf, Grol, Hutchinson, Eccles, & Grimshaw, 1999). In order for uptake to be successful in organizations, guidelines must be chosen that are credible and relevant, involve collaboration with frontline staff, and strategies must be innovative, embedded, reviewed and revised all the while involving leaders who are passionate and persistent (Matthew-Maich, Ploeg, Dobbins, & Jack, 2013). While these best practice guidelines exist on the topic of workplace violence, additional guidelines relating to the specific issue of patient violence may be beneficial, notably to address the challenges of balancing service to patients and duty to care owed to staff, as well as legal implications and processes. Including these topics into a BPG may provide clarity for nurses which has been shown to act as a moderator for role conflict and stress (Vansell, Brief, & Shuler, 1981), however caution should

be taken in appraising the currently available evidence, and where there are research gaps, addressing these prior to implementing any guidelines (Woolf, Grol, Hutchinson, Eccles, & Grimshaw).

RNs in the current study recommended that organizations support and provide opportunities for team building between nursing, allied staff and security services to enhance interprofessional collaboration. Interprofessional collaboration has been shown to have numerous benefits including improved morale in the workplace, greater job satisfaction, increased efficiency, improved patient satisfaction, and lower staff stress (Yeager, 2005). In order for teamwork to be effective, the team must be supported to come together to evaluate their current state of collaboration, define and establish their structure, function and group standards, as well as receive education on interprofessionalism and effective communication (Yeager).

Educational recommendations.

Undergraduate nursing education.

RNs in the current study acknowledged the importance of providing evidence-based education with a focus on patient violence, therapeutic communication, de-escalation, stigma, awareness of self and emotional intelligence, therapeutic relationships as well as the influence of power and control should be increasingly integrated into undergraduate nursing education and continued into ongoing staff nursing education. Similar education was identified as necessary by new nurses in a study by McKenna, Poole, Smith, Coverdale and Gale (2003). Cowin et al. (2003) argue that the ongoing education of mental health nurses is the most important criteria for providing less restrictive environments and nursing interventions and consequently reducing the level of control and restraint.

Strategies to prevent and manage violence, including nonviolent crisis intervention, de-escalation and self-defence should also be taught in undergraduate education to equip student nurses with the necessary skills to enter and remain in the profession to practice effectively and safely. These strategies are supported by similar recommendations by the RNAO (2009).

Professional development.

With the high likelihood of significant personal and organizational impacts, risk of burnout and PTSD, as well as impacts on nurses' quality of care for patients as a result of violence, should be considered an ongoing and important professional practice issue. The development of ongoing workplace education and support strategies related to patient violence are important to ensure that this issue remains a priority. It is also important for managers to allow protected time for staff development, and support such as allowing paid education days or time off work to attend additional educational opportunities. The use of reflective supervision and routine discussions about patient violence can act as a method of offering support while at the same time encouraging professional development. Reflective supervision has been most widely explored within the contexts of psychology and social work, particularly with child care and health; however it offers unique opportunities for learning and support through reflection (Tomlin, Weatherston, & Pavkov, 2014). It is necessary for clinical managers to learn this skill in order to optimize its use in practice. They must understand the fundamental differences between clinical and reflective supervision as well as have the opportunity to receive feedback on their reflective supervisory skills. Support must also be available to them to mitigate the impact of their exposure to the emotional content that is explored during these reflective sessions. Therefore, it is also essential to provide support for the clinical managers in learning and utilizing this new skill to encourage its success as they are responsible for guiding this

supervision process in practice. Reflection may not always be the most effective or accepted approach for all nurses. For example, it may be difficult for novice nurses to reflect on what they do not know, and therefore alternate supports should be identified and available (Fowler & Chevannes, 1998).

Future research.

Throughout the existing literature, as well as this study, the need to identify a consistent definition of patient violence continues to exist. Without a consistent definition, nurses are reluctant to report incidents, organizations are hesitant to commit resources to prevent violence and mitigate impacts, and policies relating to violence are difficult to enforce (Cutcliffe & Riahi, 2013; Rippon, 2000). It is also likely that the statistics on reported incidents in current research are affected by the subjectivity of definitions of patient violence (Arnetz, 1998). Future research should be aimed at promoting a consistent definition to be used throughout all research investigating patient violence. Along with creating a consistent definition, future research should explore other barriers to incident reporting and debriefing and examine existing proposed recommendations. For incident reporting, an example of a proposed solution to explore is the Violent Incident Form (VIF) (Arnetz). Patient violence has been described countless times as being underreported and researchers estimate that the occurrences of incidents are much higher than studies currently show (International Council of Nurses, 1999; Lanza & Campbell, 1991; Levin, Hewitt, & Misner, 2008; Liss & McCaskell, 1994; Gates, Gillespie, & Succop, 2011). Accurate reporting in the workplace will lead to more reliable and valid research results.

A perceived antecedent to patient violence, as well as a factor in job satisfaction is that of team cohesion and communication (Catlette, 2005; Kindy, Petersen, & Parkhurst, 2005) in the workplace therefore it is essential to investigate factors that promote and support a healthy

workplace (Registered Nurses Association of Ontario, 2009). In order to understand the current state of the work environment, the administration of the Professional Quality of Life Scale (Revised) (ProQOL-R-V) tool to RNs working in acute inpatient psychiatry would provide information related to compassion satisfaction, burnout and compassion fatigue/secondary trauma (Stamm, 2005). This information would then inform the potential need for interventions related to work life and team functioning. Repeating this measure over time may also indicate if there are predictable signs of early recognition and therefore provide the opportunity to intervene early and prevent the development of burnout, compassion fatigue or secondary traumatic stress. Further investigation is required to have a better understanding of these long term effects of patient violence within a psychiatric nursing population. In order to do this successfully, larger scale studies aimed at capturing more extreme cases to highlight the magnitude of the problem, such as nurses who have left the profession as a result of patient violence, are necessary to further explore this finding. It should also be a priority to determine the best way to support nurses who have experienced this phenomenon. If patient violence cannot be completely eradicated at this time, then we need to support the nurses in the meantime and research should further explore the barriers to debriefing and validate some of the newer debriefing models, such as strengths-based debriefing approaches (Slawinski, 2006).

More research is also needed to study the effects that patient violence has on patients' ability to receive follow-up services and other consequences of their actions within hospital as evidenced by the scarcity of existing high quality research.

The findings from the study reported here provide a rich, qualitative account of the current experiences of patient violence from within the Canadian context, and describes the strategies nurses employ to prevent and manage violence. It highlights areas of future needs and

research from the RNs' perspectives and can be used to guide the development of interventions related to practice, professional development, education and future research.

Study Strengths and Limitations

Strengths and potential limitations of the current study are presented and explored briefly.

Strengths

While the sample resulted in only 12 participants, multiple events (n=33) were explored and described which reflected the diversity of the experiences. As well, each of the RNs described a broad range of experiences across extensive nursing careers in a variety of nursing positions within different hospitals and geographic regions. Maximum variation through multiple recruitment strategies was purposefully sought amongst the sample as the goal of the study was not to evaluate patient violence within only one specific hospital, health care system or region. This heterogeneity of experiences is a strength of the research study as throughout the findings, despite the level of variation, consensus still emerged among participants that this is an important issue that still impacts RNs in this environment. It also demonstrated that the causes, contextual factors and impacts of violence seem relatively stable across these differences. Many other strategies to enhance the rigour of the study were also employed throughout the research process. The use of the "Thoughtful Clinician Test" (Thorne, 2008) throughout data analysis also enhanced study credibility and demonstrated the stability of these findings. This test involved taking the current study findings to researchers and educators with expert knowledge of patient violence in psychiatry, as well as the supervisory team, to determine whether the results were plausible (Thorne, Reimer Kirkham, & O'Flynn Magee, 2004). Along with the Thoughtful Clinician Test, a variation of member checking was conducted by sharing a written synthesis of the study data with the participants and inviting them to comment on the accuracy of findings.

This strategy was valuable as it gave RNs the ability to further explore and clarify the emerging concepts allowing further saturation of thematic patterns. Field notes and a reflexive journal were kept by the researcher throughout the research process enhancing the confirmability, or neutrality, of the study (Krefting, 1991). It effectively allowed for reflection on personal biases, pre-existing knowledge and questions arising throughout the data analysis process as well as prevented the error of going native where the researcher assumes they understand the phenomenon on the same level as a participant (Thorne, Reimer Kirkham, & O'Flynn Magee). The credibility and authority of the researcher is also a strength of the study. As previously mentioned, the Principal Investigator conducted all interviews, and has an expertise in acute care inpatient psychiatric nursing therefore having a familiarity with the setting and phenomenon as well as previous investigative and interviewing experience. As all interviews fulfilled the maximum time limit and several RNs were willing to continue past the allotted time for the interviews, it demonstrates both the interviewer's skills to have participants share their experiences as well as the comfort of RNs in being able to talk truthfully in a safe environment. Throughout data analysis, coding was completed with the assistance of the research team to obtain consensus surrounding thematic content and coding and thus enhance dependability, credibility and confirmability of the research findings through triangulation (Krefting). This procedure of multiple coding, alongside peer debriefing, also enabled the opportunity for the discussion of alternative interpretations (Barbour, 2001). An audit trail was recorded throughout the research process which enhances the auditability of the study thus allowing other researchers to better assess the quality of the study and allows other researchers to follow the decisions made in order to repeat the study and obtain similar results (Krefting). The use of NViVO 10.0 software also aided in the auditability of the study as it enabled the analysis process to be more

visible and organized, as well as reduced the risk of losing or misplacing any data (St John & Johnson, 2004) and thus ensuring all data was included and analyzed.

Limitations

There were several difficulties encountered throughout the process of this study, including difficulty with recruitment due to the sensitive and contentious nature of the study topic and thus a sample size of 12. A larger sample size may have provided saturation for other thematic patterns. There is also a question of whether the RNs most seriously affected by violence are captured within the sample as it is possible that they have left the job, organization or field. Volunteer bias may also exist within the sample as those interested in the topic may be more willing to participate (Thompson, 1999). Triangulating the results against organizational policies, and incident reports could have enhanced some elements of the findings, however was not conducted due to feasibility.

Conclusion

Registered nurses play a fundamental role within the healthcare system. Often described as caring and compassionate, available to assist those most in need (Finkelman & Kenner, 2013), but yet are also the unfortunate target of both verbal and physical violence by patients. Sadly, while a common experience, exact statistics are rarely considered accurate due to the prevalence of underreporting by nurses. Patient violence goes beyond purely physical injuries and has many significant, negative impacts for nurses, patients and organizations. For nurses, personal impacts are vast including feelings of fear, anger, guilt, and other symptoms of PTSD, job dissatisfaction and desensitization to violence leading them to believe that violence is part of the job. Patients are perceived to have diminished quality of care, difficulty finding follow-up services, and potentially, legal charges or implications. Organizations experience issues with recruitment and retention of nurses. To support RNs, an approach to mitigate the impacts of patient violence, such as PTSD and burnout, must be adopted.

Throughout the current study, RNs described a number of strategies that they routinely utilized in practice, but yet patient violence towards RNs still ensues. Changes that must occur need to be focused on improving the contextual environment, including both the physical environment as well as forming a healthy team atmosphere, and the creation of best practice guidelines for patient violence to alleviate the role conflict related to balancing the duty to self with the duty to care. Additional education continues to be necessary to reduce and mitigate healthcare workers' stigma towards patients, as well as improve their knowledge of evidence-based risk assessments, prevention and management interventions as well as the influence of power and control on patient violence. Organizations need to be open to the exploration of the phenomenon of violence and embrace an open, blame-free environment for nurses to feel

comfortable reporting patient violence. They must therefore work with managers and staff at devising strategies to further reduce the incidents of violence while enacting quality patient care. Future research needs to first, and foremost, work towards creating a universal definition of patient violence. The experiences of the Canadian RNs that were explored in this study will be of relevance to other nurses working in other acute inpatient psychiatry settings.

Despite the violent experiences that these RNs recounted throughout the study, many RNs explained that while nursing was not what they expected, they never questioned being an RN in psychiatry. They valued the moments where they felt they could make a difference for someone in a time of need. By the same token, understanding RNs' experiences and recognizing the need to support RNs in their times of need must be a priority. If RNs are not supported in their roles which can impact their ability to maintain their own mental health, how can we expect them to successfully support the mental health of others?

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APPENDICES

APPENDIX A: Literature Search Summary and Ovid Interface Search Dates

Database	Resource Searched	Dates Searched
OvidSp (Initial search)	AMED	1985-September 2012
	Global Health	1973-August 2012
Limit by: English	Health and Psychosocial Instruments	1985-July 2012
	Ovid Healthstar	1966-August 2012
	Ovid MEDLINE/OLDMEDLINE	1946-September 2012
	Mental Measurements Yearbook	1st-19th Yearbooks; July 2012
	PsycINFO	1806-September 2012
	McMaster University Journals@OVID	All available
	Embase	1974-September 2012

Database	Searches	Results
Web of Science	Violen*, psychiatr*	4, 265
	Violen*, psychiatr*, nurs*	326
Limit by: year 2000-current, English	Aggress*, psychiatr*	3, 682
	Aggress*, psychiatr*, nurs*	347
	Assault, psychiatr*, nurs*	102
	Abuse, psychiatr*, nurs*	254
	Patient-initiated violence	14
	Mental health, violen*	5, 559
	Mental health, violen*, nurs*	308
	Mental health, aggress*, nurs*	195
	Mental health, assault, nurs*	75
	Mental health, abuse, nurs*	338
	Workplace violence, nurs*	316
	Workplace violence, nurs*, psychiatr*	50
	Workplace violence, nurs*, mental health	54
	Workplace, abus*, psychiatr*	50
	Workplace, assault, psychiatr*	44
	Workplace, aggression, psychiatr*	58
	Workplace, abuse, mental health	97
	Workplace, assault, mental health	41
	Workplace, aggressi*, mental health	65

Database	Searches	Results
CINAHL	Violence AND patient-initiated	0
	Nurs* AND workplace violence	1540
Limit by: year 1982-current, English	Mental health AND aggression	1
	Mental health AND assault	3
	Mental health AND violence	13
	Mental health AND workplace violence	0
	Workplace violence AND (Hospitals, psychiatric)	9
	Abuse AND psychiatr*	84
	Abuse AND workplace AND psychiatr*	0
	Patient assault OR “assault AND psychiatr* AND work”	1060
	Aggression OR “aggression AND psychiatr*”	23584
	Workplace violence OR “Violence+ AND psychiatr*”	1426
	Workplace violence OR “violence+”	21676

Database	Searches	Results
PubMed	Violence AND psychiatr*	10789
	Violence AND psychiatr* AND nurs*	1239
Limit by: year 1980-current, English	Aggression AND psychiatr* AND nurs*	605
	Assault AND psychiatr* AND nurs*	142
	Abuse AND psychiatr* AND nurs*	1316
	Patient-initiated violence	11
	Mental health AND violence	7246
	Mental health AND violence AND nurs*	873
	Mental health AND aggression AND nurs*	306
	Mental health AND assault AND nurs*	98
	Mental health AND abuse AND nurs*	1109
	Workplace violence AND nurs*	567
	Workplace violence AND nurs* AND psychiatr*	80
	Workplace violence AND nurs* AND mental health	68
	Workplace AND abuse AND psychiatr*	115
	Workplace AND assault AND psychiatr*	33
	Workplace AND aggression AND psychiatr*	58

OvidSp Search Number	Searches	Results
1	Violence	241908
2	Psychiatr*	1338216
3	1 AND 2	46005
4	Patient-initiated	3658
5	3 AND 4	43
6	Workplace violence	3522
7	4 AND 6	5
8	Abuse	719210
9	4 AND 8	259
10	1 AND 2 AND 8	10734
11	Nurs*	2626694
12	8 AND 11	66340
13	6 AND 12	1833
14	12 AND 2	21094
15	Assault	53213
16	4 AND 15	41
17	Workplace	170434
18	15 AND 17	2427
19	Aggression	179287
20	2 AND 17 AND 19	10734
21	11 AND 2 AND 19	7286
22	Mental health	685698
23	Violence	241908
24	22 AND 23	39058
25	22 AND 19	17050
26	22 AND 15	8999
27	24 AND 11	9605
28	25 AND 11	4441
29	26 AND 11	2682

Exclusion Criteria
Physician/other non-nursing discipline specific literature
Child/adolescent specific literature
Geriatric/dementia-related literature
Specific disease processes
Forensic/criminal justice system
Horizontal violence
Bullying

APPENDIX B: Hamilton Integrated Research Ethics Board (HiREB) Approval

HHS/FHS REB: Student Research Committee

Final Approval

Date:	December 20, 2012
REB Number:	12-663-S
Title of Study:	Registered Nurses' Experiences of Patient Violence on Acute Care Psychiatric In-Patient Units
Student PI:	Kelly Stevenson
LPI:	S. Jack
Version date:	Document:
Nov 23 2012	Application
Nov 24 2012	Protocol
Dec 18 2012	Consent Form
Dec 19 2012	Advertisement
Dec 19 2012	Telephone Script
Dec 19 2012	Snowball Sampling Email Script (previous email script removed)
Nov 15 2012	Interview Guide
Dec 19 2012	Questionnaire

Dear Kelly:

We have completed our review of your study and are pleased to issue our final approval. You may now begin your study.

All recruitment and consent material must bear an REB stamp.

Any changes to this study must be submitted as an amendment before they can be implemented. Amendment forms are available on our website.

This approval is effective for 12 months from the date of this letter. If you require more time to complete your study you must request an extension in writing before this approval expires. Please submit an Annual review form with your request.

Please cite the REB number in any correspondence.

Good luck with your research,

Kristina Trim, PhD, RSW
Chair, HHS/FHS Student Research Committee
Health Research Services, HSC 1B7, McMaster University

The HHS/FHS SRC complies with the guidelines set by the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans and with ICH Good Clinical Practice.

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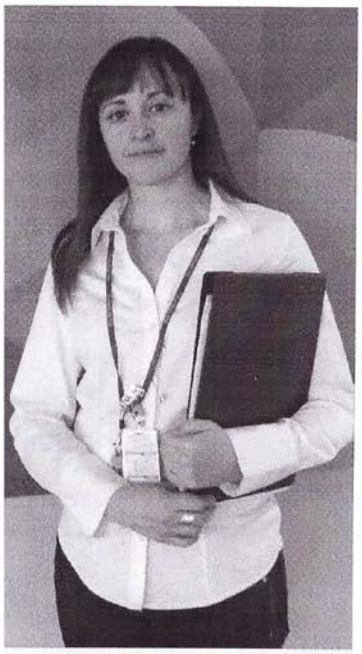
APPENDIX C: Study Advertisement Poster

McMaster University

Are you a registered nurse working in acute care inpatient (adult) psychiatry?



If you have experienced an act of violence (physical, emotional, or sexual abuse, or harassment, threats or intimidation) by a patient while you were providing nursing care on an inpatient unit, you may be eligible to participate in a qualitative study about nurses' experiences with patient violence.

Participation in this study will include the completion of 1-2 in-depth interviews (face-to-face or telephone). Each eligible participant will receive a $5.00 Tim Horton's gift card for each interview completed.

Learning about your experience is important to help health professionals design interventions and supports to prevent and respond to workplace violence against nurses.

FOR MORE INFORMATION CONTACT: Kelly Stevenson at stevekn@mcmaster.ca or 905-807-8383.

Registered Nurses' Experiences of Patient Violence On Acute Care Psychiatric Inpatient Units

Phone: 905-807-8383
E-mail: stevekn@mcmaster.ca

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APPENDIX D: Demographic Data Collection Form

Study ID: ___ ___
Date:

Registered Nurses' Experiences of Patient Violence on Acute Care Psychiatric In-Patient Units

Background Questionnaire

Thank you for agreeing to take part in this study of patient violence!

Please remember that all of the information you provide will be kept confidential.

1. What is your age? ☐☐ years

You have been chosen to participate in this study because (1) you are a registered nurse, and (2) you have experienced patient violence while working in inpatient acute psychiatry. The next few questions are related to your work experience.

2. How long have you worked as a registered nurse? ☐☐ Years ☐☐ months
3. How long have you worked in inpatient acute psychiatry? ☐☐ years ☐☐ months

4. What is your job title? _____

5. Are you employed:
   - ❍ Full-time
   - ❍ Part-time
   - ❍ Occasional

6. Do you work:
   - ❍ 12 hour shifts
   - ❍ 8 hour shifts
   - ❍ Mix of both 12 and 8 hour shifts
   - ❍ Other _____(please specify)

7. Do you work:
   - ❍ Only day shifts
   - ❍ Only evening shifts
   - ❍ Only night shifts
   - ❍ Rotating days/nights
   - ❍ Rotating days/evenings/nights
   - ❍ Other _____(please describe)

8. What areas of nursing, if any, have you worked in previously?
   _____
   _____
   _____
   _____
   _____

The next set of questions asks about you and will allow us to describe the group who participated in our study. Please remember that your answers will be kept confidential and will only be used to describe, as a whole, the nurses who participated in this study.

9. What language do you speak *most often* at home?
(Check ONE)

- ❍ English
- ❍ French
- ❍ Arabic
- ❍ Chinese
- ❍ Cree
- ❍ German
- ❍ Greek
- ❍ Hungarian
- ❍ Italian
- ❍ Other Describe: _____
- ❍ Persian (Farsi)
- ❍ Polish
- ❍ Portuguese
- ❍ Punjabi
- ❍ Spanish
- ❍ Tagalog (Filipino)
- ❍ Ukrainian
- ❍ Vietnamese
- ❍ Korean

Which of the following best describes your racial background?

(Check ONE)

- ❍ Aboriginal (Inuit, Métis, First Nations)
- ❍ Arab/West Asian (eg., Armenian, Egyptian, Iranian, Lebanese, Moroccan)
- ❍ Black (e.g., African, Haitian, Jamaican, Somali)
- ❍ Chinese
- ❍ Filipino
- ❍ Japanese
- ❍ Korean
- ❍ Latin American
- ❍ South Asian (e.g., East Indian, Pakistani, Punjabi, Sri Lankan)
- ❍ South East Asian (e.g., Cambodian, Indonesian)
- ❍ White (Caucasian)
- ❍ Other
  Describe: _____

10. Were you born in Canada?
(Check ONE)

- ❍ Yes (go to question 12)
- ❍ No (go to next question)

11. What is your country of origin? _____

12. How long have you lived in Canada? ☐☐ Years

13. What is your marital status?
(Check ONE)

- ❍ Married
- ❍ Separated
- ❍ Common-Law
- ❍ Living with a partner
- ❍ Single (never married)

14. What is your *highest* level of education?
(Check ONE)

- ❍ College (Diploma)
- ❍ Some university (partial stream to BScN)
- ❍ University (Baccalaureate)
- ❍ Some Graduate school (Master's)
- ❍ Graduate school (Master's)
- ❍ Some Graduate school (PhD)
- ❍ Graduate school (PhD)

Please provide your contact information so that I may (1) contact you to ensure I have accurately recorded your comments in the interview, and (2) share with you a copy of the study results once the study has been completed.

Name: _____

Address: _____

_____

_____

Email address: _____

Telephone number: _____

Thank you for taking the time to fill in this questionnaire.

APPENDIX E: Semi-structured Interview Guide

Study ID:
Date:

Interview Guide

Registered Nurses' Experiences of Patient Violence on Acute Care Psychiatric In-Patient Units

I. Introduction

Thank you for agreeing to participate in this interview today. The purpose of this interview is for me to learn about the experience of patient violence towards registered nurses and the needs that nurses identify in order to prevent and manage violence. When I talk about "patient violence" I am referring any incidents of aggression that is physical, verbal, or emotional that occurs when nurses are abused, threatened or assaulted in circumstances related to their work.

I am interested in learning more about your unique experience so there are no right or wrong answers. Please remember that you may choose to stop this interview at any point in time.

II. Description of Experience with Patient Violence

The intent of this series of questions is to understand the experience of patient violence from your perspective. The goal is to obtain a comprehensive description of the events.

A. Can you tell me a bit about yourself and what led to your work here in psychiatry?
   i. *Probe for information regarding their role, responsibilities, work experience*
   ii. *How many beds does the unit you work(ed) on have? What is the average workload/patient assignment?*
B. What do you consider to be "patient violence"?

When I talk about "patient violence" I am referring any incidents of aggression that is physical, verbal, or emotional that occurs when nurses are abused, threatened or assaulted in circumstances related to their work, but often everyone has their own considerations.

C. How many incidences with patient violence have you had?
   i. *Prompt to get them to talk about different types – physical, verbal, etc*
   ii. *Explore each individually; what they perceive*
D. Can you describe to me your experience(s) with patient violence?
   i. *If there are several experiences, ask participant to choose one that is "sticks" in your mind the most to start; if there are more than one incident, go through each separately*
   ii. What do you think the causes (antecedents) were leading up to the event?
   iii. What was the client's diagnosis?
   iv. What time of day/night was it?
   v. How many staff were you working with? Is this a typical staffing level?
   vi. What happened during the event?

Study ID:
Date:

i. How did it end?
ii. What were your feelings as this occurred and afterward? (Kindy, Petersen, & Parkhurst, 2005)

B. How distressing did you find your experience?
i. *Probe to get participants perception of experience*
ii. *In comparison to other incidents you described, how distressing would you consider this incident?*

III. Personal and Professional Consequences

The purpose of the next set of questions is to begin to understand and describe the impact that patient violence has had on you in both your personal life and at work.

A. What impact did your experience have on you personally?
i. What were the immediate impacts?
Probe: Do you take it home with you? How has that impacted you? When you come back to work the next shift, how did you feel?
ii. What were the longer term impacts?
Probe: What are the different impacts of verbal vs physical violence?
iii. What impact did it have on carrying out your role as an RN after the incident?

IV. Current Responses to Patient Violence

The next set of questions focuses on identifying which strategies are currently used when responding to and preventing patient violence in acute inpatient psychiatry settings. [Probing for individual strategies that are used, unit norms and guidelines, organizational policies and expectations.]

A. What practice strategies influence your **current response** (management) to patient violence?
i. What personal factors influence your response to patient violence?
ii. Policies

B. In your opinion, what unit and organizational strategies facilitate **prevention** of violence?
Probe: What do you as an individual do to stay safe and prevent violence? What about the unit as a whole? The organization?
i. What are those that increase your risk?

D. How confident do you feel in using these strategies?

V. Needs Analysis

This set of questions explores your perceptions of what is needed to prevent patient violence as well as what is needed for nurses after an event has occurred.

A. What do nurses' need from the unit and/or organization for prevention of patient violence?
B. What do nurses' need from the unit for management of patient violence?
C. What do nurses' need from the unit and/or organization following an incident of patient violence?

1

Study ID:
Date:

i. What support and follow-up did you receive after your patient violence event?
ii. Was there anything that you felt was necessary to support you, but did not occur?

VI. Reflection and Comparison

A. If you had to reflect on your experience now, would you do anything differently?
B. *If explored multiple incidents:* How would you compare these incidents? How is your response and needs different?

VII. Final Comments

Thank you very much for sharing this personal information with me. This information is very important and will help me in understanding the experience of patient violence and allow for greater public awareness of this issue.

A. Do you have any other thoughts or feelings that you want to share with me that you feel are important to understanding the experience of patient violence that I may have not covered?

VIII. Further Recruitment

These questions are aimed at further recruitment for the study by snowball sampling.

A. Do you know of other colleagues that have had similar experiences? Would you be willing to share my study information with them?

APPENDIX F: Letter of Information and Consent

McMaster University

School of Nursing

LETTER OF INFORMATION / CONSENT

Registered Nurses' Experiences of Patient Violence on Acute Care Psychiatric In-Patient Units

Investigators:

Local Principal Investigator:
Dr. Susan Jack
School of Nursing
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 26383
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Student Investigator:
Kelly Stevenson
School of Nursing
McMaster University
Hamilton, Ontario, Canada
905-807-8383
E-mail: stevekn@mcmaster.ca

Purpose of the Study

You are being invited to participate in a study conducted by Kelly Stevenson, a graduate student in the School of Nursing at McMaster University. The purpose of this study is to learn more about the experiences and needs of psychiatric nurses who have encountered patient violence. This research is being done because there is very little known about the experience of patient violence for psychiatric nurses. This information will help guide future research to determine appropriate interventions and support for those who have experienced it and bring awareness to the issues of patient-initiated violence.

What will happen during the study?

If you choose to take part in this study, we will determine a convenient time and location for us to talk in an interview about your experience with patient violence. This will take approximately 60-90 minutes. Before the interview starts, with your permission, I will ask you to complete a brief background questionnaire which asks questions such as, how long have you been a nurse, or your educational background. With your permission during the interview, I will be digitally recording our interaction, as well as taking handwritten notes to clarify what might be missed on the digital recording and to help prompt me for questions. I will be asking you about your experience with patient violence, such as details about what happened, what kind of support you received and what could have assisted you better during the experience. If necessary, I may ask you to participate in a second interview to follow-up on any information that needs to be further explored or explained so that I can ensure I have a good understanding of your experience. This interview will take approximately 30-45 minutes.

Are there any risks to doing study?

There are no known physical risks to you if you take part in this study. You may feel uncomfortable or distressed when you are describing your experiences with patient violence. Information that you provide will never be shared with your colleagues, manager or organization in order to protect your privacy. Every effort will be made to manage any potential risks that arise and information can be given to you if you need to seek assistance. You do not need to answer questions that you do not want to answer or that make you feel uncomfortable and you can stop taking part at any time.

Are there any benefits to doing this study?

I cannot promise any personal benefits to you from your participation in this study. However, your participation may help other registered nurses and researchers to create awareness and better understand patient violence.

Payment or Reimbursement

If you choose to participate in this study, you will be offered a gift card of $5.00 for Tim Horton's for your time.

Confidentiality

Your participation in this study will be kept confidential. Your information will not be shared with anyone. All personal information such as your name, address, email address, and telephone number will be removed from the data and replaced with a study number. A list linking your personal information to the study number will be kept in a secure, confidential location separate from your file where only I will have access. Any other study related data will be stored in either a locked cabinet, or password protected on a computer where only the research team will have access. When the results of this study are published or presented at conferences, your name will never be used. Your identity will be anonymous, however we are sometimes identifiable through the stories we tell. No body, other than myself and the research team, will know whether you participated unless you choose to tell them.

Legally Required Disclosure

I will protect your privacy as outlined above. If legal authorities request the information you have provided, I may be required to reveal it.

What if I change my mind about being in the study?

It is important for you to know that you can choose not to participate in this study as your participation is voluntary. If you decide not to participate, this decision will not affect you in any way at your work place.
If you decide to be part of the study, you can decide to stop, at any time, even after signing the consent form or part-way through the study and there will be no consequences to you. Any information provided up to the point where you withdraw will be kept unless you request that it be removed. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

How do I find out what was learned in this study?

If you would like to receive a summary of the study results, please let me know how you would like me to send it to you.

Questions about the Study

If you have any questions about the research now, or later, please contact Kelly Stevenson at stevekn@mcmaster.ca (preferred) or 905-807-8383, or the Faculty Supervisor, Dr. Susan Jack, at 905-525-9140 ext. 26383.

This study has been reviewed by the Hamilton Health Sciences/McMaster Faculty of Health Sciences Research Ethics Board (HHS/FHS REB). The REB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call The Office of the Chair, HHS/FHS REB at 905.521.2100 x 42013.

CONSENT

I have read the information presented in the information letter about a study being conducted by Kelly Stevenson, of McMaster University.
I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
I understand that if I agree to participate in this study, I may withdraw from the study at any time. I have been given a copy of this form. I agree to participate in the study.

1. I agree that the interview can be digitally recorded. *Yes* *No*

2. I would like to receive a summary of the study's results. *Yes* *No*

If yes, where would you like the results sent:

Email: _____

Mailing address: _____
_____
_____

3. I agree to be contacted about future research and I understand that I can always decline the request. *Yes* *No*

Please contact me at: _____

_____ _____ _____
Name of Participant (Printed) Signature Date

Consent form explained in person by:

_____ _____ _____
Name and Role (Printed) Signature Date