Emergency Nursing and Patient Violence

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Thesis Abstract

Background

Nurses are at an increased risk for violence from patients compared to other healthcare professionals working in hospital emergency departments. In this setting, there are multiple factors contributing to patient violence including long wait-times, overcrowding, insufficient staffing, and lack of security personnel. This violence can be verbal, physical, or sexual in nature, and may result in psychological, emotional, cognitive, and social consequences. While there is an abundance of literature that explores how nurses working in the emergency department experience patient violence, less is known about how patient violence affects their day-to-day nursing practice.

Purpose

The purpose of this study was to explore how nurses working in Ontario emergency departments who have experienced patient violence enact their nursing care.

Methods

This was an interpretive description qualitative study using semi-structured, conversation-style telephone interviews, set in Ontario, Canada. Data were analyzed using conventional content analysis..

Findings

The participants' experiences with patient violence and its effect on their nursing care were described using four categories and seven subcategories: 'Violent Context' (Leadership), (Wait-Times), (Security Measures), 'Being Responsible' (Work Family), 'Violent Patients' (Patient for Whom we Anticipate Violence), (Patients who Surprise Us), and 'Adapting their Practice' (Engaging with Patients).

Conclusion

Nurses working in the emergency department describe frequent occurances of physical and verbal violence as part of their daily practice. This violence leads to emotional and psychological consequences, as well as changes to their nursing care and interactions with future patients. Inconsistencies in hospital policies, resources, and supports create an environment where nurses are often left to manage both the violent encounter and their personal and professional responses.

Co-Authorship

1. Amanda Vandyk RN, PhD, Associate Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa

As my thesis supervisor, Dr. Amanda Vandyk provided guidance on the overall thesis design. Amanda provided a substantial contribution to the overall writing and development of the final document.

2. Jean Daniel Jacob RN, PhD, Associate Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa

As a member of my committee, Dr. Jean Daniel Jacob provided guidance on the overall thesis design and writing of the final document.

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As a member of my committee, Dr. Jane Tyerman provided guidance on the overall thesis design and writing of the final document.

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Chapter One: Introduction

Introduction

In this chapter, I provide an introduction to my thesis on emergency nursing and patient violence, my personal impetus, the purpose of the thesis, the research question, and the layout of the thesis.

According to the Emergency Nurses Association (ENA), violence is a serious occupational risk for emergency department (ED) nurses (ENA, 2011). This violence may be horizontal or lateral violence, vertical violence, or patient violence. “Horizontal or lateral violence” includes abusive behaviours between co-workers of similar status and is defined as any hostile, aggressive, and harmful behaviour instigated by a co-worker or group of co-workers towards one or more other co-worker(s) (Becher & Visovsky, 2012). “Vertical violence” includes abusive behaviours originating from a co-worker in a superior position towards a subordinate (Thomas & Burk, 2009). Patient violence refers to violence instigated by patients, visitors, or their families, and is defined as any incident of physical, sexual, verbal, emotional, or psychological aggression that occurs when healthcare personnel are abused, threatened, or assaulted in their place of employment (Occupational Safety and Health Administration [OSHA], 2016; Stevenson et al., 2015).

Although horizontal, vertical, and patient violence are related phenomena, their manifestations and repercussions differ (Becher & Visovsky, 2012). The focus of this thesis is patient violence, specifically that which occurs in the ED. The ED is considered one of the most dangerous healthcare settings because of frequent violent acts by patients, visitors, and relatives (ENA, 2011). This type of violence is regularly described as a “silent epidemic”. It is often considered part of everyday ED work and, subsequently, under-reported (Hyland et al., 2016; Kowalenko et al., 2013). However, there are known serious consequences affecting the

psychological, emotional, social, physical, and cognitive well-being of healthcare professionals (HCPs) who experience these situations (Brophy et al., 2018; Lanctôt & Guay, 2014; Stevenson et al., 2015).

Emergency nurses are the first clinicians to assess patients in triage and generally have more direct contact with patients during an ED visit than other emergency clinicians (Kowalenko et al., 2013). By virtue of their roles in the ED, nurses are at an increased risk of being primary victims of violence inflicted by patients (Kowalenko et al., 2013). The Emergency Nurses Association (2011) reported that 70% of ED nurses had experienced physical or verbal assault perpetrated by either patients or visitors while working, whereas Speroni and colleagues (2014) indicated that 76% of hospital nurses experienced physical and/or verbal violence by a patient or relative over the past year, with incidence highest amongst emergency nurses.

The most common reported precipitating factors leading to patient violence, specific to the ED, include long wait-times, psychiatric crises, patients or visitors under the influence of alcohol or drugs, unfamiliar ED processes and systems, ED overcrowding, lack of security personnel, and insufficient staffing (Morphet et al., 2014; Pich et al., 2010; Ramacciati et al., 2018; Wolf et al., 2014).

The consequences of patient violence, including a lack of interest in work and poor nurse-patient interactions, cause a disruption in nursing care (Hassankhani et al., 2017). Further, nurses report an overall dissatisfaction and inability to concentrate at work after experiencing patient violence (Hassankhani et al., 2017). Medical errors increase, organizations report less work productivity, and ultimately, there is a negative effect on patient care quality, patient safety, and nurse retention (Hassankhani et al., 2017; Zuzelo et al., 2012).

My experience as a Registered Nurse (RN) in the ED for approximately five years led me to this topic for my Master's research. Throughout my time working in Quebec and Ontario EDs, I witnessed and was exposed to verbal and physical violence inflicted by both patients and visitors. I believe that nurses in similar situations should be able to share their stories and help further our understanding of this phenomenon.

While working in the ED, I was yelled at, threatened, kicked, punched, and grabbed by the arm. Senior colleagues have told me that patient violence has increased over the years, and I have noticed how these encounters are psychologically and emotionally difficult to manage. Being subject to verbal and physical acts of violence has made me want to understand other nurses' experiences to increase awareness of this issue and optimally help ED nurses here in Ottawa and elsewhere.

Purpose Statement

Emergency department nurses are at an increased risk of being the primary victims of violence inflicted by patients compared to other clinicians working in the emergency setting (Kowalenko et al., 2013). Nurses who experience patient violence can suffer from psychological, emotional, cognitive, and social consequences, which can change how they engage in both their day-to-day work and their professions (Hassankhani et al., 2017; Lanctôt & Guay, 2014). While there is research that explores how ED nurses experience patient violence, less is known about how patient violence affects their practice. Therefore, the purpose of this study is to understand how nurses working in Ontario emergency departments who have experienced patient violence enact their nursing care.

Research Question

1. How do nurses who have experienced patient violence enact their nursing care?

Thesis Layout

This thesis consists of five chapters:

1) Chapter One is an introduction to the topic, including personal impetus, the purpose of the study and research question, as well as this description of the thesis layout.
2) Chapter Two is a literature review about violence, violence in healthcare, violence in nursing, and violence in emergency departments.
3) Chapter Three describes the theoretical and methodological underpinnings of the study, including the paradigmatic stance, the theoretical framework used to inform my thinking on the topic, research design, sampling, recruitment process, data collection, data analysis, and ethical considerations.
4) Chapter Four presents the study findings.
5) Chapter Five is the discussion of the findings, implications for nursing research, practice, education and policy, and conclusions drawn from the study.

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Chapter Two: Literature Review

Literature Review

In this chapter, I provide an overview of the literature, including the definitions of violence, the different forms of violence, patient violence in healthcare, patient violence against nurses with a focus on violence against emergency nurses, and the different effects that violence has on nurses. I used Nursing Allied Health, CINAHL, and Medline to locate articles for this chapter. The key words that were used during my search on the CINAHL and Medline database were Emergency nurs*, Nurses AND Patient violence. The key words were similar for my search on Nursing Allied Health, where I used Emergency nursing AND Patient Violence. A total of 19 articles were chosen from the Nursing Allied Health database, three articles from CINHAL, and one from Medline. I also continued to look for more research published on this topic and included several studies identified in my hand-search and from reviewing reference lists of selected articles. Finally, I consulted grey literature about my concepts related to violence and emergency departments.

Violence

According to the World Health Organization (WHO), violence has always been a part of the human experience (WHO, 2002). Violence occurs in all parts of the world and is defined as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation" (WHO, 2002, p. 5). Violence can take many forms, including emotional and verbal abuse, physical assault, harassment, threats, and unwanted sexual advances (Roche et al., 2010). Violent acts may be physical, sexual, or psychological in nature, including deprivation or neglect. While some populations are more affected by violence than others. Kingma (2001) argues that "violence

crosses all boundaries, including age, race, socio-economic status, education, religion, sexual orientation, and workplace" (p. 129).

Workers in a wide variety of occupations and industries face workplace violence (Schmidt et al., 2019). The Center of Disease Control (CDC) and the National Institute for Occupational Safety and Health (NIOSH) define workplace violence as "violent acts (including physical assault and threats of assault) directed toward persons at work or on duty" (CDC, 2002, p. 1). Workplace violence may range from threats to homicide (CDC, 2002). Furthering this definition, Gates and colleagues (2006) included verbal harassment, sexual harassment, verbal threats, and physical assaults as part of workplace violence. Such violence can be perpetrated by a stranger, a patient or client, a colleague, an intimate partner, close relatives, and friends (Schmidt et al., 2019). Violence is one of the most significant occupational hazards facing employees today (Schmidt et al., 2019), with recent Canadian statistics indicating that 19% of women and 13% of men experience some type of harassment in their workplace every year (Statistics Canada, 2018). "While media attention tends to focus on reports of workplace homicides, the vast majority of workplace violence incidents result in non-fatal, yet serious injuries" (OSHA, 2016, p. 2).

Violence in Healthcare

Currently, violence is more prevalent in the healthcare sector than in any other occupational setting. HCPs are at an increased risk of experiencing violence compared to other types of employees (OSHA, 2016; WHO, 2020). In healthcare, violence can be perpetrated by patients, patients' families, visitors, or colleagues (Roche et al., 2010). According to Statistics Canada (2018), within a one-year period, 28% of workers in health occupations will report workplace harassment compared to employees in sales (17%), education (18%), and law (18%).

In addition, HCPs are more affected by violence than other frontline workers, such as police and correctional officers (Canadian Federation of Nurses Unions [CFNU], 2020). The CFNU (2020) reported the number of lost-time claims due to violence filed between 2006 and 2015 was 16,617 for HCPs, compared to 7,517 claims for police and correctional service officers combined. Recently, the WHO (2020) reported that between 8% and 38% of HCPs have suffered from physical violence at some point in their careers.

Patient violence is violence instigated by patients or their families. This form of violence is defined as any incident of physical, sexual, verbal, emotional, or psychological aggression that occurs when HCPs are abused, threatened, or assaulted in their place of employment (OSHA, 2016; Stevenson et al., 2015). Acts of physical violence include unwanted sexual advances, punching, slapping, pinching, twisting or grabbing one's body parts, scratching, spitting, biting, choking, pushing or shoving, hair pulling, kicking, throwing or slamming objects against walls or hard surfaces, destroying personal property, and purposefully voiding or vomiting on (or towards) someone (ENA, 2011; Speroni et al., 2014). Verbal violence includes using unwanted sexual language or innuendos, name-calling, ridiculing, humiliating, threatening with physical violence or weapons, swearing or cursing, yelling or shouting, and threatening a person with legal action (ENA, 2011; Speroni et al., 2014).

Acts of violence directed towards HCPs inflicted by the public have been documented dating back to 1824 (Whelan, 2008). Violence in healthcare is a long-standing problem and is considered a public health concern of epidemic proportions (Kingma, 2001). Manton (2017) explained that violence in EDs was once quite rare. Now, violence is frequent, and as a society, the tolerance and acceptance of violence in hospitals and other healthcare facilities is increasing (Manton, 2017). Thus, to practice nursing today is to accept the risk for personal violence

(Manton, 2017). The mounting violence in healthcare systems causes extensive damage to the health sector and negative repercussions for HCPs and their personal lives (Kingma, 2001). Healthcare workers are abandoning the profession, fewer people are recruited into vacant positions, and an overall reduction in quality and delivery of health services is occurring (Kingma, 2001). Ultimately, there is deterioration in the quality of care, the work environment, and the health of HCPs when violence routinely occurs (Kingma, 2001).

Current organizational and environmental factors are important to consider when studying patient violence (Brophy et al., 2018). From an organizational perspective, inappropriate staffing, high turnover, and staff shortages on shift create an environment susceptible to patient violence (Brophy et al., 2018). Furthermore, deficits in the number, training, and scope of practice of security personnel are frequent realities within healthcare agencies (Brophy et al., 2018; Manton, 2017), despite their essential role in the maintenance of safety within hospitals (Gates et al., 2006; Gillespie et al., 2013). Unfortunately, not all staff working at hospitals are appropriately supported by these vital members of the healthcare team. According to Angland and colleagues (2013), HCPs report that easily accessible security personnel can prevent violent episodes, and the mere presence of security personnel, particularly in the ED, acts as a deterrent to violence. However, when resources are not available, nurses may assume a security-like role, which can be problematic for their practice. This situation was highlight be Hyland and colleagues (2016), who identified that most volatile incidents occur outside of business working hours, especially during the evening and night. At these times, adequate security personnel and resources are often not available, which is problematic for practice because HCPs do not always have the time or resources to de-escalate, manage, and

anticipate violence, amongst their other priorities (OSHA, 2016). Ultimately, nurses need to feel safe at work, as articulated in the study by Speroni and colleagues (2014).

From a unit culture perspective, violence is viewed differently across settings and by HCPs, depending on the accepted norms present. For example, the emphasis placed on continuing education regarding violence varies, with some organizations requiring mandatory training for all HCPs, and others offering optional (and on your own time) training (Speroni et al., 2014). In addition, reporting requirements differ between hospitals, as do the types of violence necessitating said reporting (Speroni et al., 2014). Research findings suggest that, often, HCPs omit reporting violent incidents to either their employers or law enforcement (ENA, 2011). Under-reporting of violent incidents occurs when the unit culture accepts that violence is an expected part of one's job (Brophy et al., 2018; Manton, 2017). HCPs are less prone to report violence when: a) reporting mechanisms are complex and time-consuming, b) they are expected to "prove their injury" by providing physical evidence, c) they have fears of being perceived as weak or incompetent, d) they do not want to draw attention to themselves or fear being blamed for the incident, and e) they are reluctant to hold patients accountable for the violent incident (Manton, 2017; Speroni et al., 2014). Under-reporting of violence leads to an inaccurate representation of this problem's true magnitude and minimizes the extent to which HCPs must 'deal' with violence.

The physical environment, layouts, and design of units also contribute to patient violence and/or the severity of these incidents. Lack of personal security alarms, presence or absence of metal detectors, and availability of private rooms, among other elements, are known to decrease the risk of violence (Brophy et al., 2018; Gillespie et al., 2013; Wolf et al., 2014). Impediments to visibility or visual access between HCPs and patients (Pati et al., 2016) are also important

environmental factors. The OSHA (2016) reports that a poor environmental design, interferes with HCPs' vision, and impedes with their ability to appropriately manage dangerous (or potentially dangerous) encounters. Physical layouts might also create a lack of privacy for patients, which can violate their sense of personal space and lead to frustration and aggression towards HCPs (International Council of Nurses [ICN], 2000; Koller, 2016). Lastly, public access to nursing stations and supply rooms containing objects (i.e. furniture or equipment) that can be used as weapons increases the risk for injury during violent situations (Brophy et al., 2018; Manton, 2017).

The ED physical layout is often constructed in a way that patients are assigned a designated area in the emergency to allow nurses the ability to continuously monitor, control, and contain patients (i.e. especially those with aggressive behaviours and/or mental health disorders). This physical layout allows nurses to intervene in situations if they feel patients are becoming 'disruptive'. Nurses may strictly monitor and observe patient behavious, actions, and whereabouts to increase control and to avoid being blamed by colleagues for improper care (Jacob et at., 2014). In the study by Jacob and colleagues (2014), ED nurses report needing more structured physical layouts, which encourage flexibility in patient observation.

Patient Violence and Nurses

Registered Nurses are more at risk for experiencing violence inflicted by patients than any other HCP, because nurses provide more direct patient care (WHO, 2020). The social image of nurses, which places them at a lower standing on the health professional hierarchy, also increases their risk for violence (Ramacciati et al., 2018). According to Ramacciati and colleagues (2018), nursing is still considered, in some social spaces, as a subordinate profession, filled with individuals who follow orders. Research by these authors suggests that nurses are not

as respected as physicians, causing patients or relatives to behave poorly towards them because they are not seen as key figures in determining patient outcomes (Ramacciati et al., 2018). Regardless, Koller (2016) argues that "workplace violence is one of the most multifaceted and dangerous occupational hazards facing nurses working in today's healthcare environment" (p. 357). In Zhang's study (2017), nurses reported an incidence of verbal violence of 61%, physical violence of 26%, and sexual violence of 3%. The findings of their study also indicated that novice nurses experience patient violence more often than senior nurses (Zhang, 2017). Overall, 62% of nurses report multiple instances of patient violence each week (ENA, 2011). The Ontario Nurses Association (ONA) reported that 54% of Ontario nurses have experienced physical abuse, 85% experienced verbal abuse, and 19% experienced sexual violence or abuse (ONA, 2015).

Nurses who are exposed to patient violence while providing patient care are at risk of developing psychological, emotional, and physical consequences (Baby et al., 2014; Schmidt et al., 2019; Stevenson et al., 2015; Tonso et al., 2016; Yang et al., 2018). Regardless of the type of violence experienced, nurses report an overall dissatisfaction and inability to concentrate or be productive at work after they experience patient violence, which leads to disruptions in nursing practice and affects overall patient care (Gates et al., 2011; Hassankhani et al., 2017). Physical effects of patient violence can include injury and temporary or permanent disability (Stevenson et al., 2015). Injuries sustained from physical violence include bites, abrasions, scratches, hair loss, bruises, contusions, musculoskeletal fractures, internal injuries, lacerations, puncture wounds, sprains, strains, and blunt traumas to the abdomen and chest (ENA, 2011; Stevenson et al., 2015). Physical injury occurs in approximately 13% of incidents where patients are violent towards nurses (ENA, 2011).

Effects of patient violence on nurses' mental health are noteworthy, yet varied. These consequences may affect the nurse in the short and long term. After exposure to patient violence, nurses frequently experience hyper-arousal symptoms, which manifest in hostility, irritability, anger, and anxiety (Gates et al., 2011). These hyper-arousal symptoms negatively impact nurse-patient therapeutic interactions, affecting the nurse's ability to provide emotional support and empathy for their patients (Gates et al., 2011). Other psychological and emotional consequences of patient violence include fear, frustration, burnout, reduced self-esteem, and detachment (Gates et al., 2011). These emotional responses can lead to distancing self from others (Gates et al., 2011), impaired interactions with patients and colleagues, and problems with interpersonal relationships (Baby et al., 2014; Hassankhani et al., 2017; Stevenson et al., 2015; Yang et al., 2018).

Nurses might also experience intrusion symptoms following patient violence, which include nightmares and visual images of the violent event itself or its aftermath (Gates et al., 2011). In some circumstances, nurses can be diagnosed with Post-Traumatic Stress Disorder (PTSD) if intrusion symptoms are severe (Gates et al., 2011). Over 80% of nurses experience these symptoms following a violent incident, which they describe as reminders that bring back feelings of the event. Research indicates that intrusion symptoms are more common when the affected person must return to their workplace, where the event occurred (Gates et al., 2011). These symptoms affect one's ability to focus and provide compassionate nursing care, and thus nurses report avoiding potentially violent patients after exposure (Gates et al., 2011).

In some cases, the emotional and psychological effects experienced by nurses following patient violence can lead to psychiatric issues such as depression, substance misuse, and anxiety disorders (Lanctôt & Guay, 2014). These mental health concerns can lead to increased

absenteeism and decreased confidence when providing nursing care, as well as a lack of motivation and interest in work (Baby et al., 2014; Hassankhani et al., 2017; Stevenson et al., 2015; Yang et al., 2018). Nurses experiencing psychological distress due to patient violence are more likely to make medical errors and be less productive at work, negatively affecting the quality of care, patient safety, and nursing retention (Hassankhani et al., 2017; Speroni et al., 2014; Zuzelo et al., 2012).

Emergency Nursing

The ED is an area in a hospital that is designed for the care of acutely ill patients needing immediate medical interventions (Eriksson et al., 2018). Nurses working in the ED are typically Registered Nurses with training in Advanced Cardiac Life Support (ACLS), which includes Basic Life Support (BLS) and Cardiopulmonary Resuscitation (CPR) (Sholheim, 2016). In addition to nurses maintaining a valid nursing license, the Emergency Nurses Association of Ontario (ENAO) offers courses and encourages nurses to maintain credentials in ACLS and other courses, including Pediatric Advanced Life Support (PALS), Trauma Nursing Core Course (TNCC), Neonatal Resuscitation Program (NRP), Emergency Nursing Pediatric Course (ENPC), the Canadian Emergency Department Triage and Acuity Scale (CTAS), and the EPICC Trauma course (ENAO, 2020). Nurses are encouraged to maintain current certification in these courses to practice safely in the ED (ENAO, 2020).

Nurses working in the ED are responsible and accountable for their practice, completing the mandatory training, and continuing education initiatives to broaden their knowledge base (Brecher, 2014). Emergency nursing involves the provision of care for a diverse patient population with low to high acuity needs (Sholheim, 2016). In most other areas, nursing care is focused by age (i.e. pediatric or geriatrics) or body systems/illness type (i.e. obstetrics or

urology) (Sholheim, 2016). ED nurses must have a broad knowledge base and skill set because they serve all ages, experiencing different disorders or illnesses affecting every body system (Sholheim, 2016). Emergency medical interventions are given the highest priority in the ED, and often only patients' basic needs are addressed (Eriksson et al., 2018).

The physical space in an ED is divided into care zones to provide appropriate care to patients based on their acuity (Calder, 2010). Typically, these areas include triage, resuscitation, observation areas, and ambulatory care areas (Calder, 2010). While resuscitation and observation areas are for patients with the highest acuity, ambulatory areas are mostly for individuals with non-urgent and minor complaints (Calder, 2010). Novice ED nurses tend to be trained in one area at a time, starting in the area where patients are least acute and unpredictable. Upon demonstrating competency in an area, they progress to the next until they are trained in each (Sholheim, 2016). The resuscitation room is typically one of the last places nurses are trained because it is where the most critically ill patients, requiring immediate life support and interventions, are cared for (Calder, 2010; Lau et al., 2012).

The first step of the ED process is triage, where patients go to be registered for ED care. At triage, nurses perform specific assessments, initial treatments, investigations, and allocate a triage category to the patient's main complaint (Lau et al., 2012). In triage, nurses have standing orders or protocols approved by medical staff, allowing nurses to initiate diagnostic tests, including bloodwork and radiology, to expedite patient care and movement through the ED (Sholheim, 2016). In most cases, triage is usually carried out by more experienced nurses because of the advanced assessment skills required and the potential of missed interventions (Lau et al., 2012). Patients arriving by ambulance are usually on a stretcher when they enter the ambulance bay, which is located next to or close to the main triage area (Lau et al., 2012). Triage

categories in Canada are allocated according to the CTAS with scores that range from level one to five (i.e. level one resuscitation, level two emergent, level three urgent, and level four and five less/non-urgent) (Calder et al., 2010). Once patients are assigned a triage category, they are then either directed to the main waiting room, an observation stretcher, or an ambulatory or resuscitation stretcher (Lau et al., 2012). Patients directed to the waiting room usually present with less serious conditions (CTAS score 4-5), whereas sicker patients with more life-threatening concerns (CTAS score 1-3) are sent directly to an acute observation or resuscitation ED stretcher (Calder et al., 2010; Lau et al., 2012). Within the EDs, it is not uncommon to have an imbalanced patient flow, where patients are registered at a faster rate than they are discharged, resulting in crowded and busy EDs and high workloads for the HCPs (Eriksson et al., 2018). The ED is not designed, staffed, nor equipped to provide care for patients for a prolonged period of time; therefore, overcapacity creates challenges for nurses and other staff working in the ED (Eriksson et al., 2018).

In the ED setting, nurses must be efficient and effective in their nursing care. High workloads and the chaotic work environment increase the risk of errors and adverse events if nursing demands exceed their capacity to safely manage their patient care (Eriksson et al., 2018). The workload of nurses working in the ED can dramatically change from one minute to the next (Sholheim, 2016). Therefore, ED nurses must prioritize interventions based on acuity, which can compromise other nursing care elements when staffing is short—a regular and concerning reality in many EDs (Eriksson et al., 2018). The overcrowded, busy, and close proximity between patients in the ED also makes it difficult for nurses to maintain privacy, confidentiality, and patient dignity (Eriksson et al., 2018). This environment can be triggering for patients, who may

already be anxious due to the uncertainty of their health or that of their loved ones (Koller, 2016).

Violence in Emergency Departments

Koller (2016) reports that calm, restful, and quiet environments are best suited to mitigate patient violence risk. The ED, in contrast, is a fast-paced, chaotic, stressful, and frequently impersonal environment (Koller, 2016). The ED setting itself is a precipitating factor that can trigger anger and aggression in patients, who then may become violent towards ED staff (Eriksson et al., 2018). Interestingly, patient violence occurs more frequently during evening and nighttime hours (Gates et al., 2006; Gillespie et al., 2013; Hyland et al., 2016). During these times, an increased number of patients presenting to the ED seek treatment for reasons such as intoxication and injuries, which are closely tied to aggressive and violent incidents (Darawad et al., 2015; Gillespie et al., 2013).

Patients cared for in the ED require different levels of intervention, and their reasons for presentation are often highly varied. At times, patients may be experiencing cognitive changes making them unaware of their actions and reality, for example, when they present with psychosis, intoxication, delirium, stroke, or advanced dementia (among other things) (Morphet et al., 2014; Speroni et al., 2014). These circumstances affect the patient's mental state in such a way that they may be unpredictable, act out, or be unaware of their actions and behaviours (Morphet et al., 2014; Speroni et al., 2014). Further, poor awareness of their surroundings may lead to fear and uncertainty, and subsequently acts of aggression or violence in response (Ashton et al., 2018; Morphet et al., 2014; Speroni et al., 2014).

Nurses working in the ED are direct care providers to the public, increasing their risk for challenging encounters (ENA, 2011; Koller, 2016; Zhang et al., 2017). Reports of patient

violence prevalence vary within the healthcare environment; however, all studies identify ED nurses face the highest risk (Ashton et al., 2018; Brophy et al., 2018). Verbal violence towards ED nurses occurs more regularly than physical violence; however, when physical violence does occur, it is described as extremely frightening with significant physical and psychological consequences (ENA, 2011). The most common factors influencing patient violence, specific to the ED, are long waiting times, overcrowding, insufficient staffing, policies (or lack thereof), security use and presence, and communication (Angland et al., 2013; Brophy et al., 2018; ENA, 2011; Morphet et al., 2014; Ramacciati et al., 2018; Speroni et al., 2014).

The ED processes and systems are not well understood by patients, resulting in frustration that can induce violence towards ED nurses (Morphet et al., 2014). At triage, patient expectations of their care they are to receive and the outcome of their triage assessment might be incompatible (Angland et al., 2013, Morphet et al., 2014), and patients sent back to the waiting room after triage may perceive this as a lack of progress or advancement in care (Pati et al., 2016). Additionally, overcrowding in waiting rooms and long wait-times are factors that contribute to frustration and patient violence (Morphet et al., 2014). Wait-times include the initial wait to see the triage nurse, waiting to see a physician, waiting for test results, and waiting for a stretcher to be available (Lyneham, 2001). Furthermore, the scale used to determine acuity and thus speed of intervention for patients is an ED process that is not intuitive to patients and, therefore, an influencing factor for violence (Lyneham, 2001). Patients might also not appreciate that other patients require more immediate attention (Lyneham, 2001), and perceptions of urgency that are not met with expected speed or action can result in anger and violent altercations (Lyneham, 2001). Finally, EDs are often short-staffed, and insufficient staffing can lead to longer waiting times and create frustration, fear, and anger in patients, which can lead to

acting out behaviours (Brophy et al., 2018). This issue of insufficient staffing is more prevalent during overnight and weekends hours, placing staff at greater risk for managing challenging behaviours (Hyland et al., 2016).

The configuration of the ED is also important to consider in light of patient violence. According to the study by Pati and colleagues (2016) the emergency entrance is considered the area most risky for violent encounters, which includes the ambulance bay and waiting room area. The authors report that these locations are vulnerable security points given the unpredictability of patients and visitors entering the ED (Pati et al., 2016). In contrast, the ENA (2011) indicates that the most common locations where nurses encounter violent patients include nursing stations, patient rooms, hallways, and admitting and triage areas. The triage area can be unpredictable for violence because it tends to be an open environment that is less staffed, and where the first contact between the nurse and patient is made (ENA, 2011; National Institute for Health and Clinical Excellence [NICE], 2005; Pati, et al., 2016).

Nurses are most often the ones applying restraints, attempting to de-escalate situations, triaging patients, performing invasive procedures, engaging in medical or trauma resuscitations, delivering bad news, or transporting patients when patient violence occurs (ENA, 2011). Triage poses a particular risk because nurses in this role are tasked with assessing unknown patients with unknown needs prior to establishing a therapeutic relationship of any kind (Pati et al., 2016).

Patients and Providers Factors

Compassion fatigue, poor communication with patients, and lack of empathy from staff are factors contributing to patient violence (Morphet et al., 2014). Communicating with patients is an essential element of the therapeutic nurse-patient relationship. When communication is

perceived as positive or effective between patients and nurses, it can mitigate or prevent violence (Angland et al., 2013). However, certain situations lead to communication breakdowns increasing the risk of patient aggression and violence in the ED. These situations include, for example, when misinformation is provided to patients by accident, when nurses feel stressed or overtaxed, or when patients requesting ED care are not perceived as requiring immediate intervention (Angland et al., 2013).

Despite the unpredictability of patient violence, there are certain patient factors shown to increase the risk of violence. Characteristics include severe pain (i.e. trauma patients), psychiatric symptoms (i.e. psychosis or manic phase), a history of violence, persons in custody, involuntarily patients, cognitive impairments (i.e. delirium, confusion, and dementia), and those under the influence of alcohol or drugs (ENA, 2011; Gillespie et al., 2013; Pich et al., 2010; Speroni et al., 2014; Wolf et al., 2014). Many patients in the ED experience feelings of anxiety, pain, loss of control, disorientation, and powerlessness during their stay, which can manifest into acts of aggression or violence towards nurses providing their care (Fern, 2007).

Interestingly, ED nurses are more likely to accept aggressive or violent actions as part of their job when the patient has impaired physical or psychological functioning, under the assumption that they are not in full control of their actions (Ashton et al., 2018). In contrast, nurses are less tolerant towards patients who act violently when they have less serious presenting health concerns (Ashton et al., 2018; Ramacciati et al., 2018). Patients with mental health issues or those under the influence of alcohol or drugs are shown to have more challenging behaviours (Gillespie et al., 2013). Emergency nurses appear more easily frustrated with patients who present with substance intoxication, which may perpetrate a negative response when their frustration is evident to the patient (Gillespie et al., 2013). Finally, when in psychiatric crisis,

patients can be brought into the ED involuntarily for psychiatric evaluation or held in police custody until care is transferred to the ED physician (Gillespie et al., 2013). Involuntarily admitted to a hospital is a known risk factor for aggressive behaviour and violence in ED patients (Gillespie et al., 2010; Gillespie et al., 2013). As mentioned above, these HCP's perceptions can be perceived as stigmating by patients and, therefore, effect patient care and nurse-patient interactions (Sawatzky & Enns, 2012; Stevenson et al., 2015).

Summary

There are various qualitative studies looking at how nurses experience patient violence. Within this literature, findings indicate that nurses recall feeling fearful, in shock, trapped, vulnerable, and/or numb after the occurrence of a violent encounter (Angland et al., 2013; Stevenson et al., 2015). They have a heighteded sense of awareness post physical violence, which is said to last several days to months (Stevenson et al., 2015). Through the many stories captured in these studies, it can be seen that nurses feel most at risk for violence while working in the triage room (Angland et al., 2013; Ramacciati et al., 2018). This area of the ED is said to be more secluded, resulting in nurses feeling trapped and more vulnerable to violent incidents (Angland et al., 2013; Ramacciati et al., 2018). Unfortunately, these studies portray a picture where nurses describe shifts including near constant abuse and aggression towards them and their colleagues (Angland et al., 2013). Included participants reported feeling frustrated, sad, insecure, and abandoned immediately following a violent episode (Angland et al., 2013; Hassankhani et al., 2017). As a result of these experiences, nurses report reduced levels of confidence in preventing or managing future episodes of patient violence (Stevenson et al., 2015).

As discussed above, violence can take many forms, including physical assault, emotional abuse, and sexual harassment. Violence instigated by patients or their relatives is a significant issue affecting all nurses in healthcare. Due to the high rates of patient violence faced by ED nurses this is particularly concerning. Nurses working in the ED are subject to physical and verbal violence, leading to burnout, high staff turnover, staff shortages, and dissatisfaction in care quality (Brophy et al., 2018; Hassankhani et al., 2017). Several influencing factors of patient violence include long wait-times, insufficient staffing, and a lack of security use and presence. Further, the characteristics of the patients, nurse-patient interactions, and the environment are shown to influence the risk of violence in the ED.

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Chapter Three: Theoretical and Methodological Considerations

Theoretical and Methodological Considerations

This chapter provides an overview of the theoretical underpinnings of the study and the methodological considerations, including the design, sample, data collection, data analysis, rigour, and ethical considerations.

Theoretical Underpinnings

My understanding of patient violence's effects on nurses and their practice is best explained through the Constructivist Self-Development Theory (CSDT) (McCann & Pearlman, 1990). The CSDT is predicated on the developmental theory, self-psychology, social learning theory, and other cognitive theories (McCann & Pearlman, 1990). This theory focuses on the interactions between the person, their situation, and the environment (McCann & Pearlman, 1990). The central concept is trauma, described as a psychological response to a stressor and not as a stressor itself (McCann & Pearlman, 1990). A traumatic experience (i.e. an experience that leads to trauma) is a sudden, unexpected, and non-normative experience that exceeds an individual's ability to cope (McCann & Pearlman, 1990). These experiences disrupt the self by affecting a person's needs, emotional processes, and understandings of their world (McCann & Pearlman, 1990). The "self" is a person's identity and inner life and is developed through interactions with others and the reflections of those interactions (McCann & Pearlman, 1990). Every person constructs their own reality; therefore, feelings and behaviours towards traumatic experiences are varied among individuals (McCann & Pearlman, 1992). An individual's life experiences such as personal history, social and cultural context, as well as past traumatic experiences, influence how they will adapt to a new traumatic experience (McCann & Pearlman, 1990). When patient violence towards an RN occurs, the violence may be lived as a traumatic experience as violence can threaten a person's safety. This can trigger a psychological response

that are dependent on the five interactive concepts (McCann & Pearlman, 1990). The CSDT proposes five interactive concepts (i.e. aspects of a person) that are particularly affected by trauma: a) frame of reference, b) self-capacities, c) ego resources, d) psychological needs related to cognitive schemas, and e) memory systems (McCann & Pearlman, 1990).

Frame of Reference

The frame of reference is a foundation of beliefs through which a person interprets experience, including worldview, identity, and spirituality. It is also a person's framework for viewing and understanding themselves and the world. It is fundamental to a person's perceptions and interpretation of life experiences and any disturbance that can be disorientating and stressful. Worldview includes a person's beliefs about the world, including moral principles, life philosophy, causality, and locus of control. Identity refers to a person's sense of self, which encompasses the situations, emotional, psychological, and cognitive states that one experiences. Identity includes one's relationship with oneself and one's perception of self in relation to others. Lastly, spirituality refers to the creation of meaning of self in the larger world. Spirituality consists of four components, including awareness of all aspects of life, relation to the nonmaterial aspects of existence, sense of connection with something beyond oneself, and future orientation and sense of meaning in life. When we consider what is known about violence in healthcare, we see that violence can affect one's frame of reference by causing a generalized sense of demoralization and the belief that the world is unpredictable, dangerous, and uncontrollable (Pearlman & Saakvitne, 1995).

Self-Capacities

Self-capacities allow for the development and maintenance of an inner sense of identity and a positive sense of self. Self-capacities help with emotional regulation, such as the ability to

tolerate strong effects, calm oneself, avoid self-loathing, and be alone without feeling lonely. A person's self-capacities are important because they moderate the internal experience of trauma and integrate into themselves the effects and meanings associated with the traumatic experience. Violence can also affect one's *self-capacities* by causing a person to avoid certain situations or topics of discussion for fear of experiencing strong feelings (McCann & Pearlman, 1990).

Ego Resources

Ego resources regulate interactions with others and the outside environment. Productive ego resources can facilitate positive adaptation after a person has a traumatic experience. These ego resources include intelligence, willpower, initiative, empathy, awareness of psychological needs, as well as the ability to strive for personal growth and perspective. Other ego resources help protect a person from future harm, such as the ability to establish personal boundaries, make self-protective judgments, establish mature relations with others, and foresee consequences. Violence can alter a person's *ego resources* and affect their ability to take initiative in purposeful activities and to do what they resolve to do. This can contribute to giving up easily and the inability to persist in the face of difficulties (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

Psychological Needs

Psychological needs help motivate behaviour and shape a person's interactions with others. People are not often aware of these needs and can be affected by a traumatic experience. The CSDT focuses on the five needs that appear to be most sensitive to the effects of a traumatic experience: a) safety, b) trust, c) esteem, d) intimacy, and e) control. A person's developmental experience (including self-capacities and ego resources) will determine which needs are more or

less salient or conflictual. The aspects of the self are affected by a traumatic experience interdependently (McCann & Pearlman, 1990).

Cognitive Schemas

These psychological needs create cognitive schemas, which are beliefs, expectations, and assumptions about the self and others. Cognitive schemas are personal constructs for organizing reality. Schemas are mental structures that represent our general knowledge of situations, events, and objects. These schemas play an integral role in the individual's response to a traumatic experience, which is varied depending on which need is disrupted by a traumatic experience. These schemas determine the way the traumatic experience is encoded in memory (McCann & Pearlman, 1990).

A significant underlying assumption of the CSDT is the notion of assimilation and accommodation. Schemas are created over the course of a person's life, and "assimilation" is the process of new information being integrated into existing schemas. Therefore, when a traumatic experience occurs, this disrupts schemas. The individual then modifies previous schemas through a process called "accommodation" (McCann & Pearlman, 1990).

Safety.

Safety refers to the need to feel safe and invulnerable to harm by oneself or others (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Disruptions in safety schemas can emerge as beliefs about one's self-safety, such as an inability to feel safe anywhere (Pearlman & Saakvitne, 1995). They can also be evident in relation to others, or other-safety (Pearlman & Saakvitne, 1995). When the safety schema is disrupted, the person feels increased vulnerability to future harm. They doubt their ability to protect themselves from potential future violent incidents or believe that they are now predisposed to future danger or harm.

Trust.

Trust refers to the need to believe in honesty and to depend on others to meet one's needs (McCann & Pearlman, 1990). Self-trust is the need to trust one's own judgment and perceptions (Pearlman & Saakvitne, 1995). Other-trust is to count on or depend on others to meet one's emotional, psychological, and physical needs (Pearlman & Saakvitne, 1995).

Esteem.

Esteem refers to the need to be valued by others, have one's worth validated, and value others (McCann & Pearlman, 1990). When a person is exposed to a traumatic experience, they struggle to make sense of things and may wish that they had done something differently. This can lead to feelings of worthlessness or self-devaluation (Pearlman & Saakvitne, 1995).

Intimacy.

Intimacy refers to the need to feel connected to other individuals through relationships (McCann & Pearlman, 1990). Victims of a traumatic experience may have self-intimacy disruptions that create difficulties tolerating time alone, being unable to care or treat themselves lovingly, and believing that intimate connections are not possible for them (Pearlman & Saakvitne, 1995).

Control.

Control refers to the need to manage one's feelings, thoughts, and behaviours, as well as to manage others in interpersonal situations (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Dissociation represents a form of attempting to control feelings and thoughts by not allowing them into one's own conscious awareness or also attempting to control one's affect by not experiencing certain thoughts or memories (Pearlman & Saakvitne, 1995).

Memory System

Trauma memories are verbal, visual imagery, affective, somatic, and interpersonal memory systems that vary depending on the schema(s) that is (are) disrupted by the traumatic experience (Pearlman & Saakvitne, 1995). Verbal memory includes the cognitive narrative of the event or sequence of events, what happened, what led up to the event, and what has happened since (Pearlman & Saakvitne, 1995). Imagery memory includes the pictures and visual images of the event in the person's mind (Pearlman & Saakvitne, 1995). Affective memory includes the emotions experienced before, during, and after the traumatic experience (Pearlman & Saakvitne, 1995). Somatic memory includes the physical sensations that represent the traumatic experience (Pearlman & Saakvitne, 1995). Lastly, interpersonal memory includes the sequences that reemerge behaviourally that reflect the person's experience of past traumatic events (Pearlman & Saakvitne, 1995). Violence can affect one's *memory system*. When the memory exists only in fragments, this can intrude the person's awareness and cause an intense effect and perhaps a flashback or panic attack (McCann & Pearlman, 1990).

Through the CSDT theory, we see that there are individual variations in how a person adapts to a traumatic experience, based in part on how the experience is encoded in their memory and the effect that it has on the above-described concepts (frame of reference, self-capacities, ego resources, and psychological needs related to cognitive schemas). In short, the adaptation to a traumatic experience is reflected by the interaction between the self and life experiences. Whether an individual adapts in a healthy or unhealthy way to a traumatic experience is dependent on how the traumatic experience affects their self-capacities, ego resources, and psychological needs, which in turn may or may not affect their frame of reference and pre-existing schemas. These changes to one's self-concept are stored in an individual's psyche as

trauma memories, and ultimately, these trauma memories then begin to influence their future experiences (McCann & Pearlman, 1990).

Paradigmatic Stance

The philosophical paradigm I chose to approach this nursing problem is the constructivist paradigm (Schwandt, 1994). Through a constructivist lens, we understand that each individual constructs their own reality and has their own experiences (Creswell, 2017). The researcher accepts that participants might hold different beliefs than their own (Appleton & King, 1997). The constructivist paradigm's relativist ontological position reflects multiple individual realities influenced by context rather than a single, knowable, objective reality (Mills et al., 2006). As explained by Creswell (2017), when situated within the constructivist paradigm, we assume that an individual's experiences are formed through their social interactions, as well as their historical and cultural experiences. Constructivism is a transactional and subjective epistemology, which places importance on the relationship between the researcher and the participants in the co-creation of research findings (Appleton & King, 1997; Guba & Lincoln, 1994; Mills et al., 2006). In terms of the transactional nature of the constructivist research, Appleton and King (1997) specified that, "the researcher must interact with study participants throughout the research process to access the multiple views of reality that may exist" (p. 1). Findings are thus co-created during the investigation process through this interactive relationship (Guba & Lincoln, 1994).

The goal of constructivist research is to construct an understanding of the complex world of lived experiences from the point of view of the individuals who lived them (Schwandt, 1994). Therefore, following a constructivist paradigm, researchers come to understand patterns of experiences and variations of these patterns (Appleton & King, 2002). Research findings stemming from constructivist work are often used by HCPs, nurses in particular because they

provide insight into the understanding of human experiences, which allows them to better understand and care for their patients (Holloway & Galvin, 2016). Constructivist research adds to disciplinary knowledge and can underpin evidence-informed nursing care by highlighting contextual or other variations that need to be considered when enacting care (Holloway & Galvin, 2016). This advances nursing practice by ensuring that strategies are meaningful, as well as effective (Holloway & Galvin, 2016).

The constructivist paradigm resonates most with my values and understanding of what can be known and how we come to know. The responses to violence are individual and influenced by historical and cultural experiences and social interactions (Creswell, 2017). Furthermore, Stevenson and colleagues (2015) reported that each nurse experience different situations that might influence how they respond to patient violence. Thus, the constructivist paradigm is most suitable for my research.

Qualitative Research

Qualitative research aims to gain an in-depth and holistic understanding of the "why" and "how" of phenomena (Polit & Beck, 2017). By using this research methodology, investigators explore subjective human experiences, such as their perceptions and understanding of a phenomenon (Polit & Beck, 2017). Qualitative research findings highlight the subjective experiences of humans. When examining a phenomenon, qualitative researchers rely on stories and observations, as well as an inductive process to construct meaningful conceptualizations (Thorne, 2016). Qualitative research is done in its natural setting, and the data are not manipulated nor predetermined by the researcher (Polit & Beck, 2017). Researchers engage in this work to seek understanding by gathering context and information personally (Creswell, 2017). Qualitative researchers tend to use open-ended questions to allow the participants to share

their stories, perspectives, and views. These narratives are then analyzed by the researcher, who has their own subjective experiences and background, which aid in the interpretation of the data (Creswell, 2017). Qualitative methodologies are often utilized when little is known about a topic (Holloway & Galvin, 2016).

Qualitative research was the most appropriate method for my topic because I wanted to learn about the multiple experiences and perceptions of nurses who have been exposed to patient violence in Ontario EDs. To achieve this, I collected my data naturally and did not manipulate or quantify the data for analysis. My main goal was to gain an understanding of the experiences of nurses working in these settings.

Methods

Design

Interpretive description (ID) was created to provide qualitative researchers in nursing a set study design that aligns with their disciplinary logic (Thorne et al., 1997). Thorne and colleagues (1997) explained that traditional qualitative methods of phenomenology, ethnography, and grounded theory have limitations when applied to the nursing context. As Thorne and colleagues (1997) stated, “these three disciplinary traditions reveal that there are complex relationships between the methodological standards and the larger objectives of the discipline” (p. 170). They recognized that nursing researchers struggled to carry out their projects using these study designs, which only partially meet their needs. In response, they developed the ID method built upon nursing’s epistemological foundations and the nursing discipline’s systematic reasoning, which generates legitimized empirical knowledge, pertinent to nursing practice (Thorne et al., 1997).

As a novice researcher, I chose to use qualitative ID by Sally Thorne (2008) for its coherent logic and structure (Thorne et al., 1997). ID studies are underpinned by the assumption that individuals have multiple and unique experiences (Thorne et al., 1997). The goal of ID research is to find meaning in an action or to understand what a particular action means through observations (Schwandt, 2001; Thorne, 2008). In doing so, the researcher needs to interpret their observations (Schwandt, 2001; Thorne, 2008). The ID approach is a transactional process, meaning that the researcher and the participants are active partners in finding what can be known about the phenomenon of interest (Thorne, 2016). The output of ID is a clinically meaningful "tentative truth claim" about what is common rather than a new "truth" about the phenomenon (Thorne, 2008).

Researchers using ID for their studies typically situate their research within the constructivism paradigm as this method acknowledges the researcher's role in (co)creating the meaning attached to what is being studied (St George, 2010). ID is well aligned with this paradigm because of the researcher's role and responsibility in exploring and creating meaning and understanding behind a phenomenon of interest while relying on inductive reasoning to build on emerging themes and concepts (Thorne, 2008; Thorne et al., 1997). Researchers using ID assume that individuals construct their own realities and everything can be interpreted differently (Thorne, 2008). Using ID helped me explore relationships, themes, and patterns within the experiences of ED nurses who have experienced patient violence and account for individual variations in these experiences.

Sampling Process

Nurses were chosen by convenience sampling with snowballing. Convenience sampling is a nonrandom sampling process that requires members of the target population to meet certain

practical criteria (i.e. accessibility, geographical proximity, and willingness to participate) in order to be recruited for the study (Etikan et al., 2016). Snowballing occurs when participants of the study reach out to other individuals who fit the inclusion criteria for the purpose of recruiting them into the study (Emerson, 2015). Convenience sampling is a practical and efficient way to begin recruitment, and snowballing enables the researcher to connect with additional potential participants (Emerson, 2015; Polit & Beck, 2017). The size of the sample in qualitative research is mainly dependent on the quality of data collected; therefore, a good sample size is small enough to allow a deep and comprehensive data analysis and large enough to ensure that the study results in meaningful knowledge of the research topic (Sandelowski, 1995). In this study, the final sample consisted of eight participants (described in the results chapter). Informational redundancy, defined as the point when no new information or themes emerged during analysis for two consecutive interviews, is a typical stopping criterion for qualitative sampling (Lincoln & Guba, 1985). In this study, informational redundancy was noted after the sixth interview, however, two additional interviews were scheduled and thus conducted.

Recruitment

I recruited eight Registered Nurses in Ontario into the study using a multipronged approach, including social media, email, and word-of-mouth. First, I used social media to recruit nurses by creating a Facebook post to advertise my study. Online recruitment methods are becoming more common (Batterham, 2014), and research supports their effectiveness in recruiting nurses for research purposes (Stokes et al., 2017). Recruitment material was created for email and Facebook (see Appendix A for recruitment poster). Second, participants enrolled in the study were encouraged to share my contact and study information with colleagues who met inclusion criteria. Third, I advertised the study through my networks and encouraged others to do

the same. Most of the nurses interested in participating in the study contacted me through Facebook messenger and email, and one nurse contacted me by phone. All participants provided informed consent and met the inclusion criteria explained below. See Appendix B for study information sheet and Appendix C for verbal consent form. I had a total of five participants that were interested in participating in my study, but then later decided to withdrawn due to other exisiting priorities.

Inclusion Criteria

The recruited nurses needed to communicate (speak, read, and comprehend) in English or French, be employed in an Ontario hospital ED, and have experience with patient violence while practicing nursing in the ED. There was no predetermined definition of patient violence because the definition is determined by the nurses and their experiences. I excluded nurses who had experienced horizontal or vertical violence from colleagues, because the consequences of this type of violence differ for nurses (Becher & Visovsky, 2012).

Data Collection

Semi-structured, conversation-style interviews by telephone were conducted with each participant at a time of their convenience (Carr & Worth, 2001). Telephone interviews allowed the participants to connect with me from a place of their choosing, eliminating the costs associated with travel and parking. They also provided the participants with more anonymity, which may have reduced their anxiety during interviews (Struges & Hanraham, 2004). Finally, by using telephone interviews, I was able to take additional interview notes without distracting or making the participants feel uncomfortable (Musselwhite et al., 2006; Struges & Hanraham, 2004). Although, telephone interviews were the best fit for my study, it is possible that I missed seeing the participants' informal, nonverbal communication (Struges & Hanraham, 2004). The

lack of visual cues might have reduced my ability to determine how involved the participant is and when probing was needed during the interview (Struges & Hanraham, 2004).

The interviews lasted between 20 minutes and 60 minutes and were conducted between December 2019 to February 2020. I used open-ended questions to guide the interviews and encouraged the nurses to provide a detailed account of their experiences of patient violence (Doody & Noonan, 2013) (See Appendix D - Interview guide). Questions included, for example, "Can you tell me about the types of violence you see in the ER?," "Can you tell me about a violent situation that was meaningful to you?," and "Now that you have lived through this experience, have you noticed anything different in how you provide care?" Probing questions, such as "How did it make you feel?," were also used to incite elaboration of the topic (Doody & Noonan, 2013). The nurses were encouraged to speak freely about what was important to them about the topic of patient violence and to share their stories. All telephone interviews were conducted in a private room and audio recorded with the permission of the nurses. I transcribed the interviews verbatim and de-identified the transcripts to maintain confidentiality.

I also collected socio-demographic information through simple questions asked at the beginning of the interview, including information about the nurses' gender, age, years of experience, education, and areas of practice.

Data Analysis

The data analysis process was inductive using conventional content analysis as described by Hsieh and Shannon (2005). This approach is compatible with ID studies (Hsieh & Shannon, 2005; Thorne et al., 1997). First, I read all the transcripts at least three times to achieve immersion of the data and a sense of the whole. Second, I read the transcripts very carefully to identify codes by highlighting meaningful words from the raw data that captured key thoughts

and concepts. Third, I read each transcript again and made notes of my first impressions and initial decisions around the analysis. During this process, labels for codes emerged that reflected more than one key thought. Fourth, I sorted the codes into categories based on how different codes were related and linked; for example, categories that were used to organize and group codes into meaningful clusters. Finally, I provided definitions for each category and subcategory and embedded verbatim quotes into the narrative findings to help show their meaning (Hsieh & Shannon, 2005). Data analysis was done in collaboration with my thesis supervisor and committee.

Rigour

To ensure the rigour of my study, I followed Lincoln and Guba's five criteria of trustworthiness (Guba & Lincoln, 1994; Lincoln & Guba, 1985). To enhance *credibility*, I recorded how the original data (the nurses' quotes) aligned with the categories and subcategories. *Dependability* was enhanced by maintaining an audit trail of all study processes, including the interview transcripts, decisions made regarding theoretical and methodological aspects, and drafts of the final report. This permits an outside party to understand how I came to my conclusions. To enhance *confirmability*, I reviewed my own ideas and feelings about the topic, such as potential biases or preconceptions about the study, and engaged in disciplined reflexivity to acknowledge these biases and how they may influence data collection and analysis. To facilitate this process, I discussed my thoughts, opinions, and presumptions with my thesis supervisor, and documentated the reflections through emails and drafts of the thesis document. For *transferability*, I provided detailed descriptions of the research context, the study participants, and their experiences to ensure that the findings were useful for future studies and settings in which Canadian emergency nurses practice. Finally, to enhance *authenticity*, the use

of open-ended questions and sharing of stories represented the multiple realities and voices of the participants. The use of open-ended questions and sharing of stories highlighted the variabilities found in their experiences to capture both breadth and depth of the phenomenon of interest (Guba & Lincoln, 1994; Lincoln & Guba, 1985).

Ethical Considerations

Research ethics approval was obtained from the Research Ethics Board of the University of Ottawa (see Appendix E). Throughout the study, I maintained confidentiality by using identification numbers instead of the nurses' names (Polit & Beck, 2017). The master list linking the identification numbers to the nurses' names was password protected. All files were securely stored during the research process to preserve privacy and confidentiality (Polit & Beck, 2017). Measures to further protect the nurses' confidentiality included using an encrypted device to store audio recordings, kept only until the transcription was completed (upon which they were destroyed/deleted appropriately). The electronic and paper data will be conserved in a secure manner for a minimum of 5 years after the study is completed (University of Ottawa, 2019). Lastly, in March of 2020, I emailed the participants who wanted to review their transcripts before the study was concluded and offered to speak with them if they desired. During data collection, four participants indicated wanting to review their transcripts, however when emailed, I did not receive any responses.

Given the topic's sensitive nature and potential to induce psychological or emotional distress, I ensured that the nurses were comfortable speaking with me. In addition, a distress protocol was put into place in the event that a nurse became upset, which included a stepwise crisis plan depending on the severity of the crisis. Although no participants required intervention for distress during or following the interview, the plan included the following measures: a) if

nurses experienced severe distress, 911 would be contacted; b) if a participant experienced mild-moderate distress, information on the Centre for Addiction and Mental Health (CAMH) distress and crisis line for Ontario residents would be provided (CAMH, 2021; Draucker et al., 2009); c) if a participant became distressed, I would offer to stop, regroup, or reschedule the interview (Draucker et al., 2009); and d) I would conduct a follow-up call with any participant requesting one within 24–48 hours of the interview to touch base and answer questions (Draucker et al., 2009; Polit & Beck, 2017). This approach was successfully used in a similar study by Angland and colleagues (2013) to minimize risk to the nurses. Finally, I was also prepared to direct nurses towards known resources available at their hospitals such as unions, health and safety committees and occupational health if needed.

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Chapter Four: Results

Results

In this chapter, I present the findings of my study, including the sample characteristics. Four categories represent the participants' experiences with patient violence while working in the emergency department. These categories are 'Violent Context', 'Being Responsible', 'Violent Patients', and 'Adapting their Practice'. Subcategories are used when appropriate (Table 1) and narrative interpretations are supported by verbatim participant quotes.

Table 1

Categories and Subcategories

Categories	Subcategories
Violent Context	Leadership
	Wait-Times
	Security Measures
Being Responsible	Work Family
Violent Patients	Patient for Whom we Anticipate Violence
	Patient who Surprise Us
Adapting their Practice	Engaging with Patients

Demographic Data

The sample consisted of eight Registered Nurses working in hospital EDs in various regions in Ontario, Canada. The participants had between five and thirty years of nursing

experience generally, on units such as medicine, surgery, intensive care, operating room and post anesthetic care, as well as long-term care. The participants also had between two and twenty years of experience working in the ED specifically. Seven of the participants self-identified as women and one participant self-identified as a man. Their ages ranged from 27 to 58 years and all participants spoke English, though three disclosed that they also spoke French. Two participants became Registered Nurses in Ontario prior to baccalaureate entry to practice and had diploma's in nursing. Four participants had bachelor's degrees in nursing and two participants had graduate degrees in nursing (Table 2).

Table 2

Participant Characteristics

Characteristics	**N**	**%**	**min-max**
Gender (*n*)			
Women	7	(90%)	
Men	1	(10%)	
Ages (years)			27-58
20's	2	(25%)	
30's	2	(25%)	
40's	2	(25%)	
50's	2	(25%)	
Highest Level of Education (years)			
College diploma or certification	2	(25%)	
Bachelor's Degree	4	(50%)	
Graduate Degree	2	(25%)	

Clinical Nursing Experience (years)			5-26
1-10	3	(37.5%)	
11-20	4	(50%)	
21-30	1	(12.5%)	
ED Experience (years)			2-20
1-10	6	(75%)	
11-20	2	(25%)	
21-30	0		

Findings

The stories shared by the participants spoke to their experiences with patient violence while working in the ED. All participants faced verbal violence, and several participants also encountered physical violence while working. Verbal violence was said to be much less frightening than physical violence, and was depicted as a routine part of daily nursing practice: "Verbal, we see more often. But physical is much more terrifying to work with" (P2), and: "There's a lot of verbal violence, and that's like everyday" (P6). There were no stories involving sexual violence reported by the participants. Overall, there was shared concern about the perceived increase in incidents of patient violence occurring in Ontario EDs and all participants considered this to be an important issue in healthcare requiring a solution:

> "Violence and harassment in the workplace, especially in the emerg is in fact – if you think about it – it's getting worse than what it used to be. People find that it's surmounted [increased] over the past couple of years" (P4).

The participants were genuinely worried about the nursing profession, and spoke about their fears for themselves and their colleagues. The participants described the increase in patient violence over the years and expressed their fears for the future of nursing. All participants believed that safety issues need more attention:

> "Nursing in general is just going to continue to get harder and harder with more patients coming in, and more sick patients coming in, and not being able to properly deal with the patients that are violent. I think we're going to see a continued uprising of people getting hurt" (P2).

Category 1: Violent Context

The participants explained how, in the ED, patients expect to receive care regardless of their conduct, behaviours, or actions. According to the participants, patients who are ultimately denied healthcare must act in a way that is so contrary to what is deemed reasonable, that rarely does someone meet this threshold: "We work in one of those environments where they tell us 'you can't turn anyone away', and so turning someone away ends up being the exception to the rule, right? And to be the exception to the rule, you have to have superseded so many boundaries of what's acceptable" (P1). The participants felt as though their right to safe working conditions is usurped by the requirement to care for all patients. The participants expressed that this dismissal of their safety was not acceptable, however, the participants reported that it appears to be deeply ingrained in the hospital culture and views of nurses as professionals:

> "Why is it that you can go to McDonalds, and throw your tray at the McDonalds clerk or throw your drink at a clerk, and next thing you know police are there? But you come to the emergency department and well its accepted – well it's not accepted, but nothings done. Nobody calls police, no charge, nobody lays charges. Why is that? Because it's a

> cultural thing right? We have always been that culture – the nursing culture – that it's okay. Well it's not. According to bill 168 everybody has the right to work in an area free of violence and harassment, including nurses" (P4).

Participants all spoke about the precipitating factors that lead to patient violence in the ED, and explained how the current context of most EDs creates an environment where the risk for violence is high and coercive preventative measures are commonplace:

> "I mean I hate to say it, but I feel like as nurses, we restrain a lot more people because we are aware of the fact that there just isn't enough support. If someone who presents is 'high risk', we are just scared that they're going to hurt somebody or themselves. We don't have support to have that one-on-one time to de-escalate them or to properly train staff even. Or like behavioral support staff or an on-site mental health [expert] that is constantly there to support us. We do use a lot of restrains, both chemical and physical, and you know it's hard to take them [the patients] out of those restraints when they've already shown that they are aggressive with us or aggressive on arrival" (P2).

Subcategory 1: Leadership

Despite the regular occurrence of violence incidents in the ED, participants recounted how support from hospital leadership is lacking. With little to no formal help following violence, the participants are left alone to debrief and reconcile the events:

> "I'm a little bit surprised at the lack of follow-up after that one incident. My boss sat down with me when it happened, and that was it. There was no [debrief], and I mean she might of said 'you know come talk to me if you ever need to, or you can talk to the employee assistance program', but there was not much more follow-up then that" (P7).

As Registered Nurses, the participants felt they are equipped to manage some forms of 'everyday' violence, but indicated that there are situations where external support from leadership is expected and needed, yet absent:

> "Yeah, they're suppose to, but you know, they often don't, when we have really, really [scary situations]. We are used to code whites or behavioral emergencies, but sometimes they can be a little worse than usual. I wish we didn't have to push our managers to offer debriefs and it's frustrating. We do have pretty basic behavioral emergencies [difficult/challenging behaviour] where we respond, and it's the same thing, and we're used to it. But if it's a new staff member that's never seen it before, or if it's like –we had some really, really bad codes were we had to fight to get a debrief, and it wasn't like anything that we ever expected. For example, when a nurse almost dies or something like that" (P8).

The lacking hospital leadership in response to patient violence, its management, and follow-up was difficult for the participants to understand, especially when circumstances contributed to their increased risk for - or vulnerability to - patient violence:

> "The biggest thing which, for me, which is what I wanted to talk about for this study, was ever since getting pregnant, I realized how much at risk we put ourselves. And in the past, having my own self at risk was one thing, but putting a child at risk is just something that – we really should have much more support and a lot more available to us. I mean even once you're pregnant, they don't really take any of those situations, it's your responsibility to do it, they don't provide you with any options" (P2).

The stories shared reflected how, despite being a part of one of the professions with the highest risk for violence, nurses perceived that they are rarely provided with accommodation or

the option to change their role if they are feeling uncomfortable or unsafe at work: “A lot of other services give their employees the option to step out of the front line. Paramedics can go work at a desk job and, you know, police officers have that option, and we're not given that option; that's not something they ever say to us, ‘do you feel comfortable or do you feel safe?’” (P2). Although the participants acknowledged that nonviolent crisis intervention (NVCI) training is provided to nurses and other healthcare personnel working in high-risk areas, such as the ED, they felt that the skills required of them surpassed their training in some situations, particularly when they are overwhelmed with fear and stress during violent events: “Hospitals put strategies into place, like the nonviolent crisis intervention and stuff, but it does not necessarily always work when somebody is lashing out, especially in the emerge department. [Patients] are in such a high, like you’re seeing them when they’re in an acute psychosis, especially they’re super agitated. You can try all the protective safety stances or whatever, but it’s not going to work” (P3).

Subcategory 2: Wait-Times

Wait-times were a specific ED process frequently discussed by the participants as contributory to patient violence: “I would say verbal [violence], any shift. I would say you are going to get at least one person who doesn’t like the wait time and starts screaming and yelling at you because of wait-times” (P5). The participants explained how they have no control over wait-times and yet they are subjected to the resulting hostility when patients and their support persons become frustrated by their length: “Most of the time it’s not the patient yelling at you, it’s the son or the daughter who’s got to go to work tomorrow, or she has kids at home that she has to take care of” (P5). In some instances, long wait-times precipitated encounters violent enough to require removal of the patient from the ED:

> "it was after a night shift around 07:00. It's the one that marked me the most. I'm still not quite over it, [which I notice] as soon as I work nights again. It was the end of a night shift and a patient came in and had blood all over his face. So, obviously, he got in a fight or something, and he wanted to be seen right away and we said it wasn't possible. He wanted to punch us, and he came to attack me and my colleague, so we just locked ourselves up and there was a code white. Somebody thought, somebody said 'we will still triage him if he stays quiet', and somebody else was like 'no, no he's blacklisted, zero-tolerance, so get him out of here'" (P6).

Subcategory 3: Security Measures

The participants also shared their views of the existing security measures in place in the ED setting. Despite security personnel being responsible for maintaining safety in the ED, participants voiced concerns related to existing practices, such as insufficient numbers of security and/or protection officers, as well as security personnel who are perceived as incapable of keeping the environment safe (or who appeared to not take their duties seriously): "They [security] are always short. Once we had a security guard that was nine months pregnant, we have old security guards, we have patients that are Formed and the security guards at the beside fall asleep" (P6). Concerns about adequate security presence were more pronounced in rural settings, where nurses are often left alone in the ED without the proper resources to avoid or mitigate dangerous situations:

> "When I worked in [hospital name], a small community hospital, there were no guards and we did not have the same system. They [patients] came right from the reception, they walk in and they walk in right to the nurse. So, there's absolutely zero security and we

don't even have a phone at the triage desk, or there wasn't a phone when I was there, and there is no panic button either. The panic button was on the other side of the triage" (P7).

Violence flags, embedded within the electronic medical record, were said to increase safety in the ED because nurses and security personnel are provided with a warning that a patient with a history of violence was present: "It also helps too, because with our security set up and with our EMR system, we have violence flags on our patients, for ones that have repeat [violence], so security is notified right away" (P8). Of note, the participants recognized that past behaviours do not necessarily reflect one's propensity to become violent, nor do they safeguard against violence in patients without a flag. Instead, the participants explained how the use of violence flags improved communication across the setting and thus had a positive influence on the perception of safety within the ED.

Category 2: Being Responsible

Similar to the requirement to care for all persons in the ED, participants explained how, as nurses, they have an ethical obligation to provide care. Regardless of circumstance, nurses cannot refuse, nor abandon a patient; this is what their profession demands: "You don't have that possibility of saying 'what about me?'. You have to be selfless, because that's what your profession demands of you. I'm pretty sure The College does not care how violent a patient was being, because if that patient was having a triple A [abdominal aortic aneurysm], it's on you" (P1). The participants described pushing aside their emotions and being selfless while on duty: "I think nursing, as a professional, we have been taught to suck it up and just get over it" (P2). This expectation to 'tough it out' was pervasive, as one participant explained how she continued to practice immediately following a violent incident: "So [patient] was gone and the rest of our shift

went on, and I actually was quite [physically] okay and unharmed from that one, even though there was a lot of fear after that situation" (P1).

According to the participants, blame is often assigned to nurses working in the ED when interactions with patients deteriorate, even when the nurses are the ones treated poorly: "I went to talk to my charge nurse, and it was a different charge nurse at this time, but they said 'was there anything you could have done? Could you have called me? Or could you have x, y, z?'. And I was like 'wow'. I called the other charge nurse before. But, it wasn't *while* [the patient] was screaming at me that I was going to be able to call her, right?" (P1). The participants explained how nurses must verbally de-escalate volatile situations, and safeguard themselves and others against becoming victims of violence:

> "There is verbal violence that I hear every day, and the onus is really put on you. De-escalate, de-escalate, de-escalate. And if something becomes physical, they say 'well did you do this? Did you do this?' If something becomes emotional, and you have a complaint or a concern, or you leave very heavy at the end of your shift. It's like, 'oh well, were there some tools you could have used?' And it's really too bad that all of the onus is put on the nurse, or on the doctor or healthcare professional, to make sure that they are not victims of violence" (P1).

If a nurse working in the ED experiences troubling or difficult consequences after patient violence, the participants explained how they are questioned (i.e. interrogated) about what they could have done differently to avoid these outcomes: "Nobody is going to care that he was swearing at me, and made me feel very unsafe in my workplace. They are going to be like 'so, did you talk about it to X? Did you talk about it to X person? You know, this person could have had this [intervention]; could have had that [intervention]'. But, what about ***me***?" (P1). In

response, the participants themselves would re-evaluate their decisions about how they might have handled a potentially violent or violent situation differently. Often, this led them to question and doubt their nursing care:

> "The emotional manipulation that comes with that is just so difficult to put up with, right, because it's always something that kind of leaves you thinking. She said all those things, 'is this true?'. Was I being lifeless, negligent, or is there something I should have done differently? All those things, and unfortunately, it's part of our reality of working in the emergency department. We are likely to have [difficult patients], but it's those things, where you're just left with, 'okay, did I do best by my patient?', while I'm also trying to keep myself safe" (P1).

Exacerbating the above realities is the fact that nurses working in the ED have more direct patient contact than other HCPs: "They just lash out for whatever reason? It's usually at the nurse, because you're the one providing care and the one that is always there" (P3). The participants explained how their interactions with patients are continuous, beginning with triage and lasting until the patient is discharged or transferred from the ED. While physicians and other allied health professionals intermittently engage with patients during this time, it is the minute by minute care that falls primarily to the nurse: "You're dealing quite closely with the patient, you're [delivering] more points of care at that time, then the doctor is" (P7). The participants reported how being the point of contact for all patients makes them easy targets for frustrated patients and families: "Frustrated with whatever it is, can't find their diagnosis or not being seen, you know? Not getting the care they think they deserve. So that always comes, usually most of the time, down to the nurse; the one who bares that brunt" (P7). Areas in the ED, such as treatment rooms, are particularly problematic according to the participants, because in these

spaces, nurses provide one-on-one interventions, repeating reassessments, and updates (or lack thereof) to patients:

> "When I was spending most of my days in the treatment area, and, easily, I would see it a lot more often, because you're the person that comes one-on-one and does the reassessment, and tells them like 'okay, I have no update for you at the moment, the doctor isn't ready to see you at this time'. And it's very easy for them to become impatient, or to turn that anger towards you, because you're the only person that they see" (P1).

Subcategory: Work Family

The idea of 'being responsible' also extended to their colleagues, whom the participants called their "work family" (P2). They described their relationships with colleagues as loving and caring connections: "It's just so difficult to see this being a reality for ourselves, but also people like our co-workers. Like we love them and we care about them" (P1). To take care of their work family, the participants look out for each other and protect each other from potentially dangerous situations: "Yeah, so they often will give us a heads up, or if we know them [patient with a history of violence], and they're in a different part in the emergency, we will go out and tell them [colleagues] why we know them" (P8). They spoke about instances when they paid special attention to colleagues whom they deemed more vulnerable to patient violence, such as novice nurses starting their careers in the ED: "You just try to protect yourself and protect the younger nurses around you" (P1). There appears to be a common practice, where senior nurses attempt to protect junior nurses by helping them through difficult encounters: "Whereas I see in the younger nurses, their faces fall when they're called names, and so if they say 'you got a fat ass', I'll come and say 'I think you have a lovely ass, don't you listen to him'. And we make jokes about it"

(P5). Humour was a commonly stated coping mechanism used to off-set the difficulty of violent patient encounters.

Once a violent incident occurs in the ED, the participants recounted the emotional distress felt by everyone: “I was just so sad when I saw him [referring to colleague], because I was triaging, and I was just walking by towards our break area. I see him and he’s just so sad and he ended up being registered and had to see a doctor and everything like that, but he was so sad” (P1). They try to provide support to their colleagues by taking charge of the situation and completing tasks within their control: “I made sure all the security guards were registered that were involved in the incident because, I mean not that I was ever prepared for violent people, but I mean security guards are only minimum wage guys, right? And I made sure they were all registered, and we put in a staff incident report for the violence episode” (P5). Sometimes, following violent incidents, the participants described being unable to take action to meaningfully improve the situation for their affected colleague(s). This left them feeling sad and helpless: “He was like ‘I have to tell my wife that I got hurt within my workplace again’. And I was just, I almost started crying too as he was explaining it” (P1).

Category 3: Violent Patients

The participants’ stories centered primarily around two groups of patients; those for whom aggression and violent behaviours were anticipated and those whose violence was unexpected.

Subcategory 1: Patients for Whom we Anticipate Violence

According to the participants, nurses anticipate volatile actions from patients with certain diagnoses or presenting conditions: “I think physical abuse is related to ‘the man with autism’ and ‘the man with dementia’. There’s nothing you can do to change it. It just happens, right?”

(P5). Given the expected nature of these acts, the participants explained how they are perceived as a routine occurrence, with little emotional impact: “I mean, like I said, these things, I do take them as part of the job. I think there was this confused lady and she scratched my forearm with her nail. It healed, it’s fine” (P7). Typically, these patients are persons diagnosed with cognitive deficits or disabilities, such as dementia, confusion, delirium, and developmental delays:

> “Confused patients, both young and old, who don't understand why they're there [here] and fight back. And then there's a lot of the geriatric population who age with dementia, and [therefore] don't understand what they're doing. And there’s quite a bit of violence from them as well” (P2).

Persons with acute psychiatric symptoms also fell within this expected category:

> “It’s not an intentional process, but we have our mental health patients, and sometimes our substance use patients, and they’re in a state where they are out of it. But, you know, like people get hurt, and it’s us who get hurt, right? So it’s difficult not to be on our guard” (P1).

Patients presenting with cognitive impairment, decreased consciousness, or altered thought processes and/or content, were said to have limited control over their actions and awareness of their surroundings. The unintentional aspect of their actions allowed the participants to rationalize this type of violent behavior.

In many cases, the participants found that fear triggered aggression and violence in these patients. When confused, routine nursing care, such as hygiene or transfers, is difficult for patients who do not understand what is happening to them: “When I first started, I had to go off work for a week and a half because we were providing peri-care to a [delirious patient] and he grabbed me by my stethoscope and was choking me. I was leaning in and something snapped in

my back" (P3). Although violence during these encounters was anticipated, it still had the potential to escalate into dangerous situations:

> "I had a demented elderly woman who was quite aggressive, and with attempts to get her safely back into bed, so that she would not fall and hurt herself. She ended up swinging and punching me in the face, and in that instant, it's hard to deal with" (P2).

Similarly, intoxication and substance misuse led the participants to expect volatile interactions, with these patients being described as amongst the most likely to become violent:

> "Overdose patients who have taken something, or are on a strange high, and those ones tend to be quite violent when they have something in their system" (P2).

Subcategory 2: Patients who Surprise Us

The participants also discussed patients who surprise them with their violent behaviours. The unpredictability of these events make them more challenging and difficult to reconcile, regardless of the outcome: "When I was in the treatment area you'll like come see people and all of a sudden there's an outrange. It is a challenge because it is not 100% predictable right" (P1). The participants described feeling uncomfortable, powerless, unsafe, scared, and confused during these situations.

The following scenario was used by one participant to depict unexpected violence. In this case, the person acting aggressively was a police officer; someone typically seen as safe and supportive by this participant:

> "She just started screaming and screaming, and she's standing, and she's powering over me, and she's saying 'if it weren't for you, I would of have been able to be seen in the back. I would have been able to be hidden away, and there were things that you guys could have done. I should of been home. I should of went to the [another hospital]. I can't

> believe you are treating us like garbage, you guys see us like we do nothing for you'. The whole rant. I just felt so uncomfortable, but I also felt very unsafe because I'm sitting on my chair and I'm looking at the door, and the door is closer to the police officer, so she's towering between me and the door. And, yes, there are other ways to get out. But in the moment I was just so scared. I just felt so powerless. I was just felt so unsure about how to move forward" (P1).

Other times, what makes a violent event unexpected is not the person involved, but instead the way the situation unfolds. In the following scenario, another participant describes an experience where multiple family members responded violently to multiple nurses. The participant explained how incidents involving more than one violent person can quickly escalate, and existing ED resources are insufficient to manage these kinds of rare, unexpected occurrences:

> "This patient was brought in, and he was very mentally sick, and he was being admitted involuntary. The family flipped out, and one of the siblings jumped a nurse. Security was already there, because the patient was not very interested in being admitted, but he didn't have a choice. The family completely lost it, yelling at us, flipped the linen cart. It wasn't just the one family member – we often see that in emerge – where one family member is upset because they're worried their loved one isn't getting proper care, and things like that. But this one, there was the whole family. We were trying to get them out of the emergency room" (P8).

Category 4: Adapting their Practice

The participants explained how the way they enact their care is different since living through a violent encounter; they now take measures to protect themselves from future violence:

“It’s more when I go back and do another night shift. I mean, until 07:30 am right before I fall asleep before my shift, I always think what if somebody came into triage and became physically aggressive, how would I escape? I always have a escape plan, which is sad to think about that” (P6) and “I find I’m always looking over my shoulder when I’m walking through the garage” (P8).

The participants described being more careful and defensive when entering new patients’ rooms, and being wary of the unknown: “I find I'm more on the defensive when I'm walking into a room now, not knowing what I'm going to encounter” (P2). Further, they recounted how they are now acutely aware of their surroundings, and find themselves keeping a greater physical distance from their patients: “I look at where they are situated in the room. I definitely keep a greater distance. And I try really hard, but it’s not always there, the intuition, to slow myself down and pick up on any cues” (P7). Some participants immediately locate exit points upon entering patient rooms, while others recognize the importance of situating themselves near the door: “Always looking for an exit, like if you’re going, especially if you’re going into a psychiatric patient’s room or a person intoxicated with alcohol or drugs, or something like that. You don’t want to put yourself in the back corner of the room, you know what I mean? You want to be the person by the door. So certainly with any patient that is a high risk, I do that” (P5). The participants explained that they were taught these universal precautions in their NVCI training, however, these instincts were much higher and enchaned once they lived a violent encounter.

Precautionary measures were also taken by the participants to prevent future violence. They reported how they enter rooms in pairs whenever the patient is unknown, displaying aggression, and has a history of violence: “I definitely don’t put myself at risk anymore for injury. So if somebody is violent or shows any form of aggression, I will either hold off on

whatever I'm going to do, or grab somebody else to come in with me, just in case" (P3). When the participants reflected on the actions of their peers, they noted that nurses with more experience are more cautious and more likely to go into patients' rooms in pairs, compared to nurses with less ED experience: "Even an unknown patient, you know if they're sounding aggressive or something like that, we go in with doubles – that sort of stuff, right? I might have gone in blindly when I was younger, you know?" (P5). The participants recounted how, eventually, all nurses become cautious, because all nurses experience violence.

Subcategory: Engaging with Patients

In addition to modifying their approach to providing care, the participants detailed the ways in which they altered their patient interactions after experiencing violence. The changes to their patient engagement are most pronounced for certain populations: Patients who repeatedly seek ED care, patients who present with intoxication or substance misuse, and patients with known histories of violence:

> "A lot of time, if they're coming in with the same reason, also known as frequent flyers, and we've had a code white on them for every three out of my fifteen shifts, then, if it's always the same reason they're coming in, we kind of go through the same routine. And if a doctor comes in, we're going to put them into restraints. And they're calling you every name under the sun, and you're just like 'yup, yup, yup', and they're like 'stop saying yup'. Versus, if it's a new code [a patient for whom there is no history of code whites], I'm like 'okay we're going get you through this, it's just going to be one step at a time'. And we have to do this one because of how you're behaving and we'll talk about it after." (P8).

The participants recognized that, because these patients frequently seek ED care, their patience and sympathy for them has waned over time: “So that part of my nursing has never changed. You know, I do think that with the alcoholics and drug abusers, and these people that are abusive, and I know that’s a sickness on its own, but I do have less patience with them” (P5). Stressing that their apathy towards these patients does not affect their ability to provide necessary medical interventions: “Yeah, even with a violence and harassment flag – I’m a bit more cautious – but I treat them the same” (P4), the participants did acknowledge their discomfort with these feelings and the difficulty they have reconciling them: “I think a lot of people at [Participant’s hospital] are burned out and experiencing compassion fatigue. There are so many overdoses and people that are under the influence that come in being physically and verbally abusive. So a lot of people are kind of tired of it” (P6).

Chapter Five: Integrated Discussion

Integrated Discussion

The nurses in this study spoke at length about their experiences of patient violence in Ontario emergency departments. The research question was: "How do nurses who have experienced patient violence enact their nursing care?". Data were collected through semi-structured, conversation-style telephone interviews. The nurses' stories and experiences were described and grouped in four categories 'Violent Context', 'Being Responsible', 'Violent Patients', and 'Adapting their Practice'. There are three key points of discussion stemming from these findings: 1) using the Constructivist Self-Development Theory to understand patient violence, 2) culture of acceptance, and 3) nursing as a relational practice that is occurring in Ontario EDs, as well as several implications for practice, policy, education, and research.

Key Finding One: The Constructivist Self-Development Theory

The Constructivist Self-Development Theory (1990), or CDST, is cited in multiple publications exploring trauma victims of childhood and family violence, sexual violence in college students, genocide, and violence towards judges and courthouse personnel (McCann & Pearlman, 1992; Miller et al., 2010; Moeller, 2011; Pearlman, 2013; Stokes et al., 2017). In these works, the CDST has been used as the underpinning theoretical perspective and used in the discussion of findings. Yet, this model has not been used to discuss how patient initiated violence come to affect emergency nurses and the care they provide. When considering the findings of this study through this lens, several elements of the CDST reflect the ways in which the participants described their experiences.

When a traumatic experience occurs, such as violence towards a nurse, the violence may be lived as a traumatic experience because it threatens the person's safety. This traumatic experience can then trigger a psychological response that influences five interactive aspects of

the person: a) frame of reference, b) self-capacities, c) ego resources, d) psychological needs related to cognitive schemas, and e) memory systems. The CDST conceptualizes how a traumatic experience can alter a person and their needs. The original authors, McCann and Pearlman (1990), described the application of the model, which provides insight into how to address the needs and adaptation process of a person affected by a traumatic experience. Described below are the similarities and differences noted between the participants' articulation of their experiences with patient violence and the explanations offered by the CDST model (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Specifically, the CDST concepts of frame of reference, self-capacities, ego resources, psychological needs and cognitive schemas, and memory systems are further explored.

Frame of Reference, Self-Capacities, and Ego Resources

Frame of reference, self-capacities, and ego resources, as described in the CDST, were most reflected in the stories shared by the participants. Frame of reference is fundamental to a person's perceptions and interpretation of life experiences, and disturbances can cause disorientating and stressful thoughts (McCann & Pearlman, 1990). Based on my study findings, once a nurse lives through a violent (i.e. traumatic) experience, they feel a sense of demoralization and a change in how they see and approach their care. Nurses post-trauma described their workplace surroundings as unexpected, unpredictable, scary, and dangerous, which left them feeling unsafe at work.

Self-capacities were also affected in the participants post-violence. Self-capacities regulate a person's emotions, such as the ability to tolerate strong stimuli or calm oneself (McCann & Pearlman, 1990). Participants explained how they would avoid situations that were

similar to those where they experienced violence, in an effort to circumvent distress or (re) experiencing of strong emotions related to the encounter.

Finally, ego resources influence a person's capacity to regulate interactions with others and the outside environment; they help facilitate positive adaptation after a traumatic experience (McCann & Pearlman, 1990). Certain aspects of ego resources, such as a person's ability to avoid future harm by establishing personal boundaries, making self-protective judgments, and foreseeing consequences, were most evident in the participants' stories. Participants frequently described using preventive measures to protect themselves from future violence, including entering rooms in pairs, remaining close to exit points, and keeping a greater distance from patients than they normally would.

Psychological Needs

The concept of psychological needs was also evident to some degree in the findings. The five psychological needs (safety, trust, esteem, intimacy, and control) help motivate behaviour and shape a person's interactions with others. Psychological needs also create cognitive schemas, which are beliefs and assumptions about one's self and others. Cognitive schemas are mental constructs that reveal a person's knowledge of situations, events, and objects. Schemas play a large role in how a person will respond to a traumatic experience and are also dependent on which need is disrupted (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

In terms of my findings, safety, trust, and esteem were reflected in the participants' stories. First, safety is the need to feel safe, and disruptions in this psychological need can cause a person to feel increased vulnerability to future harm and beliefs that they lack the ability to protect themself from potential future violence (McCann & Pearlman, 1990). After living through a violent incident, the participants shared how they felt more at risk for harm or violence

in their workplace than they did previously. Second, trust is the need to believe in honesty and to be able to accept help from others. 'Other-trust' is to count on – and believe in – others to meet emotional and psychological needs (McCann & Pearlman, 1990). The participants conveyed their difficulty trusting some patients because they viewed violence as unpredictable and sometimes unexpected. This mistrust led them to take extra precautionary measures and limit their reliance on others. Finally, esteem is the need to be valued by others and have one's worth validated (McCann & Pearlman, 1990). The participants spoke about the struggles they faced in making sense of violent encounters. They found themselves wishing that they had done something differently so that the violent incident wouldn't have happened. This also left participants questioning whether they had made poor choices, instigating violent encounters.

Memory Systems

The final element of the CDST reflected in the findings of this study is memory systems, which are verbal, visual imagery, affective, somatic, and interpersonal memory systems that can be disrupted by traumatic experiences. Throughout the interviews, participants spoke specifically to verbal, visual imagery, and affective memory systems. They were able to narrate exactly what led up to the event, what happened during the event, and what occurred afterwards. They spoke about remembering the violent patients' faces, as well as other visual images of the event. As for affective memory, the participants' emotions before, during, and after the experience were fully described in their stories. They reported feeling anxiety and distress related to these encounters, and imagining potential violent scenarios before going on shift (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

Summary

Through the CSDT theory, we see that the adaptation process to a traumatic experience is reflected by the interaction between the self and life experiences. Self-capacities, ego resources, and psychological needs are interactive concepts that help determine if an individual adapts in a healthy or unhealthy (productive or unproductive) way to a traumatic event. This may or may not affect a person's frame of reference and pre-existing schemas, and consequently, influence a person's future experiences (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). When applied to the findings of this study, the CDST provided me with a theoretical frame to further understand violent (traumatic) experiences lived by ED nurses in Ontario. While this theory has not been directly applied to violence against ED nurses, it provides insight into the ways that traumatic experiences alter nurses lives and their practices.

Key Finding Two: Culture of Acceptance

The second key finding stemming from participants' stories was the presence of an apparent culture, where violence – in some forms –is accepted. Through their stories of violent encounters, it appears as though violence initiated by older persons with cognitive deficits, as well as patients experiencing psychiatric symptoms was normalized as 'part of the job'.

The most common form of violence seen within these two populations was verbal violence and aggression, which is consistent with existing literature (ENA, 2011; Hogarth et al., 2016). Much like the participants of my study, this form of violence is known to be normalized and rationalized by nurses (Stevenson et al., 2015). According to Stevenson and colleagues (2015), nurses do not consistently recognize their exposure to verbal violence, nor the negative consequences associated with this exposure. In fact, despite the regular occurrence of verbal violence, most nurses do not label these incidents as violent (Hogarth et al., 2016). Physical

violence initiated by older persons with cognitive deficits and patients experiencing psychiatric symptoms was also normalized by the participants, which resonates with previous research revealing how nurses justify these actions based on the patients' mental states (Brophy et al., 2018; Morphet et al., 2014). These two patient populations will be further discussed below.

Older Persons with Cognitive Deficits

Participants in this study said that when caring for patients who were older (i.e. seniors "elderly") and affected by cognitive decline, such as dementia, delirium, and confusion, that violence was expected and normal. Given that many of their stories of patient violence included this population, the participants appeared to be more accepting of this type of violence, because they believed that the patients were not always aware of their surroundings, actions, and behaviour. This rationalization made experiencing this type of violence easier to handle, with the participants explaining how they neither blamed nor held these patients accountable for their actions. As a result, the violent incident, as well as the consequences of it, were deemed less emotional and severe.

Past research supports the notion that violence from older persons with cognitive impairments is considered unintentional, ordinary, and excusable (Hogarth et al., 2016; Isaksson et al., 2008). While nurses may underestimate the impact of violence perpetuated by this population, there is a risk for developing emotional and psychological consequences, which are not dependent on whether a physical injury is sustained in the process (Schmidt et al., 2019; Stevenson et al., 2015; Yang et al., 2018). When violence is enacted by younger patients, it is often viewed as intentional and deliberate, making it harder to reconcile and recover from (Isaksson et al., 2008). In contrast, nurses appear to accept violent behaviours or actions enacted by older persons, who they view as unintentionally aggressive (Isaksson et al., 2008; Morphet et

al., 2014). Nurses and other HCPs justify their actions because of cognitive deficits or disabilities (Isaksson et al., 2008). Cognitive impairment may contribute to patients being scared or confused by their surroundings, as well as uncertain of the healthcare interventions provided for them (Ashton et al., 2018; Morphet et al., 2014; Speroni et al., 2014). In these instances, patients may attempt to protect or defend themselves, which results in violent or aggressive interactions with care providers (Morphet et al., 2014; Speroni et al., 2014). Finally, communication between patients and HCPs is compromised when cognitive deficits exist, enhancing confusion and frustration in patients (Fry et al., 2015). In such instances, nurses sometimes feel responsible for being the victim of patient violence, because they were in the wrong position or standing in the wrong place (Isaksson et al., 2008). Although nurses appear to normalize violence from the older persons with cognitive impairments, this does not mean that violence should be tolerated.

Patients with Psychiatric Symptoms

Through the participants' stories, violence from patients with psychiatric symptoms was also considered less taxing. They spoke specifically to patients with psychosis or mania, as well as alcohol or drug intoxication, and described how violence from these patients was mostly unintentional and, thus, better-tolerated by staff. Participants explained how patient judgments are affected by their psychiatric symptoms, making them unaware of their surroundings. However, the participants also explained how these patients tended to be frequent visitors to the ED, which meant that the nurses and other HCPs were familiar with them. As such, they found themselves taking preventative actions and being more on guard when providing their care. While this may increase their sense of security, actions of these can lead to stigmatizing and lowered quality of care (Stevenson et al., 2015).

In this study, Ward (2013) explained how fear and uncertainty plays a large role in violence from patients experiencing psychiatric symptoms. They report that patients who are disconnected from reality may attempt to protect themselves from perceived threats (Ward, 2013). Further, severe psychiatric symptoms and/or intoxication are shown to affect a patient's mental state in such a way that they are unpredictable and impulsive (Morphet et al., 2014; Speroni et al., 2014; Volavka & Swanson, 2010). It is important to note that it is often the internalised process of a patient's mental illness that leads to their violence, rather than a desire to act aggressively toward nursing staff and other HCPs (Greenwood & Braham, 2018). Unfortunately, despite the knowledge that patients with mental disorders are not necessarily violent, the perception of increased risk for such behaviours from these patients leads nurses to take actions to mitigate potentially violent situations, which may affect the quality of their care (Brophy et al., 2018; Ford, 2011; Jacob et al., 2014; Ward, 2013).

Research suggests that the interactions and attitudes of nursing personnel may also have a direct impact on the risk for violence from patients seeking mental health care (Greenwood & Braham, 2018). Poor communication between nurses and patients can be a precursor to violence (Greenwood & Braham, 2018; Ward, 2013), and according to Greenwood and Braham (2018), a lack of understanding of their illness and/or a lack of empathy from nursing staff perpetuates patient violence. In response to the potential risk for violence, nurses caring for patients with psychiatric symptoms might resort to the use of restraints more quickly (Ward, 2013). Jacob and colleagues (2019) explored this phenomenon and found that nurses were concerned that restraints were being used too frequently, more quickly, and often for the wrong reasons with patients requiring mental health care. Other studies on the use of mechanical restraints have identified multiple circumstances when restraints are employed, including when patients display

violent behaviour, self-harm, verbal aggression, and property damage, or when they refuse medications (Bowers et al., 2012). Finally, research findings suggest that restraints are used to prevent or suppress violence behaviour or used as a strategy to maintain order within the unit environment (Jacob et al., 2014; Perkins et al., 2012; Ward, 2013).

The participants of my study explained how they were more likely to use restraints when they lacked appropriate supports (i.e. lack of nursing staff or security personnel). If patients were flagged in health records as violent or were known for violence, they were also more willing to apply restraints, and often had restraints prepared 'just in case'. The systematic review by Tyerman and colleagues (2020) concluded that educational and healthcare institutions can be influential in generating culture changes that is supportive of patients with mental illness and help reduce stigmatizing behaviours in nurses. Taking preventative measures in an attempt to maintain safety for both patients and staff, may create feelings of failure, inadequacy, or emotional distress in nurses, who do not want to implement these restrictive and defensive care strategies (Jacob et al., 2019; Ward, 2013). Further, although my study did not explore the patients' experiences of patient violence, Strout (2010) noted that feelings of fear, anger, confusion, frustration, sadness, powerlessness, and humiliation can be experienced by patients during the restraint intervention process, and thus their application requires great consideration and care (Jacob et al., 2019).

While the literature indicates that nurses are more accepting of violence from patients with psychiatric symptoms or cognitive impairment (most notably in older persons), it is also shown that nurses are more likely to use restraints in order to control or prevent violence in these population (Perkins et al., 2012; Ward, 2013). From my own experience, nurses in ED often use soft restraints or geriatric chairs to restrain older persons who are confused in order to reduce the

risk of falls, wondering, and physical violence. However, other strategies, such as the use of effective communication and de-escalation techniques should be attempted prior to defaulting to restraints. The use of mechanical restraints specifically, should only be considered as last resort when all other alternatives have been exhausted (Department of Health 2014; Registered Nurses Association of Ontario [RNAO], 2012). Therefore, we should question how we can rethink the spaces in which we work, to ensure we can provide a better environment to deal with behavioural disruption (Jacob et al., 2014).

Key Finding Three: Nursing as a Relational Practice

Nursing is a relational practice, founded on the nurse-patient relationship (Haugan, 2014). Nurse-patient relationships are therapeutic and helping relationships, where nurses establish trust and have a willingness to hear and acknowledge patient feelings and concerns (Potter & Perry, 2010). The RNAO (2012) states these relationships are based on empathy, respect, and trust. Exposure to patient violence in the workplace can disrupt the normal course of nurse-patient relationships and affect future healthcare provided (Hassankhani et al., 2017; Zuzelo et al., 2012). Nurses may become more distant with their future patients in order to protect themselves from potential harm (Sawatzky & Enns, 2012).

As mentioned, nurse-patient relationships are founded upon trust (Potter & Perry, 2010), and the nurse's ability to effectively utilize therapeutic communication techniques to explore their patient's emotions and behaviours, with the ultimate goal to create an individualized care plan for the patient (RNAO, 2012). When appropriate, violence triggers, as well as de-escalation interventions to prevent and mitigate difficult behaviours, can be incorporated into these care plans (RNAO, 2012).

Code of Ethics

Nurse-patient relationships can be compromised when patients act violently, yet it is still the nurses' responsibility to continue caring for their patients because it is the nurse's professional obligation (Canadian Nurses Association [CNA], 2017). According to the Canadian Nurses Association (2017), the nursing code of ethics states "Nurses provide care for all persons including those seen as victims and/or abusers" (p. 15). It is an ethical expectation that nurses do not abandon those in need of their care and it is "a nurse's professional obligation to provide persons receiving care with safe, competent, compassionate, and ethical care" (p. 38). Nursing in Canada is a self-regulated profession, in which nurses are bound to the code of ethics and, therefore, have an ethical responsibility to care for all patients, even those who may become violent towards them (CNA, 2017). The code of ethics also states that nurses should always work towards "preventing and minimizing all forms of violence by anticipating and assessing the risk of violent situations and by collaborating with others to establish preventive measures" (CNA, 2017, p. 9). In doing so, nurses must employ appropriate de-escalation techniques, and training, which should be continuously offered throughout a nurse's career (RNAO, 2012).

Caring is a universal phenomenon and fundamental value in nursing (Sawatzky & Enns, 2012). However, relational relationships can be affected once a nurse experiences a traumatic event, such as patient violence, because of the resulting psychological, emotional, and physical consequences (Baby et al., 2014; Brophy et al., 2018; Stevenson et al., 2015; Yang et al., 2018). The findings of my study refer to this notion that nurse-patient relationships, as well as the nurse's enactment of their care is different or changed once living through a violent encounter. The participants found themselves taking precautionary measures (keeping greater distances from patients and locating exit points) in order to protect themselves from future violence. In

addition, they altered their patient interactions after experiencing violence. These changes in patient interactions affected the development of their therapeutic nurse-patient relationships, which can limit the nurse's ability to explore patient behaviours and emotions, as well as identify individualized de-escalation tools useful in the event of a subsequent violent incident (RNAO, 2012).

Nurses caring for patients who act violently can experience emotional distress, leading them to use self-preservation actions; by distancing themselves from these types of scenarios, they protect themselves from emotional exhaustion and burnout (Sawatzky & Enns, 2012). According to Brophy and colleagues (2018), nurses are concerned for their nurse-patient relationships, and feel that code whites further deteriorate their rapport. The nurses in their study stated that they had to function like security, which adversely affected these nurse-patient relationships (Brophy et al., 2018). They feared losing their nursing license because of the nature of the interactions they were required to engage in when acting in a 'security' capacity (Brophy et al., 2018). These authors report that the therapeutic relationship is altered from the moment an interaction becomes hostile (Brophy et al., 2018). Unfortunately, there appears to be a cyclic nature to these interactions. According to Sawartzky and Enns (2012), nurses who use avoiding and distancing behaviours with patients as a consequence of prior violence, provide less holistic care, which may then cause frustration for patients and their families, possibly triggering further violence and aggression (Sawatzky & Enns, 2012). A strategy shown to ease distress following a difficult situation is debriefing. Debriefing is an approach to assist in identifying what led to the violent situation and exploring the harmful event, in an effort to establish what actions could have improved or prevented the final outcome (RNAO, 2012). Post-incident debriefing can help

reduce general stress levels among victims, and help clarify circumstances surrounding workplace violence (OSHA, 2016).

Summary

Nurses can experience psychological, physical, and emotional consequences post-violence (Brophy et al., 2018; Stevenson et al., 2015; Yang et al., 2018), and all nurses have their own adaptation process, as shown by the CDST theory (McCann & Pearlman, 1990). However, as shown from my study, nurses often adapt their practice in order to prevent future harm. These self-protective measures may inhibit the development of therapeutic nurse-patient relationships, and/or patients may perceive the resulting care as being of poor quality care (Sawatzky & Enns, 2012). Clearly patient violence has an effect on nurses and their patients. It is important that work in this area account for nurses experiences, as well as patients', and that strategies targeting violence respect both patients' and healthcare providers' needs.

Nursing Implications

Nursing implications for practice, policy, education, and research stemming from this study are presented in this section. Implications for practice focus on security measures within ED, such as security personnel and equipment, as well as zero-tolerance policies. For policy, I discuss a lack of support by management and issues with reporting.

Implications for Practice

The lack of security personnel was a concern for the participants in this study. They mentioned feeling unsafe at work when security personnel were not readily available, especially on night shifts. Being afraid affected the way they engaged in their practice, and measures are needed to ensure nurses feel safe while working. Unfortunately, not all EDs have designated security personnel, meaning that, in these settings, security personnel are responsible for entire

hospitals (Partridge & Affleck, 2017). Given the high rates of violence in EDs, Partridge and Affleck (2017) suggest that security personnel be visible and physically located within the department in order to respond to incidents quickly. Further, Koller (2016) stipulates that security personnel should be available 24 hours per day, seven days per week, be visible in key locations (e.g. at entrances to the department), and easily accessible by direct lines of communication with HCPs.

The participants also spoke about non-functional safety measures, like faulty panic buttons and alarms. This finding is also noted in the literature on violence in healthcare, with a study by Brophy and colleagues (2018) shedding light on how some areas in the ED are not equipped with alarm systems (or functional alarm systems). Fixing these issues needs to be prioritized so that nurses and other HCPs have access to appropriate tools in the event of violent encounters (Koller, 2016). These tools should be placed at triage desks, nursing stations, cubicles and observations rooms, as well as hallways (Koller, 2016).

Through the nurses' stories, differences in the zero-tolerance policies were found between Ontario facilities. Settings with well-implemented zero-tolerance policies allowed for the removal of patients off hospital grounds if they were aggressive towards staff. Conversely, in settings without zero-tolerance policies, there was the perception that all patients, including those who were violent with staff, be cared for in ED. Finally, there were settings with poorly or inconsistently enforced zero-tolerance policies.

Zero-tolerance policies are policies, procedures, and practices implemented by hospital employers to promote safety and well-being of nurses and other HCPs (RNAO, 2008). They are designed to foster a supportive environment for staff, where violence is not tolerated (RNAO, 2008). Although not all hospitals employ this strategy, research shows that when zero-tolerance

policies are absent or not consistently implemented, violence and aggression is more common (Ashton et al., 2018). In Canada, zero-tolerance policies are somewhat uncommon, with many organization opting to adopt different responses to violence, such as expediting the patient's care providing warnings, or engaging with law enforcement (ENA, 2011).

Schmidt and colleagues (2019) explored patient violence in healthcare and a practical approach for prevention. Their findings revealed that while many hospitals have existing zero-tolerance policies, they are often not enforced nor supported by management, which suggests that violent acts are tolerated in the ED (Ashton et al., 2018). Further, HCPs inconsistently abide by the policies because of the perception that zero-tolerance policies may result in a patient not receiving care, which conflicts with nursing values (Morphet et al., 2014). For example, if a patient with a head injury becomes violent, enforcing the zero-tolerance policy would result in the patient leaving the ED, potentially resulting in a deterioration of their condition or involvement with the police and/or other persons. Nurses and other HCPs often struggle with this possibility, because they are socialized to minimize harm and negative consequences, as well as ensure safe care for their patients (Morphet et al., 2014).

Zero-tolerance policies are one way to encourage a safe working environment, free from violence (Hester et al., 2016; Morphet et al., 2014). However, in order for zero-tolerance policies to be effective, consistent messaging from leadership is needed, and HCPs must be able to reconcile the consequences of the policy on their duty to care (ENA, 2011; Hyland et al., 2016; Morphet et al., 2014). As evidenced by the work of Jacob and colleagues (2014) zero-tolerance policies might actually contribute to additional violence in the ED. Such policies are assumed to ensure safe work environments for staff and patients; however, there is a risk that they promote intolerance of behaviours that are often manifested by patients exhibiting psychiatric symptoms

(Jacob et al., 2014). In the attempt to control or remove a risky and/or disruptive patient, controlling and abusive interventions may be taken (Jacob et al., 2014). While the participants discussed the possible benefits of these policies, clearly more work in needed to ensure they are implemented in a safe and ethical way for both providers and patients.

Implications for Policy

The findings from this study identified a lack of formalized support by management towards emergency nurses in the aftermath of patient violence. This is similar to what is found in the literature, which indicates that nurses worldwide feel a lack of managerial support after experiencing a violent encounter (Brophy et al., 2018; Ramacciati et al., 2018). Nurses have reported that interactions with managers leave them feeling as though they are responsible for triggering or failing to prevent patient violence rather than providing support and guidance (Ramacciati et al., 2018). According to Brophy and colleagues (2018), nurses also feel that managers regularly dismiss acts of violence. There needs to be better cooperation and communication between ED nurses and hospital leadership to minimize harm, victimization, and feelings of insecurity following violent incidents (Ramacciati et al., 2018; Wolf et al., 2014). Specific plans to promote the development of supportive measures and helpful strategies for nurses after exposure to patient violence are required (Hassankhani et al., 2017). Simple actions from managers, such as frequent follow-ups (i.e. discussions and interactions) with nurses to support and guide them after violent encounters, are shown to be helpful (Morphet et al., 2014). Further, managers need to understand the negative ways in which violence can affect nurses, and seek to support and refer their staff to appropriate services (Brophy et al., 2018; Gates et al., 2011).

Reporting violence, or lack thereof, is also important to consider from a policy perspective. Critical incident reports, which should be completed upon any violent interaction, are a standard mechanism embedded within hospital policy to provide a clear picture of what is happening and what changes need to be made in response to such events (Hester et al., 2016; Koller, 2016). Nurses sometimes omit reporting incidents, because they believe it will not make a difference in their context where patient-initiated violence is an expected outcome to be tolerated (Gates et al., 2011). The participants of this study spoke about reporting policies not being standardized across hospitals, with ambiguity about when and how to report violence. They shared how reporting systems and reporting criteria varied depending on where one works, which creates confusion and ultimately leads to less frequent reporting of 'minor' violence. This reality, where some forms of violence go unreported is evident in the literature. Hogarth and colleagues (2016) found that nurses only formally report violent incidents if there is a significant physical injury. Other reasons for poor reporting include 1) a lack of encouragement from management, 2) time-constraints related to documentation of the incident, 3) a perception that reporting will not change anything, and 4) fear of repercussion from management (Gates et al., 2011; Hogarth et al., 2016). Incident reporting provides valuable information on the type of patients being cared for and the diagnoses of those who are violent (Koller, 2016). When violence is under-reported, the true magnitude of the issue is minimized, and thus it is assigned less resources and importance. Therefore, to encourage appropriate reporting of violence, it is important for organizations to implement clear written policies (Koller, 2016) that are simple and expedient to complete (Brophy et al., 2018). Effective and accurate reporting of violent incidents will help management be aware of the frequency and nature of violence, and underpin needed interventions (Hester et al., 2016; Koller, 2016).

Implications for Education

The participants of this study explained how continuing education about violence is available to nurses, most commonly nonviolent crisis intervention. Participants found the NVCI training that was offered in their facilities helpful, but many felt earlier integration of violence training would support a smoother transition for nurses into the realities of the nursing workplace. This is appropriate given that continuous staff education on identifying and managing violence and aggression are effective strategies to mitigate violence and keep nurses informed on the most recent evidence-based recommendations (Brophy et al., 2018; Morphet et al., 2014). Nursing students should also receive some education about violence and de-escalation techniques. Through lab simulations in nursing curricula, nursing students learn to assess for patient violence and practice appropriate de-escalation strategies (Martinez, 2019). Although information is not readily available across academic institutions, based on my undergraduate training at McGill University, as well as the current practices at the University of Ottawa, violence education appears to be predominantly linked in psychiatric placements and patients requiring mental health care. I suggest that nursing students receive earlier integration of this teaching and be exposed to lab simulations involving other types of patients and situations. Not only will this approach challenge the narrative that patients with mental illness are violent, it will encourage future nurses to consider the potential for violence within their holistic assessment of all patients.

Violence from family members was also depicted in the participants' stories. They explained how family members were unfamiliar with ED processes, which caused them frustration and, ultimately, to become violent. This finding is supported by existing evidence, which reveals how violent behaviours, initiated by family members, may occur in instances of

long wait-times or when there is the perception that their loved one is not receiving appropriate care (Brophy et al., 2018; Ramacciati et al., 2018). It is reasonable that the family members do not see, nor appreciate the operational aspects of an ED; however, when this lack of understanding results in violence towards staff, something must be done. Some organizations have begun publishing their wait-times visibly in waiting rooms or on websites to provide patients and families with this information ahead of time (Children Hospital of Eastern Ontario [CHEO], 2020). Measures such as this are designed to alert the public of real wait-times in emergency to allow them to make better-informed decisions (Walker et al., 2020). This allows families and patients to consider choosing an alternate source of care or allow them to manage anxiety associated with their wait; physical needs, family enquiries, and external responsibilities (Walker et al., 2020). Other public awareness strategies addressing the contextual issues affecting the delivery of care (i.e. staffing shortages, outbreaks, capacity issues) could further general knowledge about the functioning of EDs and reduce instances of violence (Morphet et al., 2014). This information (and public education) is needed so that patients and their support persons are provided with information on what to expect while being in the ED (Morphet et al. 2014).

Implications for Research

The emotional and psychological effects on the person living through a traumatic experience are well-documented in the literature (Duffy et al., 2015; Stevenson et al., 2015; Yang et al., 2018). Further, the trauma theory informing this study, the CSDT, explores the ‘self’ and the impact that a traumatic event can have on the person who directly experiences it (McCann & Pearlman, 1990). The consequences stemming from secondary trauma (i.e. witnessing or hearing about a traumatic event) are less explored. Within the evidence that does

exist on this phenomenon, Brophy and Colleagues (2018), and Duffy and colleagues (2015), found that secondary trauma can have profound and long-lasting consequences for nurses. Unfortunately, secondary trauma is often studied with respect to nurses who care for victims of trauma. The participants of my study recounted many stories about violence towards their colleagues, and it was clear that these events were intertwined with their personal experiences. Future research is needed to understand the ways in which patient violence affects not only nurses themselves, but also their colleagues.

A second important area for future research pertains to security personnel, who play a significant role in mitigating and managing violent incidents in the ED (Johnston & Kilty, 2016). In a study by Johnston and Kilty (2016), the experiences of the security personnel on a forensic unit were explored. Findings indicated that security personnel, often disagree with physicians and nurses decisions regarding physical restraints, as well as the ways to de-escalate patient violence. While the participants of my study commented on their relationships with security personnel, as well as their views of the role of security in response to patient violence, most research done from the emic perspective includes security personnel working in forensic or inpatient psychiatric units (Ramacciati et al., 2020). While some of these findings may be transferable to the ED setting, I was unable to locate any studies about this specifically and more work is needed to broaden our understanding of this topic.

Finally, it is important to explore the influence of gender on the experiences of patient violence through future research. Nursing persists as a female-dominated profession (St-Pierre & Holmes, 2008). As such, research about nurses and nursing is also reflective of this imbalance, which was evident in the sample of nurses obtained from my study as well. Canadian research looking at violence in healthcare and gender differences are limited, yet it is possible that patient

violence, the way it is reconciled and managed, as well as its consequences is affected by the gender of the nurse (Banerjee et al., 2012; Foghammar et al., 2016). Therefore, future studies are needed to explore the experiences and perspectives of patient violence for ED nurses whose self-identified gender is not 'woman'.

Study Strengths and Limitations

There are both strengths and limitations to this study that need consideration. First, using a qualitative approach, I aimed to provide an understanding of the participant's perspectives of patient violence and its effect on nursing practice. While the findings may be transferable to other emergency nurses working in the emergency department. The sample size was comprised of (n=7) self-identified female nurses and (n=1) self-identified male nurse. Therefore, it is possible that the experiences of nurses who are men or who do not self-identify as women are not authentically represented. This seems to be the case in most research studies looking at violence. The lack of disaggregated gender data for victims and perpetrators has resulted in a knowledge gap about the nuanced experiences of persons of all genders (Foghammar et al., 2016). Third, the intent was to explore the experiences of nurses across the province of Ontario, yet study participants mostly worked in Hospitals in the Ottawa region and (n=1) in the Toronto region. My sampling approach was convenience with snowballing and I recruited through social media. Given the networking mechanism of social media and my location in Ottawa, this geographic distribution is not surprising. The findings are limited to the experiences of violence predominantly within one city, which may have political or cultural norms that influence the ways in which violent encounters are lived. Despite these limitations, this research topic is important and understudied; thus, my study adds to the knowledge base and provides a focus on how emergency nurses adapt their practice following patient violence.

A strength of my study is that it was comprised of nurses with a wide range of ED experience, ranging from 2 to 20 years, as well as differing ages, ranging from 27-58 years old. This allowed me to explore both novice and more senior nurses' experiences, which is reflective of the demographic working in the ED today (CNA, 2020). Finally, the use of investigator triangulation was a strength of the study, enhancing credibility of my findings (Lincoln & Guba, 1985). My thesis supervisor was involved in the data analysis process, allowing for an exchange of ideas that, at times, shed light on our biases and assumptions. The preliminary analyses were also presented to the thesis committee and reviewed prior to finalizing.

Conclusion

Violence is a serious occupational hazard facing all nurses in the workplace. By virtue of their roles, nurses working in the ED are at an increased risk of being victims of violence inflicted by patients and their families. It is not uncommon for nurses working in the ED to be subjected to acts of verbal and physical violence while providing care to a diverse patient population with complex medical and mental health needs.

Findings from this study help provide an understanding about how nurses working in the ED provide care post-violence, and captures how they might adapt their nursing practice in order to protect themselves from future trauma. These added precautionary measures are intended to help nurses feel safe at work, yet they require changes to the ways in which they enact their practice and interact with their patients, thus potentially affecting the therapeutic relationship. The participants of this study highlighted deficits in the functioning of existing security measures, as well as inconsistent involvement of hospital leadership during and after violent incidents. To feel safe at work, the participants supported each other and engaged in informal protective strategies. While some violence was expected and described as ‘part of the job’, other

incidents caused significant distress, fundamentally shifting their sense of security while working.

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Appendix A - Recruitment Poster

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EMERGENCY NURSING AND PATIENT VIOLENCE

WHO: Have you been exposed to patient violence as a Registered Nurse working in an Ontario emergency department?

WHAT: A conversation with me about your experiences of patient violence while at work.

WHEN: At a time that is most convenient for you.

WHERE: Any private place where you can use the telephone or participate in a video conference.

I am recruiting up to 12 registered nurses working in Ontario. Eligible participants will be selected on a first come first served basis. Participation in this study involves a telephone or video conference interview with me (Allison Bertrand, MScN student) lasting approximately 60 minutes.

This study is part of a Masters of Science in Nursing degree and is being conducted independently from the organizations and agencies from which participants may be recruited.

Your participation is greatly appreciated.

If you have any questions or would like to participate in this study, please contact me (or my thesis supervisor: Amanda Vandyk) via the information provided below. **Thank you!**

RESEARCHER

Allison Bertrand, RN
Master of Science in Nursing Student
School of Nursing
Faculty of Health Sciences
University of Ottawa, Roger Guindon Hall
[redacted]

SUPERVISOR

Amanda Vandyk, RN, Ph.D.
Thesis Supervisor and Associate Professor
School of Nursing
Faculty of Health Sciences
University of Ottawa, RGN 1118G
[redacted]

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SOINS INFIRMIERS D'URGENCE ET VIOLENCE DES PATIENTS

Qui : Avez-vous été exposé à la violence de patients en tant qu'infirmière travaillant dans un service d'urgences de l'Ontario?

Quoi : Une conversation avec moi à propos de vos expériences de violence de patients au travail.

Quand : À l'heure qui vous convient le mieux.

Où : Tout lieu privé où vous pouvez utilizer le téléphone our participer a une conférence video.

Je vais recruter un maximum de 12 infirmières travaillant en Ontario. Les participants éligibles seront sélectionnées selon le principe du premier arrivé, premier servis. La participation à cette étude implique une entrevue téléphonique ou une conférence vidéo avec moi (Allison Bertrand, etudiante en maitrise) d'une durée d'environ 60 minutes.

Cette étude est menée dans le cadre d'une maitrise en sciences infirmières et est menée indépendamment des organisations et agences auprès desquelles les participants peuvent être recrutés.

Votre participation à cette étude serait grandement appréciée.

Si vous avez des questions ou souhaitez participer à cette étude, contactez-moi (ou ma superviseuse : Amanda Vandyk) par les informations fournies ci-dessous. **Je vous remercie!**

CHERCHEUSE

Allison Bertrand, Inf
Maitrise Universitaire en Sciences Infirmières
Faculté des Sciences de la Santé
Université d'Ottawa, Pavillon Roger Guindon
[redacted]

SUPERVISEUSE

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Appendix B - Study Information Sheet

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STUDY INFORMATION SHEET

Emergency Nursing and Patient Violence

Participation in this study is voluntary. Please read this information sheet carefully before you decide if you would like to participate. This study is being conducted independently from the organizations and agencies from which participants may be recruited.

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by student researcher Allison Bertrand and supervised by Dr. Amanda Vandyk. This study is a required component of Allison Bertrand's Master of Science in Nursing Program.

Purpose of the Study: The purpose of the study is to explore the experiences of Ontario emergency nurses who have been exposed to patient violence while providing patient care.

Participation: My participation will consist of an audio-recorded telephone or video conference interview with Allison Bertrand. The interview length of time will be approximately 60 minutes during which I will answer open-ended questions regarding the research topic. My preference for the date and time of the telephone or video conference interview will be accommodated as much as possible.

Risks: My participation in this study will require me to share stories about patient violence that occurred in the emergency department. It is possible that telling these stories may cause me some distress, but I have received assurance from the researcher that every effort will be made to minimize these risks. I am invited to contact the Centre for Addiction and Mental Health (CAMH) distress/crisis line for Ontario residents if I need support. The toll free number is 1-800-463-2338. If at any time during the interview, I become upset, I will be given the option to regroup, pause or stop the interview. To further address my needs, I also have the option of receiving a follow-up phone call from the researcher or supervisor 24-48 hours after the telephone/video conference interview to touch base and answer questions. I am invited to ask the researcher for additional resources if need be.

Benefits: My participation in this study will help us to better understand what it is like for emergency nurses to practice after experiencing violence in their workplace. My participation will also shed light on further research needed in this area.

Confidentiality and anonymity: I have received assurance from the researcher that the information I share will remain strictly confidential. I understand that the contents of my interview will be used for academic purposes and that my confidentiality will be protected. My identification/employement/educational status will be not revealed. Contextual information may be altered (if need be) to help protect my identity. Measures to protect confidentiality include using an encrypted recording device and being identified through a study number

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rather than my name. Only deidentified information will be analyzed by the thesis committee and reported in academic publications or presentations. The link between your identification number, name, and contact information will be stored in Dr. Amanda Vandyk's filing cabinet and will not leave the University of Ottawa.

As a Registered Nurse, the researcher is required to obey the direction provided in the College of Nurses of Ontario document titled "Mandatory reporting: A process guide for employers, facility operators, and nurses" (2018). This will include any instance in which the researcher believes that another healthcare professional has sexually abused a patient. The researcher will inform me immediately if I disclose information that is deemed reportable according to the CNO requirements.

Conservation of data: The data collected, including interview, audio files, and transcripts, and researcher notes will be kept in a secure manner. My data will be conserved at the University of Ottawa Campus for a minimum period of five years following the completion of data collection. Electronic data will be erased from the encrypted key. Paper will be shredded into pieces in a shredder.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, my data will be destroyed and not used in the study, unless my permission to use it is granted.

Transcript Review: I would like the opportunity to review my interview transcript before the conclusion of the study.
☐ Yes ☐ No

If I have any questions about the study, I may contact the researcher or her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact:

The Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
(613) 562-5387
ethics@uottawa.ca

Please keep this form for your records.

Thank you for your time and consideration!

Allison Bertrand
Amanda Vandyk

October 2019

RESEARCHER

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FEUILLE D'INFORMATION

Soins infirmiers d'urgence et violence des patients

La participation à cette étude est volontaire. S'il vous plait lire la feuille d'information. Consignez soigneusement le formulaire de consentement avant de décider si vous souhaitez y participer. Cette étude est menée indépendamment des organisations et agences auprès desquelles les participants peuvent être recrutés.

Invitation à participer : Je suis invitée à participer à l'étude de recherche susmentionnée. L'étude de recherche est menée par l'étudiante-chercheuse Allison Bertrand et supervisée par Dre. Amanda Vandyk. Cette étude est un élément essentiel du programme de maitrise en sciences infirmières de Allison Bertrand.

Objectif de l'étude : L'objectif de cette étude est d'explorer les expériences des infirmières d'urgence de l'Ontario qui ont été exposées à la violence de patients en fournissent des soins aux patients.

Participation : Ma participation consistera d'une entrevue téléphonique enregistrée ou une conférence vidéo avec Allison Bertrand. La durée de l'entrevue sera environ 60 minutes. Au cours de laquelle je répondrai à des questions ouvertes sur le sujet de recherche. Ma préférence pour la date et l'heure de l'entrevue téléphonique ou conférence vidéo sera accommodée autant que possible.

Risques : Ma participation à cette étude nécessitera que je partage des histories sur la violence des patients violence survenue au service des urgences. Il est possible que de raconter ces histoires puisse me causer de la détresse, mais j'ai reçu l'attestation de la chercheuse selon laquelle tout sera mis en œuvre pour minimiser les risques. Je suis invité à contacter le Centre Addiction et Santé Mentale (CAMH) qui est un centre de détresse/crise. Les coordonnées sont 1-800-463-2338. Si à un moment quelconque de l'entrevue, je me fâche, j'ai le choix de regrouper, de mettre en pause ou d'arrêter l'entrevue. Pour mieux répondre à mes besoins, j'ai aussi l'option de recevoir un appel de la chercheuse ou du superviseur dans les 24 à 48 heures après l'entrevue téléphonique/vidéo conférence pour faire un suivi. Ce suivi me servira à répondre à mes questions. Je suis invité à demander au chercheuse des ressources supplémentaires si nécessaire.

Avantages : Ma participation à cette étude servira à mieux comprendre la situation des infirmières d'urgence qui pratique après avoir subi la violence dans leur lieu de travail. Ma participation éclairera également les recherches complémentaires nécessaires dans ce domaine.

Confidentialité : J'ai reçu l'assurance de la chercheuse que les informations que je partagerai resteront strictement confidentielles. Je comprends que le contenu de mon entrevue sera utilisé à des fins académiques et que ma

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confidentialité sera protégée. Mon identité/emploi/statut éducationel ne sera pas révélé. Les informations contextuelles peuvent être modifiées (si nécessaire) pour protéger mon identité. Les mesures de protection de confidentialité incluent un appareil d'enregistrement crypté où je serai identifiée par un numéro d'étude plutôt que mon nom. Seules les informations desidentifiées seront analysées par le comité de thèse et rapportée dans des publications ou présentations académiques. Le lien entre votre numéro d'identification unique, et votre nom et vos coordonnées sera gardé de façon sécuritaire, séparément de vos données et ne quittera pas le bureau de Dre. Amanda Vandyk à l'Université d'Ottawa.

En tant qu'infirmière autorisée, la chercheuse doit se conformer à l'instruction donnée dans le document du Collège des infirmières et infirmiers de l'Ontario "Déclaration obligatoire : Guide de procédures à l'intention des employeurs, des opérateurs d'établissement et des infirmières" (2018). Cela inclut tous les cas dans lequel la chercheuse pense qu'un autre professionnel de la santé a abusé sexuellement un patient. La chercheuse m'informera immédiatement si je divulgue des informations qui sont jugées à déclaration obligatoire selon les exigences du Collège des infirmières et infirmiers de l'Ontario.

Conservation des données : Les données collectées, y compris les entrevues, les fichiers audio et les transcriptions, ainsi que les notes de la chercheuse seront conservées de manière sécurisée. Mes données et documents seront conservés sur le campus de l'Université d'Ottawa pendant cinq ans, après quoi ils seront détruits. Les données électroniques seront effacées de la clé cryptée. Le papier sera déchiqueté en morceaux dans une déchiqueteuse.

Participation volontaire : Je n'ai aucune obligation de participer et si je décide de participer, je peux me retirer de l'étude à tout moment et/ou refuser de répondre à toute questions sans subir de conséquences négatives. Si je choisis de retirer, mes données seront détruites et non utilisées dans l'étude, à moins que ma permission de les utiliser soit accordée.

Relecture de la transcription : J'aimerais avoir l'occasion de relire ma transcription de mon entrevue avant la conclusion de l'étude.
☐ Oui ☐ Non

Si j'ai des questions sur l'étude, je peux contacter la chercheuse ou son superviseur.

Si j'ai des questions concernant la conduite éthique de cette étude, je peux contacter :

Agent du Protocole pour L'éthique, L'Université d'Ottawa. Pavillon Tabaret
550 rue Cumberland, Pièce 154, Ottawa, ON K1N 6N5
(613) 562-5387
ethics@uottawa.ca

Veuillez conserver ce formulaire pour vos dossiers.

Merci pour votre temps et votre considération!

Allison Bertrand
Amanda Vandyk

Octobre 2019

CHERCHEUSE

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Appendix C - Verbal Consent Form

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RESEARCHER

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VERBAL CONSENT FORM

Emergency Nursing and Patient Violence

Consent to Participant in Research

This form will be used for all interviews conducted by phone or by video conference. The full Participant Informed Consent Form includes the Study Information Sheet and Verbal Consent Form that will be sent to the participant via email and reviewed over the phone/video conference with Allison Bertrand.

All information contained in this script will be transmitted to the participant although it need not be reproduced verbatim.

Prior to beginning the interview, I would like to confirm the following:

- You understand that you are being asked to participate in a research study about Emergency Nursing and Patient Violence.
- You have read, or have had read to you, each page of this Participate Informed Consent Form.
- All of your questions have been answered to your satisfaction.
- If you decide later that you would like to withdraw your participation and/or consent from the study, you can do so at any time.
- You voluntarily agree to participate in this study.
- You will be given a copy of this signed Participant Informed Consent Form via email.
- You are aware that the interview will be audio-recorded.

Researchers Initials: _____

Participant's Name: _____

Participant's Signature: _____ Date: _____

Researcher Statement
I have carefully explained the study to the study participant. To the best of my knowledge, the participant understands the nature, demands, risks, and benefits involved in taking part in this study. I have also provided the participant with an opportunity to ask and have addressed any questions they might have about the study. The participant has verbally consented to voluntarily participate in this study.

Researcher's Name: _____

Researcher's Signature: _____ Date: _____

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CHERCHEUSE

Allison Bertrand, Inf
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FORMULAIRE DE CONSENTEMENT VERBAL

Soins infirmiers d'urgence et violence des patients

Consentement à un participant à la recherche

Ce formulaire sera utilisé pour toutes les entrevues menées par téléphone ou par vidéo conférence. La feuille de consentement éclairée complet du participant comprend la feuille d'information du participant et le formulaire de consentement verbal qui seront envoyés au participant par courrier électronique et examinées au téléphone ou par conférence vidéo avec Allison Bertrand.

Toutes les informations contenues dans ce script seront transmises au participant bien qu'il ne soit pas nécessaire de les reproduire in extenso.

Avant de commencer l'entrevue, j'aimerais confirmer les points suivants :

- Je comprends qu'on m'invite à participer à une étude de recherche sur les soins infirmiers d'urgence et la violence des patients.
- J'ai lu, ou quelqu'un m'a lu chaque page de la Feuille d'information du participant.
- Toutes mes questions ont été répondues à mon entière satisfaction.
- Je comprends qu'à tout moment je peux choisir de retirer mon consentement et de cesser de participer à l'étude.
- Je consens verbalement à être enregistré.
- Je consens verbalement à participer à cette étude sur une base volontaire.
- Je vais recevoir une copie de ce formulaire de consentement verbal et la feuille d'information par courriel, qui a été signée par la chercheuse.
- Je comprends que cette entrevue sera enregistrée en audio.

Initiales de la Chercheuse : _____

Nom du Participant : _____

Signature du Participant : _____ Date : _____

Déclaration de la chercheuse
J'ai soigneusement expliquée l'étude au participant. Au mieux de mes connaissances, le ou la participant(e) comprend la nature, les exigences, les risques et les bénéfices de cette étude. J'ai également donnée au participant l'occasion de poser des questions et de répondre à ces questions sur l'étude. Le participant a consenti verbalement à participer volontairement à cette étude.

Nom de la Chercheuse : _____

Signature de la Chercheuse : _____ Date : _____

Appendix D – Qualitative: Interview Guide

1. Socio-demographics
    a. Gender
    b. Age
    c. Years of experience
    d. Education
    e. Areas of practice (employment setting/patient population)

2. Do you think that violence in your workplace is an issue?

3. Can you tell me about the types of violence you see within the ER?
    a. Physical violence
    b. Verbal violence

4. Can you tell me about a violent situation that was meaningful to you? (Personal, vicarious)
    a. How long ago did this incident happen?
    b. How did it make you feel?
    c. What measures were taken after this violent incident?

5. How does this situation affect you?
    a. Negative psychological, emotional, or physical consequences

6. Now that you have lived through this experience, have you noticed anything different in how you provide care?
    a. Attentive
    b. Engagement
    c. Prepare

1. Socio démographie
    a. Sexe
    b. Âge
    c. Années d'expérience
    d. Éducation
    e. Domaines de pratique (milieu de travail/population de patients)

2. Pensez-vous que la violence sur votre lieu de travail est un problème?

3. Pouvez-vous me parler des types de violences que vous voyez à l'urgence?
    a. Violence physique
    b. Violence verbale

4. Pouvez-vous me parler d'une situation de violence significative pour vous?
    a. Il y a combien de temps que cet incident s'est produit?
    b. Comment vous sentiez-vous?
    c. Quelles mesures ont été prises après cet incident violent?

5. Comment cette situation vous affecte-t-elle?
    a. Conséquences psychologiques, émotionnelles ou physiques négatives

6. Maintenant que vous avez vécu cette expérience, avez-vous remarqué quelque chose de différent dans la manière donc vous prodiguez vos soins infirmières?
    a. Attentif
    b. Engagement
    c. Préparer

Appendix E - Ethics Approval

26/11/2019

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE I CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-10-19-4690
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Type de projet / Project Type	Thèse de maîtrise / Master's thesis
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Conditions spéciales ou commentaires / Special conditions or comments

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