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Experiences and perceptions of emergency department nurses regarding workplace violence

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EXPERIENCES AND PERCEPTIONS OF EMERGENCY DEPARTMENT NURSES REGARDING WORKPLACE VIOLENCE

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WITS
UNIVERSITY

A research dissertation submitted to the
Faculty of Health Sciences, University of the Witwatersrand, Johannesburg
in fulfilment of the requirements for the degree
of
Master of Science in Nursing

Johannesburg, 2022

DECLARATION

I, Khutso Brian Maimela, declare that this research dissertation is my own work. It is being submitted for the degree of Master of Science (in Nursing) at the University of the Witwatersrand, Johannesburg. It has not previously been submitted for any degree or examination at this or any other university.

Signature 

14th June 2022

Protocol Number: M200910

DEDICATION

The research study is dedicated to my lord and savior Jesus Christ for the daily strength and courage to pursue. And to my parents, Monisi and Modisheng Maimela thank you for always having best wishes for me.

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Firstly, I would love to acknowledge my source of love and strength Jesus Christ, through you I believe everything is possible.

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ABSTRACT

The purpose of this the study was to describe the experiences and perceptions of the Emergency Department (ED) nurses regarding workplace violence. The setting of the study was four emergency departments at two public hospitals in the Gauteng Province. Included were Trauma ED, Medical ED, Paediatric ED and General ED.

An explanatory sequential mixed method design was used to describe the experiences and perceptions of emergency department nurses regarding workplace violence. Data was collected in two phases. Phase one constituted the quantitative phase which used a survey. Survey data was collected through a structured questionnaire. The second phase constituted the qualitative phase of the study. Data was collected through semi-structured interviews. The results of the quantitative and qualitative data were analysed and reported separately, thereafter integrated and used to make recommendations for the prevention of work-related violence and promote a safe working environment in the emergency department.

The final sample of the quantitative data comprised of 85 (out of 138) respondents, yielded a response rate of 61.59% for the study. Data were collected from ED nurses using a validated questionnaire developed by the Emergency Nurses Association (ENA, 2010). Data were analysed using descriptive statistics (frequencies, means and standard deviation).

Findings of the study, revealed that most nurses agreed that they felt not or less safe in the emergency department (M = 4.07; SD 2.18). The results of the survey identified that most (>80%) nurses working in the ED had experienced some form of workplace violence. Physical violence such as being hit, punched, slapped, kicked, pinched, pushed, shoved or scratched was experienced by at least three-quarters (>75%) of nurses.

Additionally, documented evidence recognizes that most nurses failed to report it (81.2%; n = 69). It was also noted that around 30% (n = 25) of the nurse respondents agreed that they were advised to report the incidence, even though they did not do so. In this study, the greater majority of nurses agreed that they had not received any training in preventing or mitigating ED workplace violence, as opposed to some training 10 to 12 months and 7 to 9 months ago (5.9% and 4.7%), respectively.

In Phase 2 of the study, data was collected from nurses (n = 15) who were purposively selected using semi-structured interviews to obtain qualitative information on their opinions regarding workplace violence in the ED. Data collected was analysed using a Clarke and Braun method of qualitative thematic analysis. Fifteen categories were identified in which five themes, which provided the fundamental structure of the findings for the discussion, emerged and included the following:

- Contributing factors of workplace violence
- Factors that hinder reporting
- Inefficient performance of security officers
- Unsafe environment
- Helpful strategies

In conclusion, the study identified workplace violence as an issue and recognizes the effects of violence on staff members is of significant concern that should be addressed with leadership support to recognize and decrease workplace violence in the ED.

Keywords: *Emergency department nurses, Experiences, Perceptions, Violence, Workplace,*

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LIST OF ABBREVIATIONS

CEO	Chief Executive Officer
ED	Emergency Department
ENA	Emergency Nurses Association
ILO	International Labour Organisation
MHCU	Mental Health Care User
PTSD	Post Traumatic Stress Disorder
USA	United States of America
RN	Registered Nurses
WHO	World Health Organization
WPV	Workplace Violence

CHAPTER ONE

OVERVIEW OF THE STUDY

1.0 INTRODUCTION

This chapter provides an overview of the study, comprising the background, problem statement, research questions, aim and objectives of the study and significance of the study. In addition, there is an overview of the research methods and design, validity and reliability and ethical considerations.

This study sought to describe the experiences and perceptions of emergency nurses regarding workplace violence in the emergency departments of two public hospitals in Gauteng Province. The findings of the study may facilitate the development of policies and protocols to mitigate workplace violence and enhance safety for emergency department nurses.

1.1 BACKGROUND OF THE STUDY

There has been an increase in the prevalence of workplace violence in the healthcare system internationally (Pich, Hazelton & Kable, 2013); however, there is a limited number of statistics globally. According to World Health Organization (WHO), health professionals encounter at least 8% to 38% incidences of physical assault during their work, whilst developed countries, such as the United States of America (USA), report workplace violence as a pressing occupational risk, which is the source of approximately 900 deaths and 1.7 million of non-fatal assaults (Gacki-Smith *et al.*, 2009).

There is no universal definition of workplace violence however, Stene *et al.* (2015) defined it as any act or threat of physical violence, harassment, intimidation or other disruptive behaviour that occurs at the worksite and may cause physical or emotional harm, and nurses, as the forefront of the healthcare system, stand a greater risk of workplace violence within hospitals particularly in the emergency departments (Catlette, 2005).

The emergency department is commonly associated with a high risk of violence compared to other departments in the hospital setting (Gacki-Smith *et al.*, 2009). Findings in the Australian qualitative study by Hogarth *et al.* (2016), report that ED nurses are likely to

experience workplace violence daily. However, Kansagra *et al.* (2012) point out that increased risk in the ED may be associated with its dynamics and layout. ED enables access to a large volume of patients, operates 24 hours daily, easy entry with weapons, high level of stress, patient long waiting times and an increased number of alcohol-intoxicated patients and their companions (Gilchrist, Jones & Barrie, 2011). Alcohol-related violence is identified as a striking contributing factor to the violence in the ED. Literature examines the studies by Gilchrist, Jones and Barrie (2011), in the two major hospitals in New South Wales, Australia, among 91 participants (nurses); approximately 71 listed alcohol as the common factor frequently seen as contributing to the occurrence of workplace violence in the ED, closely followed by the use of drugs.

Although the ED has been identified as an area with high workplace violence prevalence, Ramacciati, Ceccagnoli and Addey (2015) report that most of the violent incidences in the E.D. occur in the triage area; however, the literature argues that an increased risk of violence-related incidences are not merely in triage but involve first-line health professionals (AlBashatwy and Aljezawi, 2016). Emergency department nurses report incidences such as physical intimidation and threats (Gilchrist, Jones, Barrie., 2011), being hit, grabbed with a scissor on the neck, and held by an aggressive patient on the wrist resulting in an injury (Han *et al.,* 2017). According to Hogarth, Beattie and Morphet (2016), such incidences of workplace violence against nurses remain unknown, unresolved and difficult to address because the victims never report them. Studies reveal that workplace violence can create and contribute to stress for nurses in their working environment (Wolf, Delao & Perhats., 2014; Stene., 2015; Gacki–Smith *et al.,* 2009). Gates, Gillespie and Succop (2016) report that nurses outlined having physical and psychological trauma, and experienced post-traumatic stress (PTSD), such as having hallucinations and nightmares. Workplace violence is a factor interfering with ED nurse's ability to provide care, reduces productivity and contributes to high nurse turnover and absenteeism (Gacki-Smith *et al.,* 2009).

Sato *et al.* (2013) examined a cross-sectional survey conducted in six acute care hospitals in Japan among nurses from different departments. The study consisted of 1498 (76.7%) respondents and 70.9% (1385) managed to complete the required questionnaire. Among these nurses, one in eight participants were working in the ED and critical care wards at the time of the study. The research focused on the behaviour of nurses toward reporting workplace violence. Based on the findings, 70% of participants stated they never reported

workplace violent events that happened against them. Some of the nurses believed this sort of behaviour was due to lack of experience and protection from the nursing managers.

In an interpretive qualitative study, performed in three EDs in Taiwan through semi-structured interviews, 30 participants displayed behavioural acceptance of ED violence and had developed a culture that perceived violent behaviour as part of their job; hence, they often tolerated the encountered violence in their working environment, and never reported it (Han *et al.*, 2017). Many international studies concur with such behavioural cultures (Gacki-Smith *et al.*, 2009; Hogarth, Beattie & Morphet., 2016; Stene, 2015). Han *et al.* (2017) mentioned that poor support in reporting these incidences is marked as contributing to the acceptance of workplace violence. Hogarth, Beattie and Morphet (2016) agree with the statement, stating there is no encouragement from the environment to report such incidences.

There is a lack of literature regarding workplace violence against ED nurses in South Africa; however, according to the South African police service database, there is a high frequency of crime in the country. In 2017/2018 financial year, there were about 2.1 million various crimes reported, among which were 20 336 were murder cases, 40 035 rape cases, 6 786 sexual assaults, and 186 243 common assaults. Within the context of workplace violence, there was a small study conducted in two hospitals in Johannesburg among all emergency department staff; these included doctors, nurses, porters, clerks and general workers, 73% of whom reported emotional abuse, while 34.2% experienced physical violence. This study was limited because only a small number of nurses participated (Jaffal, 2016).

Workplace violence as an occupational risk for ED nurses (Hogarth, Beattie & Morphet., 2016) includes passion for work, and contributes to substandard care for the patients. Consequently, the research indicates a gap in integrating measures to prevent workplace violence and promote safe working environments for ED nurses, and this is due to certain component measures of safety requiring alteration and implementation.

Findings in Gacki-Smith *et al.* (2009) recognise a crucial need for nursing managers to support and establish positive cultures of reporting, clear reporting systems, and also the provision of beneficial and effective educational strategies and training to inhibit these violence incidences. The literature identified areas of concern as follows: the poor structural component of the institutions, insufficient safety measures in place to inhibit these violent

behaviours, poor support from management, overcrowding and alcohol misuse, under-reporting and lack of education and training (Catlette, 2005; Gacki-Smith *et al.,* 2009).

1.2 PROBLEM STATEMENT

Workplace violence in the healthcare system is a common serious problem that results in an adverse outcome, particularly in the ED nurses' report of frequent events of workplace violence (Zhang *et al.,* 2017). Patients and their companions commonly demonstrate incidences of workplace violence towards ED nurses; this does not exclude co-workers and other professionals who also demonstrate violence on colleagues. Factors contributing to workplace violence include long waiting times, mental healthcare users, patients, and relatives under the influence of alcohol and drugs (Wolf, Delao & Perhats, 2014). Gacki-Smith *et al.* (2009) report that workplace violence on ED nurses can create physical and psychological trauma, interfere with the ability to provide care, reduce work productivity and contribute to high staff turnover and absenteeism. There is little understanding of the nature of workplace violence against ED nurses in the South African context, therefore, this study seeks to describe the experiences and perceptions of emergency nurses regarding workplace violence.

The study attempted to answer the following research questions:

- What is the nature of workplace violence against nurses working in the ED?
- What are the experiences and perceptions of workplace violence against nurses in the ED?

1.3 PURPOSE OF THE STUDY

Based on the problem, the study aimed to describe the experiences and perceptions of the emergency department nurses regarding workplace violence.

1.4 OBJECTIVES

The objectives of the study were:

- To determine the nature and extent of workplace violence experienced by ED nurses (quantitative study)

- To explore the experiences and perceptions of ED nurses regarding workplace violence in two hospitals in Gauteng (qualitative study)

1.5 SIGNIFICANCE OF THE STUDY

The study sought to describe the experiences and perceptions of ED nurses regarding workplace violence, how it interferes with their daily work and the provision of quality patient care. The results of the study will add value to the clinical area, integrate and strengthen measures of security, and develop policies and protocols to improve safe working environments for ED nurses.

1.6 OPERATIONAL DEFINITIONS

Definitions for the study are as follows:

- **Emergency department (ED)**

The emergency department is a specialised medical treatment facility within the hospital, which provide sub-acute care to patients who present in the facility without prior appointment. It provides initial treatment for a variety of illness and injuries, some of which are life threatening and require immediate medical attention (Moskop *et al.*, 2009).

- **Emergency nurse**

An emergency nurse is a registered nurse who has obtained an additional qualification in trauma and emergency at an institution approved by the SANC, under regulation number 212 of February 1993, as amended by regulation number 74 of January 1997. In this study, emergency nurse refers to all nurses registered with the South African Nursing Council (SANC), currently allocated and working in the emergency department.

- **Workplace violence**

Workplace violence is any violence that may be in the form of an act or threat of physical violence, harassment, intimidation or other disruptive behaviour that occurs at the worksite, and which may cause physical or emotional harm (Stene, 2015).

- **Experience**

A practical situation or event that an individual has ever come across, either direct contact or observation (Oxford English Dictionary, 2017).

- **Perception**

Perception is an individual awareness of something through senses, the understanding and interpreting of an event or something similar (Oxford English Dictionary, 2017).

1.7 OVERVIEW OF THE RESEARCH METHODOLOGY

To achieve its objectives, this study used a sequential explanatory mixed methods design. The study respondents were professional nurses working in the emergency departments at two public hospitals in Johannesburg, Gauteng Province.

Ethical clearance and permission to conduct the study was sought from the relevant university committees, Department of Nursing, and School of Therapeutic Sciences in the Faculty of Health Sciences. Participation in the study was voluntary and participants were free to withdraw at any time. After obtaining permission from the hospital and relevant ED nurse managers, the professional nurses who agreed to participate in the study gave consent.

The study had two sequential phases, namely a quantitative phase (Phase 1) followed by a qualitative phase (Phase 2). In Phase 1, data collection was with a self-administered survey questionnaire (Gacki-Smith *et al.,* 2009). Descriptive statistics analysed the results of the study. The researcher, being the sole data collector of the data, ensured reliability, and the sample size was achieved purposively, and the data verified by a biomedical statistician to ensure accuracy of the findings. ED clinical and education experts verified the data

collection instrument fit into the South African context, thus ensuring validity of the research.

In Phase 2, data collection used semi-structured interviews, and qualitative thematic analysis analysed the data (Clarke and Braun, 2013). Concepts of credibility, reliability, dependability, and conformability maintained the trustworthiness of the study. To enhance the accuracy of the study the researcher was the sole collector of the data, there was an enquiry audit by the supervisors, the sample size was achieved purposively, and verification of data by participants through member checking. An experienced researcher conducted an audit trail to ensure the truth of the findings.

1.8 OUTLINE OF THE STUDY

The proposed outline of the study is as follows:

Chapter One: Overview of the study
Chapter Two: Literature Review
Chapter Three: Research design and methods
Chapter Four: Findings of the study
Chapter Five: Discussion of findings and limitations
Chapter Six: Summary of the study, main findings, recommendations, and conclusion

1.9 SUMMARY

This chapter presented the reader with an overview of the study, the background, the purpose and objectives of the study, the significance, and operational definitions. Additionally, it provided a brief description of the research methodology, which involved the two diverse phases, population, sampling, data collection, analysis and ethical procedures followed. The following chapter is the discussion of the literature review of the study.

CHAPTER TWO
LITERATURE REVIEW

2.1 INTRODUCTION

The literature review communicates the evidence of the undertaken studies, providing the reader with the findings of the existing knowledge closely related to the proposed study. It critically appraises and assists the researcher to identify the knowledge gap (Creswell, 2012).

In this literature review, the main emphasis is on workplace violence against emergency department nurses. The chapter begins by describing the violence concept and its effects on the human population globally, and the adverse effect it contributes to fatality, health, and the economic system. Violence unfolds in the healthcare system against nurses, particularly in the emergency department. This section explores workplace violence against ED nurses in the emergency department; these include the causes and contributing factors, the ramification of the abuse on nurse individuals, patients, and the entire healthcare system. It further outlines and summarises the existing measures in the literature to prevent and combat the problem.

Violence is a severe problem across the world. It constitutes a direct undesirable impact on the populations, and contributes to an increased mortality rate and health-related issues in communities (World Health Organization, 2007). According to the World Health Organization's (WHO) 2007 report, based on prevention of violence in various countries globally, death related to violence in 2002 was equivalent to half the number of deaths associated with HIV and AIDS. About 1.6 million people die worldwide every year due to violence, and among the deaths, around 56 000 is homicide, 870 000 suicide and an estimated 170 000 originate from collective violence (WHO, 2007).

The WHO report revealed homicide was remarkably high among males compared to females, occurring mainly in men aged between 15 and 45 years in middle-class countries; it also discovered frequent suicide inn men over 60 years. Millions of individuals across nations experience physical injuries and disabilities, mental and behavioural disorders, and deficient reproductive health. Violence is not the only burden to the health system, but it exhausts the criminal justice and law enforcement systems and also affects the economic

circumstances. The Who cited a study conducted in Cape Town, South Africa (Allard & Burch, 2005), which found that among patients who sustained serious abdominal gunshot injuries, their medical and surgical interventions tended to cost 13 times more than the South African government's annual expenditure on health.

Violence is an unavoidable existing burden, however, it remains a challenge for comprehensive intervention due to its lack of clear definition. Various cultures and social norms view potentially harmful behavioural situations differently and act differently. With the question of what comprises acceptable behaviour, violence has become a global crisis with an insufficient collective approach (WHO, 2007). Traditionally, violence is associated with physical abuse, however, the WHO defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against group or community that either result in or has a high risk to result in an injury, death, psychological harm, and mal-development or deprivation" (WHO, 2002: p1084).

There are different definitions of violence from various sources. The Free Dictionary (2016) definition of violence encompasses individual behavioural acts and consciously applying force with a motive to cause harm or injury. The Collins English Dictionary (2014) adds unlawful and attentive exhibit use of individual/s force, including a physical force with intent to cause destruction and injury; this definition also includes intimidation as part of violence. Nonetheless, violence can present in different forms, and classification is according to its nature, such as domestic, intimate, sexual, gender-based, and workplace.

Despite the existence of different forms of violence, workplace violence in the healthcare system is a crime that requires a targeted response (Wolf, Delao, Perhats & Plaines, 2014). A survey on hospital crime conducted in the United States of America (USA) in 2014 revealed that between the years 2011 and 2012 there were approximately 24 000 cases of assault in the workplace, and among those incidences nearly 75% occurred in the healthcare system (Philips, 2019).

2.2 DEFINITION OF WORKPLACE VIOLENCE

In the findings of the International Labour Organization (ILO), South African healthcare providers face exposure to all types of violence. In a 12 months study, public sectors

reportedly encountered more violent events than private institutions (9% up to 17% of physical abuse respectively) and 52% in private and 60.1% in public institution of verbal abuse (ILO, 2006). There have been many international studies relating to workplace violence and its nature, however to date there is no universally accepted definition (Boyles & Wallis, 2016).

The Free Dictionary (online) describes workplace violence as the behaviour or treatment of physical assault and threats that impose a risk to the health and safety of one or multiple employees. The United States Department of Labour (as cited in Stene, 2015) defines workplace violence "as any act or threat of physical violence, harassment, intimidation or other disruptive behaviours that occur at the worksite and may cause physical or emotional harm' (Stene, 2015: p113). The WHO distinguishes workplace violence into two categories:

- Physical violence

The application of physical force, such as beating, biting, kicking, slapping or stabbing another person or a group, which results in harm to these.

- Psychological violence

Verbal abuse, bullying/mobbing, harassment, and threatening against another person or a group, which may harm the physical, mental, spiritual, moral, and social development of the victim (WHO, 2002: p8).

The above definitions are not explicit acts of a sexual offense, as they constitute physical and psychological violence, however, sexual harassment can cause physical and emotional harm (Baofo, Hancock & Huang, 2015). In the healthcare system, workplace violence is lengthy and comprehensive, and grouped into three different forms by the WHO (WHO, 2003.p8).

Table 2.1: Classification of levels of workplace violence

Type 1	Type 2	Type 3
External violence	Client – orientated violence	Internal violence
Perpetrator has no relationship with the workplace	Perpetrator is the recipient of the care rendered	Employment violence related to the work environment
An individual/s with a motive to commit a crime such as stealing cash, equipment, or drugs	It can be patients and relatives in the healthcare environment.	Usually another employee, a co-worker, a supervisor, a boss, or a student

2.3 VIOLENCE AGAINST NURSES

Nursing staff stand a higher risk of violence, compared to other healthcare professionals, due to their direct contact, and lengthy time spend with the patients and families (Catlette, 2005). A cross-sectional survey was performed on nurses in Heilongjiang, a province in North-East China, with 588 participants, including nurses, 7 hospital administrators and 6 health officials; 12 were involved in in-depth interviews. The results showed that 7.8% of nurses had experienced physical violence at their place of work, while 71.9% reported non-physical violence in the previous year (Jiao *et al.*, 2015).

The extent of workplace violence differs among countries. A cross-sectional study in Taiwan, in 2011, involved 26679 nurses from 100 hospitals across the country. The findings revealed that 13392 (49.6%) had experienced at least one incidence of any type of workplace violence in the previous year, 5150 (19.1%) had been exposed to physical violence, while 12491(46.3%) reported having experienced non-physical violence (Wei, *et al.*, 2015).

Nurses are the healthcare providers continuously available throughout the patient's hospitalisation (Al-Ali, Al Faouri & Al-Niarate, 2015), and the level of aggression one faces is directly dependent on the duration one spends with the patient (Viottini *et al.*, 2020). Conversely, the less time spent with patients due to being busy and the shortage of staff also

resulted in patients' dissatisfaction of care and caused aggression, as patients felt their illness was overlooked (Viottini *et al.,* 2020).

Workplace violence can create and contribute to stress in nurses in their working environment. In Gates, Gillespie and Succop's (2011) report, nurses outlined having physical and psychological trauma, and experienced post-traumatic stress (PTSD), such as hallucinations and nightmares. Workplace violence interferes with the nurse's ability to provide care, thus reducing productivity, contributing to high nurse turnover and absenteeism. Within the hospital environment, the emergency department is the area with a high occurrence of workplace violence (Gacki–Smith *et al.,* 2009).

2.4 RISK FACTORS OF WORKPLACE VIOLENCE IN THE ED

2.4.1 Environmental Factors

The ED nurses stand a higher risk to experience aggression and violence in their work environment (Han *et al.,* 2017), this could be due to their role as the first professionals to encounter families and patients (Albashtawy & Aijezawi, 2016; Gates *et al.,* 2011). Findings in multivariate analysis among attending nurses, physicians, residents and physician assistants, based on the comparison of safety among these professionals, have shown that ED nurses feel five times less safe compared to other professionals in the working environment (Kansagra *et al.,* 2012).

May and Grubbs (2002) conducted a survey study in North Florida in a 770 bedded Medical Centre, which included three departments, Intensive care unit, ED, and general nurses, with a response rate of 68.8% (86 out of 125). In the findings, approximately 88% of nurses reported having experienced verbal violence, while physical violence accounted for approximately 74%. Among these departments, ED was the most common area with frequent violence incidences, reportedly having 100% verbal violence and 82% physical violence for the past year of study (May & Grubbs, 2002). According to the National Association for Occupational, Health and Safety in the USA, geographical area and design of the facility play a role related to the rates of occurrence of workplace violence (Gerberich 2004).

The International Labour Organization (ILO) acknowledges that a physical design with poor structure, poor hygiene, and noisy and reduced ventilation space is likely to experience high rates of workplace violence than a well-designed institutional infrastructure. Poor organisation of the institution creates chaos, people enter the building from different angles, there is unnecessary queuing, and delays, and this causes an increase in the workload of the staff and frustrations in patients (ILO, 2006).

One significant contributory factor is that ED is a department operating and accessible 24 hours a day (Stene, 2015). A poorly designed institution, along with insufficient measures of safety, creates access to unauthorised relatives and members of the community, which makes it difficult to differentiate between the patients and their companion (Kansagra *et al.*, 2012). People enter the ED freely, including criminals carrying weapons (Catlette, 2005). Kasangra *et al.* (2012) point out that due to the absence of metal detectors, guns and knives enter the ED on a daily or weekly basis. Nevertheless, institutional environments differ from one country to another. There was a multi-method study performed in Australia, in two metropolitan Sydney district hospitals, using the hospital management's incidence database, and the evidence did not reveal a significant geographical element of the institution as a contributing factor leading to the challenging behaviour (Hyland, Watts & Fry, 2016).

Although identified as an area with high workplace violence prevalence, Ramacciati, Ceccagnoli and Addey (2015) report that most of the violence incidences in the ED occur in the triage area. Triage, as the first point to engage with the patients and community within the ED, nurses allocated here are three times likely to encounter violence and often to fail to deescalate violent behaviours due to lack of skills and resources (Pich, Kable & Hazelton, 2017).

The perception of nurses in triage is as gatekeepers (Pich, Kable & Hazelton, 2017). One study argues that an increased risk of violence in the ED space does not merely exist in the triage area; it is associated with the first health professional to encounter the public in the ED space (AlBashatwy & Aljezawi, 2016). In Jordan, the majority of hospitals do not possess a triage area; upon arrival in ED, patients first report at the reception area and are directed into the treatment area, to encounter a nurse as the first health practitioner. This is the area where most violent incidences are said to occur (AlBashatwy & Aljezawi, 2016), as

the majority of patients show dissatisfaction at the time taken before receiving medical care (Angland, Dowling & Casey, 2014).

Prolonged waiting times are commonly associated with increased risk of workplace violence in the ED (AlBashtaway & Aljezawi, 2015; Angland, Dowling & Casey, 2014; Gacki-Smith *et al.,* 2009). Long waiting times are widely described as the main contributing factor, co-existing with other risk factors in the ED (Pich, Kable & Hazelton 2017), due to shortage of staff and increased workload, nurses operate under a lot of stress, and such causes delay for patients to receive medical care, often nurses fail to attend patients based on set standard hours and some of the patients' demands goes unmet (Viottini *et al.,* 2020). Meanwhile, most patients and relatives expect to receive care immediately on arrival to the ED (Najafi, *et al.,* 2017).

Government hospitals are associated with high rates of violence as compared to private hospitals (ILO, 2006). These findings were found highly associated with the shortage of equipment's and human resource, long waiting queues, and dissatisfaction from the patients and relatives (Hamdan and Abu Hamra, 2015). In the ED patients are been provided with medical care according to the severity of their illness. However According to Jordanian cross-sectional study (AlBashtaway & Aljezawi, 2015), ED nurses experience that during waiting periods, meanwhile Patients with critical conditions that require immediate medical attention are being attended, the challenge regularly rise in particular instances were unstable patient whom may not appear critical, receives priority, With a lack of knowledge, these circumstances stir up frustration and anger on awaiting patients and together with their companions leading to verbal, physical and aggression towards the nursing staff (AlBashtaway & Aljezawi, 2015). Overcrowding of patients in the ED is in inverse proportion to understaffing; the nursing staff becomes overwhelmed as the workload increases and fails to meet expectations of patients (Hyland *et al.,* 2016). Hyland *et al.* (2016) indicate that such frequent violent behaviour occurs during the night and is associated with less staff allocation for the night roster.

The character of the aggressor alone does not determine the violence within the working environment, the organisation environment within which it occurs also has an impact on the existence of such violence (Kvas & Seljak, 2014). An environment with existing management that operates in a closed authoritarian form, away from the employees on the

ground level, has an increased risk of violence than a collaborative management that is open and aware of local issues (ILO, 2006).

The shortage of security officers in the hospital creates a risk of workplace violence on the employees (Partridge & Affleck, 2017). Health workers run out of choices in escalating issues of violence in the working space. An Australian study found that within four hospitals none had security officers designated to the ED. In these situations, linked to the existing high rates of physical and psychological violence within the institution, only a few security personnel were responsible for the entire hospital and often failed to respond to the calls quickly (Partridge & Affleck, 2017).

2.4.2 Staff Members Working in the ED

The precipitating factors of workplace violence in the ED are patients with mental illness, patients and relatives under the influence of drugs and alcohol, overcrowding and long waiting times (Gacki–Smith *et al.,* 2009). Findings state that workplace violence is a progressive and unresolved problem for ED nurses (Pich, Kable & Hazelton, 2013). Females are repeatedly victims of abuse and are more predisposed to violent behaviour than males (Viottini *et al.,* 2020). Ramacciati, Ceccagnoli and Addey's (2015) research reported that females have an increased risk of experiencing workplace violence compared to males, Based on the study, females' probability of violence is related to femininity; women are being perceived as less challenging to trigger violence compared to men (Ramacciati Ceccagnoli & Addey, 2015).

Although there is a high number of female in the nursing profession, Kwalenko, Gates, Gillespie, Succop and Mentzel (2012) report no significant gender difference in experiencing violence incidences in the working area. However, Gilchrist *et al.* (2011) indicated that males stand a greater risk of violence compared to female nurses, as revealed in a short survey study in Australia. In their study, males were two times more at risk ($p = < 0.001$) of experiencing any form of assault, 1.9 times likely to be threatened and 1.7 times more likely to be physically intimidated compared to female nurses in the ED (Gilchrist, Jones & Barrie, 2011).

The findings of the American study by Gacki-Smith *et al.* (2009) supported those of the Australian study (Gilchrist, Jones & Barrie, 2011), and reported that female nurses are less likely than male nurses to experience events of physical and verbal violence. They further stated that females are less likely to report physical violence compared to males, but more likely to report verbal violence.

Individual age, experience and maturity played an integral part in causative and aggravating any form of violence (Zhang *et al.,* 2017). In a cross-section survey, Darawad *et al.* (2015) revealed young and new nurses in the ED reported frequent experiences of violence unlike their older counterparts in the department. Zhang *et al.* (2017) argue that experienced nurses are unlikely to experience odds of violence due to their ability to identify and read the emotional temperature, unfolding dissatisfaction, and be in a state to negotiate and prevent violence before it begins. The report is associating work experience with the accumulation of skills of handling workplace violence (Zhang *et al.,* 2017), Conversely, Kansagra *et al.* (2012) stated that staff members who had been working in the ED for more than 5 years reported feeling less safer compared to those with minimal experience; this literature reasoned that this could be the result of being exposed to multiple violent incidences. Arnetz *et al.* (2018) recognised neither age nor gender as a non-significant factor to experience workplace violence.

Older personnel are often associated with limited exposure to violence, not this is due to their accumulated experience, their skills to deal with workplace violence, and their professional roles. Most workers over 50 years uphold managerial and coordinating positions that have minimal direct contact with the patients (Viottini *et al.,* 2020). Nonetheless, Zhang *et al.* (2017) also included family dynamics and noted that nurses originating from families where they are the only child tend to have a high probability to experience physical and non-physical violence. There were no reasons stated, and further studies are required to establish the relationship.

Poor confidence in managing the violent behaviour has a link to inadequate education and training. Research states that members of staff tend to feel less confident and unprepared when approaching violent scenes (Hyland, Watts & Fry, 2016). According to the study by Al-Omari (2015), workplace violence peaks on nurses with high qualifications, as opposed those with junior educational level, because of their role of supervisor/charge nurse. The

existing events of conflict and dissatisfaction is towards them, and lack of training and education on workplace violence can often fail to dissolve and successfully resolve the violate circumstances. Gates *et al.* (2011) found that ED nurses are unlikely to cope with the unforeseen act of violence as only a few, or none, received training on managing workplace violence.

Training of nurses on workplace violence will improve communication between staff and patients (Angland, Dowling & Casey, 2014). An Italian mixed-method study (Ramacciati, Ceccagnoli & Addey, 2015) with 100 emergency nurse respondents from a survey study and 265 in the focus group discussion from 668 National Health Service accident and emergency departments. The study aimed to obtain an emergency nurse subjective perception of workplace violence. On precipitating factors, respondents highlighted a lack of communication of nursing personnel towards patients and relatives as it creates an increased risk of stirring workplace violence behaviour. However, participants in Angland, Dowling and Casey (2014) admitted displaying unwelcoming behavioural attitude sometimes towards particular patients, because they believed those patients were not sufficiently ill for treatment in the ED. Ramacciati, Ceccagnoli and Addey (2015) concur with the outlined statement report that nurse's attitudes towards patients and relatives may contribute to causing workplace violence.

ED nurses work in an accelerating environment, coupled with increased stress levels and overwhelming emotions, looking after acutely ill patients and utilising time sparingly. The experience and acquired skills help them to overcome the stress and keep pace with the daily activities performed in the ED. However, ED nurses are likely to fail to cope with unforeseen or unpredicted acts of violence as it requires high cognitive demand and disturbs concentration (Gates, Gillespie & Succop, 2011). These acts of hostile and aggressive behaviours reduce the capacity to cope with the workload (Wolf, *et al.*, 2018).

Stress interferes with normal cognitive processing, disturbs effective thinking, and reduces concentration, hence hindering with one's ability to perform during work and reduce productivity, and these implicate adverse outcomes for patient's safety (Kowalenko *et al.*, 2013). Poor stress tolerance is associated with a high level of irritability (Najafi *et al.*, 2017), and violence elevates work pressure in the ED, often bringing out discomfort and irritability in staff members; such may lead to miscommunication towards patients and relatives, stir up

unforeseen arguments, resulting in an atmosphere filled with tension and fights (Najafi *et al.,* 2017). Workload pressure also causes difficulties for the nurses to provide effective nursing care, and it reduces time to provide care and health education (Gates, Gillespie & Succop, 2011). Additionally, patients' time is limited with the healthcare provider, particularly with doctors, causing frustration and dissatisfaction among patients, and in such situations, patients take out their anger and frustrations on the nurses (Najafi *et al.,* 2017).

The literature review results revealed health professionals predispose themselves to violence by not maximising the use of existing designated communication strategies to minimise the risk of assaults within the institutions (Ferns & Cork, 2007).

2.4.3 Poor and Lack of Reporting

Under reporting of violence incidences that exist in the workplace appears to be prevalent in the nurse's population at large (Sato *et al.,* 2013). Many nurses are not reporting acts of violence demonstrated against them, as the belief is they expect and tolerate it (Gates, Gillespie & Succop, 2011). A cross-sectional qualitative questionnaire-based study, conducted in six acute care hospitals in Japan among nurses from different departments, attracted 1498(76.7%) respondents, and 1385 (70.9%) completed the required questionnaire. Among these nurses, one in eight were working in the ED and critical care ward at the time of the study. The research mainly focused on the behaviours of nurses toward reporting, and based on the findings, 70% of participants stated they never reported WORKPLACE VIOLENCE events against them. Some of these nurses believed existing situations aggravated this sort of behaviour, such as lack of experience and protection from the nursing managers (Sato *et al.,* 2013). Al-Omari's (2015) study showed that 41.1% of participants never reported the workplace violence, while 33.1% classified reporting as unimportant.

Predominantly poor reporting appears to have grown into the norm in the ED. Hogarth, Beattie and Morphet (2016) in a longitudinal study report that workplace violence towards nurses in the ED occurs almost daily and that numerous incidences of workplace violence against nurses remain unknown, unresolved and difficult to address because they are unreported by the victims (Hogarth, Beattie & Morphet, 2016). In an interpretive qualitative study, using a phenomenological design and semi-structured interviews in three EDs in Taiwan, 30 participants displayed behavioural acceptance of ED violence and had developed

a culture that, perceived violent behaviours as part of their job; hence, when they encountered violence in their working environment it was tolerated frequently and never reported (Han *et al.,* 2017). Some international studies concur with such behavioural cultures (Gacki-Smith *et al.,* 2009; Hogarth, Beattie & Morphet, 2016; Stene, 2015). Han *et al's* (2017) study points out that the lack of reporting of these incidences is marked as contributing to the acceptance of workplace violence, and often the need for support is for junior and novice nurses. The researchers suggest that new employees who do not value themselves are less likely to report violent incidences against them (Ferns, 2005). Meanwhile, Gates, Gillespie and Succop (2011) report that violence incidences are perceived as a sign of a nurse's incompetency and might expect retaliation from the hospital management.

Nursing managers and supervisors show a lack of encouragement and support (Hogarth, Beattie & Morphet, 2016). Clinical nurses perceive the manager's behavioural response as unwillingly to defend them against violence, and no actions executed to follow up nurses' workplace violence reports (Sato *et al.,* 2012). Victims of workplace violence indicated dissatisfaction with the addressing of misconduct, and often counselling of the victim never (Al-Omari, 2015). Although May and Grubbs (2002) claimed the reason for poor reporting was that sometimes nurses become confused about what acts qualified as an assault. In an online survey study by Stene *et al.* (2015), completed by 108 registered nurses (RN) and eight patient care assistants (PAC) working in the ED in the USA. The study questions asked participants what constituted workplace violence; 40% of respondents did not know what behaviour/act was considered as workplace violence, and about 67% admitted not reporting workplace violence incidences that had occurred in the ED for the past year (,).

The nurse's perceptions of violence play a significant role in reporting (Hogarth, Beattie & Morphet, 2016). Nurses regard reporting as it develops investigation, which management may associate with poor professional performance and negligence accusations. This brings out fear and reluctance in the nurses to report (Sato *et al.,* 2012); instead, nurses would use other informal forms of reporting such as documentation on patients' records and sharing the occurred violent incidences among themselves (Hogarth, Beattie & Morphet, 2016).

The level of impact and the extent of the damage implemented on the nurse determined the chances of reporting (Sato *et al.,* 2012). Hogarth, Beattie and Morphet (2016) found that in particular situations, violence interpretation as such is only when there is a physical injury

sustained. In the study of May and Grubbs (2002), there was a lack of written reporting in 50% of abuse and assaults, with given reasons that there was no physical injury experienced during the encounter. In the same study, the majority of nurses stated formal reporting of violence incidences occurring in ED consumed too much time, and there would be no intervention executed afterwards by nursing managers (May & Grubbs, 2002).

In a qualitative research with a phenomenological approach study, performed in Australia in one of the tertiary hospitals in 2015 (Hogarth *et al.*, 2016), participants reported the method of reporting as complicated and time-consuming. In a Jordanian study, 66% of 174 nurse participants reported no legal action taken against relatives and patients who physically and non-physically assaulted them (further reasons not stated in the report), and about 68.4% claimed that these acts of assault did not alter their psychological wellbeing (Derawad *et al.*, 2015). A cross-sectional study conducted in Iran (Esmaelipour, Salsali & Ahmadi, 2010) found 85.4% (150) of nurses from 11 EDs in Tehran said no procedure for reporting workplace violence existed in their ED. It also found such backgrounds required education and training on workplace violence because under-reporting was a barrier that led to poor attention and understanding of the nature and extent of the problem, to efficiently provide measures to combat the problem (Sato *et al.*, 2012).

Great accumulation of educational qualifications corresponds with a raised probability of reporting. Al-Omari's (2015) research study discovered that nurses with Bachelor's degrees and Master's degrees are 5.4 times and 7.2 times, respectively, more likely to report verbal violence than those with a junior level of education (Al-Omari, 2015). Consistent behaviour of under-reporting is suggestive that the reality of the phenomenon in the clinical area has not yet been captured by researchers (Ferns, 2005), particularly in the South African context.

2.4.4 Perpetrator Factors

2.4.4.1 Patients and companion

Patients and their companions are the main perpetrators demonstrating violence against nurses in the ED in various studies (Gates, Gillespie & Succop, 2011; Han *et al.*, 2017 Jiao *et al.*, 2015). In a cross-section survey among 588 nurses, 93.5% of physical and non-physical violence originated from the patients or their relatives (Jiao *et al.*, 2015). Al-Omari

(2015) found that the patient's relatives contributed 50.8% of violence towards nurses, followed by 34.8% of patients, and 53% of aggressors were recognised as males (Hyland, Watts & Fry, 2016), meanwhile, Kowalenko *et al.* (2013) found the majority of women to be the perpetrator of violence.

Common precipitants of violence in the ED are workload and crowding (Derawad *et al.,* 2015). Overcrowding of patients existing concurrently with the shortage of nursing staff causes long waiting times for patients before receiving medical attention (Gacki-Smith *et al.,*2009), and often, a congested ED fails to provide fast access to medical attention (Han *et al.,* 2012). Reportedly, 67% of perpetrators exhibit acts of violent behaviour in the ED, resulting from long waiting periods to receive medical care, mainly at the triage area (Crilly, Chaboyer & Creedy, 2004). Psychiatric patients were three times more likely to cause violence. Mental health patients often become intolerant of noise; with overcrowding and confusion happening in the ED, mental health patients' become restless and frustrated and this favours violent behaviour (Pich, Kable & Hazelton, 2017).

Hyland, Watts and Fry (2016) found the most common cause of the aggression was from the mental healthcare users (MHCU), particularly from patients diagnosed with depression. Derawad *et al.* (2015) showed that among psychiatric disorders there is a 35.6% likelihood of Alzheimer and dementia triggering violence in the ED. Patients over the age of 65 years are at risk of cognitive deficit behaviours and confusion. It often takes time to adjust and understand hospital settings, but easy to become anxious and fight (Hahn *et al.,* 2017), as are intoxicated patients present in the ED with their intoxicated disruptive friends/relatives (Gacki-Smith *et al.,* 2009).

Alcohol-related violence is a contributing factor to the violence in the ED (Gilchrist, Jones & Barrie, 2009; Pich, Hazelton & Kable, 2013). The study by Hyland, Watts and Fry (2016) recognised alcohol as the main contributing factor to workplace violence. Attending intoxicated patients increased the chances of experiencing workplace violence six times (Pich, Kable & Hazelton, 2017). Alcohol impairs individual judgment and reduces patience in stressful situations (Pich, Kable & Hazelton, 2017). The survey study conducted in two major hospitals in New South Wales, Australia, by Gilchrist, Jones and Barrie (2011) among 91 nurses, found at least 71 nurses listed alcohol as the common factor frequently seen as contributing to the occurrence of workplace violence in the ED, closely followed by the use

of drugs. Among the types of aggressive behaviour, as in other international studies, verbal abuse was the most prominent; approximately 80 participants experienced verbal abuse at least once a month, while 39 individuals (43%) reported experiencing verbal abuse daily. Although Pich, Hzelton and Kable (2013) concur with the study results that alcohol is a remarkable risk to violence, they also argued this attention-seeking behaviour is frequently in young adults aged 16 to 25 years.

Generally, individual socioeconomic class is known as private circumstances, however, it has been found to play a role in acquiring respect from patients particularly in local communities (Zhang *et al.,* 2017). Findings reveal that nurses occupying high socioeconomic status are likely to receive respect in their areas of work, compared with those of low social class. Patients easily express dissatisfaction, anger, and frustrations on nurses, not doctors; somehow, such behaviour is associated with social standards (Zhang *et al.,* 2017). However, Kowalenko *et al.* (2013) argue that this could be because patients depend on doctors for the fulfilling of their medical needs.

Also reported is the mistrust patients and their companions have towards nursing care because of known negligence cases reported by the media (Najafi *et al.,* 2017). Patients/companions have the misconception that nurses are uncaring, as they are happy and laughing in the presence of patients (Gacki-Smith *et al.,* 2009).

2.4.4.2 Nurses

Workplace violence is not only perpetrated by patients and relatives, but also a nurse-to-nurse phenomenon in the form of bullying (Oh, Uhm & Yoon, 2016). Widely recognised in the past years, bullying is an ongoing, progressive problem (Wilson, 2016). Bullying is a negative behaviour displayed by an intimidating and overbearing manner towards other individuals, particularly against smaller, weaker people (Free Dictionary, 2020).

People of the same category can demonstrate bullying (Wilson, 2016). Among 471 nurses from different departments, 54% admitted the existence of workplace violence between nurses. Generally, professional and senior nurses are the common perpetrators of mistreatment on other nurses (Khalil, 2009), however auxiliary nurses frequently engage in physical violence (Khalil, 2009).

Patients contribute to the large amount of violence on ED nurses, yet senior staff members add to the impact of abuse on new nurses (Wolf *et al.*, 2018). In a survey study conducted in Slovenia, based on lateral violence within the nursing profession, nurse leaders were the most frequent cause of the violence (Kvas & Seljak, 2015). During semi-structured interviews, several participants overly expressed direct verbal aggression from superiors; in return, these perpetrators justified downwards bullying actions by saying "They toughen them up" to make better professionals and improve quality of care (Wolf *et al.*, 2018). Publicly demonstrating nurse-on-nurse violence encouraged patients and the community to initiate similar behaviour towards nurses, further precipitating violence against nurses (Khalil, 2009).

Lateral violence is also known as horizontal violence; it is a type of violence that occurs among peers at work and includes physical, emotional, sexual, and psychological (Rainford *et al.*, 2015). This type of violence is associated with specialty units, influenced by the increasing workload and quick decision-making situations (Oh, Uhm & Yoon, 2016). A survey conducted in California showed that a high degree of horizontal violence in the work area causes low job satisfaction (Purpora & Blegen, 2015).

Fatigue is a cause and effect of mistreatment among nurses; it affects communication, the shift of blame and backstabbing, causing the environment to become toxic and the staff to demonstrate low morale and poor motivation (Wolf *et al.*, 2018). A cross-section survey design with 207 nurses and midwives across wards in medium to large Australian hospitals found that emotional abuse caused by colleagues was associated with low job commitment (Demir & Rodwell, 2012).

2.4.4.3 Other co-workers

There is limited literature concerning other members of staff of the ED as perpetrators of violence towards nurses, although doctors are the second highest perpetrators of verbal and sexual abuse on nurses in the hospital setting after patients and relatives (Park, Cho & Hong, 2015). A cross-sectional study reported patients contributing 64.4% and doctors 49.3% to violence in the hospital (Park, Cho & Hong, 2015).

Among 592 participants, 12.2% reported sexual violence, and doctors perpetrated more than 50% of the sexual assaults. Females were three times more likely to experience sexual abuse, particularly young and single women.

2.5 Consequences of Workplace Violence

2.5.1 Psychological

Verbal assault is the most frequent acts of violence encountered in the ED (Stene, 2015), and reportedly, more than half of the ED staff is exposed to verbal abuse daily (Gilchrist, Jones & Barrie, 2011). The majority of the nurses experienced verbal abuse (95.3%) more than physical abuse (23.3%) in three months (Derawad *et al.*, 2015). All victims of workplace violence have experienced various psychological effects following the event (Najafi *et al.*, 2017). During the semi-structured interviews, ED nurses described workplace violence as a continuing nightmare that persists daily (Han *et al.*, 2017), and they experienced feelings of fear and insecurity in their working environment (Najafi *et al.*, 2017). A threat to ED nurses results in adverse effects as it compromises passion for work (Han *et al.*, 2017).

Workplace violence increases workload demand, and reduces concentration from cognitive disturbances (Gates, Gillespie & Succop, 2011). The study has shown that some of the ED nurses develop intrusion symptoms, such as nightmares and recurrent mind images, following occurred events, which likely lead to poor concentration and anxiety. The high mean obtained during the interpretation of the study could be because participants return to the area where they have experienced the trauma (Gates, Gillespie & Succop, 2011).

It is clear that workplace violence causes psychological distress (Gates, Gillespie & Succop, 2011). Sixteen nurses took part in a qualitative study conducted in Iran, where the theme of "suffering nurses" was prominent. Participants described workplace violence as altering their normal psychological processing, expressed feelings of depression, and poor motivation to carry out work duties. In addition, some of the participants reported being on antidepressants following workplace violence (Hassankani *et al.*, 2018). There are also increased numbers of PTSD symptoms seven days after experiencing the event of violence (Gates, Gillespie & Succop, 2011).

Consequences of non-physical violence deserve significant recognition, as it appears to be more severe than physical assaults; this is not to ignore the impact of physical violence, but to avoid neglecting the long-term psychological effect, as it creates risk for mental health outcome (Gerberich, 2004). A cross-section study from members of the emergency nurse association in the USA focused on how workplace violence from patients and visitors affects productivity and symptoms of post-traumatic stress (PTSD) on ED nurses. Two hundred and forty ED nurses fully completed the survey, and about 94% had experienced at least one symptom of PTSD, 17% had an elevated score with a high probability to be diagnosed with PTSD, and 15% had scored the association with immune deficiency functioning. ED nurses were fearful and anxious about the events they experienced during work. Stress results from workplace violence were associated with weak work productivity linked with cognitive demand, support and poor communication. An area of decreased productivity showed in the immediate response of irritability, hostility, and anger from staff towards patients and visitors, and the inability to provide patients with psychological and emotional support; the nurses were also in need of such (Gates, Gillespie & Succop, 2011).

Psychological consequences include anger, disappointments, and humiliation (Najafi *et al.,* 2017). A cross-sectional survey applied convenience sampling in the selection of 84 participants (30 men and 54 women) for data collection to establish whether there was a psychological flexibility link between learned helplessness and depression somatology. The findings revealed a high association of less psychological flexibility with low haplessness results in a depressed mood, meaning individuals experiencing unavoidable recurrent unfavourable series of events could undergo depression (Trindate, Mendes & Ferreira, 2020).

Healthcare workers experience heightened anxiety concerning workplace violence, with the more vulnerable experiencing at least one incidence, especially verbal abuse (Pai & Lee, 2010). Most of the participants in the study recognised verbal abuse as difficult to manage compared to physical abuse (Hyland, Watts & Fry, 2016).

2.5.2 Physical

Violence phenomena have weighty ramifications on the victims (Spelten *et al.,* 2020) and are a progressing problem within the ED environment (Stene, 2015), as about 25% of the

ED staff are physically assaulted monthly (Stene, 2015). In a Jordanian cross-section survey, the results showed 52.8% of nurses experienced physical attacks and 67% verbal abuse in the 12 months of the study, and among the physically assaulted nurses, 26% reported the attack was with a weapon (Al-Omari, 2015).

Nurses working night duty, particularly during the weekends, often experience more incidences of physical abuse, and poor reporting of these is regularly associated with a high risk of experiencing more violence (Gacki-Smith *et al.,* 2009).

It has been discovered that physical violence is commonly on males (71.4 %) compared to females (12. %). One of the interviewees in a qualitative study mentioned being struck with a fist, falling and breaking his leg (Hassankani *et al.,* 2018). Physical abuse was being spat on (n=37: 71.1%) punched (n=33: 63.5%), scratched (n=23: 44.2%) or kicked (n=24: 46.7%) (Hyland, Watts & Fry, 2016).

The most common acts of physical assaults are being pushed/shoved, kicked, spat on and scratched, while in another study ED nurses experienced swinging arms, dumped with a lunch box, and one patient pulled scissors from the suture set and grabbed a nurse by the neck (Han *et al.,* 2017). Physical assaults with a weapon account of about 42%, with the use of guns and sticks (Al-Maskari, Al-Busaidi & Al-Maskari, 2020).

2.5.3 Patients

Nurses have a fundamental significant role to partake in the attendance of the patient. Health education is one of the vital aspects of nursing care, however ED nurses report the time limit to engage with patients and families might trigger aggressive behaviour, and such behaviour leaves patients and families uninformed (Hamdan & Hamra, 2015). The effect of workplace violence is visible in the change of attitudes towards patients and relatives. Patients and families leave the ED without a proper discussion about the patient's condition and health education on discharge (Han *et al.,* 2017). Reportedly, nurses minimise the contact time with patients and their relatives (13.6% and 14.5% respectively) and reduce the time for patient care by 11.8% (Hamdan & Hamra, 2015).

Nurses avoid contact with patients and their companions as a form of defence, to protect themselves from violence (Hamdan & Hamra, 2015). Due to fear and anxiety, nurses develop the feeling of avoidance and detach from others, have a declined ability to experience emotions, and fail to provide emotional support to their client. It also showed reduced productivity in the area of cognitive demand (Gates, Gillespie & Succop, 2011).

Workplace violence negatively affects communication among the nurses, demonstrated by poor interaction, resulting in a break in the continuity of care, lack of staff morale and reduced level of concentration, leading to a high probability of work errors, which further compromises quality patient care (Hassankani *et al*, 2018).

In a qualitative study during semi-structured interviews with registered nurses on the experience of workplace violence in Iran, it was found that workplace violence impair patient care and produce nurse's negative attitude towards the profession (Najafi *et al.*, 2017)

2.5.4 Healthcare System

The serious adverse outcome of workplace violence may not only affect the nurses, but the health system as a whole. Following exposure to the abuse the workforce may be reduced as nurses require sick leave, there is increased institutional financial demand, quality of patient care may be compromised and an increased risk of medical errors (Hassankhani *et al.*, 2017).

Government hospitals experience a high rate of violence compared to private hospitals; this evidence relates to the shortage of equipment and human resources, long waiting queues and dissatisfaction from the patients and relatives (Hamdan and Abu Hamra, 2015). The implication of Workplace Violence on nurses increases costs directly and indirectly on the organisations; these costs include absenteeism, nurses became reluctant to care for the patients, high nurse turnover, decreased staff confidence in the institution, and poor job satisfaction (Chapman, *et al.*, 2009).

Most of the physicians (78.3%) and nurses (78.7%) demonstrate the intention to resign from work after experiencing workplace violence (Hamdan & Hamra, 2015). Among 762 nurses, 8.8% considered resigning and 6.3% changing nursing careers (Speroni *et al.*, 2013). There was a discussion of "prediction of nurses' escape work" in a systematic review, embedded

in 52 research papers, with the researchers' intent to explore experience and aggression using a meta-ethnographic approach. The finding was that frequent existence of workplace violence is an invertible occupational risk with no preventative measures, and it can cause health professionals to resign from work (Ashton, Morris & Smith, 2018).

In Taiwan, a qualitative questionnaire methodology adopted an effective events theory (Li, Chao & Shih, 2018) to determine a model of violent actions perpetrated in the workplace against ED nurses, and whether workplace violence induced negative emotions of resigning or violence avoidance among 137 ED nurses. The study results discovered that at least 123 (89.8%) participants experienced a significant form of violence. Within this group, the study developed two moderators to establish the following behavioural association: pathway A – essential focus of experienced violence with a negative motive to resign from work, meanwhile pathway B experienced violent behaviour associated with negative emotion and physical symptoms of violence avoidance tendencies while remaining at work. The results found that workplace violence on ED nurses increases adverse emotion towards work on both pathways, particularly on the sequence aspect of pathway A rather than B. Conversely, this paper (Li, Chao & Shih, 2018) shows that often ED nurses develop a high motive to resign from work rather than practice avoidance strategies (Li, Chao & Shih, 2018), leading to increased nurse turnover (Wolf *et al.*, 2018).

Meanwhile, bullying among the staff members results in the attacked person having feelings of being unskilful and unworthy, and causes frustrations and poor concentration at work, resulting in medical errors, which negatively affect the patient, and increased medico-legal risk (Wilson, 2016).

2.6 STRATEGIES TO COMBAT WORKPLACE VIOLENCE

The nursing profession should not merely consider care of life-threatening illness and practices for the service user in the ED environment, but also equip these professionals with significant knowledge and training based on priority for personal safety (Ferns & Cork, 2007); training to be able to recognise risk factors leading to violence (Najafi *et al.*, 2017).

In a qualitative study, nurses outlined that planning and solid measures are required for the common consistent, unrecognised and unapproached environmental cues, as it contributes

to daily violence in the ED, such as patients with a history of violence, psychiatric patients, alcohol intoxication and drug abuse and an environment with increased risk of violence (private treatment rooms, overflow of patients shortage of security officers and their equipment) (Wolf, Delao & Perhats, 2014).

A follow-up survey after the implementation of education and training based on workplace violence on health professionals in the ED, showed that ED staff's perception of violence as part of their job was reduced by more than half (Stene, 2015); this illustrates the effectiveness of training. Education and training are encouraged comprehensively in young nurses less than 30 years of age and less experienced nurses, as this group is associated with a high rate of workplace violence (Shi *et al.*, 2015). Although it is not common, Han *et al.* (2012) suggest that sometimes training of workplace violence might increase the sensitivity of violence towards staff, it can change the perception of acts of violence and that could contribute to an increasing number of violent events.

Nurses' misinterpretation of the patient's signs of intentions or warning signs of violence suggests that more knowledge and skills are required on ways to combat workplace violence (Lantta *et al.*, 2016). ED Nurses need better training to manage psychiatric patients; mental health patients need prioritising in the ED, pulled out of the queue and urgently attended to upon arrival, quickly triaged and offered treatment to alleviate fear, and referred to the appropriate ward/facility.

Health establishments need to provide essential training with measures that enable nurses to accumulate necessary skills to identify, manage and dissolve acts of violence, be able to recognise early patient's discontent with the care, verbally involve the perpetrator and de-escalate measures and procedures to prevent violence from occurring, deploy precautionary measures when attending high-risk patients and relatives, such as having a companion/security officer when interacting with them and maintaining a reasonable distance during the interaction, and implement institutional policies to limit visitors (Pompeii *et al.*, 2015).

One study, focused on analysing existing workplace violence programmes and comparing them among 116 hospitals in California and 50 hospitals in the New Jersey, identified gaps

and suggested the following for establishing and implementing programmes (Peek-Asa *et al.,* 2007).

- Programmes offered concerning workplace violence should be lengthy to cover most, if not all, components of workplace violence education and training, to be effective and reach objectives.
- The programme should last for at least one hour.
- Include as many employees as possible.
- Consider institutional relevant policies and procedures.
- Select a champion within the employees to oversee the correct implementation of the recommendations and formed procedures.

Training of verbal and physical violence must run concurrently (Hahn *et al.,* 2017). Confidence in preventing and managing only physical violence did not to play a role in decreasing the chances of experiencing verbal abuse (Hahn *et al.,* 2017).

Reduced numbers of violent incidences is associated with an institution that has policies and procedures to report violent behaviours (Gacki-Smith *et al.,* 2009). It is good cause for an institution to consist of policies and measures to prevent workplace violence (Gilchrist, Jones & Barrie., 2011), but they must be acknowledged and understood by employees to implement them efficiently. An Australian study identified that other members of the ED are not certain and are unaware of institutional actions of handling workplace violence. The study suggests the need for staff to be taught ways to utilise the policies and strategies in place (Gilchrist, Jones & Barriel, 2011).

Reflection of the nurse's attitude and perception regards to workplace violence enables each of them to identify personal risk of violence and valuate the professional role in dealing with violent situations. Nurses need to learn how to empower themselves efficiently to communicate professionally with their patients, relatives, and colleagues (Najafi *et al.,* 2017). The study suggests the need for the introduction of anger management for nursing students at the point of entry at the universities and colleges (Khalil, 2009).

Leader training, in particular, is important for an active member in the involvement of decision making of organisational development, and the ability to influence the modification of organisational cultures (Kvas & Seljak, 2014). The managers must acknowledge the

importance of workplace support for the nurses. Supervisor's involvement and support is important to combat emotional abuse from lateral violence and bullying (Demir & Rodwell, 2012). To eradicate workplace violence, nurse leaders must not demonstrate acts of violence towards nurses, but rather act as sources of help to the nurses, and actively engage in activities to assist and establish organisational measures to combat the problem (Kvas & Seljak, 2014).

Nursing managers need to acknowledge most ED nurses face high levels of stress from violent events, therefore, identify vulnerable individuals and refer them for counselling (Gates, Gillespie & Succop, 2011). Establishing support groups, consisting of peers and administrative personnel, to grant the victims an opportunity to process the traumatic events and debrief is a way to reduce stress and improve patient care (Gates, Gillespie & Succop, 2011). Furthermore, nursing managers encouraging ED nurses to come together and support one another is an effective way to cope with traumatic events at work, strengthen resilience, and provide emotional support (Lee *et al.,* 2020).

A preventative approach report identified a lack of studies evaluating the effectiveness of measures applied to eradicate workplace violence (Ramaciati *et al,* 2018). Consistent behaviour of under-reporting suggests researchers have not yet captured the reality of the phenomenon in the clinical area (Ferns, 2005), particularly in the South African context.

Reporting is vital to alert the nursing managers and provides a better understanding of the nature and extent of the problem (Hamdan & Hamra, 2015). The study by Stene *et al.* (2015) has shown that by following the implementation of measures to combat workplace violence, the reporting tool and provision of training and support from the institution and managers, the ED staff began to report the encountered violent events, which aids the managers to follow up.

Management needs to strengthen safety measures; the hospital must make use of surveillance cameras and alarms in the premises, ensure sufficient lighting in the space of work and passages, particularly during the night (Shi *et al.*, 2017). The hospital should develop a task team that consists of nursing managers, ED medical directives, local police personnel, security officers, and ED nurses to identify vulnerabilities elements, formulate a plan to prevent such occurrences, and develop reporting and managing strategies of workplace

violence (Gacki-Smith *et al.,* 2009). ED nurses need to be involved in the development and modification of policies and protocols for empowerment to gain control and confidence in their working environment (Hogarth, Beattie & Morphet., 2016).

There has been no adequate exploration of sexual harassment, particularly on women. Cultural diversity brings out fear in certain female groups, they became reluctant to report sexual assaults due to a fear of being stigmatised (Hamdan & Abu Hamra, 2015).

Media reports need regulating. Isolated patient-centred reports need avoiding as they implicate mutual relationships between nurses and the community, instead, mass media should provide reasonable information to assist people with health education and the national state of the healthcare system (Chen *et al.*, 2018), and provide information on how the triage process and ED operate (Najafi *et al.*, 2017).

2.7 SUMMARY

This literature review discusses violence as a concept and its impact worldwide. It shows the adverse outcome it has on the population and communities, the increase in fatality, deprivation of health, and poor economic circumstance. Violence can develop in different sectors within a country. This literature provides evidence indicating an increase of workplace violence in the healthcare system towards healthcare providers, the prevalence of workplace violence is higher on nurses, particularly in the emergency department (ED) (Wolf, Delao & Perhats, 2014). Nurses, as the frontline of the healthcare system, and healthcare providers who are available throughout patients' visits in the health establishment experience a frequent verbal and physical form of abuse demonstrated by patients and their companion/relatives (AlBashtawy & Aijezawi, 2016).

Violent behaviour in the ED environment does not only originate from the patients and relatives, but also from doctors and other disciplines, including nurse-on-nurse occurrences. However, the literature reveals multiple studies focused on patients/relatives, but few discussing violence from staff. This chapter explores the contributing factors leading to the violence against nurses in the ED. The precipitating factors are overcrowding, long waiting times, care of mental health patients, alcohol and drug abuse (Gacki–Smith *et al.*, 2009).

The majority of ED nurses experience verbal abuse in comparison to physical abuse. Violence against ED nurses causes psychological and physical trauma; nurses' experience nightmares, anxiety, signs of post-traumatic distress disorder, depression and physical injuries following the assaults (Gates, Gillespie & Succop, 2011).

Workplace violence interferes with a nurse's ability to provide care, as they work with fear and insecurity, develop increased levels of stress, work demands and lack of concentration, and such areas are associated with poor patient care and an increase in medical errors (Gates, Gillespie & Succop, 2011). An increase in medical error leads to a high number of litigations and lawsuits, therefore institutional costs may rise (Chapman *et al.*, 2008). Health facilities need to deploy measures to prevent and manage workplace violence in the ED.

Based on the recommendations, ED requires planning and execution of measures to target the common consistent precipitating factors, such as overcrowding, psychiatric patients, patient under influence of alcohol and drug abuse, long waiting times, and disorganised institutional infrastructure (Gacki-Smith *et al.*, 2009). Management needs to strengthen safety measures (Shi *et al.*, 2017), provide staff with education and training to manage workplace violence, establish procedures and policies to report violent incidences. The provision of these safety actions will protect ED nurses against their rights.

Although patient's rights need guarding against violation and abuse, both patients and nurses' rights need considering concurrently. The South African Nursing Council stipulates that nurses have the right to perform their duties at a work environment that is safe, free from harm, intimidation, and threat. Such consideration brings an effective functional health system (May & Grubbs, 2002). May and Grubbs (2002) found the nurse's rights are being neglected in favour of the patient's satisfaction. The National Health Care Act 61 of 2003 of the South African Constitution, states that a healthcare provider has a right not to participate in the care of a client/patient who verbally, physically, and sexually abuses him/her. Approaches to combat the workplace violence should focus largely on the modification of behavioural, social, and environmental characteristics, and appraise measures that are reactive and effective to reduce the violent incidences (WHO, 2003).

There is lack of literature regarding workplace violence against ED nurses in South Africa. According to the South African police service database, there is a high frequency of crime

in the country, with about 2.1 million various crimes reported in the 2017/2018 financial year; among the offences there were 20 336 murder cases, 40 035 rapes, 6 786 sexual assaults and 186 243 common assaults. Within the context of workplace violence, a small study took place in two hospitals in Johannesburg among all emergency department staff, including doctors, nurses, porters, clerks, and general workers; 73% of participants reported emotional abuse, while 34.2 % experienced physical violence. This study was limited due to the small number of nurses who participated (Jaffal, 2016).

CHAPTER THREE
RESEARCH METHODS

3.1 INTRODUCTION

This chapter describes the research design chosen to address the research questions, the methodological aspects of sampling, data collection tools, and data analysis and interpretation. Also elaborated are the data management and ethical considerations pertinent to the study.

3.2 RESEARCH PARADIGM

The research paradigm refers to a set of basic beliefs that underlie the researcher's actions concerning the question under investigation (Polit & Beck, 2014). The paradigm that underpins this study is that of pragmatism. Pragmatics believe the problem is as significant as the methods used, and the researcher uses the most appropriate approaches to understand the problem. Based on pragmatism, the researcher believed in identifying the true cause of the problem in order to reveal the best solution. In this manner, the choice of research methods and procedures remained at the researcher's discretion, deciding what would best answer the research question.

Pragmatism was more suitable for this study as it is concerned with identifying problems and solutions in a practical manner that attempts to distance itself from preconceived notions. The pragmatist view of inquiry is open to multiple realities, and it orientates itself to the solution of practical problems occurring in the real world. In this way, the researcher had freedom of choice and did not commit to one approach alone, looking at different approaches to collecting and analysing the data to best answer the research question. In addition, the pragmatic approach allowed the researcher to have a broader and deeper understanding of the research problem than if using a single approach. Pragmatism also enabled the researcher to involve different participants to get multiple views on the topic under study.

For this study, both objective and subjective data generated through quantitative and qualitative methods better represented the situation of describing the perception and experiences of ED nurses with regard to workplace violence.

3.3 RESEARCH DESIGN

The choice of research design flows directly from the particular research questions under investigation. The research design used for this study was a mixed-method, defined as a method that focuses on collecting, analysing and mixing quantitative and qualitative data in a single study. The central premise is that combining quantitative and qualitative approaches provides a better understanding of research problems than either approach alone.

The quantitative phase included a structured questionnaire, which limited the researcher to collect just enough information to address the basic aim of the study. By adding the qualitative phase, the researcher had open-ended questions to elaborate on the problem.

The researcher applied the sequential explanatory design for this study, which was more appropriate for several reasons. To begin with, the researcher conducted the study in two phases; this enabled the researcher to get back to participants to collect qualitative data in the second phase, after collecting quantitative data in the first phase. The quantitative data provided a general picture of participant's perceptions and experiences with regard to workplace violence, while the qualitative data generated more in-depth coverage of participants' views. Furthermore, the sequential method allowed the researcher to probe the question to best suit the research aim. The researcher was able to develop and emphasise the new questions that arose from the quantitative findings, which quantitative data could not answer. This enabled the researcher to probe potential problems and solutions in more depth and detail. Data collection and analysis occurred concurrently, which made the study more manageable for the researcher.

3.4 RESEARCH SETTING

The study took place in Four Emergency Departments at two public hospitals in the Gauteng Province.

The first hospital is an accredited hospital with 1088 beds serving patients from across Gauteng and neighbouring provinces. The hospital offers a full range of tertiary and secondary highly specialised services, and is the main teaching hospital for the Faculty of Health Sciences at the University of the Witwatersrand. The institution provides the service

base for undergraduate and postgraduate training in all areas of health professions. The hospital has 4000 staff members, and 1500 patients are registered daily, including 280 casualties and 100 in-patients.

The second hospital is an accredited hospital with 540 beds serving patients from the East Rand region of Gauteng Province. The hospital has one emergency department and common conditions include trauma, medical and surgical conditions. The ED has 77 staff members, and approximately 130 patients registered daily; this translates into approximately 3900 patients per month.

3.5 PHASES OF RESEARCH

The study had two phases, as explained in the following sections: a quantitative phase (phase 1) and a qualitative phase (Phase 2).

Table 3.1 Summary of study phases

Objectives	Data collection	Sample and population	Data analysis	Data integration
Phase 1 To determine the nature and extent of workplace violence experienced by ED nurses	*Data collection*: Survey questionnaire	*Population*: Nurses in EDs (N=138)) *Sample*: Convenience sample	Descriptive and inferential statistics	Mixing both Phase 1 and Phase 2 (quantitative and qualitative data)
Phase 2 To explore the experiences and perceptions of ED nurses regarding workplace violence in two hospitals in Gauteng	*Data collection:* Focus group discussion	*Population:* Nurses in EDs (n = 20) Sample: Purposive sample	Braun & Clarke (2006) method for qualitative analysis	

3.5.1 Phase 1: Quantitative Study

The first objective was to determine the nature and extent of workplace violence experienced by ED nurses.

3.5.1.1 Population

A target population is an integral population, which the researcher usually samples from an accessible population and hopes to generalise the study findings (Polit & Beck, 2014). The target population for this study comprised nurses working in the emergency departments in the selected institutions; this included the nurses working in trauma, medical, paediatric and general emergency departments.

A preliminary record review, undertaken in June 2020, indicated there were approximately 138 (N=138) nurses on the nursing allocation lists in the respective study sites (n = 4). Table 3.2 presents these results.

Table 3.2: Total number of nurses working in the selected study sites

Site	Number of nurses
Trauma ED	29
Medical ED	30
Paediatric	19
General ED	60
Total	*138*

3.5.1.2 Sample and sampling

To ensure as large a representative sample as possible, all nurses working in the emergency departments could participate in the study. The total sample was applied, and a convenience sampling method used to achieve the study sample. This method was to select the most extensive variety of participants who were typical of the population under study.

The inclusion criteria for prospective participants were:

- Registered with the South African Nursing Council (SANC) as a professional nurse, enrolled nurse or auxiliary nurse
- Working in one of the selected study sites at the selected institution
- More than six months of working experience in the selected ED

3.5.1.3 Data collection

The questionnaire for this study was a modified version of the Emergency Nurses' Association (ENA) 16-item survey on workplace violence. The tool, available on the Emergency Nurses Association website for public use (ENA, 2009), was originally developed by the ENA as part of their violence toolkit and is already reviewed for validity (Gacki-Smith *et al.*, 2009).

The self-administered questionnaire was developed to assess workplace violence (refer **Appendix A**) and consists of two sections. The first section aimed to collect demographic data of the participants, which included, gender, age, marital status, and ethnic background, cultural groups, rank, educational level and years of experience in the emergency department. The second part is concerned with safety measures existing in the emergency department, and experiences of the workplace violence; this section consists of nine items and some of these items contains sub-questions. The nature of the questions varies, and items seek yes or no responses, or a choice on the scale; additional open-ended questions were included that solicit nurses' personal experiences of violence in the workplace.

After verification by five local domain experts, i.e. medical specialists (n = 2) and emergency nurse trained, registered and nurse education experts (n = 3), the questionnaire was found to apply to the South African context.

3.5.1.3.1 Pilot testing

A small pilot test occurred prior to the commencement of the main study. The data collection tool was used on five (n = 5) respondents in the units at the selected study site. A pilot test is a small-scale study trial run on all aspects planned for the main study, with the intention of helping the researcher to fine tune the main study and to determine whether the methodology, sampling, instrument and analysis are adequate and appropriate (De Vos *et al.*, 2011).

The purpose of the pre-testing procedure was to identify any possible difficulties that may appear during the study, and make changes to the data collection instrument if necessary.

Participants indicated that the language was understandable and there were no recommendations made to change the instrument. Each participant took an average of 10 to 15 minutes to complete the questionnaire.

Results of the pre-testing procedure were not included in the main study; this was in consultation with the statistician.

3.5.1.3.2 Data collection process

A request was made of the Chief Executive Officer (CEO) of the hospital for permission to conduct the study. Once obtained, the researcher approached the nursing services manager and the operational managers to ask for their permission.

The researcher visited the selected study site and examined the respective nursing allocation lists for the selection of participants. Those respondents who agreed to participate in the study received an information letter outlining the study and its procedures (refer **Appendix B**) and a consent form to complete (refer **Appendix C**). Although the study was anonymous, the respondents had to provide information about their age, gender, marital status, ethnic groups, and cultural groups, level of education, rank and experience. Data collection occurred during day and night shifts and weekends over a three months period, which was from 1st October to 31st December 2020.

Once completed, the questionnaires were to go into self-addressed envelopes and posted in a sealed box by the participants. The opening of the box would only occur once the data collection period was completed. The researcher negotiated with the respective operation manager for a secure area to place the sealed box. The researcher visited the study sites on a weekly basis and put a notice on the nurses' notice board in the respective ED to remind the participants to complete the questionnaire.

3.5.2 Phase 2: Qualitative Study

The second objective was to explore the experiences and perceptions of ED nurses regarding workplace violence in two hospitals in Gauteng.

3.5.2.1 Population

The population for this study included a portion of emergency department nurses who participated in the initial quantitative study. These were ED nurses working in Charlotte Maxeke Academic Hospital and Tambo Memorial Regional Hospital.

3.5.2.2 Sample and sampling

This phase adopted purposive sampling, which enabled the researcher to judge on which ED nurses to invite for an interview. In Phase 2, the invited participants were to relate their different experiences, confusing and contradictory information provided in Phase 1 of the study, and be willing to communicate their views. Focus group discussions, involving four or five participants, used a semi-structured interview guide and continued until data saturation; 20 nurses participated, therefore there was more than one session conducted.

3.5.2.3 Data collection

The primary method of data collection in this part of the study was semi-structured interviews. For this study an interview guide was developed to facilitate the focus group discussion (refer **Appendix E).** The questions aimed at soliciting information from participants about their experiences concerning violence against them in the workplace. The questions were open-ended, and consisted of probes and follow-up questions, which allowed the researcher to achieve depth and detail during the discussions.

In qualitative studies, the researcher serves as the instrument. Creswell (2009) stated this is the principle observer, note-taker, interviewer and interpreter of the data collected. The researcher is an experienced nurse practitioner in this field of study, and the site is affiliated to the university where the researcher is currently registered as a postgraduate Master's student.

3.5.2.4 Data collection process

Focus group face-to-face interviews collected the data in groups of five participants. Participants shared understanding and views on the study at hand. The method is effective

and likely to yield the best information when participants are similar, cooperate with one another and preserve time (Creswell, 2012). The method encouraged the interviewees to share their views and opinions. Polit and Beck (2012) state that focus group interviews are an efficient way to collect information from several participants simultaneously and give rise to favourable dialogue.

At Tambo Memorial Hospital ED, the focus group interview sessions took place in the duty room, and for the Charlotte Maxeke Johannesburg Academic Hospital ED, the interviews were in the Department of Nursing Education at the University of Witwatersrand.

The researcher ensured the interview environment was non-threatening and away from distractions, such as noise, each interview room door had a note stating *"interview in progress do not disturb, please minimise noise,'* and the participants were welcomed in a friendly manner. As a specialist nurse practitioner, the researcher utilised nursing interviewing skills to establish rapport and demonstrate sensitivity to participant's responses, encouraged clarity and probing to obtain in-depth information, and ensured participants were aware there were no right or wrong answers to any question; the approach encouraged participants to continuously share their view and opinions throughout the interview. To gain more in-depth information the researcher was flexible enough to follow up participant's conversations and shown good listening skills (Creswell, 2012).

Prior to conducting the interviews, participants received a biographical information form, and an information letter. The researcher read the information letter, explained the significant of the contribution, enabled participants to ask questions, and provided clarity on the content outlined in the forms. This was to demonstrate to participants that there was no obligation to participate, and that participation was voluntary. Thereafter, they had to sign a consent **(Appendix C)** and audio recording **(Appendix D)** form to accept participation. Each focus group interview session took approximately 45 minutes to an hour.

The interviews were audio-recorded and field notes taken, and later transcribed to enable the researcher to gather data as accurately as possible. The researcher's supervisor then received the transcribed data.

3.6 DATA ANALYSIS

3.6.1 Quantitative Data Analysis

Data analysis aims to summarise, organise, and shape large volumes of data and provide meaning (Polit & Beck, 2014). The use of the survey results and Excel spreadsheet transferred the statistical data into a STATA version 15 software package. Statistics is an effective tool when analysing obtained quantitative data (Brink *et al.,* 2018). Descriptive summary statistics explained and summarised the data. Data were analysed using measures of relationships, frequency distributions, measures of central tendency, Chi-square and Mann-Whitney tests to determine population differences related to demographics and characteristics.

3.6.2 Qualitative Data Analysis

The audiotaped data were transcribed verbatim and analysed using thematic analysis (Braun & Clarke, 2006). This process of analysing data contains six subsequent phases.

- Phase 1: familiarising self with data

The first step of data analysis commences following gaining or collecting data. This phase involves familiarising oneself with the data, immersing oneself by repeatedly reading the data to gain in-depth knowledge of data and a more significant extent of awareness of the content of data. The researcher listened to the recorded audio tape, transcribed it verbatim into field notes to conduct thematic analysis, and then read the transcripts (**Appendix F**) constantly to obtain a broad understanding. Vigorous reading of data assisted the researcher to probe for meaning and patterns. The participants and supervisor cross-examined the transcribed data and field notes to ensure accuracy and the understanding of the transcript; such validation provides a good presentation of that said by participants, and enhances bracketing. Bracketing sets out the researchers' preconceived ideas and opinions of the phenomena under study that may taint the results (Polit & Beck, 2018).

- Phase 2: generating initial codes.

After immersing oneself in the data, familiarising and understanding the content of the data, to proceed in Phase 2 involves organising and grouping data in a meaningful way. The grouping of the produced transcripts was according to the researcher's interest, with the study's objectives and codes formed. The highlighting of the significant statements with different colours was to reflect potential patterns, and these were the common and meaningful statements that were repetitively or reoccurring ideas distinct within the data. The researcher reviewed the extract statements and ensured that they reflected the study's objective.

- Phase 3: searching for themes

After generating codes, this phase focuses on sorting the different codes into potential themes. The researcher arranged the collated relevant data and potential themes into a broader theme, wrote names of each code on a separate piece of paper, and explored and organised them into themes. At this stage, some of the codes formed themes, while others did not belong anywhere. The researcher developed a sense of understanding of nurses' experiences, and emerging themes became apparent.

- Phase 4: reviewing themes

This stage involved grouping and regrouping of themes, included reviewing and refining themes for coherence. The researcher read all collateral extracts for each theme and ensured it fit; data set that did not belong underwent regrouping, and new themes emerged. The review commenced at the coded data level and ensured themes were congruent with the data set and coded any additional data within the themes initially missed in the coding stages. The researcher's supervisor also reviewed the transcript and highlighted statements and codes to ensure rigour and accurate analysis. Themes were refined to answer the research question and represent the study's objective.

- Phase 5: defining and naming themes

Assembling themes and sub-themes, and defining and refining themes that represented analysis, outlining the content of each theme to what it represents, and the aspect of data analysis it captures. In this phase, themes were organised coherently and supported by

individual narratives. Theme names are respective to their context, and each theme was analysed in a broader story to the research question.

- Phase 6: producing the report

The final phase of data analysis commenced after organising the themes and concluded with writing up the report. The analysis demonstrated validity, and the researcher's supervisor was involved in the whole process of data analysis.

3.7 VALIDITY, RELIABILITY AND TRUSTWORTHINESS

3.7.1 Validity and Reliability

Validity relates to the extent to which the tool measures the right element and is concerned with the accuracy and truthfulness of findings of the study (Polit & Beck, 2014). During Phase 1 of the study, the workplace violence staff assessment survey toolkit **(Appendix A),** developed by the Emergency Nurse Association (ENA)from the United States of America (USA), maintained validity (ENA, 2009). The tool was validated in a study by Gacki-Smith *et al.* (2009) utilising a convenient online survey with a response of 3465 participants; based on the results the tool was concluded to be valid and feasible to meet the objectives of the study. Measures of validity ensure that an instrument, such as questionnaires and other auditing tools, achieve the goal of accurate measurement of that intended (Andrew & Halcomb, 2009).

Reliability refers to the degree in which an instrument yields the same results when repeated in the same context by the different researchers (Brink *et al.*, 2018), and in this study, it was maintained by accurate and consistent use of the same instrument for the collection of data. The researcher collected the data alone to ensure the consistency of data collection. The second round of data entry and capturing for statistical analysis and accuracy confirmed the raw data. Conducting a pilot study before the commencement of the main study was to make sure the phrases of the questionnaires were clear and understood by the participant, and to ensure the attainability of the research.

3.7.2 Measures of Trustworthiness

The term trustworthiness refers to the degree of confidence qualitative researchers have in their data, as assessed in the method of Lincon and Guba (1994), as cited in Polit and Beck (2018), using criteria of credibility, transferability, dependability, and confirmability to ensure trustworthiness.

3.7.2.1 Credibility

The confidence in the truth and interpretations in the qualitative study as the researcher attempts to demonstrate the true picture of the phenomenon under study and enhance the believability of the findings (Polit & Beck, 2018). The following techniques can establish credibility to sustain the confidence of the truth.

- Prolonged engagement

Lengthy engagement of the researcher with the participants in the field builds rapport and trust between the researcher and participants. It enhances an in-depth understanding of the participant's variety, language, culture and diversity regard phenomenon under study (Polit & Beck, 2018). The researcher is an emergency nurse, practicing in the emergency department for approximately six years, therefore familiar with the environment and the participants. The interviews lasted until no new themes emerged and there was saturation reached.

- Persistent observation

During data collection, continuous observation of participants produces high-quality data (Polit & Beck, 2018). During the interviews, the researcher did not merely focus on voices or words, but observed behaviour and attributes.

- Investigator Triangulation

This refers to the use of more than one researcher in data collection to reduce events of bias and idiosyncratic interpretations (Polit & Beck, 2018). The researcher's supervisor is an

expert in the field of qualitative and quantitative research, and supervised the researcher throughout the process of data collection and analysis.

- Peer review and debriefing

This is to seek opinions from peers not involved in the significant study, senior personnel, or expect on the phenomenon under study be able to give input and pose arguments to each step of data collection and analysis (Polit & Beck, 2018). There was consultation with senior students, graduates and nursing lecturers from the university's Department of Nursing Education, including the research supervisor, who provided input on data collection and analysis.

- Member check

Provision of information back to participants to allow intentional correction of obvious errors and generate more information (Polit & Beck, 2018). During the interviews, the participants expressed their experiences and perceptions of violence experienced in the workplace, which was summarised at the end of each interview with the audio recording re-played after each session to verify the provided information.

3.7.2.2 Dependability

The term refers to the stability and reliability of the study (Polit & Beck, 2018). Dependability involves the capacity to provide evidence demonstrating the possibility that there can be replication or performing of a study in the same context to yield the same results (Polit & Beck, 2018). In this study, a systemic presentation of the research process through thorough documentation comprehensive transcripts and field notes sustained dependability and ensured the availability of the report findings to allow the replication of the study in the future to achieve similar results.

3.7.2.3 Confirmability

This explores the accuracy, consistency, and congruency of the data. Confirmability is concerned with how data represents the context of the information and meanings provided

by the participants rather than the opinion and perception of the enquirer (Polit & Beck, 2018). Data should inherently contain the voice of the participants (Polit & Beck, 2018). In this study, confirmability was sustained by conducting focus group interviews, audiotape recording the data, taking field notes of participant's verbal and non-verbal responses during and after the interviews, and audiotape recordings transcribed verbatim for coding to support and generate themes and sub-themes. The supervisor read and audited all the transcripts to ensure the accuracy and steadiness of the data.

3.7.3.4 Transferability

This refers to the ability and extent to which findings can undergo a transfer or application to other contexts or settings. To enhance transferability, it is the responsibility of the researcher to produce a thick description of the study participants, including sufficient data collection and detailed reporting (Polit & Beck, 2018) so that the reader can make a judgment as to whether the findings apply to their situation. Transferability was maintained by the provision of documentation and enough data in the study including design, setting, analysis, and how the study was carried out so that the reader can refer to its applicability and compare it with what is obtained in their context or setting.

3.8 ETHICAL CONSIDERATIONS

3.8.1 Permission to Conduct the Research

The University of Witwatersrand Postgraduate Committee granted permission to conduct the study, and the university's Ethics Committee granted ethics clearance **(Appendix G)**. The researcher acknowledged the rights and interests of the participants in this research, Ethics included, informed consent, confidentiality, justice and avoidance of harm or non-maleficence.

3.8.2 Informed Consent

The hospital chief executive officers (CEO) and the nursing service managers **(Appendix H & I)** of the two hospitals gave written permission to conduct the study. Participants received

written and verbal information about the study, and received an information sheet outlining the purpose of the study, duration of participation, research procedures, and the risk involved. The participants acknowledged that expected of them and the manner of participation. There were no monetary benefits and incentives given or promised to participants to motivate participation. Participation was voluntary and they could decline to participate at any point during the study. During Phase 1 of the study, completing the survey questionnaire was an agreement to take part in the study, and in Phase 2, all participants received a consent form to sign upon agreeing to take part in the focus group interviews. All participants were adults with psychological competence to make informed decisions.

3.8.3 Confidentiality

Participants received the assurance of confidentiality. No form of identification was publicised or made available to other people, no names were required on the distributed survey questionnaire form, participants returned the forms without identification information, used code numbers during the recording of the focus group interviews and reporting, and there was no link of their identities to their responses. There were no names or any other form of identification included in the final report, and there was privacy as the interview took place in a secured, closed room. Raw data remains under lock and key to which only the researcher and the supervisor have access.

3.8.4 Justice

The participants' selection was via inclusion criteria, and their treatment was fair and equal throughout their participation in the research project. The researcher also took into consideration beliefs and backgrounds of the participants (Polit & Beck, 2018). Those who declined participation or to engage in the research project were also treated with respect and in a non-prejudicial manner. The researcher ensured and honoured the agreement made with the participants.

3.8.5 Avoidance of harm and non-maleficence

As the study involved the perception and experiences of workplace violence, participants received assurance that the information they provided was confidential and never used

against them (Polit & Beck, 2018). The researcher informed participants that some of the questions asked could be emotionally unsettling and for any reason one develops or found to need of professional psychological support, it would be available for them; there was free counselling arranged with the respective psychology department of the hospitals, Tambo Memorial and Charlotte Maxeke Academic Johannesburg hospitals' psychology departments. Participants acknowledged they could withdraw at any point of study without providing reasons and there would be no threats or negative consequences executed towards them.

3.8.6 Data Management and Security

The data produced in the study was to remain in a secure place. All the information including the audiotapes recordings, transcripts, memos, and field notes were securely stored in the Department of Nursing Education of the university. Only the researcher and the researcher's supervisor had access to the data. The data had to remain in storage for a minimum of two years after publication or six years if not published.

3.9 SUMMARY

The chapter described the research methodology of the study utilised to achieve the objectives and the purpose of the study. It included the research design, data analysis, pilot study, data collection procedures and ethical consideration, measures of trustworthiness, and data security and management.

The next chapter will discuss data analysis and the findings of the study.

CHAPTER FOUR

FINDINGS OF THE STUDY

4.1 INTRODUCTION

This chapter provides the findings of this study, presented in two sections, namely quantitative findings and qualitative findings. The quantitative findings, Phase 1, illustrated by descriptive statistics, are followed by inferential statistics. Thematic analysis explained the qualitative findings, which are Phase 2. The qualitative findings explanation follows the quantitative findings.

4.2 PHASE ONE: QUANTITATIVE FINDINGS

4.2.1 Response Rate

By the end of the data collection period of three months, there were 93 out of 138 surveys returned. Eight surveys were unfilled, leaving 85 surveys (response rate = 61.59%), and although considered a low response rate (Fincham, 2008), the implications thereof will be addressed in the limitations of the study.

4.2.2 Section A: Demographic Data of Respondents

This section related to respondents' demographic data, and comprised eight items. Items included age, gender, marital status, ethnic group and cultural group, level of education, rank, and experience.

Eighty-five (n = 85) respondents made up the sample size.

Table 4.1 provides an overview of these results. The grouping of the items was for ease of discussion.

Table 4.1: Demographical data of the study sample

Item	Variables	Frequency	Percentage
Q1	Age		
	18 to 24	-	-
	25 to 34	35	**41.2%**
	35 to 44	25	29.4%
	45 to 54	20	23.5%
	55 to 64	5	5.9%
	65 and over	-	-
Q2	Gender		
	Male	24	28.2%
	Female	61	**71.8%**
Q3	Marital status		
	Single	58	**68.2%**
	Married	27	31.8%
Q4	Ethnic group		
	Black	79	**92.9%**
	White	2	2.4%
	Coloured	2	2.4%
	Indian	1	1.2%
	Other	1	1.2%
Q5	Cultural groups		
	English	4	4.7%
	Pedi	20	23.5%
	Zulu	27	**31.8%**
	Venda	9	10.6%
	Xhosa	3	3.5%
	Afrikaans	1	1.2%
	Ndebele	4	4.7%
	Others	17	20.1%

Table 4.1 showed that females accounted for 71.8% (n = 61) and males 28.2% (n = 24). The majority (68.2%; n = 58) indicated their marital status as single. The largest group (41.2%; n = 35) was between the age of 25 to 34 years and 29.4% (n = 25) between 35 and 44 years. In this study, the majority (92.9%; n = 79) of the sample were Black, a close third (31.8%; n = 27) were Zulu, followed by 23.5% (n = 20) and 20.1% (n = 17) in the Pedi and Others cultural categories, respectively. Figure 4.1 displays these results.

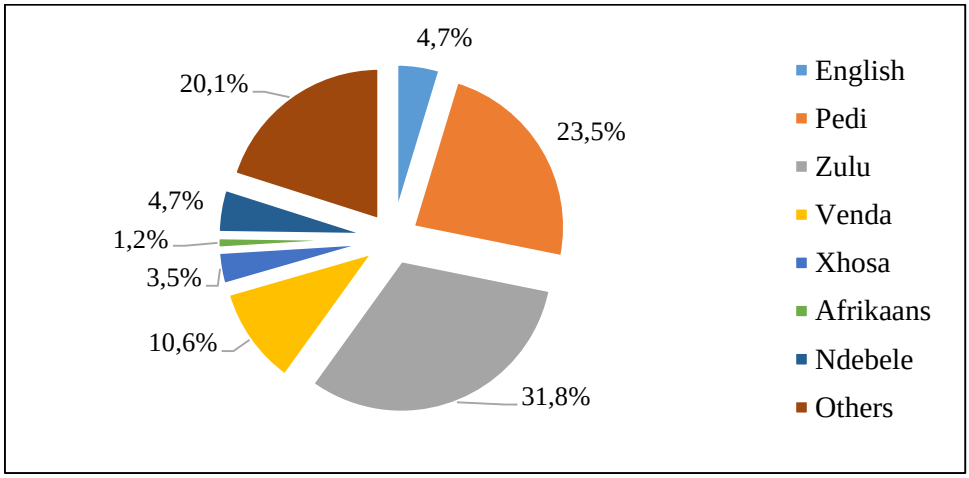


Figure 4.1: Cultural group distribution of the respondents

The majority (58.9%; n = 50) had a diploma as their highest level of education, followed by 22.4% (n = 19) and 10.6% (n = 9) indicating a higher certificate and Bachelor degree, respectively. **Figure 4.2** displays these results.

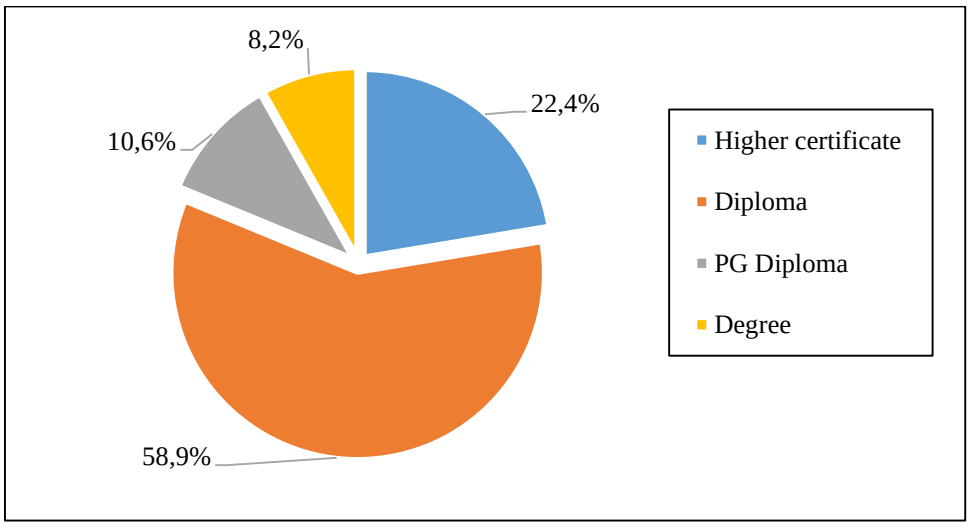


Figure 4.2: Level of education of the respondents

The majority (56.5%; n = 48) of nurse respondents indicated their current rank as professional nurse, followed by 24.7% (n = 21) in the staff nurse categories. **Figure 4.3** displays these results.

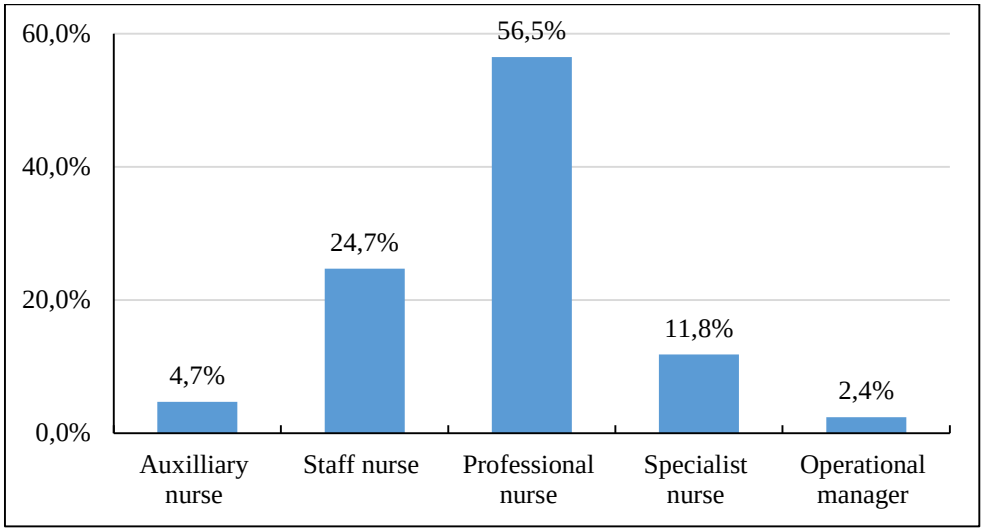


Figure 4.3: Rank held by respondents in the ED

In this study, about one third (36.5%; n = 31) of respondents had between 1 to 5 years of nursing experience, followed by 30.6% (n = 26) and 17.7% (n = 15) of nurses in the categories of 6 to 10 and 11 to 20 years of experience in nursing, respectively. **Figure 4.4** displays these results.

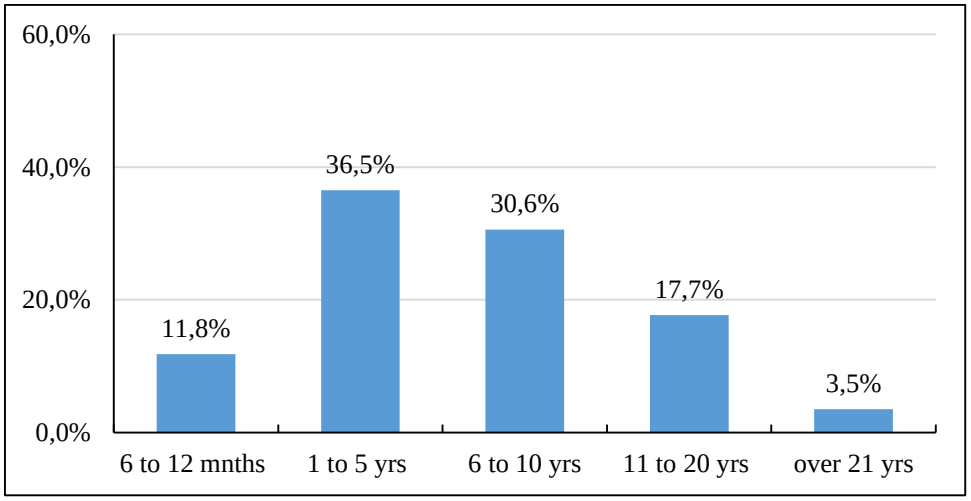


Figure 4.4: Length of the respondents work experience in the ED

4.2.3 Section B: ENA Workplace Violence Survey

This section related to nurses' responses on the questionnaire, which included 12 items (refer **Appendix A**). There is a separate discussion for each item.

4.2.3.1 Overall safety

Question 1 focused on overall rating of safety. The respondents were presented with a statement, which stated *"Rate how safe you feel from workplace violence in the ED as well as in each area of this ED"* and asked to rate their response on a Likert-type scale from 1 (not all safe) to 10 (extremely safe). **Table 4.2** displays these results.

Table 4.2: Overall rating of safety in the ED

Item	Variable	Mean (Median)	SD
1.1	Overall level of safety in the ED	**4.07 (4.00)**	2.18
1.2	Triage	3.06 (2.00)	2.16
1.3	Exam (e.g. non-critical area)	4.21 (4.00)	2.66
1.4	Crash (e.g. critical care/trauma area)	4.53 (5.00)	2.74
1.5	Paediatric	**5.85 (6.00)**	3.01
1.6	Psychiatric holding	**2.64 (2.00)**	2.10
1.7	Quick care (e.g. fast track)	3.82 (4.00)	2.42

Findings in this study revealed most nurse respondents generally agreed that they felt not or less than safe in emergency department (M=4.07; SD=2.18). More specifically, occurrence(s) related to psychiatric holding was the lowest of the listed items (M = 2.64; SD = 2.04), as opposed to paediatrics rated as highest (M= .85; SD=3.01) by the nurse respondents. **Table 4.2** displayed these results.

4.2.3.2 Workplace violence training

Question 2 focused on workplace violence training. The respondents were presented with the statement, "*How long ago did you receive training on preventing and/or mitigating ED*

workplace violence" and asked to select an appropriate response from a list of options. **Figure 4.5** displays these results.

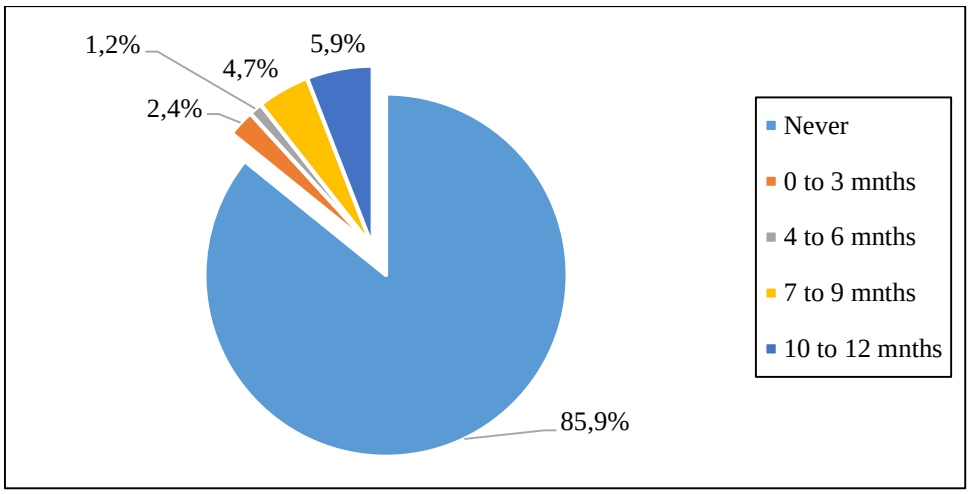


Figure 4.5: Training received by respondents on ED workplace violence

The majority (85.9%) of the nurse respondents agreed they had not received any training in preventing or mitigating emergency department workplace violence, as opposed to some training 10 to 12 months and 7 to 9 months ago (5.9% and 4.7%) respectively. **Figure 4.5** displays these results.

4.2.3.3 Reported occurrence of workplace violence

Question 3 focused on reported occurrence of workplace violence. The respondents received the statement, *"If you have experienced workplace violence while working at this facility, did you formally report the occurrence(s),"* and asked to select an appropriate response from a list of options. **Figure 4.6** displays these results.

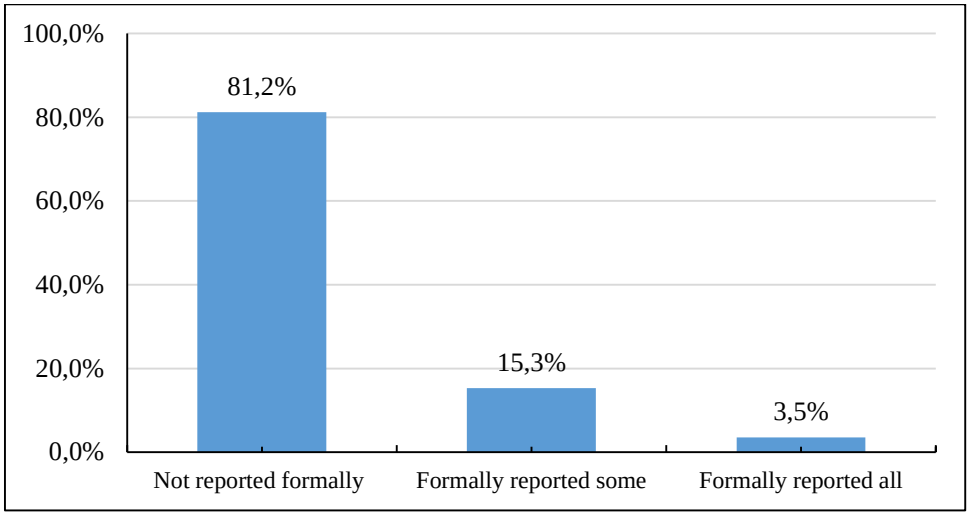


Figure: 4.6: Respondents experience of workplace violence

Findings in this study revealed most nurse respondents agreed that while working in their emergency department, they had experienced workplace violence, but failed to report it (81.2%; n = 69). **Figure 4.6** displayed these results.

4.2.3.4 Instructed to report abuse

Question 4 focused on the instruction to report workplace violence. The respondents received the statement *"Have you been instructed to report physical or verbal abuse regardless of the level of severity or harm,"* and asked to select an appropriate response from a list of options. **Figure 4.7** displays these results.

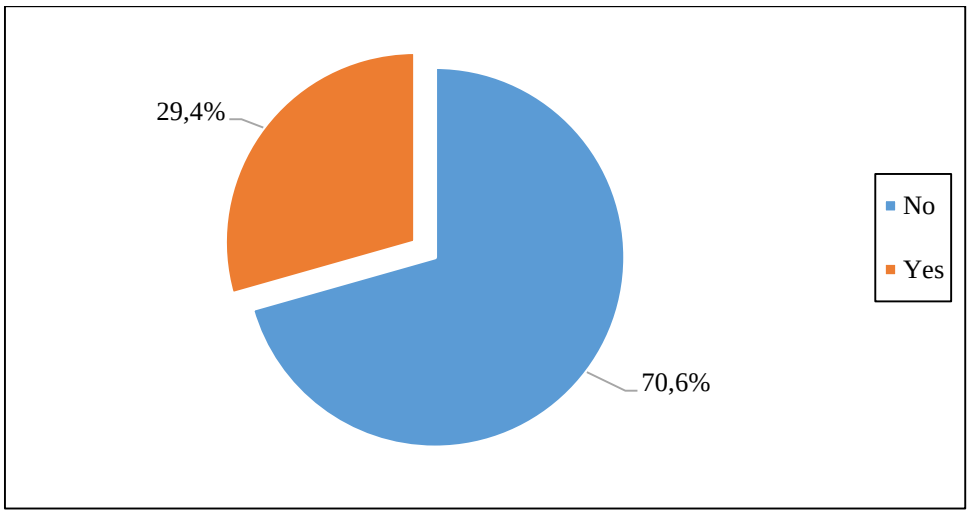


Figure 4.7: Instructed to report workplace violence

It is interesting to note that approximately 30% (n= 25) of the nurse's respondents agreed they were advised to report the incidence, even though they did not do so. **Figure 4.7** displayed these results.

4.2.3.5 Experiences of actions that constitute workplace violence

Question 5 focused on experiences of actions that constitute workplace violence. The respondents were presented with the statement "*I consider this action to be workplace violence,"* and asked to select an appropriate response from a list of set options. **Table 4.3** displays these results.

Table 4.3: Percentage of respondents that considered the action to be an example of workplace violence

Item	Variable	Yes		No	
		n	%	n	%
5.1	Bitten	67	78.8%	18	21.2%
5.2	Called names	76	89.4%	9	10.6%
5.3	Hair pulled	66	78.6%	19	21.4%
5.4	Harassed with sexual language/ innuendo	75	88.2%	10	11.8%
5.5	Hit (e.g. punched, slapped)	72	84.7%	13	15.3%
5.6	Hit by thrown objects	73	85.9%	12	14.1%
5.7	Kicked	72	84.7%	13	15.3%
5.8	Pinched	71	83.5%	14	16.5%
5.9	Pushed/shoved	73	85.9%	12	14.1%
5.10	Scratched	69	81.2%	16	18.8%
5.11	Sexually assaulted	61	71.8%	24	28.2%
5.12	Shot/shot at	56	65.9%	29	34.1%
5.13	Spit on/at	70	82.4%	15	17.7%
5.14	Stabbed	57	67.1%	28	32.9%
5.15	Sworn/cursed at	70	82.3%	15	17.7%
5.16	Threatened with physical harm	75	88.2%	10	11.8%
5.17	Verbally intimidated	77	90.6%	8	9.4%
5.18	Voided on/at	70	82.3%	15	17.7%
5.19	Yelled/shouted at	77	90.6%	8	9.4%

In this study, most of the nurse respondents agreed that many of the behaviours listed constituted workplace violence. More specifically, acts such as being hit by a thrown object (85.9%), kicked (84.7%), pinched (83.5%), punched/shoved (85.9%), scratched (81.2%), spit on/at (82.4%), threatened with physical harm (88.2%) and verbally threatened with physical harm (90.6%) were identified as workplace violence by more than 80% of the staff.

The next table demonstrates the percentage of staff who have experienced workplace violence. The respondents were presented with the statement "*I have personally experienced this action while at work in this ED,*" and asked to select an appropriate response from a list of set options. **Table 4.4** displays these results.

Table 4.4 Percentage of the respondents that has experienced workplace violence

Item	Variable	Yes		No	
		n	%	n	%
5.1	Bitten	39	45.9%	46	54.1%
5.2	Called names	65	76.5%	20	23.5%
5.3	Hair pulled	39	45.9%	46	54.1%
5.4	Harassed with sexual language/ innuendo	56	65.9%	29	34.1%
5.5	Hit (e.g. punched, slapped)	43	50.6%	42	49..4%
5.6	Hit by thrown objects	46	54.1%	39	45.9%
5.7	Kicked	43	50.6%	42	49.4%
5.8	Pinched	42	49.4%	43	50.6%
5.9	Pushed/shoved	49	57.7%	36	42.4%
5.10	Scratched	30	35.3%	55	64.7%
5.11	Sexually assaulted	8	9.4%	77	90.6%
5.12	Shot/shot at	9	10.6%	76	89.4%
5.13	Spit on/at	27	31.8%	58	68.3%
5.14	Stabbed	11	12.9%	74	87.1%
5.15	Sworn/cursed at	53	62.4%	32	37.6%
5.16	Threatened with physical harm	55	64.7%	30	35.3%
5.17	Verbally intimidated	64	75.3%	21	14.7%
5.18	Voided on/at	48	56.5%	37	43.5%
5.19	Yelled/shouted at	69	81.2%	16	18.8%

Findings revealed the majority of nurse respondents agreed they had experienced some form of workplace violence. Specifically, 75% of nurses reported they had experienced some form

of workplace violence, such as called names (76.5%), verbally intimidated (75.3%) and yelled or shouted at (81.2%). Of note was that 10.6% (n = 9) reported having experienced being shot or shot at.

4.2.3.6 Prepared to manage violent forms of behaviour

Question 6 focused on prepared to manage violent forms of behaviours. The respondents were presented with the statement *"How prepared do you feel to manage aggressive or violent behaviour,"* and asked to select a response on a Likert-type scale from 1 (not prepared at all) to 10 (completely prepared). **Figure 4.8** displays these results.

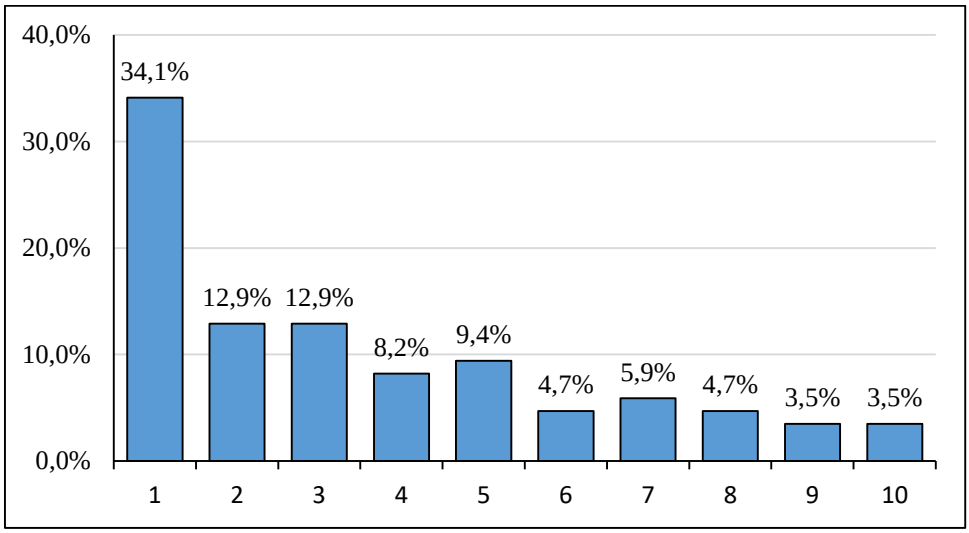


Figure 4.8: Prepared to manage aggressive or violent behaviour

Findings in this study revealed most of the nurse respondents (77.7%) agreed they were not prepared to handle aggressive and violent behaviour, as opposed to 22.3% who felt completely prepared to manage such behaviours. The average score for this item was 3.53 (SD = 2.70). **Figure 4.8** displayed these results.

4.2.3.7 Sources of workplace violence

Question 7 focused on preparedness to manage violent forms of behaviours. The respondents received the statement "Do you feel that workplace violence from patients and/or visitors is simply a "part of the job in the ED," and asked to select an appropriate response from set options. **Figure 4.9** displays these results.

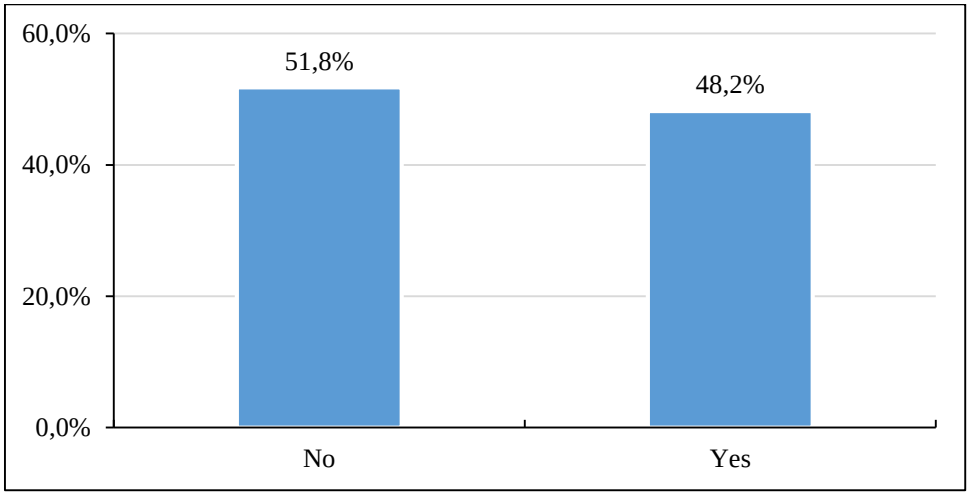


Figure 4.9: Respondents views on workplace violence from patients in the ED

In this study, a close majority (51.8%) of the nurse respondents agreed that they did not consider workplace violence from patients or visitors as part of the job when working in emergency departments. Figure 4.9 displayed these results.

4.2.3.8 Frequency of workplace violence

Question 8 focused on frequency of workplace violence. The respondents were presented with the statement *"Do you feel that workplace violence has increased, remained the same, or decreased over the past year*" and asked to select a response from the set options. **Figure 4.10** displays these results.

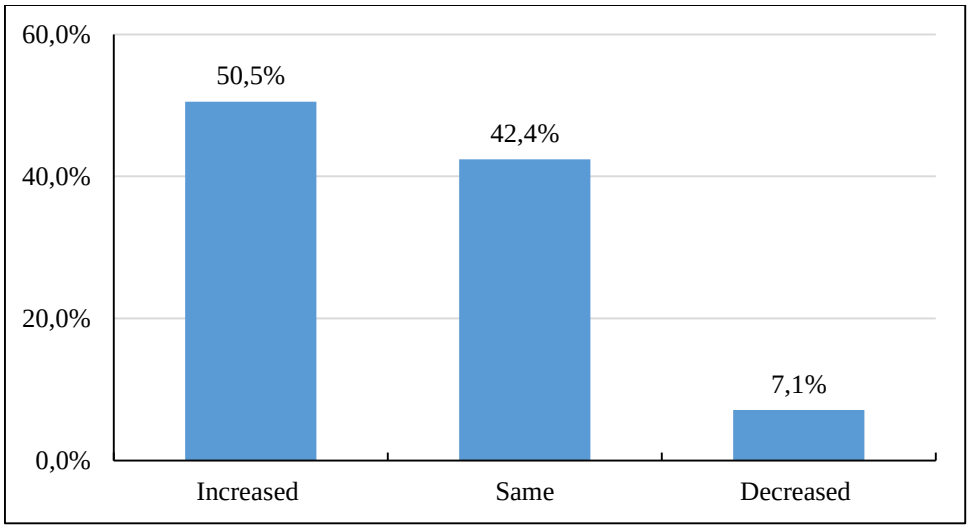


Figure 4.10: Percentage of workplace violence over the past year

Findings in this study revealed that a close majority (50.5%) agreed there is an increase in workplace violence, and 42.4% agreed it had remained the same. **Figure 4.10** displayed these results.

4.2.3.9 Effectiveness of security personnel

Question 9 focused on effectiveness of hospital security personnel. The respondents were presented with the statement *"Please rate how effective our hospital's security personnel is in preventing violence against ED staff in our ED,"* and asked to select a response on a Likert-type scale from 1 (not at all effective) to 10 (extremely effective). **Figure 4.11** displays these results.

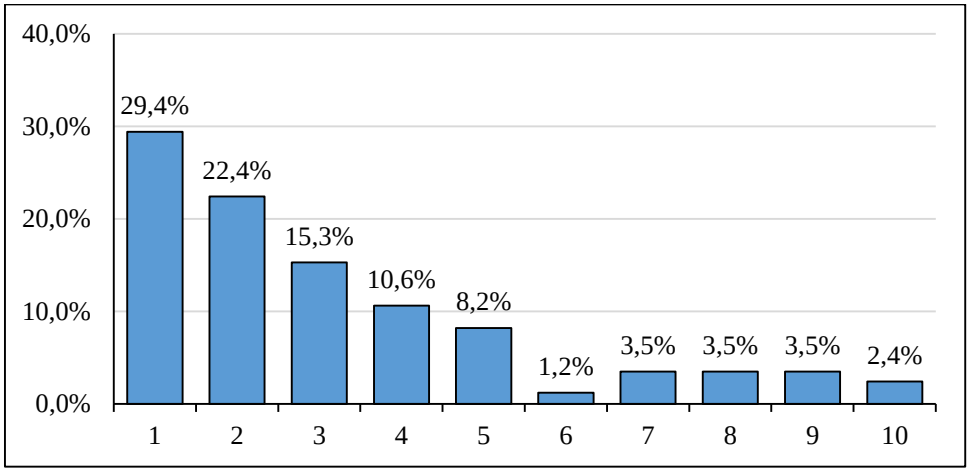


Figure: 4.11: Effectiveness of hospital security personnel

Findings in this study revealed the majority of nurse respondents (85.9%) agreed that security provided in their hospital was not at all effective, as opposed to 14.1% who considered the service as completely effective. The average score for this item was 3.19 (SD = 2.42). **Figure 4.11** displayed these results.

4.2.3.10 Time security is effective

Question 10 focused on the amount of time security is effective. The respondents were presented with the statement *"Please rate how adequate the amount of time security is provided in our ED is in preventing violence against ED staff,"* and asked to select a response on a Likert-type scale from 1 (not all adequate) to 10 (completely adequate). **Figure 4.12** displays these results.

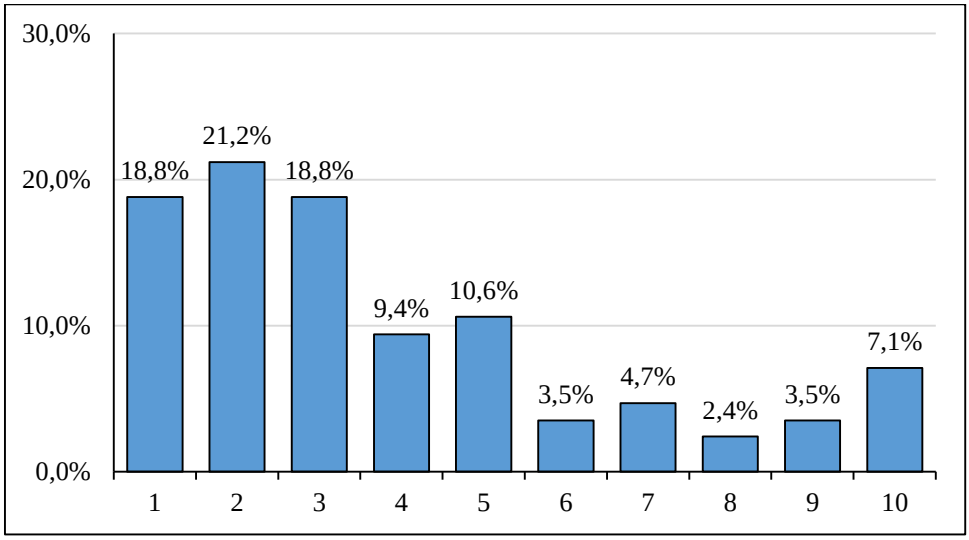


Figure 4.12: Amount of time there is security provided in the ED

Findings in this study revealed the majority of nurse respondents (78.8%) agreed the amount of time provided by security officers in the emergency department was not at all adequate, as opposed to 21.2% who considered this as completely adequate. The average score for this item was 3.84 (SD = 2.69). **Figure 4.12** displayed these results.

4.2.3.11 Type of violent behaviour prepared to handle

Question 11 focused on type of violent behaviour prepared to handle. The respondents were presented with the statement, *"What type of violent situations do you feel most/least prepared to handle,"* and asked to comment. About one third (38.0%; n = 33) of the respondents reported they felt most prepared to handle verbal violence than any other form of violence, 34% (n = 29) were not prepared to handle any form of violence, and approximately one third (32.0%; n = 28) felt least prepared to handle physical violence, followed by sexual assaults and alcohol intoxicated patients.

4.2.3.12 Suggestions for improving workplace violence

Question 12 focused on suggestion for improving workplace violence. The respondents were presented with the statement "*What other suggestions do you have for improving how workplace violence is handled in the emergency department (before, during and after incidents occur),"* and asked to comment.

The majority (50.6%; n = 43) of the respondents recommended an increase in the number of security officers in the ED to assist with access control. This is what they said:

'Increase number of security personnel; reduce overcrowding'

Some respondents suggested the security officers needed to undergo training in handling the violence events in the ED.

"Have well trained security officers at all times; training on how to handle workplace violence"

All the respondents agreed that hospital management should be available to provide support to staff members after a violent situation in the ED.

4.3 PHASE TWO: QUALITATIVE FINDINGS

This section presents the qualitative findings from the focus group discussions with ED nurse participants at the selected study sites.

4.3.1 ED Nurses Demographic Data

Table 4.5: Summary of the demographic characteristics of participants

Variables	Frequency	Percentage
Gender		
Male	2	13.3%
Female	13	**86.7%**
Age in years		
25 - 35	8	**53.3 %**
36 - 45	5	33.3%
Over 50	2	13.3%
Level of education		
Certificate	2	13.3%
Diploma	10	**66.7%**
Degree	1	6.7%
Post graduate diploma	2	13.3%
Rank		
Staff nurse	2	13.3%
Professional nurse	11	**73.3%**
Specialist nurse	2	13.3%
Years of experience		
1 - 5	7	**46.7%**
6 - 10	4	26.7%
11- 20	4	26.7%

Fifteen (n=15) respondents took part in the qualitative part of the study. The demographic profile reveals most of the nurses were female (86.7%; n = 13), aged between 25 to 35 years (53.5%; n = 8), and have one to five years of experience (46.7%; n = 7). Additionally, most

nurses held a diploma as the highest nursing qualification and worked as professional nurses (66.7% (n = 10) and 73.3% (n = 11), respectively, as opposed to being staff nurses (13.3%; n = 2). **Table 4.5** displayed these results.

4.3.2 Emergent Themes

This section focuses on findings from participants expressions of their perceptions and opinions regards workplace violence in the ED. The main prevailing issues included preconceived ideas, media, lack of knowledge, attitude of staff employees, procedure of reporting not known, there is nothing done, acceptance, short of management support, lack of skills, not available, poor access control, scary, triage, helping each other, and management support. These 15 categories generated five (5) emergent themes, which provide the fundamental structure of the findings of the study and included:

- Contributors of violence
- Factors hindering reporting
- Inefficient performance of security offices
- Unsafe environment
- Helpful strategies

The verbatim quotes of participants supporting the themes appear in *italic* form below the sub-themes. The quotes were coded during data coding (PN= participant number) and (GN= focus group number), for example (PN2; GN3) means participant two from focus group number three.

Table 4.6 presents an overview of themes and sub-themes generated from the interviews.

Table 4.6: Emerging themes and sub-themes

Theme	Sub-themes
4.3.2.1 Contributors of violence	4.3.2.1.1 Preconceived ideas 4.3.2.1.2 Media 4.3.2.1.3 Lack of knowledge 4.3.2.1.4 Attitude of institution employees
4.3.2.2 Factors hinders reporting	4.3.2.2.1 Procedure of reporting not known. 4.3.2.2.2 Nothing is done 4.3.2.2.3 Acceptance 4.3.2.2.4 Short of management support
4.3.2.3 Inefficient performance of security officers	4.3.2.3.1 Lack of skills 4.3.2.3.2 Not available
4.3.2.4 Unsafe environment	4.3.2.4.1 Poor access control 4.3.2.4.2 Scary 4.3.2.4.3 Triage
4.3.2.5 Helpful Strategies	4.3.2.5.1 Helping each other 4.3.2.5.2 Management support

4.3.2.1 Theme 1: Contributors of violence

4.3.2.1.1 Sub-theme: Preconceived ideas

Participants describe that community members who present themselves in the ED already have a misconception of the expected care to receive from the hospital. They come to the hospital already assuming they will receive bad service hence produce negative attitudes towards the ED nurses before there is any intervention executed. The following supports the statement.

> "Y*ou know what they do they bring their, some of them okay for what I observed I think it's their preconceived ideas about nurses or hospitals in general, yes we have seen what's happening what you guys do when it's like this and you see that and this sounds like already before coming here you had preconceived ideas about you know what you going to experience here and you see no here talking you don't help me because they are not going to listen, this is their perception of this place of us nurses*

so talking to them it won't help so you try and help them the best way you know how, even though you know yes it's challenging, it's difficult."

(PN4:GN1)

Other participants added that these misconceptions of patients and relatives about hospitals are difficult to overcome because the manner of approach performed towards them does not determine them; even when the ED nurses are receptive and nice, they still give them a negative attitude. The idea that nurses are bad appears to reside within the community because even first-time patients present to the ED department already having a negative attitude and dissatisfaction. The following quotes substantiate the statement.

"And another thing; patients and relatives, when they come to hospital, already they've got this attitude against nurses Immediately when they talk to you already whether you are nice or they'll give you whatever that they want tell you"

(PN3:GN3)

"…even their first time but because of that it is planted in their mind that nurses are like this."

(PN4:GN1)

"Eish, I feel like sometimes people come to the hospital already having an attitude towards nurses. So you are already thinking to yourself, ja, when I get there I'll show them."

(PN1:GN2)

Participants stated that the negative attitude is aggravated by the high level of expectations that patients have when coming to the hospital.

"Patients when they come to hospital, there they expect 'A' treatment."

(PN3:GN3)

4.3.2.1.2 Sub-theme: Media

Media, mainly TV, plays a significant role in contributing to ED violence against ED nurses. Participants report that as community members watch news reports portraying incidences of negligence and poor service occurring in the hospitals, these generally provide patients and relatives with conceptions that the care rendered in the hospitals is inefficient or substandard, and as such, build up hostile behaviours towards the ED nurses. The following corroborate the statement.

> *"Yeah, I wanted to talk about bad publicity from the media. So ja, when they come to the hospital, already they have that information. This hospital is the worst hospital; they are exchanging babies, everything that is bad. That's why they mos give us bad attitude."*
>
> (PN3:GN2)

The following statement is from a participant who added that the minute a community member presents in the ED with information obtained from media related to poor service in the hospitals, it is difficult to convince them to buy in and cooperate because they will not even grant a person a chance to explain.

> *"On the TV's you'll see programmes portraying, you know, the different Hospital scenes, oh this is what happened. Our whole news; the news; on the news as well, you see some incidents in other hospitals, this is what happened. So they will take that and then generalise. And the minute they start generalising, they're not going to give you a chance to explain yourself."*
>
> (PN4:GN1)

Another participant further claims that media tends to highlight negligence issues and fails to provide the public with the investigations' outcomes following negligence cases.

> "*It's so hard to please that person it doesn't matter what you do. And especially this issues of negligence when they are in the media, yoh but when the investigations comes back, okay this is exactly what happened they are no longer as you know trending as the beginning. it is trending when you are in the bad side, when it is investigated and when they found out, okay actually this is what happened it is no*

longer as it is when you were in the bad side where you didn't feed patients to this long way, you assaulted patients. When the report comes it is no longer the way it was when it was trending…"

(PN3:GN1)

4.3.2.1.3 Sub-theme: Lack of knowledge

In the ED, the rule is that patients receive attention according to their level of illness severity; however, Participants have outlined views showing that patients and relatives lack knowledge of how the ED operates. Participants reported that patients and their relatives often verbally demonstrate their feelings of dissatisfaction when others receive attention before them. The following support the statement.

"*They don't understand the fact that you work according to priorities and they just come there and say things*."

(PN1:GN2)

"We are not just an emergency department that is why we've got triage to sort out to prioritise our emergencies we know there is different emergency but the want to tell you this one right here he is the most urgent one."

(P4:GN1)

"There won't be an understanding like for children and adults, most we prioritise children first, yes, but it will depend on the state of urgency, ne? But they don't understand."

*(*PN2:GN2)

"Like our community has a lot of problems with lack of information and ignorance."

(PN: GN2)

4.3.2.1.4 Sub-theme: Attitude of institution employees

Community members were not only mentioned as the precipitants of violence against the ED nurses, as participants also identified employees of the same institution stirring up hostile behaviours towards them. Medical and non-medical hospital employees come occasionally to consult or bring relatives for medical attention in the ED; however, upon arrival participants stated they want urgent attention, regardless of their state of condition.

> *"Ja, the nurses, porters, cleaners. When they come here, even if we are busy, they want to, they don't want to wait. They say we are working here, why we wait, because we are nurses, also nurses."*
>
> (PN: GN2)

> "*Those who are not working in casualty. When they come, bring their relatives … they come with that thing that the casualty nurses, they think they are better. There's one other time when we working at triage, staff whose working in the other wards whilst she was bringing her father and then when he came here, he was like she doesn't want anyone to ask anything to her father. She is the one who is going to tell us whatever.*"
>
> (PN4:GN3)

One participant further stated that the employees from other hospital departments threatened to extend the violence to outside the hospital during disagreements.

> *"And the other time it was from one of our own colleagues who brought one of her relatives. The verbal violence was to another level. And then her sister was even threatening to wait for us by the gate so that she can assault us."*
>
> *(*PN2:GN1)

4.3.2.2. Theme 2: Factors hinders reporting.

4.3.2.2.1 Sub-theme: Procedure of reporting not known

Concerning routes and methods of reporting WORKPLACE VIOLENCE, participants shared views of not being well informed on the reporting system, and at times they became puzzled about whether or not to report violence incidences because they feel no follow up is done; the managers also appear not to lack sufficient knowledge on handling such incidences.

> *"You end up being assaulted what is the next step, you don't even know, do I report it? Do I not? Do I, like you don't even know what the procedure to follow up after that."*
>
> (PN4:GN1)

Another participant said that in the instance where there was a violent incident reported, the manager failed to demonstrate knowledge of handling WORKPLACE VIOLENCE and to take the matter forward, which led to the disappearance of the case.

> *"In instances where I have tried to follow the procedures by reporting to the manager, next level, actually from my experience I feel that the manager didn't know what to do. Because it was reported and to this day nobody can tell me where did that case end up and what is going on*."
>
> (PN3:GN1)

4.3.2.2.2 Sub-theme: There is nothing done

Participants shared feelings of being discouraged from reporting workplace violence because, based on their experiences, there is nothing done after reporting. On the occasions where there were incidences reported, management failed to provide feedback and solutions.

> *"In my instances I never reported because I know nothing was going to be done, nothing is going to be done."*
>
> *(*PN2:GN1)

"Nothing happens, like there is no feedback, there is no follow up, like zero, nothing".

(PN1:GN1)

"In my instances I never reported because I know nothing was going to be done, nothing is going to be done."

*(*PN2:GN1)

According to one participant, ED nurses have learned to live with events of violence against them and become immune towards such incidences because they know nothing gets done even if reported.

"So I feel, personally I feel sometimes we become numb to the situations. Someone will come to you and say insults or do whatever, even if you report, nothing gets done. So what's the point of reporting now? So you, we get so used to it, we just move on. It's a part of our lives, we are used to patients behaving like this, we are used to relatives behaving a certain way, so nothing gets done really."

(PN1:GN2)

During the focus interview, one participant added to the statement and expressed feelings of not been cared for in their working environment.

"*No one care about us."*

(PN4:GN3)

4.3.2.2.3 Sub-theme: Acceptance

Participants reported they have learnt to live with the violence they face in the working environment and have accepted it. They also shared comments of not making the effort to report and make follow-ups on the reported workplace violence incidences.

"Actually I think we have learnt to live with the violence and we have accepted it, because as a person who has reported the matter you also have a right to also ask how far we are with what I have reported."

(PN3:GN1)

"But the problem is, as they said, that we tend to normalise this, as nurses. They will shout at you insult you, but you continue as normal, like I'm just helping the patient, doesn't matter whether they say you..."

*(*PN5:GN2)

The response of one participant reflected acceptance relating to the experience on how discouraging workplace violence cases are handled, and the insufficient knowledge regarding the procedure and methods of reporting, as she reports that after the incidence has occurred, you need to report to the next level manager, however, if they do not respond, the way forward is not known.

"*But as my colleague has said the way we have normalised this like the way we have seen how workplace violence cases are handled it is discouraging we no longer reporting like we just we have normalised it. So to say the Policy or the Procedure it is in place I can show you or tell you how it is supposed to be, I think I can only remember how you know you need to report like to your next level Manager but other than that, if they don't respond to you to say what you must do…*"

(PN4:GN1)

During the focus group interviews, one participant added to the statement by saying she is aware of the right to refuse to nurse a patient who is intimidating her, however, because she normalised the workplace violence she is not exercising the right.

".....and I mean It's part of our rights to say I cannot nurse you, give you nursing care if you are intimidating me, but it's funny how, we have normalised it."

(PN4:GN1)

Psychiatric patient's violence appears to be expected, and acceptable, as participants' report that such patients are not in a good state of mind.

"I won't comment on the mental healthcare users because most of the time they are not in their state of mind"

(PN2:GN2)

"Because I thought about all of those things and I was like it's just going to be a losing case basically. Because you're reporting that a psych patient is being psych. How far can you really go with a case like that, really?"

*(*PN5:GN3)

Another participant shared a sense of not feeling protected from psychiatric patients because even when they become harmful, there is not much executed because they are not in a good state of mind.

"Somehow, we feel like you are not protected because same as what my colleagues just said, if it is a psych patient who does something like that, at the end of a day there's nothing you can because the patient is psych. So even if they hit you, you just have to bear and grin it."

(PN6:GN3)

4.3.2.2.4 Sub-theme: Short of management support

The perception of hospital management is that it lacks support for ED nurses in handling the workplace violence. Participants shared views of not receiving any form of support from their managers, and they feel the reported incidents of violence do not receive much attention, unlike patients and relative complaints. They further added that there is nothing done when these incidences are escalated to them.

"[Laughter] Oh guys I have never seen support, I have never received support in that, all that we get is like shame you know this place that is all we get."

(PN1:GN1)

"Like the support to say not even you know to even suggest employee wellness to say go there, they won't even, I haven't seen that happening not to me not to some of my colleagues, it's just a matter of you know, "

(PN4:GN1)

The same participant also added a view on how management handles the matter of violence if it occurs vice versa.

"*Mmm, and the other thing is that you are the one who experienced the violence from the patient or relatives' side. They don't put in like the same amount of energy and effort, in addressing the matter like where the things are vice versa. When it is the patient, you know they will go all in, Even the CEO you know everyone will step into that matter to say why, why did you do that? And why not like you know, you know they will come and you'll see it you know what*."

(PN4:GN1)

According to the complaint procedure in the hospital, both parties often have a platform to give their side of the story for a fair judgment and solution. However, other participants said if the patients and relatives have laid complaints, ED nurses have to apologise to the relatives to neutralise the matter.

"*If a relative go and complain that side. Whether you are right, the relative is wrong. The matron they will come and say you know what for the sake of peace, just apologise so that this person can go home*."

(PN1;GN3)

"*You report to unit manager next. And then the unit manager will call the relative or the patient. It will depend and then you know that two sides in every story. The relative will explain. "Mina" (me) will also explain my story. But there will always be I'm wrong as a nurse. The patient or the relative is right so I must apologise."*

(PN2:GN3)

Another participant agreed with the statement that says ED nurses are always told apologise if a complaint is laid against them, and added that one of the reasons is that the managers say they do not want to go to court.

I think like my colleagues are just stating now, it is only if the family members are reported that is addressed. And in it being addressed, then nurses are always at fault, you always have to apologise. It doesn't matter what I say [cross talk]. You are expected to write a statement. You expected to give an apology and they always say it's because they don't want to go to court.

(PN6:GN3)

Meanwhile, the following participants show the same sentiments of not receiving support from management.

> *"I mean escalate to management nothing is going to be done.*"
>
> (PN2:GN1)

> *"They don't even care about you. As I said the matron who was on shift on that day, who did the report to the matron, but the matron didn't say anything."*
>
> *(*PN4:GN3)

> *"That's why at the end of the day we decided not report because nothing will happen."*
>
> (PN4:GN3)

4.3.2.3 Theme 3: Inefficient performance of security officers

4.3.2.3.1 Sub-theme: Lack of skills

Participants revealed a lack of confidence in the current security officers. According to participants, the security officers failed to demonstrate capabilities to protect employees as expected. During the interviews, there was a report that security officers often failed to perform and prevent situations that could lead to violence, such as control crowds and restraining, to such an extent their work ethic was questionable.

> *"You ask yourself if you are in a safe place and the security guys, shame they can't restrain, they can't control the crowd, I don't know if they got training regarding all those things."*
>
> (PN2:GN1)

> *"Yes you know with the security in this department I feel they have no idea of what to do. In some cases we have violence in the department and they are nowhere to be found, they are not where they are supposed to be, if they are there they don't know what to do, they come and then they still going back for back-up even if they see violence they still wait for you to come and fetch them*."
>
> (PN3:GN1)

In addition, one participant viewed the structure within the security and their system as the problem, because the security personnel are there but demonstrate no skills or knowledge of that expected of them.

> *"I blame the system, because I believe there is a lot, a lack of structure within them, they don't know their scope of practice. They don't know what it is exactly, what they are supposed to be doing. A person is there by the gate, we are not supposed to let anybody to come in; they are just sitting there standing, why you are there."*
>
> (PN5:GN2)

4.3.2.3.2 Sub-theme: Not available

Participants also reported the security officers allocated to the emergency department (ED) station were always not available. When violence arises there is a need for security officers, however, sometimes they are not in the ED area.

> "*When you call for back-up there is no one to you know restrain the patient as the other participant was saying that, this people they need to come in and restrain the patient, but there is no one, and you end up being assaulted*,"
>
> (PN4:GN4)

> *"So now, our securities they were not to be found Brian*."
>
> (PN3:G3)

Another participant added that at times ED nurses have to go looking for the security officers. In the following statement, the participant further expressed the issue of the security officers as a complex matter.

> *" And the fact that sometimes there is no security at that door. It's wide open and the security is not there, if there is violence you are even going outside to look for him, he is not doing what he is supposed to do, actually the security it's just an issue. It's a whole different story."*
>
> *(*PN3:GN31)

One participant noted that the absence of security officers in the ED often occurs during their shift change, because most security officers are using the same transport.

> "*Oh and Brian can I just mention one thing. During shift change, you see a thirty minute gap when there's no security at all. Because isn't they have their own transport especially when the shift change? That gap is a bit of a problem because most of when incidents normally happen at that time when there's no one to look out for us as healthcare professionals*."
>
> (PN6:GN3).

4.3.2.4 Theme 4: Unsafe environment

4.3.2.4.1 Sub-theme: Poor access control

Participants reported that ED becomes an area of high violence because hospital entrances are not managed accordingly by security personnel, especially monitoring and controlling access of community members entering the hospital. Participants added that access control is the root cause of the problem and the security officers often fail to enforce it.

> "*So I think the root cause about this what is aggravating it is because there is no, there is no access control, if we can have good access control whereby only patients that are supposed to be escorted come in with escorts that will limit or minimise.."*
>
> (PN2:GN1)

One participant added an idea that community members enter and leave the hospital premises freely, and security personnel fails to enforce access control.

> "*They draw back and allow the person to go in, so access control it is not there, and they should be doing that, they should be enforcing it, there shouldn't be waiting for the nurse to say it and you know enforce access control, no everyone they do what they like even though we have got the security officers,"*
>
> *(*PN4:GN1)

4.3.2.4.2 Sub-theme: Scary

During the focus group interviews, when participants shared their experiences of the incidences experienced during work, most of them expressed feelings of fear and being scared. Participants reported being threatened, not only with words but also with weapons, such as knives and guns. The following give proof to the statement.

> *"They just came with a gunshot patient dumped him on the floor and they were like they "help him now or else we going to shoot you" and then they were swearing at us and calling us big names, so they were like, they were like literally forcing us to stop whatever we were doing, stop helping other patients and attend to their, their relative. I mean if someone has a gun, what are you going to do? That is scary so…"*
>
> (PN1:GN1)

> *"We were so scared, because anything could have happened. What if he took out the knife and stabbed all of us? You see. It was a very scary moment.*"
>
> (PN3:GN2)

Another participant added that the moments of WORKPLACE VIOLENCE leave her shaking and even scared to go back and continue with nursing the patient. The following validates the statement.

> *"You end up really feeling frightened like shaking or you feel your heart beat it is really going up and you are shaken and you're scared even to go and continue with the patient*."
>
> (PN2:GN1)

One participant shared an intense moment of violence against her, in which the perpetrator was a prisoner who threatened to send his people to follow her on the way home after work. The participant described it as one of the scariest moments and fortunately, her colleague rescued her and took over helping the prisoner.

> *"So, Brian, can I just mention I had this violent inmate prisoner. So, I was in triage 2. So, I was triaging this guy and this guy suddenly became violent in such a way that he said to me, you know what; I'm going to send my people outside. You know they're going to follow you blah, blah, blah. When you go home you'll find them outside. You know I was so scared Brian. [cross talk] This other colleague of mine*

took over that patient, but I'm telling you Brian. "Chaile" (knock off) time, I was so scared. I was so scared Brian, because every time when I'm driving, I'll just look in the mirror and see the car coming. I'll even think, maybe it's that inmate who send maybe his friends. You know this other colleague of mine, help a lot. Because I think she was listening to the conversation. Then she saw that ah ah man, haai! and the correctional service, they were there Brian. They didn't even say anything. I think they were still new. But they kept quiet Brian."

(PN3:GN3)

4.3.2.4.3 Sub-theme: Triage

The triage area is the first point of entry in the ED. In this area, patients receive medical classification according to their level of severity and priority. During the focus group interview, participants identified it as the area with the most violent incidences, as patient and relatives became impatient while awaiting attention. Furthermore, their dissatisfaction is expressed verbally towards the ED nurses.

"Yes, we do experience violence in the work place, be it phy/...well, I haven't experienced physical violence, but then sometimes it's verbal from both patients and relatives. Especially when working in the Triage area, where people are impatient and they want things to happen quickly."

(PN1:GN2)

"I feel it happens mostly in triage, because it's the first point. People, after you past triage, people feel more at ease. They feel like they've been helped, so they are more settled. But in triage on arrival, that's where you experience the most."

(PN1:GN2)

Adding to the statement, one participant stated verbal violence was the most frequently experienced.

"I normally mostly verbal, when I work the triage…"

(PN1:GN3)

Another participant said this violent behaviour was most common in triage over the weekends when patients and relatives were intoxicated.

> *"In triage; most of the time when you are working in triage, especially on weekends. Like when they are drunk. I once attended a patient who I said she must go to the toilet; the doctor wanted her urine dipstick to check because she was complaining of lower abdomen pain. She came back. She told us she doesn't have urine. So, the doctor told her, I won't see you if there is no urine because we do not know what is going on. And apparently the patient, it was she, took my wig off."*
>
> (PN2:GN3)

In agreement with the statement, another participant also viewed the crowd of people at triage as intimidating during assessment and prioritising patients because sometimes they talk at once and are frightening.

> *"The triage nurse who is receiving them already there is a crowd, they speak at once some of them, they intimidate you and you try by all means you know the patient care is very important and you try to prioritise that but sometimes you do feel intimidated and it feels like you know violence it's about to take place here."*
>
> *(*PN4:GN1)

4.3.2.5 Theme 5: Helpful Strategies

4.3.2.5.1 Sub-theme: Helping each other

Participants' views demonstrated the practice of collectivism. They said not to only find comfort among their colleagues by sharing the experiences of workplace violence, but such talks also assisted them to cope with the unfavourable experiences of violence. In other cases, ED nurses assisted each other, taking over patients or relatives who are personally aggressive towards them. The following support this statement.

> *"We just tell your Colleagues for comfort…then they comfort you."*
>
> (PN3:GN3)

"I was going to say, that's our only coping mechanism. We have each, we vent to each other, and then we ended up sometimes joking about it."

(PN5:GN2)

"You just ask one of your colleague can you please attend the patient for me. So there won't be drama."

(PN3:GN3)

One participant added that patients and relatives became so aggressive to a level that she leaves everything and calls other colleagues to her to take over.

"She was so aggressive in a way that I just left everything there. I called other sister to come and help me."

(PN4:GN3)

4.3.2.5.2 Sub-theme: Management support

In proposing the strategies to benefit the ED nurses concerning workplace violence, participants shared various ideas on the institution's management. Among the suggestions was support and showing understanding of the violence ED nurses are predisposed to, in doing so, execute activities of counselling, produce a prominent process of what happens after an encounter, install measures to attempt to eradicate the problem and also provide the ED with well-trained security officers. Various statements authenticated this.

"Support from Management, where at least you feel supported by Management you are not scared to raise such issues or report such incidence when they happen."

(PN6:GN3)

"And then from another strategic point of view it's our Managers who are not able to; how can I put it, to roll out the process of what happens after I've been exposed to, this violence even that violence in the workplace procedure, which we don't know for now."

(PN2:GN3)

Another participant said violence in the ED was inevitable; therefore, management should be understanding and concerned. The following substantiate the statement.

> "*Because we know that some violent incidences are inevitable, like say patients attacking nurses and what not. It would mean a lot if it's from our Management, for them to be compassionate and understanding. And support you...Yeah like you provide counselling after that briefing sessions you know, ja that's another thing."*
>
> *(*PN6:GN3)

In agreement with the statement, one participant reported that arranging counselling for the ED nurses would produce feelings of caring.

> *"No, can I, I am agreeing with her in saying that you know counselling, we don't really get counselling, so that's a big deal. And once you don't get counselling you automatically feel like, you know, nobody really cares because they are not offering that service to you when it's supposed to be there."*
>
> *(PN5:GN3)*

As with other participants, one participant supported the idea of implementing counselling for traumatised staff members and further mentioned that managers should treat victims with sensitivity and seek to understand how the workplace violence affects ED nurses.

> *"I mean like you know a simple thing; before you even get to counselling and stuff, a simple debriefing session you know maybe something happened you were traumatised you reported, if a person can just say, you know what next time walk away. What is that? How about, like a simple thing to say, how are you feeling, you know like just to show that no you care, like you know am I fine? No walk away, you don't even want to know which part of me is affected; how is this matter affecting me? Walk away, as you are, so you know that is why we are not reporting, you are not going to get to the level of counselling and whatnot."*
>
> (PN4:GN1)

In addition, one of the participants added that management is aware of the workplace violence, therefore should provide the ED with skilful security.

"Because if Management is well aware of what is workplace violence, they will install the proper measures like they will know we need properly trained Securities."
(PN1:GN1)

4.4 SUMMARY

This chapter presented and analysed the study's findings, as broken down into themes and sub-themes for the qualitative phase. The presentation of the findings of the quantitative phase, in which data collection was from questionnaires, was in the form of tables.

Chapter 5 will discuss the findings of the quantitative and qualitative data analysis in relation to relevant studies.

CHAPTER FIVE
DISCUSSION OF FINDINGS

5.1 INTRODUCTION

This chapter presents a discussion of the findings of the study supported by the literature. It consists of the findings of Phase 1 (quantitative) and Phase 2 (qualitative) of the study.

5.2 DISCUSSION AND FINDINGS

5.2.1 Phase 1: Quantitative Discussion of Findings

The study was conducted in the emergency departments of two public hospitals in Johannesburg, South Africa, and data collection was from n=85 (100%) emergency nurses of the respective hospitals. The majority of the respondents were females (n=61; 71.8%), with n=24(28.2%) males. The dominating age group was the young adults 25 – 34 years, (n=35; 41.2%) followed by 35 to 44 years and 45 to 54 years (n=25; 29.4%) and (n=20; 23.5%) respectively. More than a quarter (n=31; 36.5%) had 1 to 5 years of working experience in the ED.

In Phase 1 (quantitative study), the researcher collected the data through structured survey questionnaires consisting of 17 items about the experiences and perceptions of emergency nurses regarding workplace violence.

The study revealed verbal violence was the most common form of violence against the nurses in the ED, with approximately 69 (81.2%) and 65 (76.5%) admitting to having been yelled at and called names respectively, followed by physical abuse, where more than 50% of respondents indicated having had objects thrown at them, pushed/shoved and threatened with physical harm. These results are similar to those in the literature (Gacki-Smith *et al.*, 2009; Gilchrist *et al.*, 2011), and the high rate of verbal abuse is recognised as more people express anger verbally than physical (Derawad *et al.*, 2015). The study discovered that security officers play the most significant role in controlling violence in the ED. Approximately 45 (52.9%) ED nurses regard the presence of the security officers in the ED as the most effective way of preventing and alleviating events of violence. The findings of

Gillespie, Gates, Miller and Howard (2009) revealed similar perceptions that security officers play an integral part in preventing workplace violence in the ED. However, in the present study, almost a quarter of the respondents (29.4%) revealed the current security personnel in the ED were not effective at all, with the Likert scale showing mean and standard deviation M=3.19 (SD 2.42).

Based on other effective methods of controlling workplace violence in the ED, almost quarter (19; 22%) of the respondents noted access control, demonstrated by monitoring the movement of community members and relatives entering the institution, and the use of locked doors and surveillance cameras benefitting the ED to contain a violence-free environment. Derawad *et al.* (2015) support these findings, stating that poorly controlled ED, with an unlimited number of visitors, may cause crowds leading to noise and risks of violence. Only a small number of respondents (n= 4; 4.7%) stated that calmness when interacting with patients can reduce the violence in the ED. The results of Angland and Dowling (2013) further elaborated that it is significant for ED nurses to demonstrate communication skills when interacting with patients and relatives to bring a form of understanding and manage expectations.

More than quarter of the respondents (n=24; 28.2%) suggested that an increase in the number of security personnel would help with handling high-risk patients, such as those with an altered mental state and suicidal patients. The findings of the study by Partridge and Affleck (2017) supported these findings and added that shortage of security personnel causes a delay in response to workplace violence calls, therefore a sufficient number of security personnel is required to embark on workplace violence events instantly. Only a few (n=3; 3.5%) suggested there should be a psychiatrist stationed in the ED.

Most of the respondents felt less safe in the psychiatric area, mean=2.64 (SD 2.18) and triage area mean=3.06 (SD 2.16) of the ED. Similar results were found by Pich *et al.* (2017), who further stated that the Triage area is the primary area in the ED with a high prevalence of workplace violence. Mental healthcare users are more than three times at risk of displaying aggressive behaviour, and the overall feelings of being unsafe among the ED nurses is found to be linked with lack of existing policy of reporting, as well as other barriers of reporting (Lee *et al.,* 2020). In the present study, ED nurses felt safer in the paediatric area, mean=5.85 (SD 3.01), although it was revealed that parents of patients in this area in the ED act

aggressively out of frustration and anger while waiting to receive care, with the perception that the needs of their children are not prioritised (Pich *et al.,* 2013). In this study, approximately 34.1% of respondents were found ill-prepared to handle any violent or aggressive behaviour, and more than half of the respondents (58.8%) indicated insufficient provision of a numbered of security personnel in the ED, mean=3.84% (SD 26.9).

From the sample size of the study, the majority were novice ED nurses, and they experience workplace violence more than do experienced nurses (Derawad *et al.,* 2015). More than three-quarters of the respondents (n=73; 85.5%) showed they were never offered any training related to the handling of workplace violence in the ED, while, the majority (n=69; 81.2%) illustrated there was no formal reporting of the experienced events of violence in their working environment. In addition, about 60 (70.6%) of the total sample pointed out that they were never instructed by the institution's administration to report the events of workplace violence.

The violence events in the ED were reported to the team leaders, according to approximately 16 (18.8%) respondents and 16 (18.8%) reported to the unit managers, while 16 (18.8%) revealed they have never reported experienced events of workplace violence in the ED. The ED nurses with less experience were often reluctant to report aggressive behaviours towards them because they considered themselves as not valued, and still establishing grounds within the profession (Ferns, 2006). Such poor reporting is because other ED nurses perceive reporting as useless, following personal experiences; in most of the outcomes from reported workplace violence, the perpetrator only received a verbal warning (Al-Omari, 2015). Ramacciati (2018) found lack of reporting has a link with fear that the managers may perceive it as poor performance and reflect negatively on their nursing career. Furthermore, the ED nurses are discouraged to report due to a perceived lack of support from the management by not paying attention to workplace violence and encouraging staff to report (Ramacciati, 2015).

Workplace violence occurs frequently due to a lack of management support (Wolf *et al.* 2014) and often, mild incidences are not reported (Sato *et al.,* 2013). Meanwhile, a minority group (n=6; 7.1%) showed there are no channels of reporting to follow, and such institutions that lack clear policy and procedure of reporting create uncertainty in the ED nurses in reporting occurred events of violence (Hogarth *et al.,* 2016).

In this study, it was revealed by 35 (41%) respondents that in a situation where an event of workplace violence has occurred and reported to the managers, generally nothing is done. Such behaviour corroborates with the study of Al-Omari (2015), in which half of the participants who formally reported the events workplace violence to their managers were not satisfied with how their cases were handled. In the present study, only a few (n= 10; 11.8%) indicated that after the workplace violence incident members involved are called upon to discuss and resolve, although management often sides with patients and relatives and ED nurses are always expected to apologise. Where ED nurses did not to report incidences of workplace violence, approximately 45 (52%) gave the reason that it is because there is no outcome. The lack of intervention in the proceedings of reported workplace violence is a regular occurrence; during the post-violent events in the ED often there is no action taken to resolve the matter nor prevent reoccurrence, and there is no support offered to nurse victims (Pai & Lee, 2015).

A small group of ED nurses (n=8; 9.4%) were not aware of the channels of reporting, while six (7.1%) revealed a lack of support from management to report and four (4.7%) regarded workplace violence as normal. Furthermore, almost half (n=41; 48.2%) of the respondents felt that the violence demonstrated by patients and relatives towards them was part of their job. In the findings of this study, half the respondents (n=43; 50.3%) stated workplace violence had increased in the past year.

Among the different types of violence occurring in the ED, the study found that most of the respondents (n=33; 38%) felt confident to handle verbal forms of violence, 29 (34%) were not prepared to handle any kind of violence in their working environment and only a few (n=7; 8.2%) were prepared to handle physical violence and any violence from MHCU. The limited number indicating being prepared to handle workplace violence is associated with a study that revealed that due to lack of skills and resources, nurses have demonstrated incompetence in handling violence from MHCU (Pich *et al.*, 2017). A group of respondents (n=26; 30.1%) stated they were not prepared to handle any form of workplace violence, whereas 28 (32%) specified they are least prepared to handle physical violence and five (5.9%) revealed they are least prepared to handle sexual abuse and intoxicated patients/relatives.

Management needs to develop approaches to apply on the identified precipitant of workplace violence in the ED, and extensive involvement of the management does produce better outcomes and reduce incidences of workplace violence in the ED (Gacki-Smith *et al.*, 2009). Zhang *et al.* (2017) proposed that managers should concentrate on cultivating the empathy level of nurses, because it does improve nurses' behaviour towards patients/relatives and decreases the occurrence of workplace violence. In the present study, respondents (n=43; 50.6%) suggested there should be an increase in the number of security officers in the ED area, and this was associated with controlling access of patients/relatives in the ED. The need for additional security officers was found proactive, because their work is required in multiple areas of the institution, such as parking, hospital entrance, and other units of the institution.

Additionally, 10 (11.8%) added that these security officers should also undergo specific training to be able to demonstrate skills in managing workplace violence in the ED. Gillespie *et al.* (2011) also suggested this, as participants have outlined the need for security officers to become well trained to attain a variety of skills to the level of police officers in anticipation of overcoming incidences of workplace violence in the ED. Other respondents in the current study (n= 4; 4.5%) found it significant to also equip ED nurses with education and training on workplace violence. Al-Omari (2015) reported that is important that nurses receive training and education concerning workplace violence because the absence of training leads to mismanagement of violent incidences. Among the suggestions was that management should establish clear ways of reporting and provide support to the ED nurses.

5.2.2 Phase 2: Findings from the Qualitative Study

This section of the study examines the experiences and perceptions of emergency nurses regarding workplace violence at the emergency department of a government hospital in Johannesburg. Phase 2 (qualitative) of the study provides a discussion of findings of the focus group semi-structured interview supported by the literature. Emerged themes are contributing factors of workplace violence, factors that hinder reporting, the inefficient performance of security officers, unsafe environment, and helpful strategies.

In the emerged theme’s contributing factors, participants narrated that the risk factors associated with workplace violence against ED nurses had a direct link to human behaviour.

The conception is that community members, patients and relatives have misconceptions about the care rendered by the ED nurses. They present themselves in the ED with a negative attitude towards ED nurses because they anticipate receiving substandard care, and these negative attitudes experienced by ED nurses are apparently unrelated to the manner of approach nurses offer, or care offered to the patients. Such behaviours were interrelated in the study by Jiao *et al.* (2015) in which patients, known as clients and consumers of care, display the role of the consumerist, and tend to be demanding and entitled. Gacki-Smith *et al.* (2009) have found that patients and relatives believe that ED nurses are uncaring and not empathetic when seen displaying behaviours such as laughing during the work process.

Factors such as overcrowding, long waiting periods and the presence of psychiatric patients in the ED also precipitated events of violence in the ED (Gacki-Smith *et al.*, 2009). In addition, participants have identified that workplace violence relates to the high-level expectation care patients and relatives have of the healthcare system in other circumstances. Tucker *et al.* (2015) stated that community members develop mistrust and reduced confidence towards the care system when their needs are not as expected.

The lack of trust of community members in the healthcare system relates to news of negligence and poor health services conveyed by media, particularly on TV. The study by Ramaciati *et al.* (2018) agrees that media has prejudiced community members against the ED nurses. Meanwhile, Jiao *et al.* (2015) also included newspapers and the internet as significant precipitants in causing public mistrust towards the healthcare system, because at times, the reports are misleading. Zhang *et al.* (2017) have revealed that posting videos of poor service and dissatisfaction with the healthcare received in the hospital creates public anger and distrust towards the health service delivery. In addition, participants reported that media news allegations are frequently one-sided, favouring the patient's side of the story and often fail to provide the public with findings from the investigations, leaving the public with deficient information.

Moreover, from lack of knowledge, patients and relatives have demonstrated various types of violence to obtain attention from ED nurses. Participants have pointed out that some of the patients and relatives are not aware of the system utilised in the ED in attending to patients, particularly prioritising and provision of healthcare to patients according to their state of illness, instead of first-come-first-served. However, Ramaciati *et al.* (2017) argues

that certain workplace violence is a result of poor communication from ED nurses towards the patients/relatives.

Community members were not the only ones to precipitate the workplace violence against ED nurses, even the staff employed in the same institution, both medical and non-medical, were reportedly aggressive and demanding during their consultation in the ED, or while accompanying their relatives to receive healthcare services in the ED.

There is no capturing of the frequency of events of workplace violence, as participants' report events of violence in their work environment going unreported due to multiple reasons. The participants shared views of being uninformed on routes and systems of reporting workplace violence, and further state that in violent incidences reported to the unit manager, there were no follow-ups done, and the unit manager appeared to be unaware of the procedure to carry through. Hogarth *et al.* (2015) suggest that the under-reporting of workplace violence that exists in the ED may be due to unclear processes of reporting and lack of knowledge of the reporting system by the ED nurses. They also argue that ED nurses regard or report workplace violence only when there is physical injury sustained, and the findings of Sato *et al.* (2012) add that reporting of workplace violence by ED nurses depends on the degree of injury sustained by the nurse victim.

Moreover, participants have reported that in instances where the incidences of workplace violence occur with no measures taken following the incidents, the management of the institution often fails to follow up and bring solutions. Reported cases of the event of violence end up disappearing without investigations and elucidation; hence, ED nurses become discouraged to report. There is nothing done.

It is common for ED nurses not to formally file a report concerning workplace violence events because the belief is that it is insignificant as there were no intervention nor preventative strategies implemented. The participants indicated that post-event of violence, ED nurses repeatedly become hesitant to notify their superiors of the event because there is no follow up, and it has come to their attention that management do nothing regarding acts of violence against them. Participants felt no one cared about them at work; this has led to nurses' habitual acceptance of violence as part of their job. Jiao *et al.* (2015) cited frequent

observation of such behaviours of violence in ED nurses of lower category, meanwhile Angland and Dowling (2013) report this a regular occurrence with novice ED nurses.

The acceptance of workplace violence was associated with the ED nurses' experience of the discouraging way of handling workplace violence cases, and the scarcity of knowledge regarding the procedure and systems of reporting. Meanwhile, psychiatric patients' violence appears to be expected and acceptable, as participants' reported psychiatric patients are not in a good state of mind. Such behaviours are relative to the findings of study by Hogarth *et al.* (2015) who found ED nurses made excuses for violent patients, reporting that violence from a sick patient is not deliberate and they regard such violent behaviour as part of their job. Most ED nurses allow aggressive behaviour from patients and relatives because they believe it is part of their work (Angland *et al.*, 2013). The study by Sato *et al.* (2012) indicated that some ED nurses become reluctant to report acts of violence against them because they feel this may lead to punishment against the patient. According to participants, there is no use reporting workplace violence because the managers of the institution are not providing interventions when there is an escalation of an incidence to them; nobody cares.

Participants reported a lack of support from management in dealing with workplace violence events experienced by the ED nurses. There is no encouragement to report such events, no follow up nor planning of preventative measures and no trauma counselling, debriefing sessions arranged for the nurse victims, and in event reported events of violent behaviours were captured by the managers, the nurse victims were unfailingly found at fault and told to apologise to the perpetrator particularly to patients/relatives. Ramaciati *et al.* (2018) cited a similar trend, where managers who are inconsiderate about the episodes of violence against ED nurses have a link with poor reporting.

Participants stated the institution pays less attention to the aggressive behaviours received by ED nurses from the community members and focuses more on the complaints laid by the community members against them, and often when ED nurses report workplace violence, it is not because it is a procedure, but to protect themselves for possible future complaints against them. According to Sato *et al.* (2012), nurse victims who regard managers' behaviour as failing to demonstrate support and defend staff is strongly linked to not reporting aggressive behaviours against them.

The poorly formed security system in the institution was associated with a high prevalence of workplace violence against nurses in the ED. Hyland *et al.* (2017) showed that the presence and response of tough security officers in the ED enforces controlled access of community members and effectively lowers the rate of violence in the ED. Unlike in this study, participants had lost confidence in the security system of the hospital, particularly security officers. Reportedly, there was an increase in violent incidents with the available security officers because they often failed to demonstrate capabilities to control and dissolve violent incidences. When the ED became crowded, they showed poor access control and no skills of restraining patients. Participants further perceived the security personnel structure as disorganised and lacking knowledge, because although they are present in the ED they fail to contain and prevent the violence. Additionally, the security officers are not always available in the department.

The ED is a high-risk environment of workplace violence because, at times, security officers are not there to minimise factors such as overcrowding and preserving order. The participants identified the issues related to the security officers as complex, because they not only experienced them to be incompetent but at times, the ED area operates without a single security officer. The participants overly expressed the issue, and stated that ED nurses have to walk around hospital premises to look for them at times. Hence, specific incidents of violence are unavoidable due to the absence of security officers; most of the time, this absence of security officers is observed during the change of shifts. The participants perceived this poorly controlled environment as unsafe.

One of the purposes of the security officers in the ED is to control the number of community members entering the department. Free access to relatives and other members is associated with many violent behaviours in the ED (Gacki–Smith *et al.,* 2009). Participants stated that security officers stationed at the hospital entrance failed to control and monitor patients/relatives coming into the hospital premises, and these create a burden in the ED. As the ED becomes crowded, this gives community members a chance to enter and leave the ED freely, access control is not enforced, and due to the absence of metal detectors, some of these people enter the hospital premises with weapons. A poorly controlled institution that allows free movement of community members in the area creates an increased risk of violence (Stene, 2015).

The free access and overcrowding have brought fear to ED nurses as community members bring along dangerous weapons to the department, and ED nurses with elevated anxiety associated with an increased risk of workplace violence. Participants have shared horrible experiences and have reported that while working, relatives/patients threaten them with guns and knives to subject them to their demands. Most of the participants expressed feeling fear at work, and specific violent incidents have left them shaking and in distress because other perpetrators threaten to extend the violent behaviours to outside work. Stress and anxiety at work is linked with reduced productivity (Gated *et al.,* 2011)

The workplace violence that occurs in the ED reportedly occurs frequently in the first segment of the ED, the triage area. This area differentiates patients according to their medical and trauma illness so that severely ill patients receive urgent attention to reduce mortality. With that stated, participants report that at times the area becomes overcrowded, patients and relatives become impatient while waiting for medical attention and aggressively direct their dissatisfaction toward ED nurses. Verbal abuse is a regular experience compared to other forms of violence, especially over the weekends when more patients and relatives are intoxicated with alcohol. Gilchrist *et al.* (2011) report alcohol as the most contributing factor in the ED.

Through the experiences of violent behaviours, participants report having established ways to cope with such unfavourable moments. Participants state they have found it relieving and distressing to share the feelings of the events of violence happening to them verbally, and have developed a strategy of helping each other by taking over patients or relatives that have a personal clash with any of the ED nurses. Another study suggests that ED nurses must formulate strategies to build relationships with the public and media to gain trust and revive the distorted image of the profession (Ramaciati, 2018)

Other strategies found helpful by the participants were the extensive involvement of the institution's management, to place attention to the problem of workplace violence, and capture the extenet of the problem for proper planning and implementation of corrective measures. Derawad *et al.* (2015) state that it is not only nursing care provision that causes workplace violence, environmental factors also influence the problem. Therefore, it is the responsibility of the hospital's management to consider the enforcement of security measures and clinical development coordination to improve the communication skills of ED nurses

and practical training on the handling of workplace violence (Ramaciati, 2018). In supporting the ED nurses, participants suggested that nurse victims' require sensitive handling, and counselling to be available for the victims. In other countries, it is helpful for ED nurses to undergo workplace violence training (Kasangra *et al.,* 2012; Gacki-Smith *et al.,* 2009).

5.2.3 Interpretation of Results and Integration of Data

To achieve the objective of the study, there was a mixed-method design derived from an explanatory sequential study applied, a two-phase method consisting of a quantitative and qualitative approach. The researcher firstly conducted and analysed the quantitative study, and used the findings to build on and expand for a broad understanding of the phenomenon under investigation during the second phase - qualitative research (Creswell, J.W., & Creswell, J.D., 2018).

The study has revealed the existence of workplace violence in a diverse form, such as physical, verbal, and sexual, against nurses in the ED; verbal abuse was the most common form and these results were consistent with previous studies (Jaffal, 2016; Gacki-Smith *et al.,* 2009; Pich *et al.,* 2017). More than three-quarters of the ED nurses reported being shouted at, yelled at, and called names, while more than half reported being pushed, kicked, and threatened with physical harm while performing their duty at work. According to ED nurses, patients and relatives often demonstrate such behaviour of abuse towards them. These behaviours were multifarious and culturally bound. Community members present themselves in the ED armed with the misconception they will receive poor treatment from the ED staff. Public mistrust towards the health professionals is one of the main causatives of workplace violence (Tucker *et al.,* 2015). Furthermore, media, such as TV, was a precipitant - the visuals of malpractice and negligence occurring in the hospitals creates negative behaviour from the community members towards the hospitals, and often media storylines side with patients and relatives, rarely providing the public with conclusions of the investigations. Due to lack of knowledge of ED operations, patients and relatives show feelings of frustration and dissatisfaction when other patients come after them and they offered immediate treatment; these dissatisfactions are regularly directed towards the ED nurses.

It is not only from community members who show violent behaviour, but also the hospital staff. As reported by the ED nurses, medical and non-medical staff, who occasionally come to the ED to seek medical attention or accompany their relatives, display hostile behaviour towards ED nurses when not offered first preference despite the severity of the illness of the patient. According to South African Cape Triage Score, it is significant to provide care to patients in the ED according to score of the urgency and failure, or a delay in receiving care of priority patients may lead to an increased mortality rate (Gottschalk *et al.*, 2006).

In this study, the channels of reporting were unclear for many ED nurses. The majority of the ED nurses stated they verbally report or file reports with the shift leader, while others report to the unit manager. More than three-quarters of the participants revealed they never reported events of violence experienced at work, and more than half of them stated they never received instruction to report events of workplace violence. The system of reporting was not available to the ED nurses and on several occasions, ED nurses found themselves in between whether to report the incidences or not, because even the managers could not to demonstrate confidence in handling the workplace violence incidences and in most cases, no follow up occurred.

The incidences of disappearance of the cases and no follow-ups are associated with habitual poor reporting, and lack of reporting is associated with recurrent physical abuse (Gacki-Smith *et al.,* 2009). The ED nurses reported feelings of lack of care for them, and being discouraged from reporting aggressive behaviours towards them as management failed to provide feedback and corrective measures. The absence of support from the managers is a barrier to reporting workplace violence events in the ED (Gacki-Smith *et al.,* 2009). It was revealed in one study, with regard to workplace violence against ED nurses, nothing changes and nobody shows concern (Wolf *et al.*, 2014), and nurses have developed an approach of acceptance that workplace violence is inevitable; almost half of ED nurses perceive workplace violence as part of their job. In the study of Hemati-Esmaeli *et al.* (2018), the nurses have shown dissatisfaction towards management and the administration, as they are receptive to the workplace violence.

Furthermore, the security personnel of the institution had insufficient skills to act effectively in the event of workplace violence to protect the employees. The majority of ED nurses rated the security personnel as not effective at all. The study revealed that the security personnel

had poor structure, lacked numbers, lacked the skills and capabilities to control and restrain crowds, and at times were not available at their station in the ED; in addition, they failed to enforce access control. The events of workplace violence were associated with an increased number of community members in the ED, and as hospital entrances had free access for everyone, this enabled community members to enter the hospital premises with weapons. The suggestion was that the level of training required by the security personnel in the ED should equal that of one police officer to eradicate the precipitants effectively (Gillespie *et al.,* 2011)

Upon entering the hospital premises, triage is the first point in the ED and this study revealed that most of the violent incidents occur in this particular area. Apparently, ED nurses are three times more likely to encounter violence while attending patients in the triage area (Pich *et al.,* 2017). Patients and relatives became impatient while waiting to receive care, and are found to be intimidating, especially in large numbers. ED nurses revealed feelings of fear due to the experiences of verbal intimidation, and threats with knives and guns. Hassankhani *et al.* (2017) revealed such experiences of workplace violence may tamper with mental health, causing sleeping disturbances, psychological distress, and depressive disorders. Moreover, the majority of ED nurses, more than three-quarters, have never received any workplace training.

The participants found it significant to limit the number of community members entering the hospital and the ED. The suggestion to control access is to improve the ED environment, because a crowded ED is associated with increased violence (Gacki-Smith *et al.,* 2009). There is a need for an increase in number of security personnel and for them to undergo training to improve skills particularly relevant to the ED, such as restraining and access control, and the utilisation of other measures of security, such as metal detectors and effective use of CCTV cameras. Management is encouraged to support the ED nurses by establishing clear routes of reporting, provision of counselling, and debriefing to the nurse victims.

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5.3 SUMMARY

This chapter discussed the findings of the quantitative and qualitative study supported by the literature and the integration of the significant findings.

The next chapter concludes the study, and includes the discussion of the summary of the study, main findings, limitations, conclusions, and recommendations.

CHAPTER SIX

SUMMARY OF THE STUDY, MAIN FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

6.1 INTRODUCTION

The concluding chapter outlines the summary of the study, main findings, limitations, conclusion, and recommendations to the clinical practice, education, management, and further research.

6.2 SUMMARY OF THE STUDY

6.2.1 Purpose

The study aimed to describe the experiences and perceptions of emergency department nurses regarding workplace violence.

6.2.2 Objectives

- Determine the nature and extent of workplace violence experienced by ED nurses (quantitative study)
- Explore the experiences and perceptions of ED nurses regarding workplace violence in two hospitals in Gauteng (qualitative study)

6.2.3 Methodology

The Human Research Ethics Committee (medical) of the University of the Witwatersrand granted ethical clearance before data collection, and the Faculty of Health Sciences Post-graduate Committee granted permission prior to commencement of the study. The researcher also sought approval to conduct the study from the CEOs and nursing managers of the respective hospitals, including field unit managers.

There were four emergency departments of two public hospitals situated in Johannesburg, South Africa, used to conduct the study. The study consisted of ED nurses as participants.

The participants' selection was through purposive sampling. Only nurses with more than six months of working experience in the ED, and who consented to participate could take part in the study. The main developer gave permission to use the validated survey instrument to collect data. The researcher formulated a semi-structured interview question for the focus group, which underwent pre-testing by the first focus group before collecting data to test the feasibility and seek clarity.

This study applied an explanatory sequential method design to achieve the objectives. The study ran through two phases. During Phase 1, the survey questionnaire-based data was collected from 85 (n=85) participants over 14 weeks, and the findings described using descriptive statistics. In Phase 2, data collection was through semi-structured interviews with three focus groups (n=4, n=5, and n=6) over 10 weeks and the findings analysed using the thematic analysis method of Clark and Braun (2013).

6.3 SUMMARY OF MAIN FINDINGS

This study established the experiences and perceptions of ED nurses regarding workplace violence during two subsequent phases. In Phase one, the quantitative phase was with survey questionnaires with open-ended questions, with the findings elaborated in Phase 2 of the qualitative study during a semi-structured interview setting in two public hospitals situated in South Africa.

In Phase 1 of the study the sample size was n=85 (100%). The study revealed challenging behaviour experienced by the ED nurses, with reports such as physical, verbal, and sexual abuse. Although verbal abuse was frequently found to originate from patients and relatives, more than three-quarters of the participants reported having been yelled at (n=65; 76.5%), and called names (n=69; 81.2%). Prominent physical acts of violence experienced was having an object thrown at them (n=46; 54.1%), hit (punched, slapped) (n=43; 50.6%) and harassed with sexual language or innuendo (n=56; 65.9%).

The presence of security personnel in the ED was the most effective method of controlling violence by the ED nurses, with approximately one quarter of the participants stating the access of patients and relatives into the hospital and ED as the root cause of the problem and revealed that an access control approach may lessen the occurrence of workplace violence.

Furthermore, there was the suggestion of the identification of high-risk patients, such as mental healthcare users and suicidal patients, for immediate intervention to reduce the risk of workplace violence. Sixteen (18.8%) participants further revealed it was not effective to verbally engage with the perpetrator of the violence with the motive to dissolve the conflict. Psychiatric holding in the ED and Triage areas were specifically those with an increased risk of violence, with the mean (median) score and standard deviation on level of safety M= 2.64 (2.00) SD 2.10 and M=3.06(2.00) SD (2.16) respectively. Almost three-quarters of the respondents had never received any training related to workplace violence, and such training programmes concerning workplace violence did improve feelings of safety among staff (Kasangra *et al.*, 2012).

The findings of the study revealed a lack of reporting of the violent incidences that occur in the ED. Approximately 60 (70.6%) ED nurses did not report the violent events experienced at work, although 30(35%) reported such events to the shift leader. The reasons for poor reporting were that no measures were implemented following the reported incidents, procedures of reporting were not known, and there was poor management support, and additionally, in circumstances where both parties are called upon to resolve the conflict, often the management of the institution expects the ED nurses to apologise to patients and relatives despite who is at fault. It was also revealed that a group of ED nurses were unaware of what qualifies as an act of violence, as about 18 (21.1%), and 28(32.9%) considered bitten/ hair pulled and stabbed non-workplace violence behaviour respectively.

The perception was that the rate of workplace violence had increased from the past year by half of the ED nurses, and while most were not prepared to handle it, 33 (38%) respondents felt they were prepared to handle verbal abuse. Almost half of ED nurses perceived workplace violence as inevitable and regarded it as part of the job. These findings relate to the security personnel's lack of skills to handle violent events, and at times not being available in the ED. On the time availability of security personnel in the ED, results ranked from 1= not adequate at all to 10= completely adequate, with most respondents signifying a rating below 1.

During the focus group semi-structured interview, five broad themes emerged, "contributors of the workplace violence," "factors hinder reporting," "inefficient performance of security officers," "unsafe environment" and "helpful strategies."

It was found that patients and relatives who come to the hospital already have the misconception that they will receive substandard care, hence on arrival, display negative attitudes towards nurses in the ED before receiving care; this behaviour related to media news, mostly TV, displaying visuals of negligence and misconduct occurring in the hospitals, which created a perception that health workers were not dedicated and worthy of trust, similar to the findings of Zhang *et al.* (2017). ED nurses, as the first healthcare providers in the ED, often have these views and dissatisfaction shown towards them.

This study also found that patients and relatives lack knowledge on how the ED operates, they show dissatisfaction and frustration when other patients who arrive after them are attended to first; they fail to understand that in ED patients are given medical attention according to the level of severity, not time of arrival (Gottschalk *et al.,* 2006). Furthermore, employees of the hospital also display hostile behaviour towards ED nurses when they do not receive prioritised medical attention in the ED.

Due to lack of reporting, there has been little capturing of the incidences of workplace violence (Gacki-Smith *et al.,* 2009; Hogarth *et al.,* 2016). ED nurses were found not to have the confidence to report workplace violence events, coupled with reasons that no action is taken by the management after reporting, and even the managers appear not to have enough knowledge regarding WORKPLACE VIOLENCE to carry through the procedure, thus nothing is done, no follow-up, no corrective measures and counselling to the nurse victims offered and these behaviours have led to the habitual acceptance and perceptions that workplace violence is part of the job. ED nurses perceive their managers as uncaring and unsupportive. The study revealed that managers pay less attention to acts of violence demonstrated against the ED nurses compared to complaints compiled by patients and relatives, and in an event where ED nurses experience violence, there is no psychological support offered.

In the study, the security personnel were not effective to the level of expectations; ED nurses perceive the security of the hospital as limited in number, poorly skilled, and failed to demonstrate skills to control crowds, and restrain and control access in the ED. The structure and operation of the security personnel did not to cater to the need of the emergency department in diffusing violence. The ED was scary and feared by ED nurses, as members of the community threatened them with weapons, knives, and guns, similar to the findings

of Kasangra *et al.* (2012), who added that access of weapons in the ED was associated with the unsafe feelings of the staff.

ED nurses help each other in dealing with the events of workplace violence, acting collectively and forming strategies, such as taking over patients in personal conflict with certain ED nurses. The proposed suggestions for the management were to engage with ED nurses and seek an understanding of the violence they are predisposed to, and in doing so, execute activities of counselling, establish clear process reporting, install measures such as metal detectors to attempt to eradicate the problem and also provide the ED with well-trained security officers.

6.4 LIMITATIONS OF THE STUDY

The research recognised limitations.

The study occurred in two public hospitals within the city of Johannesburg with a small sample size, therefore the findings cannot be generalised to other public and private hospitals in the South African context. The study took place during the Covid-19 pandemic and lockdown restrictions could have influenced the behaviour of ED nurses and patients/relatives. A purposive sampling method recruited the participants, which might have affected the results of the study as volunteer ED nurses have certain perspectives and experiences that may influence the results. The semi-structured interview took place with a focus group and some participants were not free to voice their opinions, therefore there could be data bias, as participants influence answers among themselves.

6.5 RECOMMENDATIONS OF THE STUDY

The findings of the study have brought an understanding of the experiences and perceptions of workplace violence against nurses in the EDs of two public hospitals in South Africa. The following recommendations are imperative to clinical practice education and management of the institutions.

6.5.1 Recommendations for Clinical Practice

The study has revealed a high prevalence of workplace violence in the ED, and ED nurses have shown inevitable vulnerability as the front line health professionals, particularly in the triage area. The findings have reflected wide differences in the perceptions of workplace violence among the ED nurses, and it is unclear as to what constitutes acts of violence on the ED nurses, although the majority have admitted experiencing various types of abuse in the work environment.

Therefore, it is significant to inform the clinicians on behavioural acts of violence to enable them identify the origin and precipitants, create or improve an efficient user-friendly reporting system and make follow-ups, and provide a secure structural environment that enhances access control of patients and relatives into the ED. It lies with the clinical area to execute measures to run an organised system that reduces unnecessary waiting times, a format to identify high-risk patients and promote an environment that is free from noise, crowds, and stress (Derawad *et al.,* 2015). Training ED nurses and other clinicians on workplace violence may enhance the demonstration of skills, including communication abilities and knowledge, to not only identity and handle the exposing factors, but also to construct planning for preventative measures. The involvement of security officers in the preparedness of the workplace violence events will encourage accountability, acknowledge individual roles in dealing with these acts of violence and bring confidence to act the part as expected during the incidences.

6.5.2 Recommendations for Education

The study by Zhang *et al.* (2017) suggests that the increased prevalence of workplace violence in the ED has a link with awareness and knowledge deficit. An institution with a poor reporting system and policies is associated with frequent acts of violence (Gacki-Smith *et al.,* 2009). Work environment safety in the ED is still under improvement, and more is necessary to improve it.

- Establish an awareness campaign to inform staff regarding workplace violence, including which behavioural acts constitute as workplace violence; offer education

on the channels and significance of reporting the occurrence of violent events and the channels thereof.

- Provision of education and training for ED nurses in order to enhance communication skills, develop the ability to be able to identity precipitators' factors, and demonstrate techniques to de-escalate and defuse violent behaviour. The education should incorporate security officers to decide the clear description of the role of ED nurses and security officers in an event of workplace violence, in which circumstances a security officer needs calling in anticipation of violence, and the limitations.
- Inform the healthcare workers concerning the existing available resources in place that are designed to prevent and deal with events of violence, such as the use of organised work strategies, avoid overcrowding of patients/relatives with use of waiting areas, use of battler doors, and reduce multiple entrances.
- ED nurses are encouraged to keep up to date with the existing knowledge concerning workplace violence across the world to be able to gain strategies to prevent such instances.

6.5.3 Recommendations for Management

The proposed suggestions from the open-ended questions and focus group semi-structured interviews were directed at the management of the institution for them to promote a safe working environment for the ED nurses.

- Management to recognise the nature and impact of workplace violence against the ED nurses.
- Develop a task force, including clinical nurses, quality assurance and managers to analyse, and identify vulnerabilities within the ED for immediate response, reporting, and planning for elucidation and prevent future reoccurrence.
- Provide ED nurses with clear and consistent channels to report the incidences of workplace violence, make follow ups and provide the nurse victims with feedback.
- Demonstrate physical and emotional support to the ED nurse victims in the form of debriefing sessions, and counselling to ease psychological distress.
- Equip the ED with sufficient and skilful security personnel, and control access of the public in the ED and hospital premises as a whole.
- Develop ED nurses with education and training on workplace violence.

- Nursing and institution management should raise awareness to the local police station and the state's justice system of South Africa regarding workplace violence in the EDs, to integrate strategies and actions of response.

6.5.4 Recommendations for Further Research

The study took place in the emergency department of two public institutions in the Gauteng Province in South Africa, with a small sample size. A replication of the study in other EDs of public and private institution across the country is necessary to support the findings. Furthermore, similar studies may generate data for an in-depth understanding of the extent of workplace violence in the EDs and its impact on the ED nurses, and also to identify various approaches and safety measures to promote a safe working environment free from harm, intimidation, and violence.

6.6 CONCLUSION

The study has explored the experiences and perceptions of ED nurses regarding workplace violence in the ED of two public hospitals. Workplace violence does exist within the South African context. Patients and relatives were those who showed aggressive behaviour. Verbal violence was the most prominent form of violence, although there were other types of workplace violence, such as physical and sexual, reported. The triage area was the common place where violence occurred, and factors such as waiting times, lack of access control, lack of sufficient skilled security officers, and poor reporting were precipitants of workplace violence.

The data from this dissertation suggested an improvement in the support from management for the ED nurses in handling cases of workplace violence, and the establishment of an organised reporting system, provision of a sufficient number of skilled security officers, and counselling and debriefing sessions for the nurse victims. Further research is necessary to bring about a broad understanding of the concept.

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APPENDIX A

THE EXPERIENCES AND PERCEPTIONS OF EMERGENCY DEPARTMENT NURSES REGARDING WORKPLACE VIOLENCE

WORK VIOLENCE STAFF ASSESSMENT SURVEY

SECTION A : BIOGRAPHICAL DATA

Please circle the single letter that is the correct answer in the following:

1. Age:

(Circle one number)

18 – 24 years 1
25 – 34 years 2
35 – 44 years 3
45 – 54 years 4
55 – 64 years 5
65 and 0ver 6

2. Gender:

(Circle one number)

Male……..1
Female……..2

3. Marital status:

(Circle one number)

Single…….....1
Married……..2

4. Ethnic group:

(Circle one number)

Black 1
White 2
Coloured 3
Indian 4
Other, please state 5

5. Cultural groups:

(Circle one number)

English 1
Pedi 2
Zulu 3
Venda 4
Xhosa 5
Afrikaans 6
Ndebele 7
Others please specify 8

6. Level of education:

(Circle one number)

Higher certificate 1
Diploma 2
Degree 3
Postgraduate diploma 4
Masters 5
PhD 6

7. Rank:

(Circle one number)

Auxiliary nurse 1
Staff nurse 2
Professional nurse 3
Nursing specialist 4
Operational manager 5
Others please specify 6

8. How long have you been working in the emergency department?

(Circle one number)

< 6 months 1
6 – 12 months 2
1 – 5 years 3
6 – 10 years 4
11 – 20 years 5
Over 21 years 6

SECTION B: ENA WORKPLACE VIOLENCE SURVEY

1. Rate how safe you feel from workplace violence in the E.D. overall as well as in each area of this E.D.

	Not at all Safe									Extremely Safe
Overall level of safety in the E.D.	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Triage	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Exam (e.g. non-critical area)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Crash (e.g. critical care/trauma area)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Paediatric	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Psychiatric holding	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
Quick care (e.g. fast track)	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

2. Over the past year how many times have you personally experienced workplace violence?

0-2 times ..... ①
3-5 times ..... ②
6-8 times ..... ③
9-10 times ..... ④
More than 10..... ⑤

3. If you have experienced workplace violence while working at this facility, did you formally report the occurrence(s)?

No, I did not formally report the occurrence(s)..... ①
Yes, I formally reported <u>some</u> of the occurrences …②
Yes, I formally reported any occurrence of workplace violence …③

4. **From the actions listed below, indicate which of the following items you believe to constitute workplace violence. Additionally, indicate whether you have personally experienced any of the items.**

	I consider this action to be workplace violence		I have personally experienced this action while at work in this E.D.	
	Yes	No	Yes	No
Bitten	①	②	①	②
Called names	①	②	①	②
Hair pulled	①	②	①	②
Harassed with sexual language/innuendo	①	②	①	②
Hit (e.g., punched, slapped)	①	②	①	②
Hit by thrown objects	①	②	①	②
Kicked	①	②	①	②
Pinched	①	②	①	②
Pushed/shoved	①	②	①	②
Scratched	①	②	①	②
Sexually assaulted	①	②	①	②
Shot/shot at	①	②	①	②
Spit on/at	①	②	①	②
Stabbed	①	②	①	②
Sworn/cursed at	①	②	①	②
Threatened with physical harm	①	②	①	②
Verbally intimidated	①	②	①	②

5. Do you feel that workplace violence from patients and/or visitors is simply a "part of the job" in the E.D.?

No ..... ①
Yes..... ②

6. Do you feel that workplace violence has increased, remained the same or decreased over the past year?

Increased ..... ①
Remained the same ②
Decreased..... ③

7. **How prepared do you feel to manage aggressive or violent behaviour ?**

Not prepared ..... ①
Somewhat prepared.. ②
Prepared ..... …..③
Very prepared ..... …..④
Extremely prepared….⑤

8. **How has your experience (s) with workplace violence within your department affected you?**

9. **What other suggestions do you have for improving how workplace violence is handled in this emergency department ?**

Thank you for your participation

APPENDIX B

THE EXPERIENCES AND PERCEPTIONS OF EMERGENCY DEPARTMENT NURSES REGARDING WORKPLACE VIOLENCE

INFORMATION LETTER

Dear Colleagues,

My name is Khutso Brian Maimela, and I am an emergency nurse. Currently registered for MSc (Nursing) degree at the University of Witwatersrand in the Department of Nursing Education. Intend to describe perception and experiences of violence against emergency nurses in the emergency department at Tambo memorial Regional hospital and Charlotte Maxeke Johannesburg Academic Hospital. May I ask you to consider participating in this study? I would be interested in your experiences and view regarding workplace violence.

Should you agree to participate, I will ask you to allow me to ask you questions in the form of survey questionnaire or interview you in a group of about four or five in the convenience space of you all. The interview should approximately last for about 30 to 60 minutes of your time, with permission of audiotape in the interview for transcription and analysis.

Participation in the study is voluntary. You may choose to participate or withdraw from the study at any time. Anonymity and confidentiality are assured, transcription of the tape recordings will be done by me and be kept separately from the transcripts, and they will be destroyed once the study is completed, no names or any identification of personnel will be noted in the transcribed data, all transcripts will be kept under lock and key, and only my supervisor will have access to the data, I will be happy to provide you with a copy of the transcription of the interview should you wish to have. Information in the report will be written in general terms, and no personal information will be given.

I appreciate that you will derive no direct benefit from participating. However, I hope that the completed study will assist in understanding the experiences and perceptions of workplace violence against emergency nurses. I have applied to the faculty of health science, school of therapeutic postgraduates' research committee and the ethic committee of the Witwatersrand to conduct the study, and I have also applied to the management of Tambo Memorial Hospital and Charlotte Maxeke Johannesburg Academic Hospital to conduct the study.

Thank you for taking the time to read this information letter. If you wish to participate, please sign the attached consent form, however, should you require more information please do contact me on 0793122254 or email address maimela.kb@gmail.com.

Yours sincerely

Khutso Brian Maimela

Supervisors: Professor Shelley.Schmollgruber, email: Shelley.schmollgruber@wits .ac.za

APPENDIX C

THE EXPERIENCES AND PERCEPTIONS OF EMERGENCY DEPARTMENT NURSES REGARDING WORKPLACE VIOLENCE

CONSENT FORM

I…….. (Name of participants) emergency nurse I permit to participate in the study. I have read and understood the content of the information sheet, and I have been allowed to ask questions regarding the study, and I give consent to participate in the study.

I hereby declare voluntary participation in the study.

Date…… Signature…….

APPENDIX D

THE EXPERIENCES AND PERCEPTIONS OF EMERGENCY DEPARTMENT NURSES REGARDING WORKPLACE VIOLENCE

CONSENT FOR AUDIOTAPE RECORDING

I …… (Name of participant) have been informed about the purpose of audiotape during my participation in the interview, I hereby give a consent to have the audiotaped for the study called "The experiences and perceptions of emergency department nurses regarding workplace violence".

Date…… Signature…….

APPENDIX E

THE EXPERIENCES AND PERCEPTIONS OF EMERGENCY DEPARTMENT NURSES REGARDING WORKPLACE VIOLENCE

SEMI – STRUCTURED INTERVIEW QUIDE

Opening question

As an emergency department nurse based on your work experience. What are your experiences and perceptions with regard to workplace violence?

Workplace violence is defined any form of aggressive behaviour either be physical, verbal and sexual experienced while you are on duty.

Follow up questions.

- As an emergency nurse, what kinds of violent behaviour do you usually experience in the workplace? (probe for communication and understanding)
- What is the precipitant of these violence incidences?
- As an emergency nurse, can you share with me the story of the violent events that you have experienced in the emergency department?
- How do you feel after exposed to workplace violence?
- How do these violent incidences affect your work and patient care?
- What kind of support do you receive from the hospital managers after exposure to violence event?
- What are hospital strategies in place to prevent the occurrence of workplace violence?

THANK YOU FOR YOUR TIME.

APPENDIX F

Example of Transcript

GROUP 4 FOCUS GROUP INTERVIEW
Participants - 4

INTERVIEWER: Hello everyone.

PARTICIPANTS: Good morning.

INTERVIEWER: In proceeding with the interview, according to your experience as an Emergency Nurse in the Emergency Department, what are your experiences and perceptions with regards to workplace violence? By this I mean do you perhaps experience workplace violence in the, in the Emergency Department?

PARTICIPANT 1: Yes, Okay with me personally I have several times encountered workplace violence right here in this Emergency Department which is mostly the, like most of it was verbal like verbal violence where by it like, where like a patient would call me, call names, swear at you like threaten you, sometimes even the relatives, I don't know maybe if I can go on and share that at some point the relatives came with the patient, we were like extremely busy in the resuscitation room,

INTERVIEWER: mmm ehe

PARTICIPANT 1: they just came with a gunshot patient dumped him on the floor and they were like "hey help him now or else we going to shoot you" and then they were swearing at us and calling us big names, so they were like, they were like literally forcing us to stop whatever we were doing, stop helping other patients and attend to their, their relative. I mean if someone has a gun, what are you going to do? And that is scary so…

INTERVIEWER: oh so, one of the relatives had a gun?
PARTICIPANT 1: Yes, proper.
INTERVIEWER: ijoo okay. And how did you feel about that?

PARTICAPANT 1: Oh my gosh, we were like proper scared, we were all shaking we didn't even know what to do, you know when like the moment when you just frozen there, I mean you, you have to like, we tried, initially we tried to say "okay we are going to help him" because that time it was full, there were no beds there was no space so they were like "you help him or else all of you here will be dead" so we had to make it happen, [laughter].

INTERVIEWER: So, at the end you ended up helping him?

PARTICIPANT 1: Yes, definitely we ended up helping the patient because I mean at the end of the day the patient comes first, so we have to help the patient, we helped the patient.

INTERVIEWER: Yes that sounds scary.

PARTICIPANT 1: It was scary it was trust me…

PARTICIPANT 2: Yes workplace violence especially in the ED department it is very, very, very common, yes we experiencing almost, I can say everyday especially the verbal violence and it's mainly most of the time I can say maybe 80% it is from the relatives or the people accompanying the patient and you know their attitude, the way they look at you, they are really intimidating, you end up really feeling frightened like shaking or you feel your heart beat it is really going up and you are shaken and you're scared even to go and continue with the patient, that's how it happens and the other time even one of my colleagues experienced a very, very scary one, she was pointed with a gun had to block the gun with the stretcher, she was on her way to help the patient but the people who accompanied the patient was so violent that she had to use the stretcher to block the gun from her. And funny after that she has to go back and work and the other time it was from one of our own colleagues who brought one of her relatives.

INTERVIEWER: I see.

PARTICIPANT 2: The verbal violence was to another level. And then her sister was even threatening to wait for us by the gate so that she can assault us.

INTERVIEWER: So, they wait for you at the gate when you go home?

PARTICIPANT 2: Yes when you go home, they wait at the gate and they're going to show you who they are.

INTERVIEWER: So how do you, how do you respond to that?

PARTICIPANT 2: You know what it's scary, it's scary, you ask yourself if you are in a safe place and the security guys, shame they can't restrain, they can't control the crowd, I don't know if they got training regarding all those things, most of the time we are helped when there is EMPD (Ekurhuleni Metro Police Department) or SAP(South African Police) or what is the other one who helps to restrain such people?

INTERVIEWER: But do you have security in that department?

PARTICIPANT 2: We do, we do, in inverted commas [laughter].

PARTICIPANTS: [laughter].

INTERVIEWER: So, you are saying that they are not effective in a way?

PARTICIPANT 2: They are not effective in terms of they can't restrain a violent person, you even see the way they handle them, they can't restrain them number one which is the most, is a priority to be able to restrain somebody who is violent, number two, they can't, I don't think they were trained in what they are supposed to be doing which is restraining in most of the time in casualty.

INTERVIEWER: Yes I hear you.

PARTICIPANT 3: Yes you know with the security in this department I feel they have no idea of what to do. In some cases we have violence in the department and they are nowhere to be found, they are not where they are supposed to be, if they are there they don't know what to do, they come and then they still going back for back-up even if they see violence they still wait for you to come and fetch them, if they taking out relatives who are violent in the department they tell the relatives that the nurses are saying you must go out, what is your role there? They actually with my experiences I feel the security guards they don't know what to do, they need a little bit of training, guidance whether they know what to do in instances where by the relative or the patient is violent towards the staff, and you can't even record, report any verbal they don't know what to do to be honest, they don't know what to do.

INTERVIEWER: So, you are saying they just stand when…

PARTICIPANT 3: Actually, I feel from if I am asking with my experiences, I will tell you I feel they need a little bit of training, just so that they have guidance as to what to do, imagine if the security is telling the relatives that the nurses are saying go out… What is that?

INTERVIEWER: So, to you it makes you look …

PARTICIPANT 3: And it's even making me not to be safe, now it means I am the enemy, and I am not the enemy, he is here to work, he needs to take out the people… this person is here and then this person is, is actually I am intimidated, I need assistance, but the person that are supposed to assist me is not assisting me, that person feels I am the one that says they must go out, then what is your role, because I don't need you to deliver the message I was just going to go if it was my role to say go out, why do I need them the security quard.

INTERVIEWER: Yes I understand.

PARTICIPANT 4: It is very bad in this institution. I concur with the other participant because really as she is saying the security officers they need guidance or training for them to really be effective in controlling our workplace violence, because as she is saying like in some instances that you can observe that a relative in fact, a relative can threaten the security officer and they will end up giving into the demands of the relative and they will be like but this is my mom they want to come inside with the patient because it's their mother or their what

and the minute the relative or whoever the escort is start raising up their voice and they are taking a stand and saying "I'm going in it's my mom, it's my dad" and what not, they, you know like sort of they, they draw back and allow the person to go in, so access control it is not there, and they should be doing that, they should be enforcing it, there shouldn't be waiting for the nurse to say it and you know enforce access control, no everyone they do what they like even though we have got the security officers, so for me workplace violence I think we experience it every day, especially the verbal one, it's every day you will get verbal violence in the workplace from the relatives, from the patient, colleagues it's not really that high you know, [laughter] and physical I haven't like really experienced the physical violence directly but I think I've, I've seen a patient you know assaulting a staff member, the physical part of it and it goes back to that problem, when you call for back-up there is no one to you know restrain the patient as the other participant was saying that, this people they need to come in and restrain the patient, but there is no one, and you end up being assaulted, what is the next step, you don't even know, do I report it? Do I not? Do I, like you don't even know what the procedure to follow up after that.

INTERVIEWER: So, you don't know the procedure to follow, you are saying that there is no procedure in place or there is?

PARTICIPANT 3: In instances where I have tried to follow the procedures by reporting to the manager, next level, actually from my experience I feel that the manager didn't know what to do. Because it was reported and to this day nobody can tell me where did that case end up and what is going on. The only time when I see paper flying and what not it's if I am at fault. If the relative of the patient is at fault there is no follow up and remember this is a busy department, this workplace violence is there every day, it's so hard to follow up on a case if from my perspective I feel even the manager does not know what to do. Because this incident what happened is that the, the gentleman who brought his son, wanted to sort of I don't know how can I explain this because we wanted to do a dip stick and what happened is he wanted to pour the urine on us and we all went quiet and the shift leader was there and the shift cleaner took initiative to sort of call the manager, we are having a problem here and we don't know even understand what is going on, and the security was right there, but because I wanted to leave out the security issue and focus on the managers that is just not doing it's, that is where it ended, we never got response whether we are having follow up, is that person going, it just ended there.

INTERVIEWER: So how do you, how do you report, how is the reporting system, how do you do you report?

PARTICIPANT 2: In my instances I never reported because I know nothing was going to be done, nothing is going to be done and like my colleague has just said if it was me being violent to a patient there was going to be follow up at all levels, so I think the root cause about this what is aggravating it is because there is no, there is no access control, if we can have good access control whereby only patients that are supposed to be escorted come in with escorts that will limit or minimize and I think as people working in the ED because there are like psych patients and I mean if I am a relative my role is to fill in the forms but in terms of restraining or any other role I don't have a role, so I think we can have an SOP (Standard Of Procedure) that says, a psych patient must just come in being escorted maybe by security if they are violent and their relative goes to the table just to fill in forms then they go out, I don't know I'm just brainstorming here, because yes and then the other thing we must have trained securities. They must know what they are doing here, they must know their job description, their job description with the securities mustn't be the same throughout the hospital, their job description should be different in casualty, in theatre, in psych wards, so it's like they all having a uniform job description which doesn't make sense and they don't know what to do they are clueless. I work in triage, I have to control access, I have to inform the relatives of what their patients, the condition, and that stuff you know, they even come to me, sister come and control them you understand, and this.

INTERVIEWER: So, the security are calling you to come and help?

PARTICIPANT2: Yes.

INTERVIEWER: Because they are failing to control?.

PARTICIPANT 2: Exactly, exactly, you know.

INTERVIEWER: So, with such instances what do you do?

PARTICIPANT 2: I mean escalate to management nothing is going to be done.

PARTICIPANT 4: And it is discouraging to even report.

PARTICIPANT 1: Now with my experience as far as reporting is concerned, nothing is going to happen, I agree with my colleague, nothing is going to happen, because with the, like so many incidents that we have had I mean like in the work place we have your lines of communications, there is a manager and there it the matrons, so you report it immediately to a superior, okay so this is what happened and they are like "oh okay" the best thing that I have seen happened is just the incident report to fill in that incident report but still there is no feedback after that, even if you ask they would be like "oh but you know so and so" like because in that case the patient was our usual client so they are just like "ah but you know him he is, he is just like that" because he actually he literally threw a glass at like one of the colleagues, yes like almost hit her like on the head so they are like "ah but you know mos he is, he is like that" nothing happens, like there is no feedback, there is no follow up, like zero, nothing.

INTERVIEWER: oh ok...

PARTICIPANT 3: Actually I think we have learnt to live with the violence and we have accepted it, because as a person who has reported the matter you also have a right to also ask how far are we with what I have reported, as much as we are saying it was our fault it was going to be followed up until the last point but what about you because if you reported something yesterday you go to your manager, how far are we and then with such things, like how are, we accepted it and now we are moving on and make it normal especially the verbal, I don't even think I still reported it that time. I just take it as you know what you are useless and then I'm like yes and then I just move on with that, it's not acceptable and we should take steps back and make it zero tolerance, we don't want people to be swearing at us, I'm not swearing at you, respect me, I respect you, I came to work, you also have your own workplace where nobody is swearing at you, let's focus on the problem at hand.

PARTICIPANT 4: and I mean It's part of our rights to say I cannot nurse you, give you nursing care if you are intimidating me, but it's funny how, we have normalised it.

INTERVIEWER: But do you ever exercise that right by saying?

PARTICIPANT 3: No, we are not exercising it, we put that right aside, it's our mistake as well, we put that right aside we need to just do it even for the next coming generation because now it means as you accept it those that come will accept it and then we are going to end up leaving being sweared at and everything and then we have accepted it.

PARTICIPANT 4: But now the thing is, if it is the relative you can't really leave the patient, because the patient you know is sick and you see they are very ill, and they are not saying anything, the person who is busy pushing you know for this violence is the escort and the poor patient cannot suffer for the sake of this escort, so I think we just, we've you know, I think yes each case is different and you dealing with it the best way you know how, you know as it comes.

PARTICIPANT 3: But in most cases where the relative is aggressive, the patient is not aggressive, know you are so confused with as to, do I report this one and then you just end up accepting it that you know it's,

PARTICIPANT 1: and also guys it's difficult, imagine if someone is standing here with a gun and then say you help him now, you drop everything, people are like no how are you going to exercise your right to say "oh okay because now you are, you are aggressive toward me and the I choose not to help you", because your life is in value, so it goes back to the issue like we are saying security and access control,

PARTICIPANT 4: because how did this item the gun, how did it get into the emergency department, into the department?

INTERVIEWER: So, let's go back to the security, do you only have the security to control, or do you have any other measures in place to help with controlling the violence?

PARTICIPANT 2: I think the other thing it's, our attitudes, like for now the casualty has been renovated, we've got those doors, when those doors were being put up some of the staff members but not health workers said "what do you think you doing?" they think they are closing us out, we, you never, you never succeed in what you are doing, so the attitudes of other team members, number two, the attitudes of other security guards,

INTERVIEWER: mm I see.

PARTICIPANT 2: I can point a few security guards who tried to close the door and if they control it, it becomes controllable inside, but there are those who come they keep the door wide, this one thinks better why should they close this door, this door must be open, you know I don't know if they could have been educated before why closing the doors because the main the root cause it's access control, it's access control.

INTERVIEWER: All right so, so access control is the main?

PARTICIPANT 2: I think so, it's the root cause.

INTERVIEWER: Okay.

PARTICIPANT 1: Yes, I also think it depends, like, like who is insinuating the violence because if it's a psychiatric patient we have control over them, we have our chemical restraints we can like be as like six of us hold down the person and like sedate them so that is better but validate the main thing that we can't run away from are the security guys.

PARTICIPANT 3.And the fact that sometimes there is no security at that door. It's wide open and the security is not there, if there is violence you are even going outside to look for him, he is not doing what he is supposed to do, actually the security it's just an issue. It's a whole different story.

PARTICIPANT 2: You benchmark with other institutions, you go to Tembisa Hospital from the gate they check your bag, they check you, you are screened and everything. Tambo Memorial Hospital I think we are facing very big security issues, access control, I don't know whether it's because we've got multiple accesses, it might be the cost.

PARTICIPANT 4: I don't think the multiple access is the problem because if you are at this gate, this is a gate, the main gate for pedestrians and then for vehicles, if you know what you supposed to do to ensure you know there is the safety of the people who are inside and stuff, you will enforce that and by that gate if the problem is right at the gate, all the way to the department the different department entrances, all the way in, like if the problem has come inside the department it is difficult to manage, but if at the gate the access point whether it's multiple but who is there? Who is controlling the access? It they can manage it there then even the, those people insinuating this problem they wouldn't have allowed to be in you know this patient came in to consult, they are well, they can speak for themselves, they are in the in the you know orientated and everything, so the escort what is the escort going to do? They must be behind even if it is a family car, they are accompanying one person, the other ones why are they coming in all of them? And we know there is a parking you know for family cars and stuff but we understand that other patient conditions they don't allow them you know they need to be dropped-of at the emergency department but the other family members where are they going and when they get off from the car they are all here, the triage nurse who is receiving them already there is a crowd, they speak at once some of them, they intimidate you and you try by all means you know the patient care is very important and you try to prioritise that but sometimes you do feel intimidated and it feels like you know violence it's about to take place here.

INTERVIEWER: So why would they intimidate you why are they intimidating you when they come?

PARTICIPANT 4: No when they come, isn't it when they come they are pushing for their patient, you are a triage nurse, you know what you are supposed to be doing there but when they get to the entrance where you are they want to tell you what to do, they want to tell you how urgent this person is and I mean we are trained we are professionals, we are not just an emergency department that is why we've got triage to sort out to prioritise our emergencies we know there is different emergency but the want to tell you this one right here he is the most urgent one.

PARTICIPANT 2: You try to educate them like, and say look here as I am here each and every one who is coming is, I observe the gate, I observe how the body is saying, what the body is saying, the responsiveness.

PARTICIPANT 3: If you are one person you have six people who is talking to you at the same time doesn't matter how strong you are you are also intimidated, you even call the security who doesn't, like there is this situation it was not supposed to be like my colleague is saying if there is controllers at the gate, no we can't have nine people with one patient that is unrealistic.

….

End

APPENDIX G

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R49 Mr KB Maimela

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M200910

NAME: (Principal Investigator)	Mr KB Maimela
DEPARTMENT:	School of Therapeutic Sciences Department of Nursing Education Medical School University
PROJECT TITLE:	*Experiences and perceptions of emergency department nurses regarding workplace violence*
DATE CONSIDERED:	2020/10/02
DECISION:	Approved conditionally
CONDITIONS:	Approval applies to those study sites listed in Annex 1 to this Clearance Certificate Others may be added on receipt by the HREC (Med) of evidence of management approval
SUPERVISOR:	Professor S Schmollgruber
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	2021/02/15

This Clearance Certificate is valid for 5 years from the date of approval. An extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office secretariat on the 3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to submit details to the Committee. **I agree to submit a yearly progress report**. When a funder requires annual re-certification, the application date will be one year after the date when the study was initially reviewed. In this case, the study was initially reviewed in **«Missing mail merge field»** and therefore reports and re-certification will be due in the month of **«Missing mail merge field»** each year. Unreported changes to the study may invalidate the clearance given by the HREC (Medical).

Signature of Principal Investigator Date

APPENDIX H

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

MAXEKE JOHANNESBURG ACADEMIC HOSPITAL

Office of the Nursing Director
Enquiries: Mr. Moses Tshabuse
Tel: (011) 488-4558
Email: Moses.Tshabuse@gauteng.gov.za
17 February 2021

GP_202012_009

Dear Mr. K.B Maimela

STUDY TITLE: The experiences and perceptions of emergency nurses regarding workplace violence

Permission is granted for you to conduct the above-mentioned study as described in your request provided:

1. Charlotte Maxeke Johannesburg Academic Hospital will not anyway incur or inherit costs as result of the said study.
2. Your study shall not disrupt services at the study sites.
3. Strict confidentiality shall be observed at all times.
4. Informed consent shall be solicited from patients participating in your study.

Please liaise with the HOD and Unit Manager or sister in charge to agree on the dates and time that would suit all parties.

Kindly forward this office with the results of your study on completion of the research.

Supported / ~~not supported~~

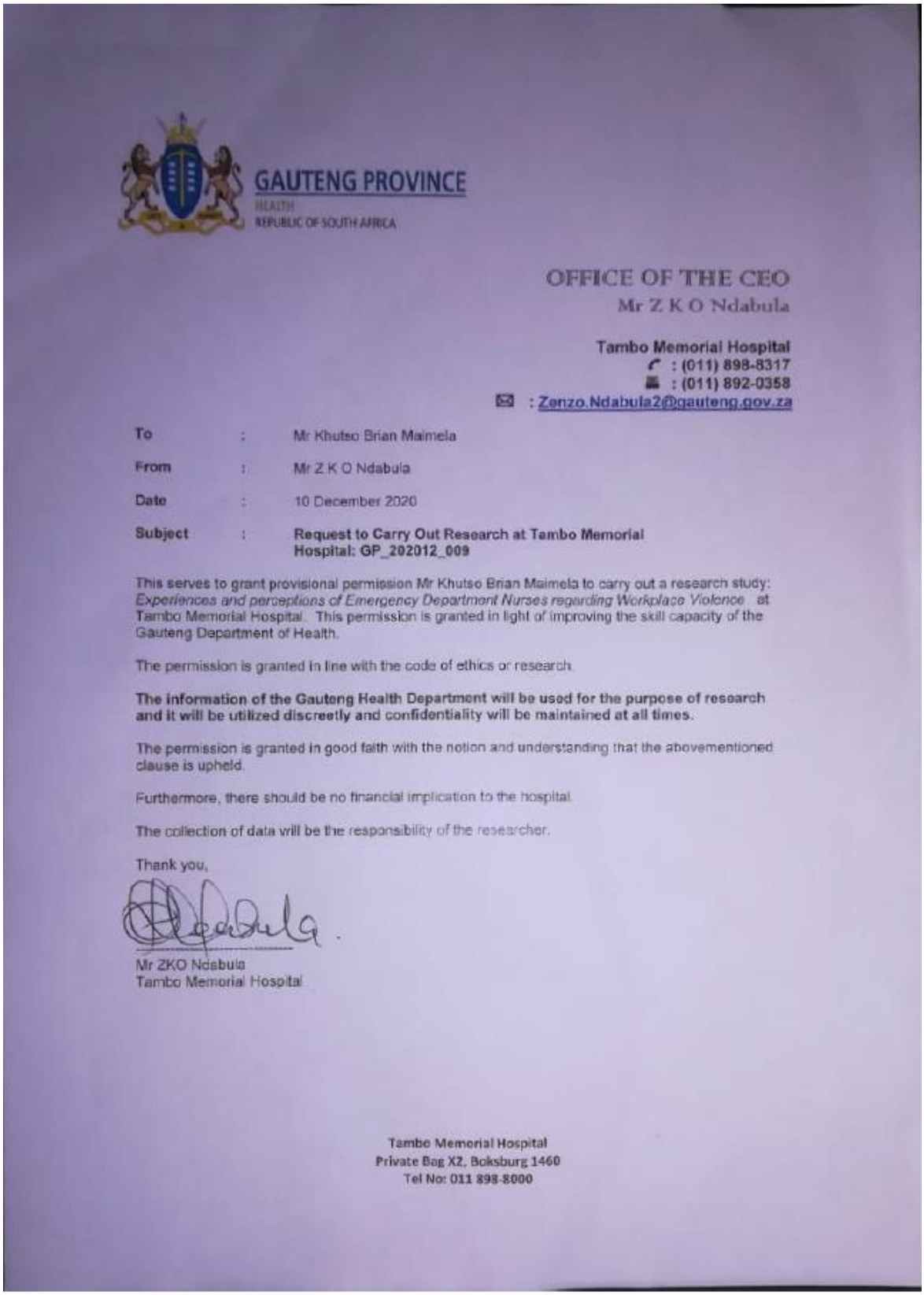
Ms. M Pule
Nursing Director
DATE: 17/02/2021

Approved/not approved

Ms. G.M Bogoshi
Chief Executive Officer
Date: 18.02.2021

APPENDIX I

Hospital approval



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

OFFICE OF THE CEO
Mr Z K O Ndabula

Tambo Memorial Hospital
: (011) 898-8317
: (011) 892-0358
: Zenzo.Ndabula2@gauteng.gov.za

To	:	Mr Khutso Brian Maimela
From	:	Mr Z K O Ndabula
Date	:	10 December 2020
Subject	:	**Request to Carry Out Research at Tambo Memorial Hospital: GP_202012_009**

This serves to grant provisional permission Mr Khutso Brian Maimela to carry out a research study: *Experiences and perceptions of Emergency Department Nurses regarding Workplace Violence* at Tambo Memorial Hospital. This permission is granted in light of improving the skill capacity of the Gauteng Department of Health.

The permission is granted in line with the code of ethics or research.

The information of the Gauteng Health Department will be used for the purpose of research and it will be utilized discreetly and confidentiality will be maintained at all times.

The permission is granted in good faith with the notion and understanding that the abovementioned clause is upheld.

Furthermore, there should be no financial implication to the hospital.

The collection of data will be the responsibility of the researcher.

Thank you,

Mr ZKO Ndabula
Tambo Memorial Hospital

Tambo Memorial Hospital
Private Bag X2, Boksburg 1460
Tel No: 011 898-8000

APPENDIX J

PERMISSION TO USE SURVEY INSTRUMENT

From: khutso brian maimela <maimela.kb@gmail.com>
Date: 26 May 2020 at 06:18:18 SAST
To: Shelley Schmollgruber <Shelley.Schmollgruber@wits.ac.za>
Subject: Fwd: request for permission to use an instrument.

---------- Forwarded message ---------
From: **Delao, Altair** <Altair.Delao@ena.org>
Date: Mon, May 18, 2020 at 4:41 PM
Subject: RE: request for permission to use an instrument.
To: maimela.kb@gmail.com <maimela.kb@gmail.com>

Hello Mr. Maimela,

This email serves as your permission to use the survey developed by the Emergency Nurses Association with results published in the Journal of Nursing Administration [39(7/8):340-349, July-August 2009].
I am one of the authors (listed as Juarez) and am happy to answer any questions you may have.

Though not required, we encourage you to consider publishing your results in the Journal of Emergency Nursing. Thank you for addressing this important issue.

Sincerely,

Altair

APPENDIX K

Language Editing and Proofing

Gill Smithies

Proofreading & Language Editing Services

59, Lewis Drive, Amanzimtoti, 4126, Kwazulu Natal

Cell: 071 352 5410 E-mail: moramist@vodamail.co.za

Work Certificate

To	Dr. Shelley Schmollgruber
Address	Faculty of Health Sciences, University of Witwatersrand
Date	13/03/2022
Subject	Experiences and Perceptions of Emergency Department Nurses Regarding Workplace Violence
Ref	SS/GS/38

I, Gill Smithies, certify that I have proofed the following for language, grammar and style:

Experiences and Perceptions of Emergency Department Nurses regarding Workplace Violence, by K.B. MAIMELA

to the standard as required by the University of Witwatersrand.

Gill Smithies