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A DESCRIPTION OF THE PSYCHOSOCIAL WORK ENVIRONMENT OF EMERGENCY NURSES IN TWO JOHANNESBURG CENTRAL HOSPITALS

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A research report submitted to the Faculty of Health Sciences,
University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements
for a Master's of Science Degree in Nursing.

Johannesburg 2019

DECLARATION

I, Nokuthula Masuku, declare that the research report on “The psychosocial work environment of emergency nurses in two Johannesburg hospitals”, is my original work in design and execution, and that all sources cited have been duly acknowledged. This report has not been submitted before for any other degree or examination at any other university.

…… ……..
Signature Date

Protocol number: M170603

DEDICATION

This research study is dedicated to:

- My two children, David and Sibonginkosi, for their understanding and support.

- My family and friends who supported me and helped me to turn this manuscript into a finished product.

ACKNOWLEDGEMENTS

My appreciation and sincere thanks to the following people who supported me throughout:

My children, David and Sibonginkosi.

My family members, Bongani, Siphiwe, Sipho. Louise, Nothando, Nobubelo, Beke, Makoti Siphiwe and Skhululekile.

My friends, Patience, Mercy, Sithini, Saziso, Fiona, Virginia, Rose, Bhekinkosi and Otty.

The Accident and Emergency team of Botswana for their support and encouragement. Thank you very much.

My supervisors, Ms. Agnes Huiskamp and Dr. Nokuthula Nkosi-Mafutha, for their guidance and support.

The Gauteng Province Medical Advisory Committee for granting me permission to do research in the two Johannesburg Hospitals, and also the nursing directors of the two hospitals for granting me permission to conduct this study in their hospitals.

The Human Research Ethics Committee of the University of the Witwatersrand for their support.

Above all, l thank God for His blessings.

ABSTRACT

Background: Emergency nurses are at the forefront of human health care resources. They are the first people encountered by those who are in pain, critically ill, or fighting for their lives. Emergency nurses are exposed to many health and safety hazards such as psychosocial, physical, chemical and ergonomic ones, in the emergency departments. Traditionally, occupational health mostly focused on the identification of physical hazards and risk assessment. However, there is now a global movement to include the identification of psychosocial hazards and risk assessments, as well as to the management of occupational health practice. In addition, the International Council of Nurses is advocating for positive practice environments for nurses.

Purpose: The purpose of this study was to describe the psychosocial work environment of emergency unit nurses in two Johannesburg central hospitals.

Method: A cross-sectional survey design was used for this study, and data was collected using a self-administered questionnaire, namely the Copenhagen Psychosocial Questionnaire II (COPSOQ II).

Data analysis: Data was scored according to the Copenhagen Psychosocial Questionnaire scoring system, and analysis by the Stata Window English Version 10.0(StataCorp, 2008). Statistical analyses included descriptive statistics and the open-ended comment section was analyzed by means of quantitative content analysis and coding. Assistance was sought from a statistician from Botswana regarding the entry and analysis of captured data. **Setting:** The setting for this study was in the Emergency Departments of two central hospitals in Johannesburg, South Africa. **Results:** A total of 91 (56.2%) of emergency department nurses participated in the study. From the study 76 (83.5%) were females, and 15 (16.4%) were males and mean age for the participants was 34 years. High emotional work demands; lack of appreciation recognition, job satisfaction, justice& respect in the workplace; and burnout and stress were the major indicators of poor psychosocial health among nurses working in the emergency departments .Bullying was rated as the highest inappropriate behavior 51(56%), followed by threats of violence 41(43%),sexual harassment13(14.3%) and physical assault 12(13.2%) respectively. **Conclusion:** The results of the study highlighted the need for an Occupational Health Programme for nurses working in emergency departments where they are exposed to psychosocial hazards.

Key words: psychosocial work environment, emergency nurses, central hospitals.

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NOMENCLATURE

COPSOQ II	Copenhagen Psychosocial Questionnaire II
EAP	Employee Assistant Program
ENs	Emergency Nurses
GHWA	Global Health Work-force Alliance
ICN	International Council of Nurses
ILO	International Labour Organization
OHN	Occupational Health Nurse
OHNP	Occupational Health Nurse Practitioner
OHSA	Occupational Health and Safety Act (Act No 85 of 1993)
RSA	Republic of South Africa
SD	Standard Deviation
SANC	South African Nursing Council
WHO	World Health Organization

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CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

An overview of the study including the background, motivation, and problem statement, purpose of the study, research questions, and significance of the study is presented in this chapter. Furthermore, brief descriptions of the research method and design as well as the clarification of concepts used in the study are given.

1.2 BACKGROUND

Professional/ registered nurses practising in Emergency Departments (EDs) are at the forefront of the curative health care service. As noted by Hooper, Craig, Janvrin, et al (2010:420 - 427), “Emergency nurses are the first people that those who are in pain, critically ill, or fighting for their lives encounter”.

ED’s are described as specialized health facilities where there is no need for any patient appointment. The patients present to the ED’s without prior bookings, mostly in critical states with life threatening conditions in need of emergency care (Sharma, 2017). ED’s operate 24 hours of the day and seven days of the week (24/7) with no public holidays and have to cater for all types of emergencies that may present themselves (Schuur & Venkatesh, 2012). ED’s cater for injured patients, critically ill patients, and at times, the dying or the dead (Wedgewood, 2018). According to Margolis (2018), the ED is challenging, fast paced, and high pressured coupled with a lack of resources, and, at times, nurses are exposed to acts of violence, injury or even death. Nurses working in the emergency departments provide nursing care to a large number of patients with severe symptoms that require immediate attention.

Due to the nature of their work, ENs are exposed to many health and safety hazards such as psychosocial, physical, ergonomic and chemical hazards in the ED (Neira, 2010).

From an occupational health (OH) and occupational health nursing (OHN) perspective, all hazards need to be identified and risks assessed, as well as, managed within the physical and psychosocial work environments. The psychosocial work environment pertains to the way people, think, behave and interact in the workplace, influenced by interpersonal and social factors (Rugulies, 2014). Similarly, the World Health Organisation (WHO 2010), states that the

psychosocial work environment includes the organization, culture, values, beliefs, daily practices, and attitudes encountered in the work setting that may affect the mental and physical health of the workers. The factors which cause mental or emotional stress are also referred to as workplace stressors (Burton, 2010). Johnston, Abraham, Greenslade et al, (2016) are of the opinion that stressors can include poor work organization and management styles, bullying, and harassment. In the past, occupational health focused mainly on the physical work environment. However, there is now global emphasis on the identification of psychosocial hazards, risk assessment and management thereof in occupational health practice (Burton, 2010).

According to the International Datasheet in Occupation (2012), nurses practising in EDs are exposed to psychosocial hazards such as stress, burnout related to shift work and overtime, poor work/life balance, poor support from supervisors, and being exposed to critically ill patients and death. Practicing as a registered nurse in the ED involves a lot of emotions and critical thinking, and is, therefore, psychologically demanding (Stathopoulou, Panagiotopolou & Papathanassglou, 2011).

The authors, De Gucht & Maes, (2015), are of the opinion that this specific work environment demands a lot of communication, teamwork, and working under pressure in which nurses aim to save lives and are continuously exposed to stress. If psychosocial hazards continue for long without being attended to, it leads to the affected nurses being irritable, having poor health, and sometimes being mentally affected (Andriaenssens et al, 2015 & Stathopoulou et al, 2011).

Li, Fu, Hu et al (2010:69-80) say that, “The consequences of working in ER is revealed in the European NEXT study (Nurses’ Early eXit sTudy) which indicated that there were 9,92 % -36,59% of nurses who had the intention of leaving their jobs in relation to the psychosocial work environment factors, while in the United States of America (USA), about 22,7 % intended to leave, in Canada about 16,6% and about 12,8% in Shanghai, China, between 2001-2005”.

The WHO and the International Labor Organizations’ (ILO) Healthy Workplace Model (2010) emphasizes that the hazards and risks emanating from the psychosocial work environment should be made a priority (Burton, 2010). In the past, occupational health focused mainly on the physical work environment. However there is now global emphasis on psychosocial hazards identification, risk assessment, and management thereof in occupational health practice (Burton, 2010).

Furthermore, the International Council of Nurses (ICN) is advocating for positive environments for nurses. The Fact Sheet on Positive Practice Environments of the ICN , International Hospital Federation, International Pharmaceutical Federation, World Confederation for Physical Therapy,

World Dental Federation and World Medical Association are all of the opinion that unhealthy work environments are a key reason for a global health workforce crisis (Schmidt, 2012).The Positive Practice Environments (PPE) Campaign is a global campaign aiming to improve work environments for health professionals, thereby strengthening staff retention and recruitment as well as quality of care. Positive practice environments are viewed as settings that support the provision of quality patient care by ensuring the health, safety, and personal well-being of staff (Schmidt, 2012).

The Occupational Health and Safety Act (OH&S) (Act 85 of 1993 as amended) governs the health and safety of persons at work in South Africa, even though Acutt and Hattingh (2016) are of the opinion that the Act is mainly a preventative act, as it describes the measures that should be taken to prevent accidents and diseases. According to the OH&S (Act 85 of 1993 as amended), "The employer has the responsibility as far as reasonably practicable to provide and maintain a working environment that is safe and without risks to the health and safety of the employees" (Republic of South Africa: 150-152). The OHSA furthermore states that all employers need to identify the hazards present in the workplace. In addition the employers need to take steps to minimize or eliminate the hazards and risks, as identified and assessed.
From this perspective, it is clear that psychosocial hazard identification and risks assessment (HIRA) needs to be done in the two selected hospitals which I researched because currently, there is no literature indicating that surveys to identify psychosocial hazards experienced by nurses in the EDs of the identified hospitals have been conducted.

1.3 MOTIVATION AND RATIONALE FOR THE RESEARCH

Emergency nurses need to practise in a physically and psychosocially safe and healthy work environment as is reasonably practicable to prevent high turnover and absenteeism due to physical and psychosocial health problems. In addition to the legal framework that needs to be adhered to, there is a global movement to make the work environment for health care professionals as healthy as possible (Neira, 2010).

As an occupational health nursing student, the researcher has become aware of the importance of the identification of not only the physical, but also the psychosocial dangers and risks in the workplace, upon which an integrated occupational health and workplace health promotion programme can be based. In addition, as a registered nurse practising in an ED in Botswana, the

researcher is aware of the challenges facing ED nurses and has therefore been interested in how South African professional nurses practising in EDs describe their psychosocial work environments.

1.4 SIGNIFICANCE OF THE STUDY

Occupational health nursing practice has as focus the promotion of health at all times and prevention of work related diseases. It is envisaged that the results of this study can possibly be used to find solutions for some of the psychosocial hazards that emergency nurses face. Potentially, the study can contribute to the development and implementation of an integrated occupational health and workplace health promotion program, by the hospitals' occupational health and safety services. The information can also help occupational health nurse practitioners (OHNPs) to explore ways in which to support the psychosocial well-being of emergency nurses. The research also aims to contribute to the body of knowledge regarding occupational health nursing, occupational health, human resources management, and organizational psychology. Similar studies have been conducted in Nigeria, Uganda, and also in South Africa regarding stress and stress- related conditions among ED nurses, but none has been done on the psychosocial work environment of ED nurses in South Africa.

1.5 RESEARCH PROBLEM AND QUESTION

Anecdotal evidence suggests that the ENs practicing in these EDs do not have an integrated occupational health and wellness programme to care for their holistic health and safety. The literature reveals that stress has been investigated extensively as a psychosocial risk in nursing and among emergency nurses. However, no literature was found describing the psychosocial work environment, based on ED nurses' experiences in the two selected hospitals. Therefore, the psychosocial hazards (stressors) that emergency nurses are exposed to, in the selected emergency departments of the two selected Johannesburg hospitals, are not known.

The research question this study aimed to answer was: How do emergency nurses describe their psychosocial work environment?

1.6 PURPOSE OF THE STUDY

The purpose of the study was to describe how emergency nurses experience their psychosocial work environment in two specific Johannesburg Central Hospitals.

1.7 RESEARCH METHOD AND DESIGN

This study made use of a cross sectional design and a survey method. A detailed description of the research design and method is given in chapter 3.

1.8 DEFINITION OF MAIN CONCEPTS

Emergency Nurses: Health care professionals educated to quickly recognize life threatening conditions/ problems and trained to resolve them on the spot. They can work in hospital emergency rooms, ambulances, helicopters and urgent care centers (Trimble, 2013). For the purpose of this study, emergency nurses refer to professional (registered) nurses with or without a trauma nursing qualification practising in an ED.

Psychosocial work environment: Jacobs, Hellman, Markwitz and Wuest (2013:103) define a psychosocial work environment as 'the interpersonal and social interactions that influence behavior and development in the work-place'. In this study, the psychosocial work environment pertains to how patient/task related factors, organizational factors, and social factors affect ED nurses, both mentally and physically.

A psychosocial hazard is defined by Comcare (2018) as 'any hazard that affects the mental wellbeing/ health of the worker by overwhelming the individual's coping mechanisms and impacting on the worker's ability to work in a healthy and safe manner'. For the purpose of this study, psychosocial hazards are those factors in the work environment that cause stress and influence both the mental and social health of the nurses, negatively.

Risk: A chance which is either high or low that a hazard will actually cause harm to somebody, for example, causing loss of life (Nunes, 2010).

Hazards are thought to be anything that can cause harm/ human injury /ill health. It can be present in the workplace and have the potential to cause injury to workers through an accident or occupational disease (Nunes, 2010).

Stress: Although the concept ‘stress ‘is not present in the title of this study, it is an important concept in terms of the study, and therefore stress is defined as, “A state of mental/ emotional strain/ tension resulting from adverse or demanding circumstances” (Merriam Webster Dictionary).

Emergency departments are seen in this study as the area of a facility devoted to the provision of an organized system of emergency care that is staffed by emergency nurses and specialist physicians and has the basic resources to resuscitate, diagnose, and treat patients in emergencies (Aacharya, Gastmans & Denier, 2011).

Central Hospitals are defined as tertiary/academic health care centres which provide specialist care in large hospitals, after referral from primary and secondary care. Services include complementary services like: paediatrics, general medicine, gynaecology, and various branches of surgery, psychiatry, oncology and intensive care. They also serve as a forum for the education of specialist nurses and medical specialists (Gauteng Department of Health, 2017).

1.9 OUTLINE OF THE RESEARCH REPORT

The research report is divided into five chapters.

Chapter 1 provides an overview of the study.

Chapter 2 focuses on a detailed discussion of the concepts and the related literature pertaining to this research.

Chapter 3 describes the research design and method.

Chapter 4 presents and discusses the results.

Chapter 5 focuses on the conclusions, limitations, and recommendations of the study.

1.10 SUMMARY

Emergency departments operate 24 hours of the day, seven days of the week (24/7) and are focused on delivering emergency care to patients, often with life threatening diseases or injuries. Emergency nurses practising in EDs are exposed to many health and safety hazards/risks which are both physical and psychosocial in nature. The psychosocial hazards include stress, violence, sexual harassment, bullying, and secondary stress disorder (compassion fatigue).

The researcher, an occupational health nursing student practising in an ED, was motivated to conduct this study because nurses working in EDs are exposed to both physical and psychological hazards. The research aim for this study was (i) to investigate the psychosocial hazards (stressors) that emergency nurses are exposed to and (ii) to answer the research question: How do emergency nurses describe their psychosocial environment?

The research purposes and objectives were given, concepts were discussed, and the report was outlined.

CHAPTER TWO

REVIEW OF LITERATURE

2.1 INTRODUCTION

A review of both national and international literature, organizational culture, health and well-being is presented in this chapter.

To broaden the researcher's knowledge and understanding of the topic and increase her ability to conduct the study, an extensive literature review was undertaken. The literature review included electronic searches of data bases such as CINALH, MEDLINE, Science direct, Google Scholar and PubMed, and print media such as text books, eBooks reports, policies, and acts published over the past ten years.

Key words used in the research were: emergency nurses, emergency department, psychosocial stressors, stress, and psychosocial work environment.

2.2 THE NATURE AND CAUSES OF PSYCHOSOCIAL HAZARDS IN EMERGENCY NURSING.

Emergency Department nurses, by virtue of their jobs, are at risk of experiencing stressful events. The WHO (2010) identifies the following psychosocial factors as having the gravest risk to workers'/employees' health:

- **Workload and work pace:** This entails the work pressures of either:
  (i) too much or too little work and
  (ii) Insufficient time allocated to complete a task/ work speed.
- **Job content:** Routine and repetitive work, tasks that have no ordered sequence, and poor application of on-the-job knowledge/ performing tasks that the workers/employees are unsure of.
- **Work schedule:** Involuntary shift work, working at night, inconsistent work schedules, and irregular hours.
- **Control**: Lack of participatory management and a poor locus of control regarding work speed and changing hours.
- **Environment and equipment**: Lack of resources, poor working conditions & unhygienic conditions, inadequate working areas, poor lighting, and noise pollution.

- **Organizational culture and function:** Lack of communication, lack of systems for effective problem-solving, and lack of personal/career advancement.
- **Interpersonal relations**: Alienation/ feelings of loneliness or withdrawal, lack of good personal relations, decreased interpersonal relations with superiors and colleagues, poor/inadequate social support regarding work relations
- **Employee role:** Lack of clarity about one's job profile, incompatibility of the different tasks for the same role, and insufficient support from supervisors.
- **Home and work interface:** Conflicting work and family roles.
  (WHO, 2010)

Some of the above mentioned psychosocial factors are supported by the literature, as discussed in the section below.

According to Garcia-Inquired et al (2012) and Viotti et al (2016), psychosocial hazards among health care workers and ENs can entail: interpersonal conflicts; lack of resources when facing daily tasks; lack of social support; excessive work burdens; a rise in tension, fatigue & professional exhaustion, and witnessing human suffering and death, all of which may lead to depression and anxiety.

An integrative literature review on occupational stress among nurses in emergency care, by Bezerra da Silva and Ramos (2012), revealed that the most frequent work related stressors experienced by ENs are: a shortage of human resources & material resources; insufficient physical facilities; long hours worked; night shifts; interpersonal relationships; work and home interface, working in a competitive climate, and a theory/ practice gap.

Nursing as a profession is by nature stressful as it involves caring for the human being at all stages of life similar factors, noted by Kilic, Ozagla, Kurkmazel et al (2016,) are that the nursing as a profession is rated as stressful, with negative working conditions like night shifts, long working hours, overtime, conflicting roles, a shortage of staff, and being in contact with critically ill patients and death. Often in these sensitive situations the ED nurses need support from their supervisors/ managers and ENs often meet with little support from managers/supervisors who have high job expectations & poor conflict resolution skills; who over-allocate duties; have little time to listen to nurses' grievances and, often, poor communication skills (Seow, 2013).

The work environment of nurses working in ED is characterized by working at fast pace, catering for clients who present with emergency situations needing immediate assistance and care. Goodazi et al (2015) confirms that ENs work at a fast pace and have little time to rest in the

workplace. At the end of the day the nurse is exhausted and fatigued. In a study conducted in South Africa by Jolsen (2011), revealed that nurses are faced with challenges of a constant inundation of clients, with patients as many as 500 per day and nurses attending to about 32 patients each in understaffed hospitals. Moreover, nurses can be faced with uncooperative patients, demanding relatives, and with conflicts with management (Edgar, Cowin & Gregory et al, 2010). Relatives and patients often interfere while nurses are attending to emergencies, and the nurses may lose focus on what they are doing relatives mostly complaining about long waiting times, poor pain management, and feeling neglected, thereby increasing the nurses' psychological stress levels ((Cypress, 2014 & Aacharya et al, 2011). Wedgwood (2018) concludes that at times there is very little support from colleagues and subordinates which leads to stress, poor coping mechanisms, and fatigue. It is important that nurses get good support from their leaders and supervisors, as it fosters good working relationships, enforces team spirit, staff is motivated despite shortage of resources(Mbindy, Gilson &Baauw, 2009).

More often than not nurses in public hospitals are faced with shortage of both human and material resources. Patricia, (2015) agrees that lack of resources or poor quality of equipment is stressful for nurses, especially when the unavailability of these resources causes loss of life. Nurses working in South Africa's public hospitals are faced with shortage of staff and resources which compromises quality of patient care and health service efficiency. This mostly stems from poor retention of staff and poor distribution of resources, and needs to be addressed (Professor Rispel, 2017(Health-E-News).

Being short staffed means the nurses work longer shifts which cause fatigue and burnout. Fatigue is a feeling of being excessively tired, having low energy levels, having the desire to constantly sleep and in most cases interferes with daily routine. It occurs mostly in nurses due to lack sleep due to shift work and work overload (Health line, 2019).Working for long hours causes mental and physical fatigue and it affects the nurses negatively (Barker & Nussabaum, 2011). Fatigue is worsened by increased shifts without an off in between the shifts or at times working four consecutive 12 hour shifts. Nurses work long shifts, night shifts, and rotating shifts which result in sleep deprivation/sleep 'debt' and stress (Caruso, 2014). Night shift nursing causes sleep deprivation which when not addressed contributes to reduced productivity due to exhaustion which dulls awareness and fogs the mind prevent rational and logical thinking. Driving after night shift leads to drowsy driving which is equaled to drunk driving (Breus, 2011).

ED nurses are faced with work overload which often leads to exhaustion from high job demands, nurses are often experience a lack of balance between work and life outside work or private life (Kowitlawkal, Yap, Makabe et al 2018).

High job demands cause negative health issues among ENs, affects the quality of life outside the workplace, and cause a poor work-life balance (Bragard, Fleet, Etienne, et al, 2015) These psychological issues compromise both the health of the nurses and their quality of life (Kogien & Cedaro, 2014).Nurses should learn to balance the time they spend at work and private life so that they are happy and healthy (Kowitlawkal, Yap, Makabe et al 2018).

At times during emergency situations, orders are laid out and at times it is difficult to understand what the leader needs and this is role ambiguity. Role ambiguity is defined as a lack of clarity regarding one's role & how it should be performed, and this can lead to disunity and poor quality of care (Kalkman, 2017). Twibell & Townsend, (2011) conclude that ENs are exposed to role ambiguity related to excessive work demands, limited scope of practice, and sometimes going that extra mile, all of which may result in disciplinary action when things go wrong (Twibell &Townsend, 2011). A study conducted in Iran by Mahmoudi et al (2017), about 70 000 nurses work in Iran's various nursing departments, but more specifically among nurses working in the EDs who have to attend to several patients and many emergencies, revealed that there was a lack of role clarity within most of the emergency departments.

Nurses are human beings and have emotions, in the ED nurses are exposed to severely injured patients and gruesome deaths, it is difficult to practise as a nurse and not be concerned about your working surroundings & your patients, and nurses working in the emergency department are no different (Curtis, 2014). Most patients present to the emergency department with disturbing instances of human suffering. These ED nurses have to attend to victims of domestic violence, gunshot wounds, road traffic accident victims, rape victims (especially children), acts of violence and angry relatives or members of the public (Kinsella, 2016).All this exposure is emotionally taxing for the ED nurses especially if debriefing is not done, the nurses are susceptible to compassion fatigue.

Each department has a leader, the person with a passion to see the values and vision of the institution through, leaders provide direction, inspire, guide, encourage, instill passion, commitment and ambition(Page, 2017). The ED has a team leader/ manager who delegates tasks, settles disputes, conducts ward meetings, convenes meetings to communicate the latest information and/or changes to the health team (Hamoudi &Mahmmadi, 2013). The same authors

relate that ineffective management can lead to conflicts in the work place, lack of motivation & trust, apathy, and staff demoralization. This leads to staff shortages as a result of high absenteeism/ sick leave and staff turnover (Hamoudi &Mahmmadi, 2013).Job satisfaction among nurses is mostly influenced and affected by nurse leadership, management and organizational commitment as they influence the retention of nurses (Sojane, Klopper &Coetzee, 2016). Nursing is influenced by the workplace culture, economic factors, and institutional values which come into play to provide quality nursing care (Hahmoudi & Mahmmadi, 2013). At times, the rigid rules of the workplace can prove stressful for nurses, especially when they cannot influence their working conditions regarding items such as the work schedule, tasks which are not in the job description, and the amount of work allocated per given shift (Oliveria et al, 2013). A study conducted in South Africa revealed that the intention-to-leave rate was higher among South African nurses in comparison with United States nurses and Europe mostly due to poor working conditions (Sojane, Klopper &Coetzee, 2016).

Health care workers worldwide are exposed to workplace violence, nurses working in EDs are no different, and they are exposed to confused or medicated patients, the angry public, patient escorts, criminals and psychiatric patients and have had to endure violence from the above. Workplace related violence (WPV) is described as any abnormal disruptive behavior , threats, physical confrontation, harassment, acts of intimidation, or other disruptive behavior that happens in the workplace which can cause physical or emotional harm (Stone et al, 2015). Workplace violence is a problem in the health sector worldwide and it is demoralizing and demeaning and it poses risk to the health and safety of the worker(s). Suarez, Asenjo &Sanchez (2017) endorse that many nurses practising in EDs are demoralized by the workload, violence, and harassment they are exposed to at work. Similarly, Stone et al (2015) state that emergency nurses are exposed to A study conducted in the United States of America (USA), in 2011, revealed that 97.8% of ED nurses were physically assaulted and 92.3% were verbally abused in most facilities (Gacki-Smith, Juarez, Boyett et al, 2009). Most of the perpetrators of violence were relatives of patient or patients themselves (Gacki-Smith, Jaurez, Boyett et al, 2009). Emergency nurses are exposed to verbal abuse from relatives and patients alike (Spector et al, 2014). The same authors noted that acts of violence arose from failure to meet the clients'/ patients' demands/expectations regarding waiting times, communication, irritation, and at times poor pain management (Spector et al, 2014). These conclusions are supported by a study done in Riyadh, in Saudi Arabia, where 61% of reported cases are of verbal abuse, and the majority of the perpetrators were patients' relatives (80%), followed closely by patients themselves (51%) (Alhantly et al, 2017).

Nurses practising in emergency departments are also exposed to non-physical violence like bullying and sexual harassment. Most of the time, health care professionals who are exposed to bullying and harassment suffer in silence, become withdrawn & depressed, have low morale, and are irritable, which can lead to absenteeism and high staff turnover, if not addressed effectively (Strauss,2019). These types of violent acts can happen laterally either from other nurses, or from clients/patients (Hamdan &Hamra, 2015).

A study conducted in Anglo-countries (United States of America, Canada, Australia, New Zealand and United Kingdom) as well as in Asia, Europe and the Middle East revealed that 39.7% of nurses were bullied and 25% were sexually harassed. The Anglo world had the highest statistics regarding physical violence and sexual harassment while the highest statistics in the Middle East were of physical violence and bullying (Spector, Zhou & Che, 2014).

According to Stene at al (2015), physical violence has become endemic for health care professionals. Research by Gillespie, Gates & Berry in 2013 revealed that physical violence affects nurses across all working environments all over the world, but nurses working in EDs are affected the most (Gillespie, Gates & Berry, 2013). ENs, faced with a large influx of patients waiting to be attended to, a shortage of staff, work overload, fatigue and exhaustion, find it difficult to attend to all patients within 4 hours of arrivals as per triage (Parker & Marco, 2014). This gives rise to complaints, verbal abuse, threats of violence, harassment, and physical abuse (Alhantly et al, 2017).

A study conducted in Riyadh in Saudi Arabia by Alyaemni & Alhudaithi (2016) found that 89.3% of emergency nurses experienced violent incidents within 12 months of starting work in the ED, 74% of which of experienced verbal abuse, and 18% of which had experienced both verbal and physical violence. The instigators of violence, were (i) patients (82.4%) and (ii) relatives (64.8%) (Alyaemni & Alhudaithi, 2016).

Other types of abuse as occurs laterally among ED nurses and is known as bullying and hazing it involves behavior like colleagues withholding crucial information from or sabotaging each other, name calling, berating, acts of intimidation, and/or spreading malicious gossip. This kind of behavior may cause the affected nurses to leave their workplace (Robbin, 2015). Bullying, i.e. being persistently mistreated by co-workers in the workplace causes physical or emotional harm to the affected worker. Hazing ranges from sexual & physical harassment to emotional harassment (Samnani & Singh, 2012). Bullying is thought to be responsible for many new nurses leaving their jobs before completing their 1st year of employment (Spector & Che, 2013). New

recruits mostly do not have any one to turn to, as managers/ supervisors are not always supportive. Bullies are often the most favored nurse, and their word is usually taken as the truth (Swafford, 2014). Bullying also puts the patients' life in danger/ risk, as bullies may refuse to assist the targeted nurses (Spector & Che, 2013). At times a targeted nurse is given an unmanageable workload and is excluded or ignored (Robbin, 2015). While in a study conducted in South Africa in 2017 by the Medical Research Council on workplace violence, the study revealed that about 85% of the participants experienced workplace violence within 12 months, a range of 95% were threats of violence and 60% for bullying and the main perpetrators of violence(71%) were females(Mahani, Akinsola& Mabunda,2017).

Many nurses practising in EDs are exposed to sexual harassment coming from peers, superiors, patients and relatives (Knowles, 2018). Nurses are thought to be the ones who mostly report misconduct and inappropriateness from colleagues, patients and relatives (Franz, Zeh, Schablon et al, 2010). A study conducted in Germany, by Franz et al (2010), concluded that 20.7% of nurses had been sexually harassed in the 12 months prior to the study. Similar results, albeit a lower incidence, was reported by Boafo, Hancock & Griangant (2016) in a study in Ghana (2016), which revealed that sexual harassment was a major problem among nurses, and that most perpetrators were medical doctors. The same authors concluded that 72 (12.1%) of 592 nurses had been sexually harassed in the workplace 12 months prior to the study. Of the 72 nurses, 83% were reported to have been harassed in the hospital. Fifty percent indicated that they had been harassed by a medical doctor, and/or relatives and patients (Boafo, Hancock & Gringant, 2016).In the South African context, the Labour Law has set laws to create a protected environment for the worker. The Employment Equity Act 55 of 1998 in section 6 cites that,"no person may unfairly discriminate against another and that harassment of an employee is a form of unfair discrimination and is prohibited on any one or a combination of grounds of unfair discrimination" (Workman-Davies & Livingstone,2018).

A statement released by the International Council of Nurses (ICN), in 2004 and revised in 2006, states that, "The ICN strongly condemns all forms of abuse and violence against nursing personnel ranging from passive aggression to homicide, and including sexual harassment. Such action violates the nurses' rights to personal dignity and integrity, and freedom from harm" (International Nursing Review, 2015). If the perpetrators are not brought to book, it may go on for a long time and the victims will continue to suffer (Spector et al, 2014 & Walsh et al, 2011).

The International Labour Organisation (ILO) recommends that both nurses and patients should be educated about potential violent situations and how best to prevent them from occurring. (Johnston et al, 2016& Wu et al, 2012).

2.3 EFFECTS OF EXPOSURE TO PSYCHOSOCIAL HAZARDS IN EMERGENCY NURSING

Exposure to psychosocial stressors impacts negatively on nurses practicing in EDs. They may experience fatigue, stress & secondary stress disorders such as burnout, depression, and other mental health problems (Scala, 2013).

2.3.1 Physical health effects experienced by ENs

According to the World Health Organisation (WHO, 1948), health is defined as, “a state of complete physical, mental and social well-being and not the absence of disease and infirmity” (Hafgastein, 2011).

Practising as a nurse in the ED can be challenging as these health care professionals work under pressure. They have to be alert at all times and be critical thinkers to preserve life (Freimann& Merisalu, 2015). ENs spend long hours standing while caring for the critically ill (Aacharya et al, 2011). The physical environment of EDs affects all health care professionals, including nurses (Goodzai et al, 2015). If the physical environment is not positively conducive, it leads to ill health for the ENs (Scala, 2013). Structurally, most EDs do not have rest rooms or areas where their nurses might take time to unwind (Goodzai, et al, 2015). Physically, there is a lack of ergonomics in the work space resulting in nurses standing for long hours, lifting heavy patients, and bending over during resuscitations, all of which may cause musculoskeletal disorders (MSDs). Standing for long periods of times causes MSDs, chronic diseases like cumulative muscle disorders, and cardiovascular disorders (Waters & Dick, 2015). A study conducted in Iran revealed that 89% of ENs experienced musculo-skeletal pains in 3.33 regions, while in Netherlands 57% of the nurses experienced MSDs in at least one region. In Brazil, about 80.7% of the nurses complained of MSDs, in particular in the upper extremities, for example neck and shoulder injuries (Alavi, 2014).

Insufficient sleep causes mood swings, poor work performance, decreased cognition, and health and safety risks (Caruso, 2014). Irregular sleeping time leads to misalignment with circadian rhythms leading to insomnia and poor sleep quality (Viotti &Converso, 2016). Sleep deprivation and sleep debt over a long time may lead to chronic illness like hypertension, diabetes, heart problems, gastric ulcers, risk of obesity, and injuries (Caruso, 2014). Nurses in the ED are faced

with an ever increasing workload which poses unique challenges and opportunities, which often leaves them fatigued and uninspired (Lynch, 2016). It is therefore important that these nurse take responsibility for their health and well-being, by aiming for a healthy work/life balance and making time to relax (Scala, 2013).

Workplace stress does contribute to high staff turn-over, a lot of sick leave, and staff shortages which affect the quality of nursing care. Repeated exposure to stressful situations can affect nurses in a negative manner physically (Ahwal, Arora, 2015 & Smriti, 2015), giving rise to health problems such as mental health disorders, and chronic diseases like hypertension, diabetes, and obesity (Kilic et al, 2015).

Also nurses feel they are bound by 'a scope of practice'. They feel that, instead of being critical thinkers and deciding what is best for the patient before the physician arrives, they are governed by inflexible protocols and have to adhere to them to avoid institutional penalties. This ambiguity can be stressful and may cause ill health (Ficher, 2016).

A survey conducted in the United States of America, in 2014, showed that 3,300 nurses were stressed, overworked, underappreciated and underutilized; 64% of these nurses reported having poor sleeping patterns, and 31% slept well for just 2 to 3 days a week. Despite being health care professionals, ENs have poor eating habits exposing them to obesity and chronic illnesses (Ficher, 2016). The above survey also found that 75% of the nurses felt they did not have enough authority, and they faced difficulties regarding insufficient support and trust from their supervisors/ managers (Ficher, 2016).

Other nurses cited low salaries as being demoralizing and leading to stress. A lack of resources and poor equipment was a burden and also contributed to ill health (Scala, 2013).

2.3.2 Psychosocial health effects of ENs

2.3.2.1 Work/ life balance

To avoid developing ill health, nurses working in ED have to learn to strike a balance between work life, personal life and family life. Work/life balance is a state of work/life equilibrium where enjoyment of life is equal to or exceeds the fulfillment of work or business, on a daily basis (Newman, 2014). Striking such a balance may prove difficult for nurses due to shift work, job demands, and extra working hours (Scala, 2013). They fail to cope or even to handle family issues and to balance life outside work. Some families become dysfunctional, e.g. there are high divorce

rates; alcoholism; and high levels of chronic illnesses like hypertension, cardiac disease, and diabetes mellitus (Sarafis et al, 2016). Stress and burnout could contribute to an improper balance between work and life. There are so many barriers to balancing work and life, e.g. staff shortages, poor coping skills in the work-place, fatigue, and poor job satisfaction. If all the above are not addressed, they lead to stress (Scala, 2013).

Boertjie (2013) believes that for nurses to achieve a healthy work/life balance, they need to make adjustments in their lives regarding time management by seeking mentorship and setting priorities & values, both at home and at work. They should set boundaries on time, both at work and at home. Emergency department nurses need to acknowledge that they do the best they can for patients, and know that it is fine to trust a colleague to take over the care of the patient to avoid burnout and stress (Scala, 2013).

Moreover, for ED nurses to achieve a work/life balance, supervisors/ managers can introduce short breaks between seeing patients. Nurses should also allow themselves time to reflect on the positives of the day (Scala, 2013 & Boertjie & Ferron, 2013).

2.3.2.2 Burnout, compassion fatigue, and post-traumatic stress disorder

Over time, an unhealthy workplace might lead to work-related depression and a fatigue which is psychological in nature. Fatigue has a gradual onset and it is mostly alleviated by periods of rest (Viotti & Converso, 2016). A study conducted in the United States of America, in 2012, showed that 60% of nurses working in EDs have 12hour shifts with day/night rotating schedules, which are exhausting. These types of shifts cause sleep disturbances, sleep deprivation, and the risk of developing acute and chronic fatigue (Curro & Jones, 2014). Nurses also develop fatigue due to

conducted in Queensland, Australia, among ED nurses, the results revealed that 1 in 5 of ED nurses are affected by burnout (Crilly et al, 2017). Burnout is caused by excessive work overload; role the nature of their work, i.e. working in a fast paced environment with a high demand for care giving, and ever increasing patient numbers (Curro & Jones, 2014 & Viotti & Converso, 2016).

In a study ambiguity; lack of control/power; and a lack of support from co-workers, managers, and the organisation (Powell, 2011). Due to poor working conditions, employees are exposed to occupational risks which often give rise to workplace accidents, stress, and physical & mental fatigue (Oliveria et al, 2013).

Burnout is quite common among professionals who work with people, and it is usually a response to chronic occupational stress. It affects the health of nurses negatively and also influences the quality of the healthcare that they render to patients (Garcia-Inquired& Rios-Risquez, 2012).

Nurses often have differences among themselves, it is up to the supervisor to resolve in house problems to develop good team spirit .Often working in conditions with unresolved interpersonal conflicts, excessive work burden, lack of resources (human and material) and lack of support from managers/ leaders can lead to burnout, and there is high staff attrition rate (Garcia-Inquired & Rios-Risquez, 2012).

Compassion comes as second nature to nurses; compassion & empathy drive nurses to bring out their best to promote patient safety and well-being, save lives, and satisfy patients and their relatives (Boll, 2014). They go the extra mile to please, and this gives rise to fatigue due to work overload. Work demands leave the nurse stressed, exhausted and irritable (Scala, 2013). Compassion fatigue is caused by working with traumatized individuals, witnessing gruesome injuries, absorbing the problems of others, and suffering and death (Borodignon& Monterio, 2016). Exposure to these experiences often lead to secondary traumatic stress, and compassion fatigue is usually coupled with burnout (Patricia, 2015).

2.4 PSYCHOSOCIAL HAZARDS PREVENTION AND MANAGEMENT IN EMERGENCY NURSING

2.4.1 Self-care by ENs

To manage stress, ENs can take time to exercise – even just a ten minute walk around the hospital or walking to the staff canteen- as exercise is the best anti-depressant (Wilcox, 2014). In their free time, nurses working in EDs can join exercise groups like yoga, Pilates, or meditation which can be of benefit to the body and mind (Boertjie &Ferron, 2013). Hobbies like reading and journal writing help relieve stress. Nurses also need to learn to set realistic goals with the help of mentors and coaches (Boertjie &Ferron, 2013).

The hospital organization may assist their workers by setting up employee assistance programs (EAP), having nursing peer coaches, and appointing a clinical psychologist in the occupational health clinic (Scala, 2013).

According to Riberio, Pompeo, Pinto& Riberio (2015), nurses need to:

- Try to cope with their problems that cause stress by 'redirecting', it means doing things like exercises, going on holiday, consider getting a pet, go ball room dancing, keeping a journal and staying positive at all times.
- Seek psychological help when the need arises, e.g. being debriefed after stressful traumatic events.
- Improve their quality of life by taking time to rest, exercise, and sleep; practising hygiene, and eating healthily.
- Strike a balance between work and life.
- Develop problem solving skills
- Get social support.

2.5 THE HEALTHY WORKPLACE

The current study was undertaken from the occupational nursing perspective. Therefore the World Health Organisation (WHO) & International Labour Organization Workplace Model (2010) is discussed in this section.

The ultimate vision and goal of any workplace should be to be the healthiest work environment possible with healthy workers/ professionals. As the current study has as focus the psychosocial work environment of an ED, it was deemed important to describe the WHO/ILOs' Healthy Workplace Model (HWM 2010) which underpins the actions and activities required to achieve a healthy workplace. In addition, the Positive Practice Environment (PPE) movement which aims to promote and ensure health and safety in the work place; improve individual worker performance; a good work/life balance; gender equity in the workplace, positive remuneration, and professional growth for all workers, is discussed.

2.5.1 WHO/ILO's Healthy Workplace Model (2010)

This study draws on the perspectives of the **WHO/ILO: Healthy Workplace Model (2010).** The Healthy Workplace Model (HWM) was developed to provide guidance which could easily be adapted to a specific workplace (WHO, 2010). Burton (2010:82-94) states that the Healthy Workplace Model (2010), 'was developed mostly for occupational health and safety professionals, scientists, and medical practitioners to provide a scientific basis for a healthy workplace framework'.

A healthy work place is viewed as a place where all employees and employers work together in harmony to achieve a common goal, which is to protect the health and well-being of the worker/professional and the surrounding community. This involves collaboration regarding the process of continually protecting and promoting health and safety in the workplace (Neira 2010 & WHO/ILO 2010). To maintain a healthy workplace, emphasis needs to be put on health, safety & well-being, including the workplace culture (Burton, 2010). In a safe and healthy environment, emergency nurses have ownership of their health and have control to improve it (Lefton, 2012). In a study conducted in South Africa by Sieberhagen, Rothmann & Pienaer(2014:24) on "the role of legislation and management standards", revealed that "South African organisations lack adequate policies to govern employee health and wellness, and should establish an executive body to deal with policy and operational matters relating to occupational health, wellness and safety matters". Figure 2.1 below presents the healthy workplace model according to the WHO& ILO.

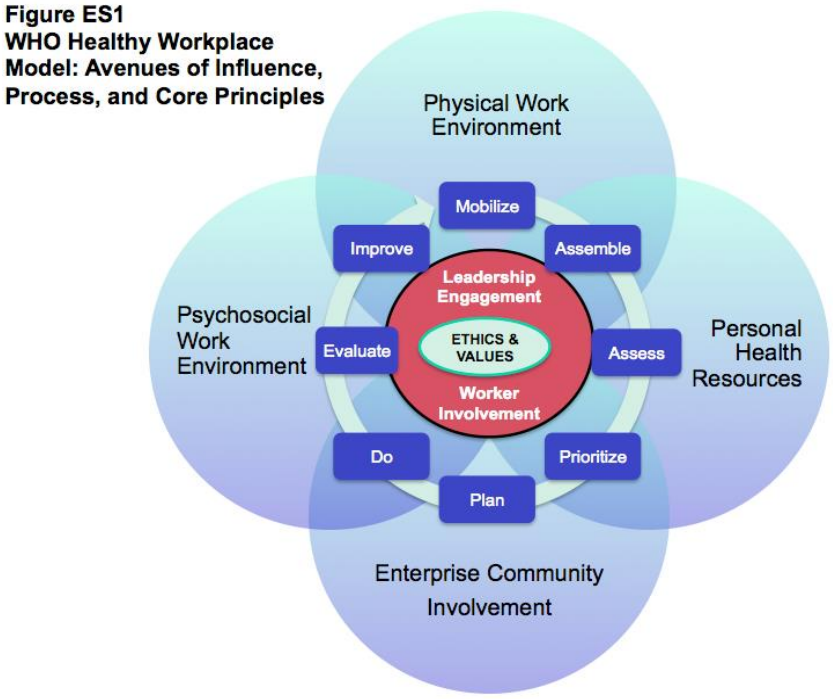


Figure 2.1 WHO/ILO Healthy Workplace Model (2010) Burton (2010:3) Business Case for a Healthy Workplace model

As is evident from figure 2.1, the healthy workplace model presents four avenues of influence, namely the psychosocial and physical work environments, personal health resources, and enterprise community involvement. Continuous quality improvement entails eight steps, namely *mobilize, assemble, assess, prioritize, plan, do, evaluate and improve* (Burton, 2010:3).

The core principles underlying the model are leadership engagement, ethics, values, and worker involvement.

For the purpose of this study only the psychosocial work environment is elaborated on.

Personal Health Resources in the Workplace is defined by Burton (2010:82-94) as, 'a supportive environment, health services, information, resources, opportunities, and flexibility that the enterprise provides to workers to support, improve & maintain healthy personal lifestyle practices, and also to monitor and support their ongoing physical and mental health'.

The issues that arise from poor management are the following: poor information distribution; lack of flexibility in allocation of rest between shifts; and a lack of access to health and healthy meals in the workplace (Burton, 2010). There are neither designated smoking areas nor smoking cessation programmes; there is poor follow up on injuries or illnesses in the work-place; there is a lack of information regarding hazards, and also a lack of resources and knowledge about sexually transmitted infections, including HIV/AIDS (Smith et al, 2015).

The HWM (2010) is concerned with making the workplace safe, and sustaining it, instilling health promoting practices, and promoting health and well-being. This is done by making sure that all health and safety concerns are attended to in the physical environment and that psychosocial concerns take priority, including the organization & workplace culture (Burton, 2010). It includes putting in place personal health resources and being active in the community to improve the health of the worker, his/her family, and the people around him/her (Burton, 2010). Workplace health is based on health promotion and prevention (Micheals & Greene, 2013).

2.5.2 Positive Practice Environments

The International Council of Nurses calls for positive practice environments(PPEs) in which the work setting provides a supportive environment which ensures the health, safety & well-being of workers; supports quality patient care; keeps workers motivated, and enhances the performance of individuals & organizations (Schmidt, 2012 & The International Council of Nurses 2010). The PPE campaign is a global campaign aiming to improve work environment for health care

professionals and thereby strengthening staff retention and recruitment, as well as quality of care. The campaign was initiated by the Global Health Workforce Alliance (GHWA) (Schmidt, 2012). PPEs are viewed as settings that support the provision of quality patient care by ensuring the health, safety, and personal well-being of staff (Schmidt, 2012).

Positive Practice Environments include having occupational health, safety & wellness policies in the workplace; addressing hazards such as sexual harassment, violence, psychological harassment, personal security, and workplace discrimination (Schmidt, 2012).There should be a fair distribution of material and human resources to reduce burnout and stress. Managers should make use of effective leadership strategies which are supportive and encourage teamwork and job satisfaction. There should be open communication and transparency to reduce conflicts in the workplace (Finch, Smith &Patricia, 2010).

2.5.3 The mentally healthy workplace

According to the authors Knapp & Evans (2017:8) “the aim of mentally healthy workplace is to promote mental health in the workplace, and create broad coalition to promote best practice, decrease negative attitudes, discrimination and empower individuals to promote mental health and dignity for all”. While a mentally healthy workplace is a workplace that constantly identifies and assesses the psychosocial hazards that employees experience and the negativity that they cause (The National Mental Health Commission - Mentally Healthy Workplace Alliance, 2014). Workers should feel mentally free in the workplace, i.e. the workplace should promote mental well-being (Canadian Centre of Occupational Health and Safety (CCOHS) Fact Sheet, 2012). When workers are mentally healthy, they are motivated and productive in the workplace. A psychologically positive work environment positively affects the job performance of employees, workers realize their full potential and can easily cope with life stressors (Badayai, 2012). Mental illness if not treated negatively affects production in the workplace, there is poor performance with poor quality of work it also compromises safety in the workplace and is responsible for illness related absenteeism (Hamdulay, 2015).

2.6 SUMMARY

Literature shows that nurses are exposed to different demands in the workplace such as physical & psychological hazards which are mentally and physically draining leading to fatigue, burnout, stress, depression, and post-traumatic stress disorders. Working in emergency departments can

expose nurses to psychosocial hazards which may affect them negatively and also interfere with their social lives. It is important to have supportive leadership with good conflict resolution abilities. Nurses working in emergency departments need to have their opinions valued and be involved in decision making & planning. Chapter two has discussed psychosocial factors affecting ED nurses in the workplace; the workplace environment as such; the balance between work and private life; the types of violence ED nurses are exposed to, and the health and well-being of ED nurses.

CHAPTER THREE

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This chapter describes the research design & methods, the study setting, the population, and the sampling method used. It also describes the data collection instruments, the procedures used for data collection, the data analysis and, finally, the ethical integrity of the study was achieved by obtaining clearance from the Human Research Ethics Committee, obtaining approval to conduct the study from the School of Therapeutic Sciences, Department of Gauteng Health and Managers from both hospitals and an information leaflet explaining to the participants about consent to participate in the study, confidentiality and anonymity.

3.2 RESEARCH DESIGN

To enable a researcher to conduct a study in a methodical manner, the research design and methods used are important. The research design is a set plan by which to obtain answers for the questions being studied. It sets a blueprint for handling challenges and strategies in order to obtain research evidence (Polit & Beck, 2012).

A quantitative cross-sectional design was used for this study, meaning the study was conducted at a specified point in time, and with the same respondents (Brink, van Der Walt &Van Rensburg 2015). Setia, (2016) states that a cross-sectional design is a type of observational study design whereby the investigator measures the outcomes and exposures of the respondents over a certain set period (Setia, 2016).

3.3 RESEARCH METHOD

The research method referred to techniques that are used by the researcher in order to structure a study to be able to gather and analyse information relevant to the research question (Polit & Beck, 2012). Answers obtained from the study are used to make decisions and find solutions for problems (Ismail, 2014). A quantitative cross sectional survey study with use of self-administered questionnaires was used to answer the question of the study. Self- administered questionnaire

were used for the survey they are valuable and cost effective way of collecting data, its uses minimal infrastructure (Polit & Beck, 2012).

The survey method of data collection has many advantages and disadvantages as discussed by Mathiyazhagan & Nandan (2010):

3.3.1 Advantages of the survey method:

- It is a fast method of collecting data from many respondents at a given time.
- The survey method is cost effective as it uses methods, materials, & the setting of a real life situation.
- The survey method has generalized simplified information which makes it easy to collect information from respondents at a given time.

The researcher found that the use of the survey method had many advantages in this study such as many questionnaires were completed in a short space of time.

3.3.2 Disadvantages of the survey method

- The data collected can be superficial, as the respondents respond only to the set questions and do not further explain their answers.
- If there is a poor sampling or response bias, the data does not reflect external validity.
- It only caters for individualised responses and is not suitable for group studies.

3.4 SETTING OF THE STUDY

The research setting is the physical site where the researcher conducts the study; it is where the respondents socialize or practise their cultural beliefs (Given, 2014).The setting for this study was the emergency departments of two Johannesburg Central Hospitals.

The first central hospital studied has 1088 usable beds and a professional and support staff exceeding 4,000 people. It is also an academic hospital which provides a service base for undergraduate and post-graduate training, for all specialties of health professionals. The hospital offers a full range of secondary, tertiary and highly specialized services with emergency units

(Gauteng Department of Health, 2017). It has a Trauma Resuscitation Area which has 8 resuscitation bays, an X-Ray department nearby. There is a Triage area with cubicles with ventilation facilities and between the trauma and triage units is large triage area that can accommodate about 20 to 30 trolleys in case of disasters. There is an emergency theatre ready 24 hours and are at a distance of 10metres from the resuscitation area, close to the theatre is a trauma intensive care unit which accommodates more than six patients and are managed by trauma consultant who is available 24 hours of the day and the general ICU staff who are on shift work round the clock.

The second hospital has about 3200 usable beds and about 6760 professional and support staff. It also provides a base for undergraduate and post graduate education and training for all health professional specialties. The hospital has the highest accident, emergency, and ambulance service rate with about 350 patients per day, in Gauteng, of which about 70% of all admissions are emergencies (Gauteng Department of Health, 2017). It has a Trauma Resuscitation Area which has 16 resuscitation bays, a Low dose X-Ray (LODOX) machine for stable patients to have a total body scan, within the unit are a CT scanner, the angiogram and screening suits at a distance of 50metres. There is a Triage area which consists of 11 cubicles with ventilation facilities and between the trauma and triage units is large triage area that can accommodate about 40 trolleys in case of disasters. There are three (3) emergency theatres ready 24 hours and are at a distance of 30metres from the resuscitation area, close to the theatre is a trauma intensive care unit which accommodates eight patients and are managed by trauma consultant and the general ICU staff (Gauteng Department of Health, 2017).

The two hospitals were chosen because they are in the same Department of Health classification (academic hospitals) with a large catchment areas and will therefore give more or less the same results and are affiliated to one another.

3.5 POPULATION

A population is the group of persons or objects that are of interest to the researcher, who meets the inclusion criteria, and that the researcher wants to conduct a study on (Burns and Grove, 2010). For the purpose of this study, it was not feasible to include all emergency nurses in all Johannesburg Central Hospital. Therefore, only emergency nurses of the two selected central hospitals comprised the accessible population. The accessible population is also known as the

population from which researchers obtain their conclusions (Ismail, 2014). A total of 162 nurses work in both emergency departments, of which 68 nurses work at the first hospital and 94 nurses work at the second hospital. A total of 121 nurses from both hospital answered the questionnaires but only 91 were completed and accepted for the study. A total of 15 trauma trained nurses were captured in the study and 4 nurses were from first hospital and 11 from the second hospital.

The accessible population selected was based on certain inclusion criteria. In this study, the inclusion criteria were limited to professional (registered) nurses working in the emergency units of the two selected Johannesburg Central Hospitals.

3.6 SAMPLING AND SAMPLE SIZE

The sampling method and sample size are described in this section.

3.6.1 Sampling method

According to Polit & Beck (2010: 307), “Sampling is the process of selecting a portion of the population to represent the entire population”.

In this study, a total/ census sampling method was used which involved the entire population of ED nurses who had a particular set of characteristics (Setia, 2016).

3.6.2 Sample size

A sample is a subset of a population (Polit & Beck, 2010). The sample size for this study consisted of all 161 registered nurses practising in the emergency departments of the two Johannesburg hospitals.

3.7 DATA COLLECTION

According to Burns & Grove (2012:283), “data collection is a process of acquiring participants and collecting the data”. The steps taken to collect the data vary according to the research design and the measurement techniques (Burns & Grove (2012). Collection of data involves identifying the participants for the study and in this study nurses working in the ED in the two hospitals were selected. A meeting was set with the heads together with nurses of the emergency departments and the contents of the questionnaire were explained. Data collection also includes maintaining consistency which means maintaining a certain way of data collection as this maintains the validity

of the study (Polit & Beck (2012). There were data no collectors for this study, the researcher was the sole distributor of the questionnaires to nurses working in the ED of both hospitals. The participants were left to complete the questionnaires on their own without being pressurized, completed questionnaires were immediately collected by the researcher. Some nurses opted to fill in the questionnaire at their spare time. A sealed box was placed in the nurses' station, where the ED nurses deposited their answered questionnaire and the box was collected at the end of data collection period which was at the end of three weeks in this study. Burns & Grove (2012) emphasize that, maintaining consistency and controls during selection of participants and data collection protects the integrity when data collection is examined as a whole. Problem identification and problem solving is also an important aspect of data collection, the researcher anticipates problems that may arise from the process of data collection and should have solutions to resolve the problems as they arise (Polit & Beck (2012). Debriefing and counselling was available to the participants for those who may have experienced emotional discomfort due to the nature of the study (see appendix A). There were no traumatic situations arose during the aa scollection of data.

A pre testing of the questionnaire was not conducted in this study as the instrument has been used in studies internationally and nationally.

3.7.1 Data collection instrument

The data collection instrument used was a self-administered questionnaire, namely, the Copenhagen Psychosocial Questionnaire –COPSOQ II, developed by the National Research Centre for the Working Environment (NRCWE), Copenhagen, Denmark (Arbejdsmiljoforskning.dk, (2011)- see Appendix F).

The instrument was divided into two sections, namely;

Section one:

Socio-demographic information gathering regarding years of practice, professional level, gender, age and department of work. It was developed by the researcher.

Section two:

Information gathering regarding the seven domains of the COPSOQ II, i.e.

- Demands at work, with a total of 3 questions

- Work organization and job content comprising of 4 questions
- Interpersonal relationships and leadership (work environment), comprising of 5 questions
- Work/individual interface, comprising of 2 questions
- Values at workplace level, comprising of 2 questions
- Health and wellbeing, comprising of 3 questions
- Offensive Behavior Domain, comprising of 4 questions

The COPSOQ II has closed-ended questions on a 5 point Likert scale .The 5 point Likert scale responses were: Always, Often, Sometimes, Seldom, Never/ Hardly ever, To a very large extent, To a large extent, To a small extent.

Aspects of the COPSOQII questionnaire is also evident in The WHO Healthy Workplace Model (2010) such as:

- Poor work organization like, time pressure, decision latitude, work-load. support from supervisors and job clarity
- Organisational culture like, lack of policies and practice related to dignity and respect, harassment and bullying.
- Command and control management style like lack of consultation, negotiation and two way communication.
- Shiftwork issues, lack of support for work-life balance (Adapted from WHO Healthy, Workplace Model,2010).

Table 3.1: Domains from questions 1 - 19 of the COPSOQII

MEASURING	DOMAINS	QUESTION NUMBER:	PSYCHOS-OCIAL DIMENSIONS OF COPSOQII
WORKPLACE	Demands at work	1	Quantitative work demands
		2	Work pace
		3	Emotional work demands
	Work organization and job content	4	Influence on work
		5	New skill development
		6	Meaningful work
		7	Commitment to workplace
	Interpersonal and (work relationships Leadership environment)	8	Predictability
		9	Appreciation & recognition
		10	Role clarity
		11	Leadership quality
		12	Social support from Superiors.
WORK INDIVIDUAL	Work/ Individual Interface	13	Job satisfaction
		14	Work/family conflict
	Values at work-place level	15	Management/worker Trust
		16	Justice& respect
Individual Outcome	Health & Well-being	17	Self-rated health
		18	Burnout
		19	Stress

Questions 20 - 23 related to the Offensive Behavior Domain. The Offensive Behavior Domain scale responses were, *yes daily, yes weekly, yes monthly, yes a few times* and *no*. If the response was a Yes, the respondents were expected to indicate from whom they had experienced the behavior, namely, either from colleagues, managers/supervisors, and subordinates or from clients/customers/ patients.

Table 3.2 Questions 20-23 related to the Offensive Behavior Domain, frequency of offensive behavior and perpetrated by whom

DIMENSIONS	NO	HOW OFTEN?														
		Yes a few times	Yes daily	Yes weekly	Yes monthly	Colleagues	Managers	Subordinates	Clients	Col+ CL	Col + Man	Col+ Man+ Cl	Man+ Cl	Man+ Sub+ Cl	Col+ Man+ Sub+ CL	Sub+ Cl
20.Sexual Harassment																
21.Threats of Violence																
22.Physical violence																
23.Bullying																

KEY abbreviations

1. **Col-** Colleagues
2. **Man-**Managers
3. **Sub-** Subordinates
4. **Cl-** Clients

In addition, the COPSOQ II has also an open-ended section for any comments, at the end of the questionnaire.

3.7.2 The reliability and validity of the COPSOQ II

The validity of an instrument is established when the instrument measures what it intends to measure (Polit & Beck 2010). Reliability of an instrument is the degree of consistency with which the instrument measures an attribute (Polit & Beck 2010). The COPSOQII instrument is used both nationally and internationally and is known to provide necessary information regarding (i) the psychosocial work environment and, (ii) psychosocial factors at work in diverse work settings. Validation studies have been conducted in many countries namely, Scandinavia, France, Spain, Germany, Colombia, Portugal, Argentina, Hungary, Iran, and Chile (Berthelsen, Hakanen & Westelund, 2018). The same authors state "The COPSOQII Questionnaire has been recognized as an assessment tool by both the ILO and WHO and is used in workplace surveys worldwide, for work environment development and follow up of organizational changes.

The Cronbach Alpha for COPSOQII in English was found to be between 0.50 and 0.89. The construct validity was confirmed by correlation analysis and factor analysis Arbejdsmiljoforskning.dk, 2011). The COPSOQ II short version in English has been used in the South African context in a scholarly study conducted by Volmink (2014), in a study to measure Occupational stress in a South African Workforce. Criterion validity was tested during construction of the original tool (Arbejdsmiljoforskning.dk, 2011).

3.7.3 Data collection procedure

- Meetings with the unit managers were arranged to explain the study to them and to seek their support.
- Meetings with the emergency nurses were arranged to explain the study and hand out the information letters and questionnaires (see appendices A & F)
- Completed questionnaires were placed in sealed boxes in a secure corner at the nurses' station in each department.
- Data was collected over a 3 week period in December 2017, after ethical clearance was obtained from the University of the Witwatersrand and also permission from the management of the hospitals and of the Gauteng Department of Health.

3.8 DATA ANALYSIS

Data was grouped and entered on an Excel Spreadsheet, then the data was scored according to the COPSOQ II scoring system. Each of the responses were scored individually and then added together to make up the dimension score (Ardejmilforskning .dk, 2011). Table 3.3 shows the interpretation and scoring system of the COPSOQ II questionnaire. Coding: GREEN-Good, YELLOW-Medium, RED-High risk.

Table 3.3: Scoring System for COPSOQ II (Arbejdmilj0 Instituttet, 2011)

Quantitative Work Demands	0	1	2	3	4	5	6	7	8
Work pace	0	1	2	3	4	5	6	7	8
Emotional Work Demands	0	1	2	3	4	5	6	7	8
Influence on work	0	1	2	3	4	5	6	7	8
New Skill development	0	1	2	3	4	5	6	7	8
Meaningful Work	0	1	2	3	4	5	6	7	8
Commitment to the workplace	0	1	2	3	4	5	6	7	8
Predictability	0	1	2	3	4	5	6	7	8
Appreciation & Recognition	0	1	2	3	4	5	6	7	8
Role clarity	0	1	2	3	4	5	6	7	8
Leadership quality	0	1	2	3	4	5	6	7	8
Social support from superiors	0	1	2	3	4	5	6	7	8
Job satisfaction			0	1	2	3			
Work/family conflict		0	1	2	3	4	5	6	
Management/ worker trust	0	1	2	3	4	5	6	7	8
Justice & respect	0	1	2	3	4	5	6	7	8
Self-rated Health			0	1	2	3	4		
Burnout	0	1	2	3	4	5	6	7	8
Stress	0	1	2	3	4	5	6	7	8

After completion of the individual questions, the mean scores were calculated for all the

respondents against each question, and the mean values were used for the interpretation of the scoring system.

In this study, RED was interpreted as high risk, YELLOW as medium risk, and GREEN as low risk.

High risks are risks deemed as not acceptable, improvement of controls is necessary to reduce the risk to a tolerable level.

Medium risks- considerations should be made on how to lower the risk and reduction measures should be put in place. Arrangements should be made to make sure the controls are maintain.

Low risks are considered as acceptable and no additional controls are needed, the ones in place should be maintained (Adapted from Comcare (2018)

The data was transferred manually onto a Microsoft Excel sheet Data was analyzed using the Stata Window English Version 10.0 (Stata Corp, 2008), averages, standard deviation were calculated, and pivot tables were formulated. Statistical analyses included descriptive statistics (frequencies, means ranges, and standard deviations). Assistance was sought from a statistician from Botswana regarding the entry and analysis of captured data, using the Excel spreadsheet.

The open-ended comment section was analyzed by means of thematic analysis and coding. Quantitative content analysis involves classification of part of the text by applying a set systematic coding, so that conclusions are drawn from the data obtained (Rose, Spinks& Canhoto, 2015).

3.9 RELIABILITY AND VALIDITY OF THE STUDY

Methodological rigor in quantitative research refers to the soundness or precision of a study in terms of planning, data collection, analysis, and reporting.

Validity

According to the authors Reis, Hino & Rodriguez-Anez (2010:107-114), “The validity of a study is the extent to which the scores from a measure represent the variable they intend to; confirmed internal consistency, and confidence in the scores that represent what they are supposed to”.

Validity in this study was maintained by ensuring consistency in data collection. This was done in strict adherence to the data collection tool and guidelines provided by the developers of the

questionnaire and various aspects of validity were tested. Authors, Price, Jhaniani & Chiang (2013), explain that to test if a study has construct validity, the researcher has to make sure the key concepts are measured in the study.

Reliability

The reliability of a study refers to the consistency of a measure (Reis et al, 2010),
Reliability was assessed by the consistency of the responses in each questionnaire, and, in this survey, the respondents' scores from the questionnaire correlated with each other. The authors Price, Jhangiani &Chiang (2013) reflect that if there is a consistency in the responses on multiple items, then the results will correlate with each other.

3.10 ETHICAL INTEGRITY

Ethical integrity was ensured by:

Obtaining ethical clearance from the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, before conducting the study (see Appendix B).

Obtaining approval to conduct the study from the School of Therapeutic Sciences' Post Graduate Research Committee (see Appendix C).

The Gauteng Department of Health and the two hospitals provided permission for the study to be conducted (see Appendices D& E).

No permission is required to use the COPSOQ ii short version as is indicated on the website. It is meant for public use (see Appendix F).

In the final research report, the names of the hospitals were not reflected

To ensure confidentiality and anonymity of the respondents, no names appeared on the questionnaire.

Participation in the study was voluntary, and participants could withdraw from the study without explanation or penalty, at any time. The participants were offered emotional support, should completing the questionnaire trigger traumatic memories and Mrs. Annalie van den Heever at Witwatersrand University was identified to be contacted.

Completed questionnaires were interpreted as informed consent to participate in the study.

Data was stored in a safe place where only the researcher and supervisors could access the data, ensuring privacy and confidentiality.

3.11 SUMMARY

This chapter has described the research design and method which was used for this study. It has also described the research method used for data collection, the sampling method, and the sample size. The population & the inclusion criteria, which consisted of nurses working in the emergency departments of the two Johannesburg hospitals, were identified. The data collection instrument the Copenhagen Psychosocial Questionnaire II (COPSOQ II) and reliability & validity were also discussed. Finally, the ethical integrity and methods of data analysis were laid out.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF THE RESULTS

4.1 INTRODUCTION

The presentation and discussion of the results from this study are presented in this chapter.

4.2 RESEARCH RESULTS

4.2.1 Response rate

A total of 161 nurses were reported as practising in the emergency departments at the two Johannesburg central hospitals. Of these, 121 emergency nurses responded by completing the questionnaire, of which 30 were discarded due to a lack of completion. Ultimately, 91 completed questionnaires were analysed, yielding a response rate of 56.5%.

4.2.2 Research results of section one of the questionnaire: Socio-demographic Profile

In this section of the questionnaire, emergency nurses were asked to provide information regarding their age, gender, professional level, years of work experience in the ED, and the type of departments in which they work.

Table 4.1 indicates that the highest percentage 31(34.1%) of respondents was in the age group 31-39 years. Twenty-three (25.3%) nurses were in the age group 40-49, while 22(24.2%) were in the less than 30 year age group. The 50 -59 age group had the least respondents, with only 15 (16.4%). The mean age was 34 years.

Most of the emergency nurses (83.5% n=76) were female, and 16.5% (n=15) were males.

Of the 91 respondents, 83.5% (n=76) were registered nurses without an additional qualification in trauma and emergency nursing, and 16.5 % (n=15) had a specialist education in emergency and trauma nursing.

Most of the respondents (83.5% n=76) practiced in the adult emergency department, and only 16.5 %(n=15) worked in the medical emergency department.

Over half of the respondents (50.5%, n=46) had 1-5 years of professional experience in ED and

Table 4.1: Socio- demographic profile of the ENs (n=91)

Characteristics	Frequency	Percentage (%)
Age (years)		
< 30 years:	22	24.2
31 to 39	31	34.1
40 to 49	23	25.3
50 to 59	15	16.4
>60	0	0
Gender		
-Female	76	83.5
-Male	15	16.5
Professional Level		
-Registered nurse	76	83.5%
-Trauma educated nurse (Specialist)	15	16.5%
Department		
-Medical Emergency	15	16.5
-Adult Emergency	76	83.5
Years of experience in ED		
< 1	22	24.2
1 – 5	46	50.5
6 – 10	14	15.3
< 10	9	9.9

4.2.3 Section two of the questionnaire: COPSOQ II

This section of the questionnaire asked questions in relation to the seven domains, namely: demands at work, work organization, job content, interpersonal relationships and leadership (work), work/individual interface, values at workplace level, health and wellbeing, and the offensive behavior domain.

The results obtained from the COPSOQ II questionnaire are presented in Table 4.2 below. A colour coded scheme was used to indicate various risk levels. The colour green indicates good levels, yellow shows that there is a need for attention, and red indicates poor levels (Arbejdsmilij0 Instituttet, 2011) .In this study the colour green represents low risk, yellow colour represents medium risks and red colour represents high risks.

High risks are risks deemed as not acceptable (colour red), improvement of controls is necessary to reduce the risk to a tolerable level.

Medium risks (colour yellow) - considerations should be made on how to lower the risk and reduction measures should be put in place. Arrangements should be made to make sure the controls are maintained.

Low risks (colour green) are considered as acceptable and no additional controls are needed, the ones in place should be maintained (Adapted from Comcare 2018)

Table 4.2 shows that the **aspects that needed immediate attention** are the following: work pace, emotional demands of work, appreciation and recognition, job satisfaction, justice and respect, burnout and stress.

Dimensions rated as needing some attention are the following: role clarity, leadership quality, social support from superiors, work/family conflict, management/worker trust, and self-rated health.

Areas that were rated as good are the following: quantitative work demands, influence on work, new skills development, meaningfulness of work, commitment to workplace, and predictability.

Table 4.2: Results from 1 - 19 dimensions of COPSOQII

MEASURING	DOMAINS	QUESTION NUMBER	PSYCHOSOCIAL DIMENSIONS OF COPSOQII	TOTAL SCORE	MEAN SCORE	STANDARD DEVIATION	COPSOQII ROUNDING
WORKPLACE	Demands at work	1	Quantitative work demands	348	3.82	1.73	3
		2	Work pace	551	6.05	1,54	6
		3	Emotional work demands	491	5.05	1.52	5
	Work organization and job content	4	Influence on work	476	5.23	1.95	5
		5	New skills development	547	6.01	1.62	6
		6	Meaningful work	637	7.00	1.44	7
		7	Commitment to workplace	530	5.82	1.79	5
	Interpersonal relationships and Leadership.(work environment	8	Predictability	361	3.98	2.21	3
		9	Appreciation & recognition	321	3.52	2.28	3
		10	Role clarity	508	5.58	1.86	5
		11	Leadership quality	378	4.15	2.19	4
		12	Social support from Superiors.	397	4.36	2.27	4
WORK/ INDIVIDUAL	Work/ Individual Interface	13	Job satisfaction	139	1.52	0.78	1
		14	Work/family Conflict	349	3.83	1.71	3
	Values at work-place level	15	Management/worker Trust	369	4.05	2.24	4
		16	Justice& respect	313	3.44	1.94	3
Individual Outcome	Health & Well-being	17	Self-rated health	229	2.51	1.01	2
		18	Burnout	454	4.99	1.69	4
		19	Stress	430	4.72	1.76	4

Questions 20 to 23 cover the last questions of the offensive behaviour domain and include: sexual harassment, threats of violence, physical violence, and bullying. Table 4.3 shows the results for these last four questions.

Table 4.3 reveals that a total of 13 (14.3%) respondents reported being exposed to sexual harassment mainly by clients (patients), of which 12(13.3%) were females and 1(1.10%) was male. Table 4.3 further reveals that 41(45%) ED nurses were exposed to threats of violence, whereas 12(13.3%) of ED nurses reported being exposed to actual acts of physical violence. It is evident from table 4.3 that the majority (56% n= 51) of the respondents were exposed to bullying in the workplace.

Table 4.3 Questions 20-23 related to the Offensive Behavior Domain, frequency of offensive behavior and perpetrated by whom n=91

DIMENSIONS	NO	HOW OFTEN?															
		Yes a few times	Yes daily	Yes weekly	Yes monthly	Colleagues	Managers	Subordinates	Clients	Col+ CL	Col + Man	Col+ Man+ Cl	Man+ Cl	Man+ Sub+ Cl	Col+ Man+ Sub+ CL	Sub+ Cl	% of Total N=91
20.Sexual Harassment	n=78 85.7 %	9	2	2	0	0	3	2	8	0	0	0	0	0	0	0	n=13 14.3 %
21.Threats of violence	n=50 54.9 %	32	6	3	0	4	4	1	24	3	2	0	0	0	3	0	n=41 45%
22.Physical violence	n=79 86.8 %	8	1	1	2	1	0	0	11	1	0	0	0	0	0	0	n=12 13.2 %
23.Bullying	n=40 43.9 %	40	7	1	3	5	16	1	8	1	5	1	9	1	1	2	n=51 56%

KEY

5. **Col-** Colleagues
6. **Man-**Managers
7. **Sub-** Subordinates
8. **Cl-** Clients

Because workplace violence (WPV) is an important psychosocial hazard and risk, detailed results are provided in the following figures.

KEY

1. **YAFT** Yes, a few times.
2. **YD** Yes, daily.
3. **YW** Yes, weekly
4. **YM** Yes, Monthly.

Figures 4.1 and 4.2 reflect the results from question 20 related to sexual harassment.

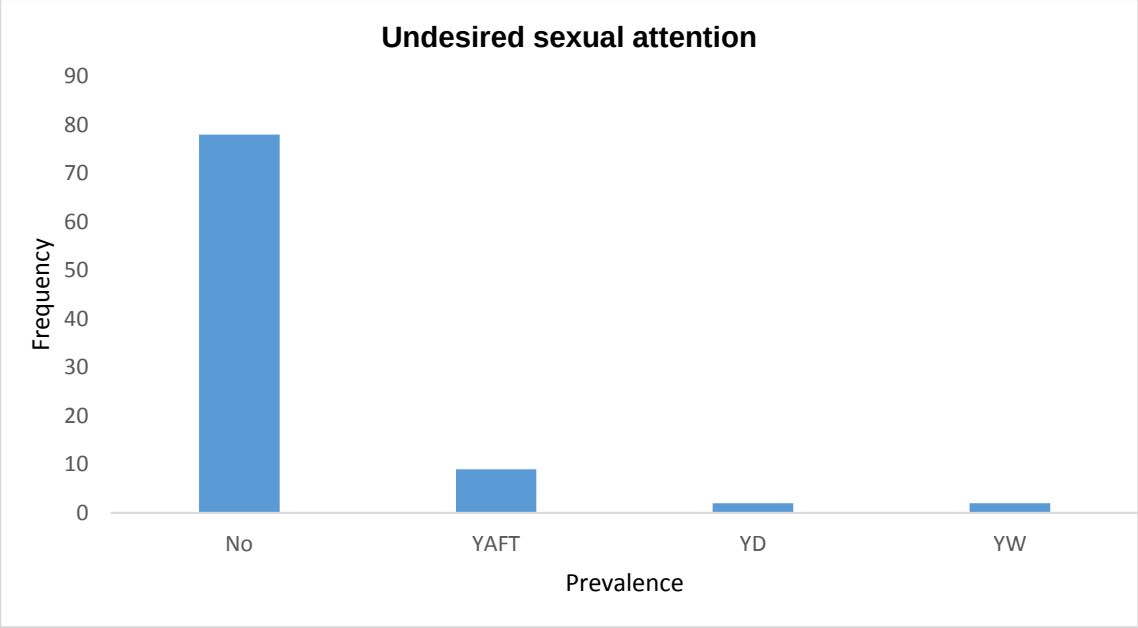


Figure 4.1: Prevalence of undesired sexual attention n=91

It is evident from figure 4.1 that most of the respondents 78(85.7%) were not exposed to undesired sexual attention, but 13(14.3%) were exposed to sexual harassment of which 12(92.3%) were female respondents, while 1(1.1%) was a male respondent. Of these respondents, 9(69.2%) had been exposed to it a few times, while 2(15.4%) were exposed to it on a daily and weekly basis, respectively.

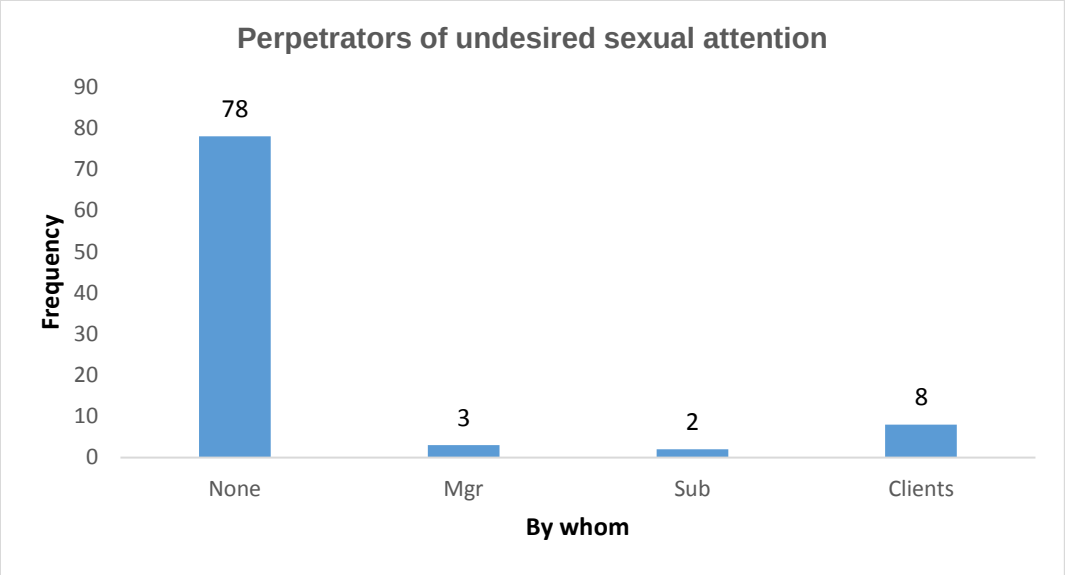


Figure 4.2: Perpetrators of undesired sexual attention (n=91)

Figure 4.2 illustrates that some of the respondents 8(61.5%) reported sexual harassment by clients (patients), mostly reported by female respondents. About 3 (23%) had experienced sexual harassment by managers. Two (2) respondents (15.4%) also reported being exposed to sexual harassment from subordinates, of the respondents, one (1) respondent reported being exposed to sexual harassment by the manager on a monthly basis. Figures 4.3 and 4.4 provides an overview of question 21 regarding threats of violence in the workplace.

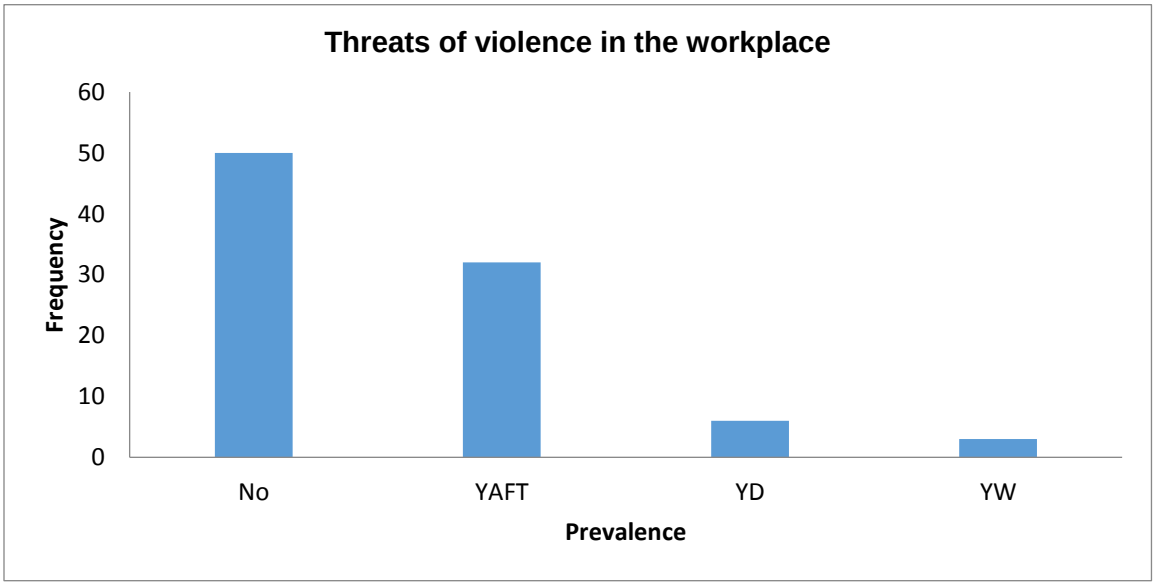


Figure 4.3 Prevalence of threats of violence in the workplace n=91

More than half of the respondents 50(54.9%) reported that they had not been exposed to threats of violence in the workplace, while 41(45%) reported having been exposed to it. Of the exposed 32(78%) had been exposed to threats of violence a few times, while 6(14.6%) had been exposed to it daily and 3(7.3%) on a weekly basis

Figure 4.4 below depicts the perpetrators of threats of violence.

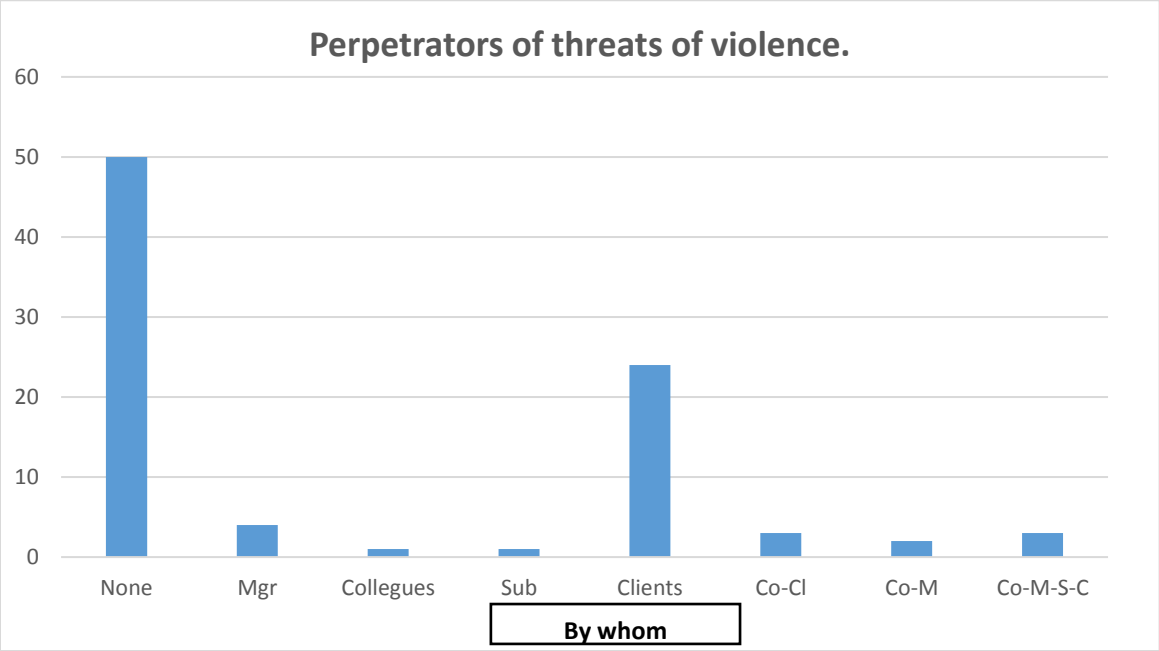


Figure 4.4: Perpetrators of threats of violence (n =91)

Twenty four (58.5%) had been exposed to threats of violence from patients while 4 (9.8%) had threatened by managers and 4(9.8%) by colleagues. Some respondents 3(7.3%) had been exposed to threats of violence from colleagues and 3(7.3%) respondents from managers, colleagues, subordinates and clients. A total of 2 (4.9%) had been threatened with violence by colleagues and managers, while subordinates 1(2.4%) had perpetrated threats of violence in the workplace. In question 22 of the questionnaire, respondents were asked if they had experienced physical violence in the workplace, and they had to indicate the perpetrators. Figures 4.5 and 4.6 below provide detailed results from question 22 pertaining to physical violence.

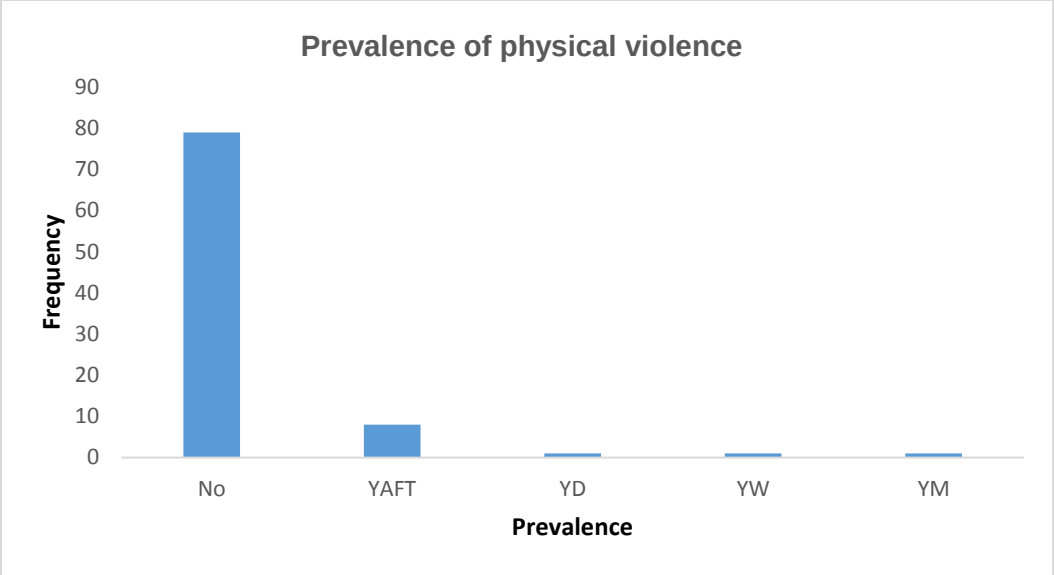


Figure 4.5: Prevalence of physical violence n=91

Figure 4.5 shows that most of the respondents 79(86.8%) had not been exposed to physical violence. Of those exposed to physical violence, 8 (66.7%) had been exposed to it a few times, while 2(16.6%) were exposed to it on a monthly basis and 1(8.3%) were exposed to it daily/weekly basis, respectively.

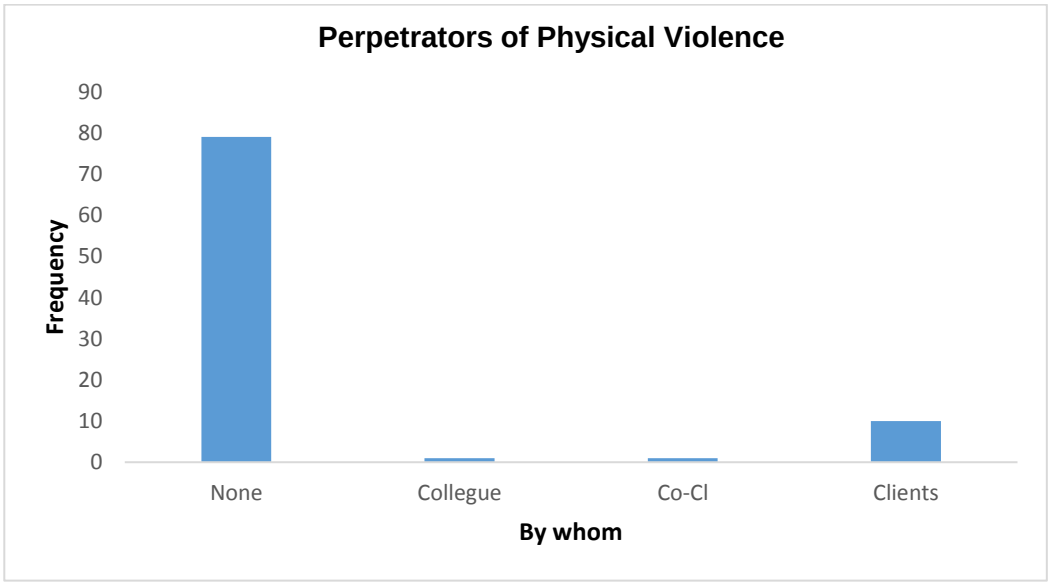


Figure 4.6: Perpetrators of physical violence (n=91)

Figure 4.6 depicts that 10(83.3%) of had been were violated by clients; colleagues contributed to 1(8.3%), and nurses violated by both colleagues and clients equaled 1(8.3%).

In question 23, respondents were asked if they have been exposed to bullying and to indicate by whom. Figure 4.7 and 4.8 illustrates the both prevalence and perpetrators of workplace bullying as per responses form question 23 of the questionnaire.

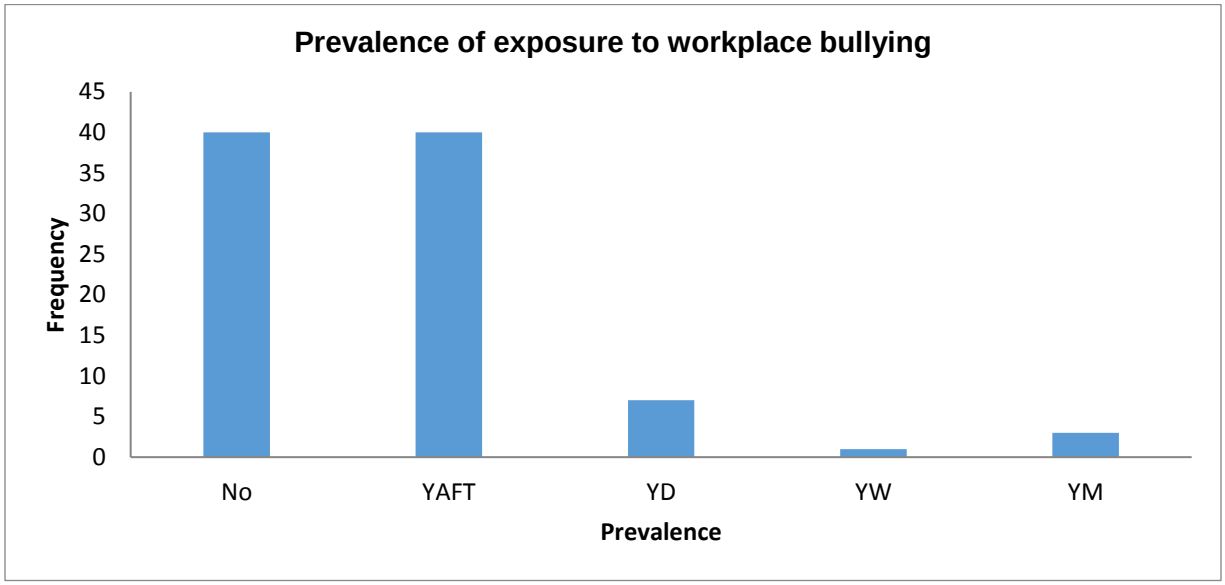


Figure 4.7: Prevalence of workplace bullying (n=91)

Figure 4.7 reveals that 51 (56%) of the respondents had experienced bullying in the workplace while 40(43.9%) had not experienced bullying. Of the exposed 40 (78.4%) of the respondents had been exposed to bullying a few times, while 7(13.7%) had been exposed to bullying daily, 3(5.9%) were exposed on a monthly basis and 1(2%) was exposed on a weekly basis.

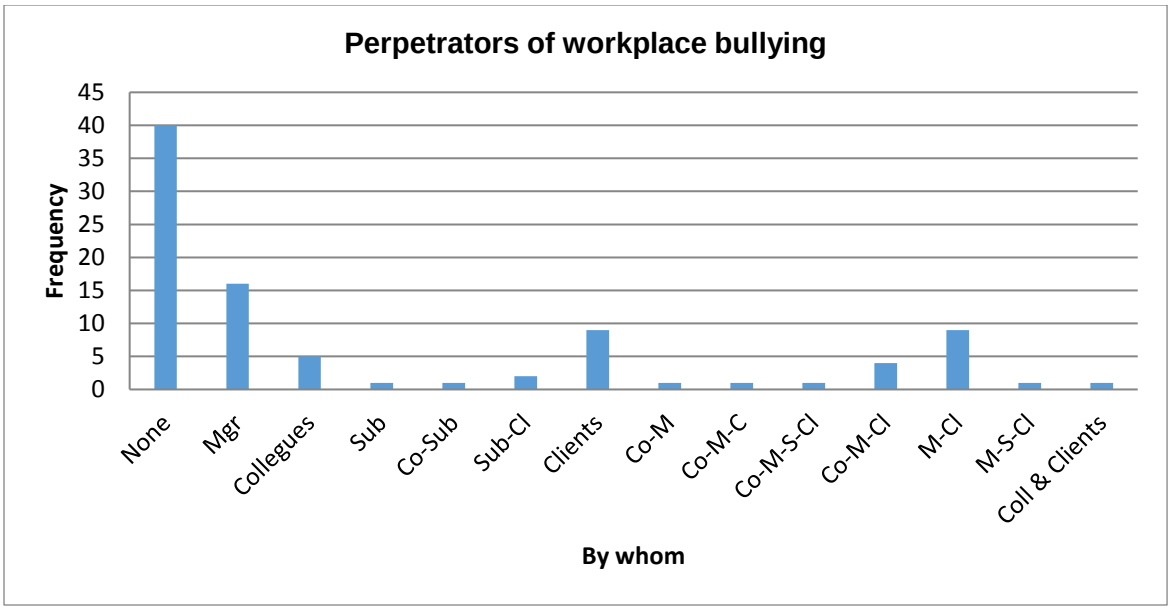


Figure 4.8: Perpetrators of workplace bullying (n=91)

It is evident from figure 4.8 that 16(31.4%) of emergency nurses reported that they had been bullied by managers, while 9(17.6%) reported that they had been bullied by both clients and managers. About 9(17.6%) reported being bullied by clients only. Figure 4.8 further reveals 5(9.8%) had been bullied by colleagues only and 4 (7.8%) had been bullied by colleagues, managers and clients, while 2(3.9%) were bullied by sub-ordinates and clients. About 1(1.9%) were bullied by sub-ordinates, 1(1.9%) were bullied by colleague and sub-ordinates, while others were bullied by1(1.9%)colleagues and managers,1(1.9%)colleagues, managers &clients, 1(1.9%) colleagues, managers, sub-ordinates and clients, 1(1.9%) were bullied by managers, sub-ordinates and clients and lastly 1(1.9%) were bullied by colleagues and clients.

At the end of the questionnaire, the respondents were given an opportunity to write more about their working conditions, stress, health & well-being and other aspects affecting them.

Findings from the open-ended last section of the questionnaire are described in this section.

In this study, the open-ended responses were categorized into groups; themes were identified and formulated, and then tagged with a code. The information was presented in a graph and then

analyzed (e.g. the multiple response questions). There were 16(17.6%) responses from the open-ended question and four (4) themes were derived and coded. These were:

- Psychological effects
- Lack of resources
- Lack of trust
- Exposure to infectious diseases

Respondents were given a chance to express themselves by also answering an open-ended comment:

"Here you may write more about your working conditions, stress, health, etc".

Psychological effects of working in the ED indicated by the respondents included:

"*Working conditions in this unit are unpleasant, stressful, depressing and management is unprofessional, one wonders how they were appointed as manager. They don't care, we work like slaves, short staffed and no respect. We are not even consulted, we are very, very angry and an angry person will make stupid decisions".*

" work in a trauma casualty and most of the time briefing sessions are not offered. I am not sure if the people around here (Management in the department), have insight about mental health, emotional well-being of us as their employees. I am very saddened about the situations, we deal with all kinds of patients, rapists, drunk people, and criminals and yet we have to treat them equally. It gets me emotionally".

"It is hard at times to cope with what we see at work. At times we talk about it but it stays there".

"Patients' family do not respect us, they do not appreciate what we do for them and at times shout at us".

The other theme that was identified was **Lack of resources**. The respondents stated that it was difficult to fulfill their duties with a shortage of resources (both human and material).The respondents expressed that they were overwhelmed by staff shortages which lead to work overload and fatigue. The responses were:

"My working condition is so stressful, due to shortage of staff, poor management lack of resources, negative staff attitude. Staff shortage is a big challenge, we become exhausted and are in stressful situations always".

"We work under strenuous environment where there is high volume of patients in relations to shortage of staff. Working hours are strenuous especially when changing from day to night the body does not adjust well. Shortage of resources like medication and other materials.

"Shortage of staff leads to over stretching, lack of equipment which makes working hard."

Lack of trust was the second theme identified. The respondents felt that there was not enough trust between managers and subordinates. They felt that the managers misused their power, had poor conflict resolutions skills, and that they as workers did not have the right to express themselves. The responses were:

"At my workplace supervisors and patients have more right than nurses. A matron can come to your workplace and start undermining you as the junior in front of patients. As a junior nurses you are not allowed to defend yourself against accusations labelled at you".

Management does not listen to us then don't treat us fairly. They don't attend to our work problems and they don't recognize our hard work".

It is really difficult and stressful to work in an environment that has no management skills, where managers do not appreciate your hard work. I wish nurses were taken seriously and importantly like every other profession. The working environment & equipment has bad influence on our performance. Change is needed to empower nurses to work with joy and confidence".

"There is favoritism from management which leads to people not getting along".

The fourth theme that was identified was "**Exposure to infectious diseases"** in the workplace. The respondents expressed that there was very little done to keep them safe from infections in the workplace. These were their responses:

"We are also exposed to patients with infectious diseases before they are diagnosed and we are at high risk".

"If there is an infectious disease we do not even get screening have been moved out".

4.3 DISCUSSION OF THE MAIN RESULTS

A discussion of the main results of the study is given in this section.

4.3.1 Section 1 -Socio-demographic data

In this study, the age group of between 31-39 years had the highest number of respondents. Literature also identifies this age group as the most active workforce. Cardillo (2011) believes that this age group is quick to respond and always think on their feet. As the nurse ages, he/she becomes slower to react to emergency situations, however, these older nurses are very experienced and mostly willing to teach younger, less experienced nurses (Mason, O'Keeffe &Carter, 2016). Experienced nurses enforce teamwork and possess critical thinking skills which is vital for optimal patient care (Alzghoul, 2014). New nurses need to learn to adapt to urgent situations, work autonomously, and become critical thinkers (Cardillo, 2011).

Experience in the nursing field is important for patient care and provision of quality nursing care. ED nursing is a specialty area, and trauma trained nurses are trained to face challenging situations and deal with raw emotions & physical trauma (Bratianu, 2010). In this study, there are few nurses who have actually been trauma educated, most of the nurses are professional nurses.

4.3.2 Section two of the questionnaire: COPSOQII

In this study, the aim was to describe the psychosocial hazards of nurses working in emergency departments.

4.3.2.1 High risk dimensions that need immediate attention

Work Pace, Emotional Demands of Work, Appreciation & Recognition, Job Satisfaction, Justice& Respect, Burnout and Stress.

4.3.2.1.1 Work pace

The emergency department being the entry point into a hospital often contributes to 40% of hospital admissions (Curtis & Waters, 2014). EDs are the busiest department in a hospital with a high patient turnover (Kennedy, 2014).The one hospital in the current study admits about 350 patients per day. About 70% (245) of all admissions are emergencies (Gauteng Department of Health, 2017). Set standard ratio of nurse-patient is 1:4 but with the staff shortages nurses are attend to about 6 to 10 patients in a 24 hour day per hour which demonstrates that the work pace in the ED is pressurized and fast paced (Ramsey, Palter & Bailitz, 2018). Anecdotal evidence

exists that other patients are sometimes nursed in the EDs of central hospitals in Johannesburg because no beds are available in other wards.

In this study, results indicate that ED nurses practice at a very fast work pace - which is supported by Kennedy, (2014) and Greenslade et al (2017) who note that nurses work under high pressure in EDs. The same authors conclude that these conditions are exhausting, draining, and often lead to fatigue (Kennedy, 2014 & Greenslade et al.2017).

ENs are faced with challenges imposed by working in an environment which is more often characterized by a high demand of care which requires critical thinking, initiative, emotional stability, and management skills (Santos, Lima, Pestana et al, 2013).

It involves being a multi-tasker and being able to switch roles as the need arises (Forseberg, 2015).

4.3.2.1.2 Emotional work demands

According to the COPSOQII questionnaire, emotional work demands involve emotionally disturbing situations relating to other people's personal problems (Arbejdsmiljo (2011).The authors Johnnessen, Tynes & Sterud (2013:605), define emotional demands as 'dealing with strong feelings such as sorrow, anger, depression and/or frustration at work'. A case study conducted in Norway on the working age population, by Johnnessen et al (2013), revealed that emotional work demands contributed to the development of psychological distress, which presents as anxiety and depression and is linked to poor productivity at work and high absenteeism.

Rugless and Taylor (2011) conducted a study in Australia among ED nurses and medical practitioners to examine sick leave patterns and to compare nurses' and doctors' psychosocial work conditions. The results of the Australian study demonstrate that ED nurses experience high psychological/emotional demands, similar to this current study which revealed that ED nurses in the two central hospitals experienced fatigue and frustration which could be contributory factors to depression in the work place.

Emotional demands can lead to compassion fatigue, which is a term used to describe weariness and stress experienced by most nurses working in the emergency departments (Crilly et al, 2017).

According to the outcome of a study in Ireland on ED and medical nurses by Harkin & Melby (2014), emotional work demands is an issue that needs to be addressed. Nurses in emergency departments felt very little was done to address their emotional needs and mental health. The outcome of the Irish study is similar to this present study in which emotional demands were rated as a high risk dimension that required immediate attention.

In this study, conducted in the two Johannesburg Central Hospitals, it became clear that nurses were affected by the emotionally disturbing situations they are faced with in the ED. These nurses also stated in the study that they needed to relate to other people's problems, in the workplace. The authors Adriaenssens et al (2011 :1317-1328) state that," Nurses are exposed to various pathologies in the emergency department, like being in contact with human suffering, death, and victims of rape, They are exposed to violent patients or relatives and infectious diseases". The presented literature correlates with the results from this study, indicating that ENs relate to their patients' problems.

4.3.2.1.3 Appreciation and recognition

The act of being appreciated and recognized in the workplace means that the worker is constantly shown his/her worth, by being complimented and praised or given a pat on the back, to show that his /her input is valued (Lefton, 2012).

A study conducted in Shiraz, Iran, in three teaching hospitals, by Gholamzade, Sharif & Rad (2011), revealed that the biggest stressor among nurses working in emergency departments, was a lack of support from nursing supervisors. The results from this study revealed that nurses working in ED felt unappreciated and unrecognized by their supervisors and managers. If the problem is left unaddressed, it leads to the staff being demoralized & stressed and to a high staff turnover, as evidenced by the study conducted in Iran in 2011.

4.3.2.1.4 Job satisfaction

Job satisfaction is defined as a positive feeling that one has about his/her job/ employment (Liu, Zhang, Ye, Zhu, Caa, Lu & Li (2012) & Wang (2012).

The nurses working in the two Johannesburg hospitals revealed that they were dissatisfied with their work/jobs. A study done by Suarez, Asenjo and Sanchez (2015), in Spain, on job satisfaction among ED nurses, doctors, administrative staff revealed that nurses and doctors had less work satisfaction than the administrative staff. The study concluded that their work satisfaction was not high. The results in the current study are also supported by the Report from the National

Healthcare & RN Retention, 2014, by Helbing & Teems, which revealed that nurses working in emergency departments had a 20.3% work turn-over. They gave their reasons for leaving as being overworked, lack of professional growth, little or no respect, no teamwork among co-workers, and poor communication with managers.

Lack of job satisfaction is demoralizing to individuals, and hospitals suffer due to high staff turnover and shortages which lead to poor quality of care and longer waiting times in EDs.

4.3.2.1.5 Justice and respect

For any department to function successfully, the manager has to plan for the day, week, month and a year ahead. Daily plans should be reviewed on a daily basis and involve the nurses. Workers' contributions should be considered critically but with respect (Suarez et al, 2017).

In this study, respondents indicated that they were treated unfairly in the workplace. They also felt that their opinions were not considered. Managers/ supervisors are highly work-oriented and do not much value input form their sub-ordinates. Literature shows that managers are mostly concerned with patient care and satisfaction and may, therefore, put pressure on the already exhausted nurse (Oliveria et al, 2013).

Poor communication in the workplace can result in conflicts. For a manager to practise fairness, he/she should be a good communicator and a good listener.

Effective communication is essential in the ED, as ineffective communication can lead to conflict (Oliveria et al, 2013). Turley (2015) states that, "The goal of effective conflict resolution is to optimize immediate outcomes and improve subsequent interactions, and that success depends on being aware of one's own communication styles and the needs of the other party".

It is important that conflicts are resolved in a fair manner and with respect. Managers should build a working relationship with their subordinates, as this reduces conflicts, absenteeism, & high staff turn-over, and improves team work and job satisfaction (Twibell & Townsend, 2011).

4.3.2.1.6 Burnout

Burnout is described as a feeling of physical and mental/ emotional depletion, mostly associated with prolonged exposure to stressful situations or environments (Sibanda, Mambende& Maunganidze, 2017). Burnout is described as being associated with fatigue & frustration, and it affects work performance in a negative way (Lambardo, 2011).

In the present study, burnout was indicated as a psychosocial hazard that needed immediate attention. Burnout can be attributed to the heavy work load, many patients, people with serious injuries, shortage of staff and undue pressure & demands in the work-place (Morrison & Joy, 2016).

A cross-sectional study was conducted in Palestine, in 2015, by Hamdan & Hamra about workplace violence towards workers in the EDs. The study showed that high levels of emotional exhaustion was experienced by 69.8% of nurses and high levels of depersonalization by 48.8%.The same study also concludes that burnout is associated with workplace violence.

Burnout can have negative consequences for the individual, the department, and the organization, as is evidenced in this study in the two Johannesburg Central Hospitals where a total of 61.5% of the ED nurses were affected by burnout. According to Johnston et al (2016), ENs often feel emotionally worn out due to high pressure and the demands of their work. They work at a fast pace, have very little time to rest in between patients, and, to top it off, there is pressure regarding productivity demands from the organization, the clients, and the relatives (Johnston et al, 2016).

4.3.2.1.7 Stress

Stress is an adaptive response to both internal and external factors which helps an individual maintain a state of equilibrium, both internally and externally (Stathopoulou et al 2010). Healthy stress makes ENs aware of their surroundings, gives them energy to complete tasks, and provides the ability to handle emergencies (Sichel, 2016). However, over time, if not properly managed, stress causes health problems like tension headaches, migraines, insomnia, weight gain/loss, depression, digestive problems, hypertension, cardiac problems, and even diabetes type 2 (Stathopoulou et al,2010).

The USA Occupational Safety and Health Institute has reported that the nursing profession is ranked as 27th of the 130 professions that have been studied with regard to work-related mental health problems. (Akbar, Elahi, Mohammadi et al, 2017).

Several types of stressors have been identified among nurses working in EDs of which excessive workload was the highest. Also listed are conflicts with doctors; problems with supervisors & colleagues, and dealing with death and problematic patients & relatives (Garcia-Izquierdo &Rios-Risquez 2012).

Nurses are constantly faced with many physical and psychological stressors in the workplace (Akbar et al, 2017). Organizational & work cultures can be workplace stressors, as they

encapsulate attitudes, values, and work practices that may negatively affect workers, both mentally and physically (Hooper et al, 2010 & Stathopoulou et al, 2011).

A study conducted in India (2013), among ENs, revealed that about 20.93% of nurses suffered from severe stress, while 65.11% suffered from moderate stress. These nurses reported that their functioning at work was negatively affected due to stress (Singh, 2013).

Fifty six (61.5%) of the registered nurses practising in the two EDs, of the current study, are experiencing stress at a high risk level, as demonstrated by the results. These nurses tend to have reduced morale and poor judgement leading to individuals making mistakes in the workplace (Crilly et al, 2016).Stress has a negative impact on ENs, as it compromises their ability to accomplish delegated tasks and alertness and focus is reduced which leads to poor decision making, poor judgment, anxiety, and apathy (Akbar et al,2017).

4.4. MEDIUM RISK: YELLOW COLOUR CODE

The yellow colour code, according to the COPSOQII Colour Code, is rated as issues requiring attention

The issues requiring attention were:

- Role clarity
- Leadership quality
- Social support from superiors
- Work/family conflict
- Management /worker trust
- Self-rated Health

4.4.1 Role clarity

Role clarity means understanding what your role is within the team and involves knowing what needs to be done and what is expected to be done (Lankshear, Rush, Weeres& Martin, 2016).

Roles should be clearly clarified, as this improves performance in the health care team. Clear and defined roles, define and set clear boundaries, and as roles are interdependent and complementary to each other, maximum use of team capabilities is possible (Khademian, Sharif, Tabei et al, 2013).

The authors Khademian et al (2013), in their study conducted in 2013, discovered that mostly the nurses with little trauma experience felt that there was a lack of support and clarity about their roles in the trauma team, and that there was also confusion about leadership and managerial styles. When roles are defined in the workplace, workers tend to work more efficiently and produce very good results (Hasan, 2017). This study revealed that ED nurses had poor role clarity, and based on the literature, poor role clarity can lead to stress, which, if not addressed, leads to poor patient care, high staff turnover, absenteeism, and staff shortages (Coburn & Gage-Croll, 2011).

4.4.2 Leadership qualities

According to Hasan (2017), a good leader has, 'futuristic visions and knows how to turn his/her ideas into success stories. These qualities include being honest at all times, and being confident, committed and passionate about his/her vision. The good leader has good communication skills, good decision making capabilities, and is accountable for all the short falls in the department. The good leader knows how to delegate duties according to skills and experience, is creative, empowers subordinate, and is empathic'.

Results in the current study show that nurses in ED are neither satisfied with the quality of leadership from their managers/ supervisors, nor with their planning abilities.

The emergency department is one of the busiest departments in the hospital and is usually coupled with a lot of chaos, therefore, it operates in a unique way (Kennedy, 2014). Supervisor and managers have to ensure that these units are run smoothly to ensure quality healthcare, and at the same time, ensuring nurses are at optimal health to perform these tasks (Twibell& Townsend, 2011). Managers and supervisors have to foster teamwork, ensure that communication between team members is good, have an open door policy, and also a structure in place for conflict resolution (Mahmoudi, & Mohmmadi, 2013). Good supervisors and managers have contingency plans in place, and they are always aware of changes in the department (Turley, 2015). They know their team members' weaknesses and strengths and build on these strengths and improve the weak points (Oliveria et al, 2013). Leaders have to continuously assess the department and have strategies in place for unexpected events of any kind, from both patients and members of staff. If a leader is rigid and resistant, the subordinates will be rigid and resist change. (Suarez et al, 2017). A leader's attitudes will make or destroy the health team in ED (Suarez et al, 2017). A positive working environment will yield positive results (Seow, 2013). Leadership qualities need to be addressed, according to this study.

4.4.3 Social support from superiors

The authors Nahum-Shani, Bamberger & Bacharach (2011:123-139), define social support as, 'behavior that leads the subject into believing that she is to be cared for, and loved & valued as a member of a network of mutual obligation' which involves emotional support, informational support & approval support.

- Emotional support involves being empathetic, and showing love and care to the person confiding in you.(Ebrahimi et al, 2016)
- Informational support is concerned with providing advice/information, especially in times of need. This information may be used to either solve current problems or help deal with them. (Nahum-Shani, Bamberger & Bacharach, 2011).
- Appraisal support is part of informational support which emphasizes communication as the basis of all solutions to problems that the unit may face. (Nahum-Shani, Bamberger & Bacharach, 2011). Members of the health team need to be constantly appraised and encouraged to lift their spirits and to improve job satisfaction. They need to be *heard*.

A study in 15 Flemish (Belgian) General Hospitals revealed that of the 248 nurses who participated in the study, 1 in 3 of the emergency nurses suffered from anxiety, depression, and somatic complaints. They felt that if management was supportive, communicative, empathetic, and provided time out facilities and psychological counselling for emergency nurses, they would be able to cope better in the workplace (Adriaenssens et al, 2012).The same authors report that with good support from supervisors and colleagues nurses tend to have a lower rate of developing PTSD symptoms.

4.4.4 Work/ family conflict

It is difficult to strike a balance between work and life, as nursing is demanding, and nurses work shifts and long hours (Newman, 2014). Nurses who work longer hours usually take time to recover on their days off which negatively affects the family since there is little time for them (Boertjie & Ferron, 2013). From the OHNP point of view, it is important to get proper rest and to balance work and life. ED nurses are encouraged to take care of their physical, mental, and social health. Nurses can balance work and life by reducing stress and burnout, advocating for 6 to 8 hour shifts instead of 12 hour shifts, and also making plans to spend time with family and friends (Ericksen, 2016).

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Nurses working in ED are exposed to a lot of psychosocial hazards and these impact negatively on them. They are exposed to stress, fatigue, burnout, depression and other mental health issues. With all these health problems it becomes difficult to strike a balance between work and family life. When there is an imbalance, families become dysfunctional, and there is divorce, alcohol misuse and chronic illnesses like hypertension, and even mental illness (Sarafis et al, 2016 & Borodignon & Monterio, 2016). In this study, about 58.2% of ENs reported not being able to strike a balance between work and life, and they reported that they were tired most of the time due to work pressures. The results of the current study is in line with a study conducted in Singapore (2014) among nurses working in hospitals, where the results revealed that most nurses spent more time on their work than on their private lives (Kowitlawkal, Yap, Makabe et al, 2018).

4.4.5 Management/ worker trust

Trust is rated to be the biggest key component of a healthy environment. (Twibell, 2011). The same author further explains that, “Trust among healthcare workers is built, weakened, or destroyed on a daily basis”. If there is trust in the workplace, more work gets done. Trust buffers stress, reduces absenteeism, and improves job satisfaction, staff morale, and staff retention (Twibell 2011). A study in the Health Education Centres of Isfahan in Iran (University of Medical Sciences) on 165 nurse managers and administrators, in 2012, revealed that the major feature of high performance in the work place is mutual trust among the members of a team. If nurses trust their managers, they feel empowered, and they go an extra mile (Bahrami, Hasanpour, Rajaepour et al 2012). The results of this current study revealed that ENs did not completely trust their managers. A study conducted on nurses in Turkey (2017) revealed that trust in their managers was low while trust in their colleagues was high (Basit &Duygulu 2018). Therefore nurses and managers need to build a relationship of trust, as this strengthens the team and improves the quality of care for their patients.

4.4.6. Self-rated health

Self-rated health is self-assessed health or perceived health. Self-rated health is how the individual rates his/her status of health on a 1 to 5 Likert point scale, from excellent to poor (Wood,

2015). A healthy workplace should have factors that influence positivism. A negative/ unhealthy workplace has negative outcomes like stress, a lot of sick leave taken, a high rate of staff resignations/staff turn-over, development of chronic illnesses, and the onset of mental conditions like burnout (Johnston et al 2016). ED nurses, according to this study, show poor health (57.3%). If nurses are unhealthy, time is lost due to sick leaves, staff shortages, and longer waiting time for patients thereby increasing complaints, violence and threats (Ericksen, 2016) .When nurses are not coping well, this results in poor health and they develop diseases like cardiac problems, stress ulcers, cancers, diabetes mellitus and musculoskeletal disorders (Wood ,2015).

4.5 THE OFFENSIVE BEHAVIOR DOMAIN

4.5.1 Bullying

Bullying is defined as someone who is vulnerable being mistreated and abused by someone who is stronger or more powerful than he/she is (Dalton, 2016). The same author further explains that bullying may be horizontal and/or vertical. Horizontal bullying takes place when an employee targets another employee of the same level, while vertical bullying happens between a manager and his/her subordinates (Dalton, 2016 & Spector et al, 2014).

Bullying includes behavior that involves the abuse of position. It includes intimidating, degrading, offending, or humiliating the weaker person, mostly in front of co-workers or the public (Spector et al, 2014). The victim feels useless & defenseless and is robbed of dignity. Bullies like to show that they dominate; they are mean and controlling (Stokowski, 2010).

In this study, the prevalence of bullying was 43.9%. The high prevalence of bullying reported in this study is cause for concern and needs to be addressed because bullying has negative effects on the victim's social life, both inside and outside of the institution (Dalton, 2016).

About 40% of the respondents in this study reported that they had been bullied by their managers. In a study conducted in the Free State in 2013 on bullying among nurses revealed that prevalent behaviour of bullying included: flaunting one's status or authority ,interrupting a person while speaking, been excessively monitored at work and belittling someone's opinion(Du Toit, 2013).This is vertical violence as it involves a person who holds a high position and a subordinate. Spector et al (2015) suggests that nurses are the only people who can end all forms of violence in their work place by raising awareness about bullying, by reporting workplace violence, and also by developing anti-violence teams/committees.

4.5.2 Threats of violence

A study conducted in Istanbul, Turkey revealed that 74.9% of nurses working in EDs had been exposed to verbal and physical violence within the past 12 months (Pinar & Ucmak, 2011). They reported that patients' relatives (45.7%) were the main instigators of violence, followed by patients, themselves (23.6%), especially males (Pinar, Acikel, Pinar et al, 2015). In this study, 26.4% of the nurses had been exposed to threats of violence within the past 12 months of working in the ED. By November 2017, more than half of the respondents (58.5%) had reported that they had been subjected to threats of violence by clients, some on a daily basis (14.6%).The current study coincides with the study conducted in Istanbul, Turkey, as clients were the instigators of violence in the two Johannesburg Hospitals.

A study conducted by Alhantly et al (2017) in Riyadh, Saudi Arabia, confirmed that verbal violence was the most prevalent form of violence against nurses. The authors reported that in their study, 61% of reported cases were of verbal abuse, mostly from relatives (80%) and/or from clients (51%). Preventing violence will ensure both a safe workplace and patient safety, in health institutions. It will also reduce the prevalence of mental health and other physical health problems (Hassankhani, Parizad, Gack-Smith et al, 2018).

4.5.3 Sexual Harassment

Sexual harassment is a form of sex discrimination that usually occurs in the workplace. It includes requests for sexual favours, unwelcome sexual advances, and verbal or physical conduct of a sexual nature which creates an offensive and hostile environment (Chuck, 2018).

A study by Boafo et al (2016) in Ghana, among nurses, showed that 12.5% of the participants had experienced at least one incident of sexual harassment, and that 50% of the instigators of sexual harassment had been medical doctors. Mostly owing to the hierarchical system used in the hospitals, hegemonic gender relations, and acceptance of sexual harassment as normal, there is little or no reporting of such cases (Boafo et al, 2016). A separate study by Franz et al (2010) carried out in Germany, revealed that 38.8% of the respondents had been sexually harassed in the 12 months prior to the study.

In a study conducted in the USA (2018) on nurses working in emergency departments, about 71% of the nurses stated that they had been sexually harassed by a patient within the past 12 months

of working in an ED (Sampsel, 2018). The literature concedes with the current study where 14.3% of the respondents reported having been sexually harassed in the workplace, and 61.5% of the respondents stated that they had been harassed by clients. Sexual harassment affects both the social and work life of the victim, their physical and emotional domains, and also their surrounding relationships (Sampsel, 2018).

4.5.4 Physical violence

Physical violence is defined by Stene et al (2015:113-117) as, " the intentional use of physical force with the potential for causing death, disability, injury or harm, which includes but is not limited to, scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, burning, use of restraints, or using one's body size or strength against another person".

Workplace violence involves the perpetrator being physically aggressive which may or may not cause injury (Abbas & Selim, 2011). The International Labor Office, International Council of Nurses, World Health Organizations and the Public Service have set guidelines to address issue of workplace violence (Schmidt, 2012).

Workplace violence, according to international studies, is on the increase, especially against workers in EDs (Burton, 2010). According to a study done in Palestine, 32% of physicians and 76.2% of ED nurses suffered from workplace violence. In the current study, a total of 13.2% of the respondents had been exposed to physical violence in the workplace, and 91.6% of the respondents stated they had been assaulted by clients. The results of this study tally with a study conducted in Australia (2011) among the nursing staff working in the ED, where about 60-90% of the nurses reported having been exposed to patient related violence (Pich &Kable, 2011).In a study conducted in South Africa by Jaffel (2016) on healthcare workers, nurses and doctors were found to be at risk of WPV, with about 73% of the participants exposed to psychological violence, 34.2% exposed to physical violence and patients(64.5%) were the perpetrators of WPV.

Workplace violence has a negative impact on nurses with psychological and physical effects. Nurses who are exposed to physical violence tend to become fearful, angry, and frustrated, and in most cases, feel helpless (Gillespie, Gates & Berry, 2013). They may at times exhibit signs of post-traumatic stress disorder where symptoms such as avoidance of the issue, flash-backs of events, and problems with sleep (Pich et al, (2011) & Gillespie et al, (2013) are presented.

4.6 RESULTS FROM THE OPEN ENDED COMMENT

The majority of the respondents expressed that they had been exposed to negative psychological effects:

- *As I am new in the department, I am gaining experience in a lot of things, gaining knowledge but it is very stressful and strenuous.*
- *The working conditions are not conducive and managers are not supportive with stress related problems and they don't even care about our health.*
- *"I am not coping well".*
- *Lack of debriefing and refusal to grant unplanned leaves lead to burnout making it hard to enjoy work.*

According to Schmidt & Haglund (2017:317-322), "Debriefing after adverse outcomes, following a structured model, has been used in healthcare as a non- threatening and relatively low cost way to discuss unanticipated outcomes, identify opportunities for improvement, and heal as a group".

Trust between managers and subordinates was identified as an issue that bothered most of the respondents:

- *Managers are always shouting at members of staff.*
- *There autocratic leadership styles from most supervisors/ management leading to unit disorganization and miscommunication.*
- *Favoritism from management leads to people not getting along.*

Trust between nursing managers and their subordinates is very important, and trust is an effective attribute of a good manager. When nurse managers inspire trust with their subordinates, it yields positive organizational outcomes and empowers staff (Mullarkey, 2011).

Another theme that was identified was **lack of resources** in the workplace, both human and material

- *Staff shortage has a negative impact, we are always overwhelmed and over worked and there is no ample empathy to our struggles.*
- *We work under pressure with more workload with few staff.*
- *Shifts are tiring, being day shift for 2 days the 3 night shifts, its tiring coupled with shortage of staff and material resources.*

Emergency departments operate at peak capacity and are mostly unable to meet all demands on their resources. The nurses are overstretched, experience burnout, and cannot meet the demands of patients. Lack of resources is worse when there are natural disasters, pandemics, or terrorist attacks (Yarmohammadian, Rezaei, Haghshenas et al, 2017)

The final theme that was identified was "**Exposure to infectious diseases**"

- *Patients come with different diseases at times infectious and nurses are at risk. There is no prophylaxis, no preventive measure.*

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When patients who are seen in EDs present with injuries or are critically ill seek health care, it is not always known that the patients could be harbouring communicable diseases which could be spread to unsuspecting health care workers and other patients (Lisang, Theodoro, Schuur et al (2014). The authors also indicate that it is easy to overlook the issue of infection prevention amidst saving a life and other emergency situations.

Emergency departments are deemed as the most dangerous areas in hospitals for nurses, mostly due to upset families, angry patients, and personal confrontations which happen in EDs. (Filion, 2016). To prevent workplace violence, nurses have to anticipate problems before they occur, and there should be ongoing staff training regarding the diffusion of potentially volatile situations with families and patients (Stene et al, 2015). Communication techniques, e.g. to keep tempers from flaring, need to be developed, and one way of doing this is calling for back-up when dealing with difficult patients (Filion, 2016).

4.7 SUMMARY

In chapter 4, the findings of the research study were presented using tables, bar charts, and descriptive statistics. The socio-demographic profile of the respondents was presented and described, and numerical data was described using means, percentages, and standard deviation.

According to this study, there were more females (83.5%) working in ED than males (16.5%), and there were more registered nurses (83.5%) than trauma trained nurses (16.5%), The mean age for the respondents who practised in ED was 34 years, with most respondents being in the 31-39 year age group (50.5%). Only 9.9% had worked in ED for than 10years.

In section two (2) of the questionnaire, *dimensions* (Questions 1-19 of COPSOQII) *identified as needing immediate attention*, were the following:

- work pace, emotional demands, appreciation and recognition, job satisfaction, justice and respect, burnout and stress.

While *dimensions needing attention* were:

- role clarity, leadership quality, social support from supervisors, work/family conflict, management/ worker trust, and self-rated health.

Areas that were *rated as good* were:

- quantitative work demands, influence on work, new skills development, meaningfulness of work, commitment to workplace, and predictability.

The offensive behavior domain (question 20-23 of COPSOQ II):

Bullying in the workplace was rated as high (56%) and the perpetrators of bullying identified as managers (31.4%). Respondents reported being exposed to threats of violence (45%) and the instigators of threats of violence were identified as clients (58.5%). Sexual harassment (14.3%) was deemed as a problem in the two Johannesburg central hospitals, and again clients (61.5%) were identified as the perpetrators of sexual harassment. In this study, the majority of the victims of sexual harassment were female (91.7%), with only 7.3% being male.

ENs were also exposed to physical violence (13.2%), and the biggest number of perpetrators of physical violence were clients (83.3%).

The open-ended question responses were analysed using quantitative content analysis and themes were identified and coded. The themes were the following: psychological effects, lack of trust, lack of resources and exposure to infectious diseases. Respondents expressed that they were exposed to negative psychological effects such stress, depression, and post-traumatic stress disorder which resulted in respondents having difficulties with coping in the workplace. Little trust between managers and subordinates was an issue that bothered them. They also felt that they were not appreciated and that their problems were not attended to. A lack of resources (human and material) was identified, and the respondents expressed being stressed out and exhausted by both staff shortages and a lack of material resources. The respondents also felt that they were not safe in the workplace as they were exposed to infectious disease from patients

during screening and in the cubicles. And, lastly, they felt disrespected by both patients and relatives.

The research findings, recommendations made and limitations of the study will be discussed in chapter 5.

CHAPTER FIVE

SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

A summary of the study and a description of the limitations and recommendations are provided. The conclusion is also stated in this chapter.

Describing the psychosocial work environment of nurses working in emergency departments was essential to this study regarding the psychosocial hazards that affect them.

5.2 SUMMARY OF THE STUDY

The objective of the study was to describe the psychosocial work environment of registered nurses practising in emergency departments, by means of the COPSOQII. A cross-sectional study was conducted in 2017 among emergency nurses practicing in the EDs of two Johannesburg Central Hospitals. Of the potential 161 nurses, a total number of 91 nurses participated in the study. In summary, the results revealed:

Socio-demographically:

There were more females than males in the two EDs, and there were more registered nurses (83.5%) than trauma trained nurses The age group of between 31-39 years had the highest rate of while the respondents with the longest experience of working in the EDs were those who had worked there for between 1-5 years (50.5%).

In terms of **section two** of the questionnaire, the areas which needed immediate attention (RED) were the following: work pace, emotional demands of work, appreciation & recognition, job satisfaction, justice and respect, burnout and stress.

Dimensions that were rated as needing attention (YELLOW) were the following: role clarity, leadership quality, social support from superiors, work/family conflict, management / worker trust, and self-rated health. Dimensions that were rated as good (GREEN) were the following: quantitative work demands, influence on work, new skills development, meaningfulness of work, commitment to work place, and predictability.

The last question was an open-ended comment, where the respondents rated exposure to psychological effects as the highest in the work place, followed by lack of trust, lack of resources and exposure to infectious diseases respectively.

5.3 LIMITATIONS

The study was restricted to the emergency departments of two central hospitals in Johannesburg, only. Therefore the results cannot be generalized to include the registered nurses in other central hospitals in Johannesburg or in the Republic of South Africa.

The COPSOQ II is a relatively long questionnaire, which could have influenced why so many of the nurses did not complete it.

Data was collected by means of questionnaires, only, and therefore no triangulation took place by means of focus groups or interviews. Qualitative data collection methods could have added richer information to the quantitative data.

The time of the year when the researcher collected the data could have a bearing on why only there were fewer nurses in the emergency department, it was the time when many people go on annual leave.

5.4 RECOMMENDATIONS

The following recommendations are made based on the results from this study with regard to nurses practising in ED, nursing research, occupational health nursing education and practice, and hospital management.

5.4.1 Recommendations for nurses practising in EDs

Emergency departments of large central hospitals are known to be stressful work environments and many stressors are inherent in this workplace setting. It is therefore clear that stress cannot be eliminated totally. In the light of this, the following recommendations for nurses practising in EDs are made.

- Attend workshops on stress management so as to improve their knowledge of stress in general, i.e. how to identify stressors and manage stress more effectively.
- Maintain a healthy work/life balance as far as possible.

- Establish a support group in the ED.
- Advocate for a more positive practice environment and an integrated occupational health and workplace health promotion programme.

5.4.2 Recommendations for Nursing Research.

The current study focused on the description of the psychosocial work environment of nurses practising in only two EDs of the central hospitals in Johannesburg. Therefore, replication of this study in different settings such as in other provinces or in the private sector is recommended to provide additional evidence.

The ED nurses' coping behaviours, levels of stress, extent of burnout and PTSD, and status of general and mental health were not researched in these setting, and, therefore, further research on these topics is recommended.

5.4.3 Recommendations for Human Resources, Nursing, Executive Hospital Management, and the Occupational Health Department.

Occupational Health and Safety measures aim to improve employee health and well-being by encouraging nurses to develop healthy behavior like a good work/life balance (Scala, 2013).The employer is obligated to prove a safe working environment free from harassment, violence, threats, and physical harm (Spector et al, 2015).

The results of the study demonstrate that there is a need for managers and occupational health nurse practitioners to act as a team in putting first the health and safety of ED nurses, by means of:

- Applying the WHO/ILO Healthy Workplace Model (2010) to enhance the work/life balance and provide a more positive practice environment for nurses.
- Dedication and commitment to establishing and maintaining health & safety, and an organizational culture that is caring and conducive to promoting the health and well-being of health care professionals.
- Giving urgent attention to the implementation of a workplace-related violence policy, and taking extra measures to halt cycles of bullying.

- Implementing and evaluating an integrated occupational health and workplace health promotion programme and services put together by management, occupational health practitioners, and health and safety personnel in collaboration with all staff and based on their needs and risks plan.
- Avoid scheduling employees to work more than two to three consecutive night shifts to provide recovery time between shifts especially for employees on rotating shifts.
- Offering debriefing and counselling sessions with a professional like a psychologist after traumatic events, on a weekly basis, for members of EDs who may need it.
- An effective employee assistance program (EAP) may be put in place to help nurses to be financially healthy; to improve their mental health and life style through exercise, improved sleeping hygiene, and improved coping strategies in their busy working environment (Schmidt, 2012).
- The Human Resources Management (HR) can employ more nurses in the ED to reduce shortages, which will improve the nurse-patient ratio and reduce the workload (Wu, Sun& Wang, 2012).

5.4.4 Occupational Health Nursing Practice

Psychosocial hazards were identified, and for these to be dealt with properly, (i) occupational health service providers (occupational health nurse practitioners and occupational health medical practitioners), (ii) human resources management, and a (iii) clinical psychologist should be involved to provide the appropriate resources.

The mental and physical health of nurses working in emergency departments is taken care of by occupational health nursing practitioners (OHNP). The Occupational Health Medical Practitioner (OHMP) and Human Resources (HR) department need to find the best ways to manage problems like debriefing, counselling, and involving an industrial psychologist (Grainger, 2011). Occupational health nurse practitioners have the obligation to advocate for the health and safety of workers in the workplace (Acutt & Hattingh, 2015).Nurses perform at their best when they are healthy, and optimal employee performance is necessary in the health sector.

Part of occupational health nursing is providing a health promotion programme as a strategy to help tackle psychosocial hazards. Health promotion means encouraging supportive conditions that favor health (Grainger, 2015), and can be done in the following ways:

- Identifying psychosocial and organizational hazards through health surveillance and surveys done by the occupational health nurse practitioner.
- Involving the clinical psychologist in the assessment of the psychosocial hazards that affect nurses working in EDs and offering psychotherapy for those affected.
- Comprehensively assessing all risks and hazards in the workplace, for nurses.
- Educating nurses on healthy behaviour and early signs of psychological ill- health.
- Providing supportive care for nurses affected by psychosocial hazards, together with their families.

5.5 CONCLUSION

Emergency nurses describe their psychosocial work environment as a workplace setting in which they practise at pace and pressure and are exposed to high emotional demands with low appreciation, recognition, work satisfaction, justice and respect. In addition, burnout and stress are also highly present. From an occupational health nursing perspective, these stressors require attention.

The psychosocial work environment is further more described as one that lacks role clarity, leadership quality, social support from superiors, and trust between management and nurses. In addition, the work environment leads to nurse/ family conflict and compromises nurses' health. From an occupational health nursing perspective, these stressors require attention.

What the ED nurses rated as positive/good in their psychosocial work environment was mainly: work organization and job content; influence on their work environment, new skills development, meaningfulness of their work, commitment to workplace, and predictability. The quantitative work demands on them were also rated as good/positive.

Regarding the four dimensions of the offensive behavior domain - sexual harassment, threats of violence, physical violence, and bullying - ED nurses reported being exposed to sexual harassment (mainly by users of health care), being exposed to threats of violence & acts of physical violence; and the majority being bullied in the workplace. ED nurses described the perpetrators of bullying as ranging from managers, clients, and colleagues to subordinates.

Moreover, some ENs described their work environment as one in which working conditions are not conducive to good health because managers are not supportive and do not care about their health. Shortages have a negative impact as does being overworked with little appreciation. Debriefing sessions are not being offered. Doubt is cast on the unit managers' insights about the mental health and emotional well-being of their employees, as can be seen in the quote here below:

"I am saddened about the situation, we deal with all kinds of criminals, rapist and drunken people and we are expected to treat all clients equally". Managers do not help us with stress related problems and they don't even care about our health. If a client has a communicable disease and not properly screened all the nurses are exposed to the disease."

In the two Johannesburg hospitals researched, it appears that there is currently not enough psychosocial support for the nurses working in the EDs.

It is believed that this study will contribute to the body of knowledge regarding the psychosocial work environment of nurses in EDs. The research results will create awareness of the psychosocial hazards that nurses in ED are exposed to, so that a healthy and safe work environment can be created where nurses feel safe. As stated in the Occupational Health and Safety Act, No 85 of 1995 as amended, nurses need to feel and be safe in their working environment.

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APPENDICES

APPENDIX A

DESCRIPTION OF THE PSYCHOSOCIAL WORK ENVIRONMENT OF EMERGENCY NURSES IN TWO JOHANNESBURG CENTRAL HOSPITALS

PARTICIPANTS INFORMATION LEAFLET

Dear colleague

I am Nokuthula Masuku, an MSc (course work) student at the University of the Witwatersrand, conducting a study on in the psychosocial work environment of Nurses working in Emergency Departments' in two Johannesburg Central Hospitals in South Africa. The research study is part of my academic requirement to obtain my MSc (Nursing) in Occupational Health.

Research is a process conducted to answer questions. In this study I want to learn about the psychosocial work environment of emergency nurses. Stress and burnout in emergency nursing has been researched as is evident from the literature. However no comprehensive description and analysis of the psychosocial work environment of emergency nurses in Johannesburg hospitals was found in the literature.

I hereby invite you to participate in this research study.

To participate in the study you are requested to complete a questionnaire on the psychosocial work environment and place the completed questionnaire in the sealed box provided in your department.
The questionnaire will take about 20- 25 minutes to complete. Completion of the questionnaire will be seen as informed consent.

Your participation in this study is voluntary and you can decide to withdraw from participating at any time without any penalty. Confidentiality and anonymity will be ensured, as the researcher will use numbers for reporting the results. There will be no direct benefit to you, but the findings of the study will be made available to you once it is complete
Completing the questionnaire could trigger trauma (a trauma trigger is an experience that triggers a traumatic memory in someone who has experienced trauma. A trigger is thus a troubling reminder of a traumatic event, although the trigger itself needs not be frightening or traumatic).

Should you experience trigger trauma or any emotional discomfort please contact Annalie van den Heever at 011 488 4061 or 0832589953

Your participation is important and thank-you for your willingness to participate. You may contact my study supervisors Agnes Huiskamp and Nokuthula Mafutha at the University of the Witwatersrand at 011 488 4267 if you have any questions.

Nokuthula Masuku Email:nokuthulakhumalo77@gmail.com

APPENDIX B

R14/49 Nokuthula Masuku et al

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M170603

NAME: (Principal Investigator)	Nokuthula Masuku et al
DEPARTMENT:	Nursing Education Chris Hani Baragwanath Academic Hospital Charlotte Maxeke Johannesburg Academic Hospital Emergency Departments
PROJECT TITLE:	A Description of the Psychosocial Work Environment of Emergency Nurses in Two Johannesburg Central Hospitals
DATE CONSIDERED:	30/06/2017
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	AA Huiskamp
APPROVED BY:	Professor P. Cleaton-Jones Chairperson, HREC (Medical)
DATE OF APPROVAL:	23/08/2017

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary in Room 10004,10th floor, Senate House/3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. I/We fully understand the conditions under which I am/we are authorised 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 resubmit to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. in this case, the study was initially review June and will therefore be due in the month of June each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX C

School of Therapeutic Sciences
Faculty of Health Sciences · Private Bag 3, Wits, 2050, South Africa
Tel: +27 11 717 2063/4 · Fax: +27 11 717 2065/086 553 5954 · E-mail: irene.janse.vannoordwyk@wits.ac.za · www.wits.ac.za

SUMMARY OF ASSESSORS FEEDBACK

Date of Assessor Group Meeting : 10 May 2017

Assessor Group : Group 3

Student Number : 850440

Student Name : N. Mbeuku

		Yes	No
i.	Revision of the protocol to the Supervisor / Head of Department: (**Candidates**: x1 copy of protocol, list of corrections (x1), supervisor's approval letter (x1) - submit to: Mrs I Janse van Noordwyk, Room 4B02, Level 4, Medical School)	✓	
ii.	Revision of the protocol to the satisfaction of the Assessor Group: (**Candidates**: copies of protocol (x2), list of corrections (x2), supervisor approval letter (x2) - submit to: Mrs I Janse van Noordwyk, Room 4B02, Level 4, Medical School)		
iii.	Revision of the protocol and resubmission of the revised protocol to the next Assessor Group Meeting: (**Candidates**: as per the guidelines for submission to an assessors meeting - submit to: Mrs I Janse van Noordwyk, Room 4B02, Level 4, Medical School)		
iv.	Candidate goes ahead		

Name and Signature of Chair of Assessor Group:

APPENDIX D

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITAL

Enquiries:
Ms. G. Ngwenya
Office of the Nursing Director
Tell: (011): 488 4558
Fax: (011): 488-3786
27 September 2017

Ms. Nokuthula Masuku
University of the Witwatersrand
Department of Nursing Education
Faculty of the Health Sciences
NHRD REF: GP_201708_048

Dear. Ms. Nokuthula Masuku

RE: "A description of the psychosocial work environment of emergency nurses in two Johannesburg Central Hospitals"

Permission is granted for you to conduct the above recruitment activities as described in your request provided:

1. Charlotte Maxeke Johannesburg Academic hospital will not in anyway incur or inherit costs as a 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.
5.

Please liaise with the Head of Department 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.M Pule
Nursing Director
Date: 2017/09/27

Approved / not approved
Ms. G. Bogoshi
Chief Executive Officer
04.10.2017

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

MEDICAL ADVISORY COMMITTEE
CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL

PERMISSION TO CONDUCT RESEARCH

Date: 29 Nov 2017

TITLE OF PROJECT: A description of the psychosocial work environment of Emergency nurses in two Johannesburg hospitals

UNIVERSITY: Witwatersrand

Principal Investigator: N Masuku

Department: Nursing Education

Supervisor (If relevant): A Huiskamp, N Mafutha

Permission Head Department (where research conducted): Yes

Date of start of proposed study: Dec 2017
Date of completion of data collection: Dec 2019

The Medical Advisory Committee recommends that the said research be conducted at Chris Hani Baragwanath Hospital. The CEO /management of Chris Hani Baragwanath Hospital is accordingly informed and the study is subject to:-

- Permission having been granted by the Human Research Ethics Committee of the University of the Witwatersrand.
- the Hospital will not incur extra costs as a result of the research being conducted on its patients within the hospital
- the MAC will be informed of any serious adverse events as soon as they occur
- permission is granted for the duration of the Ethics Committee approval.

.....
Recommended
(On behalf of the MAC)
Date: 29 November 2017

.....
Approved/Not Approved
Hospital Management
Date: 8/12/17

APPENDIX F

COPENHAGEN PSYCHOSOCIAL QUESTIONNAIRE (COPSOQII)

The questionnaire consist of two parts (demographic data) and part two (the psychosocial factors at work)

Part one: Socio-demographic information.

Please tick the appropriate block.

1. **How many years have you been practicing in ED?**

Less than 1 year ☐

1-5 years ☐

6-10 years ☐

More than 10 years ☐

2. **Are you a professional/ registered nurse or you are educated in trauma nursing?**

Professional Nurse ☐

Trauma educated Nurse ☐

3. **Gender**

Female ☐

Male ☐

4. **How old are you?**

Under 30 years ☐

30-39 years ☐

40-49 years ☐

50-59 years ☐

60 years or more ☐

5. **Which department do you work in?**

Pediatric emergency ☐

Medical emergency ☐

Adult emergency ☐

See the attached questionnaire for part two.

Psychosocial factors at work

NRCWE's short questionnaire for assessment of the psychosocial work environment

2007 edition



The questionnaire

The questionnaire was developed by the National Centre for the Working Environment (NRCWE, previously AMI), Copenhagen, Denmark. It was developed as a tool for workplace assessment of the psychosocial environment. When the employee have filled in the questionnaire, the overall results for the workplace and for each of the departments are calculated. This is a simple task due to the very simple scoring system. If the survey seems to indicate problems with the psychosocial work environment, the work environment committee or other relevant actors at the workplace should discuss how to act on the basis of the results. If help from the outside is needed, the workplace may contact consultants, the Labour Inspection, or relevant organizations.

The NRCWE has developed a user's guide for understanding and interpretation of results. This guide should be used in connection with the questionnaire. The guide also includes a short overview on the issue of "going from survey to action" in connection with the psychosocial work environment.

It is important that all ethical rules are respected in connection with the use of the questionnaire*:*

- Participation is voluntary. Nobody should feel under pressure to participate.
- The individual is anonymous. The results are calculated for groups so that the individual responses cannot be identified.
- All employees, who have contributed to the survey, are entitled to see the overall results.
- It is the company and it's department that are being studied. Not individual employees

Which department are you working in?

The following questions are about your psychosocial work environment. Please choose the answer that fits to each of the questions.

	Always	Often	Sometimes	Seldom	Never/hardly ever
1A. Do you get behind with your work?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
1B. Do you have enough time for your work tasks	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

1A. and 1B.Total number of points: _____ (Between 0 and 8 points)

	Always	Often	Sometimes	Seldom	Never/hardly ever
2A.Is it necessary to keep working at high pace?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2B. Do you work at a high pace throughout the day?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

2A. and 2B. Total number of points: ____(Between 0 and 8 points)

	Always	Often	Sometimes	Seldom	Never/hardly ever
3A. Does your work put you in emotionally disturbing situations?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3B. Do you have to relate to other people's personal problem as part of your work?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

3A.and 3B.Total number of points: _____ (Between 0 and 8 points)

	Always	Often	Sometimes	Seldom	Never/hardly ever
4A. Do you have a large degree of influence concerning your work?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4B. Can you influence the amount of work assigned to you?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

4A. and 4B. Total number of points: _____(Between 0 and 8 points)

	To a very large extent	To a large extent	Somewhat	To a small extent	To a very small extent
5A. Do you have the possibility of learning new things through your work?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
5B. Does your work require you to take the initiative?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

5A. and 5B. Total number of points: _____(Between 0 and 8 points)

	To a very large extent	To a large extent	Somewhat	To a small extent	To a very small extent
6A.Is your work meaningful?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
6B. Do you feel that the work you do is important?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

6A. and 6B. Total number of points:___ (Between 0 and 8 points)

	To a very large extent	To a large extent	Somewhat	To a small extent	To a very small extent
7A. Do you feel that your place of work is of great importance?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
7B. Would you recommend a good friend to apply for a position at your workplace?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

7A.and 7B. Total number of points: __ (Between 0 and 8 points)

	To a very large extent	To a large extent	Somewhat	To a small extent	To a very small extent
8A. At your place of work, are you informed well in advance concerning for example important decisions, changes, or plans for the future?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
8B. Do you receive all the information you need in order to do your work well?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

8A. and 8B.Total number of points:___
(Between 0 and 8 points)

	To a very large extent	To a large extent	Somewhat	To a small extent	To a very small extent
9A. Is your work recognized and appreciated by management?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
9B. Are you treated fairly at your workplace?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

9A. and 9B. Total number of points: ___
(Between 0 and 8 points)

	To a very large extent	To a large extent	Somewhat	To a small extent	To a very small extent
10A. Does your work have clear objective?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
10B. Does you know exactly what is expected of you at work?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

10A. and 10B.Total number of points: __
(Between 0 and 8 points)

	To a very large extent	To a large extent	Somewhat	To a small extent	To a very small extent
11A.To what extent would you say that your immediate superior gives high priority to job satisfaction?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
11B. To what extent would you say that your immediate superior is good at work planning?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

11A. and 11B.Total number of points:
___ (Between 0 and 8points)

	Always	Often	Sometimes	Seldom	Never/hardly ever
12A.How often is your nearest superior willing to listen to your problems at work?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
12B.How often do you get help and support from your nearest superior?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

12A. and 12B. Total number of points: ____(Between 0 and 8 points)

	Very Satisfied	Satisfied	Unsatisfied	Very Unsatisfied
13. Regarding your work in general. How pleased are you with your job as a whole, everything taken into consideration?	☐ 3	☐ 2	☐ 1	☐ 0

13. Number of points: _____
(Between 0 and 3 points)

The next two questions are about the way your work affects your private life and family life.

	Yes Certainly	Yes, to a certain degree	Yes, but only very little	No, not at all
14A. Do you feel that your work drains so much energy that it has a negative effect on your private life?	☐ 3	☐ 2	☐ 1	☐ 0
14B. Do you feel that your work takes so much of your time that a negative effect on your private life?	☐ 3	☐ 2	☐ 1	☐ 0

14A. and 14B.Total number of points ____(Between 0 and 6 points)

The next four question are not about your own job but about the whole company you work at.

	To a very large extent	To a large extent	Somewhat	To a small extent	To a very small extent
15A. Can you trust the information that comes from the management?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
15B. Does the management trust the employee to do their work well?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

15A.and 15B. Total number of points: ____

(Between 0 and 8 points)

	To a very Large extent	To a large extent	Somewhat	To a small extent	To a very small extent
16A. Are conflicts resolved in a fair way?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
16B.Is the work distributed fairly?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

16A. and 16B. Total number of points: ___

(Between 0 and 8 points)

The following five questions are about your *own* health and well-being. Please do not try to distinguish between symptoms that are caused by work and symptoms that are due to other causes. The task is to describe how you are in general.

The questions are about your health and well-being during the <u>last four weeks</u>:

	Excellent	Very good	Good	Fair	Poor
17. In general, would you say your health is:	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

17. Number of points: _____
(Between 0 and 4 points)

	All the time	A large part of the time	Part of the time	A small part of the time	Not at all
18A. How often have you felt worn out?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
18B. How often have you been emotionally exhausted?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

18A. and 18B. Total number of points:
_____(Between 0 and 8points)

All the time	A large part of the time	Part of the time	A small part of the time	Not at all

19A How often have you been stressed? ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0

19B. How often have been irritable? ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0

19A. and 19B. Total number of points: _____(Between 0 and 8 points)

Yes, daily	Yes, weekly	Yes, monthly	Yes, a few times	No

20. Have you been exposed to undesired sexual attention at your workplace during the last 12 months? ☐ ☐ ☐ ☐ ☐

Colle-agues	Managers/ supervisor	Sub-ordinates	Clients/ patients customers/

If, yes from whom? (You may tick off more than one) ☐ ☐ ☐ ☐

Yes, daily	Yes, weekly	Yes, monthly	Yes, a few times	No

21. Have you been exposed to threats of violence at your workplace during the last 12 months? ☐ ☐ ☐ ☐ ☐

Colle-agues	Managers/ supervisor	Sub-ordinates	Clients/ patients customers/

If, yes from whom? (You may tick off more than one) ☐ ☐ ☐ ☐

Yes, daily	Yes, weekly	Yes monthly	Yes, a few times	No

22. Have you been exposed to physical violence at your workplace during the last 12 months? ☐ ☐ ☐ ☐ ☐

Colle-agues	Managers/ supervisor	Sub-ordinates	Clients/ patients customers/

If, yes from whom? (You may tick off more than more) ☐ ☐ ☐ ☐

Bullying means that a person repeatedly is exposed to unpleasantly or degrading treatment, and that the person finds it difficult to defend himself or herself against it.

	Yes, daily	Yes, weekly	Yes monthly	Yes, a few times	No
23. Have you been exposed to bullying at your workplace during the last 12 months?	☐	☐	☐	☐	☐

	Colle-agues	Managers/ supervisor	Sub-ordinates	Clients/ patients customers/
If, yes from whom? (You may tick off more than one)	☐	☐	☐	☐

There are no more questions.

At this page you may write more about your working conditions, stress, health, etc