A mixed method study of violence against nurses in a rural and regional Emergency Department (ED)

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I am humbled by the wonderful people who loved and supported me throughout my Thesis journey. Like many other wonderful triumphs in life, this Thesis was possible because of the people who shared this experience with me and helped me learn and grow.

My best friend and partner Donna. Thank you for always believing, encouraging and loving me. Thank you for showing me the sunny side of the street. My love and gratitude to my Mum. I can never thank you enough and could never be who I am without your steadfast, unconditional love and guidance.

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Above all I would like to thank the Registered Nurses who welcomed me into their work lives and selflessly shared themselves with me.
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

(Signature)
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Abstract

Background
Internationally violence persists as a complex problem for nurses. While it is widely accepted that nursing staff in any health care setting can be the target of violence, in high acuity areas such as Emergency Departments (ED) nurses have an increased risk of violence. There is limited Australian research into violence experienced by nurses in the Australian Health sector, in particular the rural and regional Australian ED. Greater understanding of the phenomena of violence towards ED nurses, as it is manifest in the ‘real world’ rural and regional Australian setting is needed to enable development of context specific solutions for this problem.

Aim
This thesis presents a contextual, specialty specific description of violent events, nurses’ assessment of violence risk, strategies for violence prediction and management, and the sequelae for the nurse. The aims of this study were to:

- Explore and describe the contextual assessment skills and preventative strategies rural and regional ED nurses use to understand and predict violent events, where the agent of violence is the patient, their family or friends, and
- Understand the nature and scope of the sequelae of work place violent events from the nurse’s perspective.

Method
A mixed method instrumental case study was used to generate both qualitative and quantitative data. The instrumental case study framework provided a delineated boundary for inquiry, and a structured process within which the chosen methods were able to define ‘the case’ and answer the research question. This study was undertaken in 2005, at a regional Australian ED. Twenty (20) Registered Nurses were recruited into the study and consented to being observed. Textual qualitative data were generated from two hundred and ninety (290) hours of participant
observation, sixteen (16) semi-structured interviews, thirteen (13) unstructured field interviews, and researcher journaling. In addition, sixteen (16) violent events were observed and recorded via a structured observation tool. Textual data were analysed thematically assisted by the qualitative data management and retrieval software NVivo2, and numeric data were analysed using frequency counts.

Findings

The participants used their nursing knowledge(s), experience and context to assess their risk of violence. Embedded in the practice of these ED nurses was their ability to convey caring and respectfully approach all people presenting to ED. The participants’ caring respectful demeanour underpinned their understanding of violence prevention strategies. Using this violence prevention approach, they attributed contextual meaning(s) to the violent event and agent of violence. The meaning(s) they attributed in turn shaped their response(s) to both the violent event and the agent of violence. A high level of observable collegial awareness supported and fostered their resilience towards the potentially negative affects of violence in the workplace. The five themes revealed by this study were:

- Conveying caring: Averting violence
- Being alert: Recognising, assessing and responding to violence
- Attributing meaning: Subjective understandings that shape responses to violence
- Collegial awareness: Forming trusting relationships to help manage violence
- Fostering resilience: resisting the negative sequelae of violence.

Conclusions

Violence was interpreted by these ED nurses in a more systematic and complex way than the current definitions make possible. Violence assessment, prevention and management skills were embodied in the participant ED nurses’ routine practice and their conceptualisation of caring. The meanings given to violence were contextually constructed and these ascribed meaning(s) and judgments informed the actions that the nurses took in response to both the violent event and the agent of violence.
Chapter One - Introduction

Introduction

Nurses are practising in increasingly hostile and violent health care settings. Violence towards nurses is endemic internationally (Hinsby & Baker, 2004; International Council of Nurses, 2001, 2005; Winstanley & Whittington, 2004a), in Australia and in rural and regional Australian Emergency Departments (ED) (Alexander, Fraser, & Hoeth, 2004; Farrell, Bobrowski, & Bobrowski, 2006). The escalating violence in health care settings is well recognised and this is reflected in the increasing amount of attention given to the topic in educational programs, nursing research and literature. Existing nursing research into the problem of violence towards nurses includes exploratory and descriptive studies of issues such as the incidence, frequency and prevalence of violence in various nursing specialties, and the types and level of violence experienced by nurses (Deans, 2004; Fernandes et al., 1999; O'Connell, Young, Brooks, Hutchings, & Lofthouse, 2000; Ryan & Maguire, 2006; Tighe, Woloshynowycz, Brown, Wears, & Vincent, 2006). Work has also been undertaken on the efficacy of various preventative strategies ranging from staff education and training, environmental management, organisational policy and procedures, to the implications for human and fiscal resources. Other issues that have received attention include community, organisational and individual consequences of violence towards nurses in the workplace. Despite this increasing awareness and concern, violence towards nurses is an escalating problem.

Currently in Queensland Australia, regulations for violence prevention in the workplace, including the health care sector, are mandated by Queensland Government Occupational and Health Safety (OH&S) policies (Queensland Government, 2004, 2005). The State health care department, Queensland Health, has implemented the OH&S directives on violence assessment and prevention in a number of ways. All Queensland Health facilities have a zero tolerance policy towards violence and all violence in the workplace is considered unacceptable (Queensland Government, 2004, 2005). To support this policy, Queensland Health has introduced an ‘Aggressive behaviour management for healthcare workers course’, which is
currently being implemented in all facilities across the state. Other components of the Queensland Health Occupational Violence strategy include a detailed risk management process and violence management and control plans (Queensland Government, 2004, 2005; Queensland Health, 1995, 2003). To sustain their violence management and control plans, Queensland Health facilities employ security personal to protect the physical capital of the organisation, employees, patients and people accompanying them. These policies are in response to the escalation of violence towards health workers, including nurses.

Specific figures for the number of nurses who have experienced violent events in Australia are not readily available (Farrell et al., 2006; Maskell-Knight, 2002). Queensland Government statistics indicate that hospitals and nursing homes have some of the highest levels of OH&S risk factors in the state. This is reflected in the percentages of ‘severe’ injuries reported in 2002-2003 from Queensland Government industry sectors, and of the reported state wide ‘severe’ injuries, 19.5% were from hospitals (except psychiatric hospitals) and 7.5% from nursing homes (Queensland Government, 2005). The highest numbers of severe injuries were reported by Registered Nurses 8.6%, followed by police officers 5.7%, personal care assistants 5.7% and nursing assistants 4.8% (Queensland Government, 2005). The reported mechanisms of injury in 2.6% of these cases were assault or harassment. These statistics are very broad and offer limited insights into the complex problem of OH&S risk factors and more specifically violence towards nurses. They illustrate, however, the need for research into OH&S issues in the Queensland health care sector, including the problem of violence towards nurses.

Little research has been conducted in rural and regional Australian Emergency Departments (ED) to understand how ED nurses prevent, manage, reduce and respond to violent events in their routine nursing practice. Further, there is limited work on violence towards nurses that has been undertaken in ‘real life’ contexts using multiple methods of data generation and this has been noted by various commentators (Lau & Magarey, 2006; Lau, Magarey, & McCutcheon, 2005; Lyneham, 1999, 2000). In this research the nursing knowledge(s) that ED nurses typically and routinely use during the nurse patient interaction when the patient, their family or friends are violent towards the nurse will be elucidated.
Purpose of the study

The purpose of this concurrent mixed methods instrumental case study is to extend current knowledge about the phenomena of violence towards rural and regional ED nurses when the agent of violence is the patient, their family or friends. The phenomena are explored using qualitative interviews, structured and unstructured observation and document review.

Study question

What strategies are used by Australian rural and regional ED nurses when there is violence directed towards them and the agents of violence are patients, their family or friends, and what are the initial consequences for these nurses?

Research framework and methods

Case studies generically are: holistic, contextual; undertaken in the real world; uncover knowledge that is descriptive or exploratory; and use multiple methods for data generation (Creswell, 1998; Mason, 2002; Ragin, 1992; Stake, 1995, 2000; Tellis, 1997; Yin, 2003). This study adopts the framework of a concurrent mixed methods, instrumental case study (Creswell, 1994; Stake, 2000; Tashakkori & Teddlie, 1998). The study was designed to uncover strategies that ED nurses use during their routine nursing practice when there was a violent event or potential for violence, and the initial consequences of violent events for the participant ED nurses. The case was a single instrumental case because the geographically bounded ED and the participant ED nurses were not the phenomenon of interest. Rather, the ‘case of’ interest was the phenomena of violence towards ED nurses and the initial sequelae of violent events for ED nurses, and this was revealed through the bounded case. The instrumental case study was, therefore, a single mixed methods case study design. Understanding ED nursing practices contextually acknowledges the potential social, psychological, physiological and organisational factors experienced by individuals, the nurse, the patient, their family and friends, within the bounded context within which the violent event occurs.
For the purposes of this study the physical boundaries of the case included the geographical location, an ED in a hospital in rural and regional Australia, and the bounded interactions between the ED nurse and patients, their family and friends who attend the ED. The delineation of the instrumental case study geographically and thematically enhanced clarity of the boundaries of the instrumental case. What was included in the case, and the answer to the question of what is this case ‘a case of’, was discovered inductively through the research process. The phenomena of interest, the ‘case of’, were also defined empirically. This mixed method instrumental case study design, therefore, enabled construction of the case of as both an empirical entity and a theoretical construct, thereby facilitating an extensive and complete understanding of the phenomena of interest, contextualised in real life ED nursing practice. The phenomenon of interest was revealed through the instrumental case, and understandings of complex human interactions and personal meanings about violence towards ED nurses were developed through multiple methods and sustained engagement in the field. The constructed empirical ‘case of’ was reflected in, and explored through, the structured observation tool. The data generation methods were unstructured participant observation, structured observation, semi structured interviews, unstructured interviews, researcher journaling and document review.

The consenting ED nurse participants experienced violence in their workplace and the consequences of violent events. The data generation methods of unstructured participant observation and interviews were used to capture the richness of the field and the contextualised phenomena of interest. Knowledge about emergent the ‘case of’ was therefore discovered by watching and talking to the participant nurses. Data about the attributes of the participant ED nurse, the agent of violence and the context, were also collected. Concurrent data generation and data analysis of the instrumental ‘case of’ enabled a complete description of violence towards the ED nurses and substantiation of findings. Data from relevant facility documentation provided additional context specific information. Finally, researcher journaling was extensively used as a means to ensure rigour and to contribute to the observational data.
There were 20 Registered Nurses from the chosen ED who voluntarily consented to participate in the study and to being observed and interviewed by the nurse researcher. Sixteen semi structured interviews and 13 unstructured interviews were completed. Two hundred and ninety hours of unstructured participant observation and data from 16 violent events were generated over a five month period from September 2005 to January 2006. Quantitative observational data were analysed using descriptive statistics. The level of measurement was nominal and ordinal and therefore descriptive statistics of frequencies and means were appropriate (Polit & Beck, 2004). All textual data generated were analysed thematically with the assistance of NVivo2, a qualitative data management and analysis software package.

**Study Phases**

There were three phases of the current study. These can be diagrammatically represented (see Appendix A) and are briefly outlined below. Further detailed discussions of these phases will follow in chapter four.

**Phase one**

The first phase of the current study used the data generation strategies of unstructured participant observation, unstructured open ended interview and researcher journaling. Fifty hours of participant observation, three (3) unstructured open ended interviews and researcher journaling were completed in 2004, and thematically analysed. The findings from this phase were the source of the items in the structured observation tool. The phase one findings also focused the participant observation data and informed the content of the semi-structured open ended interviews.

**Phase two**

Two hundred and ninety hours (290) of participant observation, 16 semi-structured open ended interviews, 13 unstructured open ended interviews, organisational documents and researcher journal comprised the qualitative data generation methods for this phase. Sixteen (16) structured observations were collected using the
structured observation tool developed from phase one. This comprised the quantitative data of phase two. Phase two data generation was completed in 2005.

*Phase three*

Phase three refers to the data analysis processes of the current study. All data from phase two were analysed concurrently.

*Language used*

Violence towards nurses is contextually bound; therefore what is or is not acceptable in nurse-patient interactions reflects the social and institutional culture within which the violent event occurs. What is deemed acceptable or not, what is condoned, prevented or averted is dependent upon these socially and institutionally constructed boundaries. The particular context within which violent events occur, co-constructs the attitudes nurses have about violence that is directed towards them, which in turn contextually defines the violent event and the individuals involved in the violent event. The language used to signify the roles of the individuals involved in a violent event, therefore, reflects this social construct of violence. There is currently a limited repertoire of ‘labels’ that can be used to denote the position, or role, of the various people involved in violent events, and frequently the language of ‘victim’ and ‘perpetrator’ are used. This language is itself value laden and presupposes a number of social and interpersonal attributes and conditions that include inferences of innocence, guilt and accountability. Depending upon the particular context and particular social interaction, the value bias associated with the terms ‘victim’ and ‘perpetrator’ can, therefore, include covert or overt levels of blame and responsibility.

It is because of the value ladenness of the current terms that describe the individuals involved in violent events that these terms will not be used in this thesis. Rather, descriptive language will be used to denote those involved in violent events. It is acknowledged that using the nomenclature ‘agent of violence’ to indicate the person who initiates or engages in violence towards the participant nurse increases the verbosity of the descriptions of events. This descriptive term, however, uncovers the
contextual phenomena of interest, violence towards ED nurses, without the presuppositions that are implied by the value laden language of ‘victim’ and ‘perpetrator’.

**Significance of the study**

As this thesis will show, research into the phenomena of violence in the health care setting, and towards nurses, has predominantly been explored using retrospective questionnaires or survey research. Previous research has demonstrated the extent of the problem of violence towards nurses, but it has resulted in reducing the scope of the problem and therefore the potential understandings of this contemporary challenge for nurses. In order to understand the phenomena of violence towards rural and regional ED nurses comprehensively, the various contextual and interpersonal features that are present during a violent event need to be simultaneously explored and acknowledged. Violence towards nurses has subjective, personal dimensions as well as readily measurable and observable characteristics. A comprehensive, contextual understanding of violence towards nurses therefore needs to capture data that is both subjective and objective. Further, understanding(s) of violence towards rural and regional ED nurses for the practice discipline of nursing need to be bounded in the context within which the violence manifests. The mixed method instrumental case study framework used in this study supported exploration of the bounded phenomena contextually. The comprehensiveness of the understanding of violence towards nurses was enabled by defining the phenomena as both a theoretical construct and empirical unit. Development and application of an instrumental case study in this way has not been previously reported, and this also adds to the significance of the study.

The mixed methods research framework used in this study therefore enabled a more complete exploration and a greater depth of understanding of the phenomena than has been previously reported. These real world insights will inform new nursing violence management strategies and practices. The contextual observation of violent events has contributed to understandings about the assessment and prevention strategies rural and regional ED nurses used in their routine nursing practice. The outcomes of this mixed methods case study also included the development of
knowledge about the attributed meaning(s) of violence towards nurses, an issue that has not previously been reported in the nursing literature. Further, the effect these meaning(s) have on nurses’ choice to report or not report violence in their workplace has been uncovered, and this adds new insights into why nurses under report violence in the workplace. These outcomes will inform improvements in prevention, assessment and aversion of violence both for individual nurses and health care organisations. Further, the study revealed insights into the nurses’ capacity to develop collegial, nurturing relationships within a milieu where there is frequent violence, and potential for violence, and the mechanisms and strategies they used to enhance and support their resilience to violent events. These findings have not been previously revealed and thus add practice based understandings and insights.

**Organisation of thesis**

This chapter has introduced the problem of violence in the health care setting and violence towards nurses. The research problem and purpose and the study questions have been presented. A brief overview of the methods and research framework has been offered and the relevance of using the descriptive term ‘agent of violence’ has been argued.

Chapter two will review the contemporary nursing literature on violence in nursing, including the theoretical aetiologies of violent behaviour. It will focus on the current nursing violence assessment and prevention strategies, including education and training and the effects of the environment. Research findings related to the sequelae for individual nurses following a violent event will be explored. The definition of violence, as it is used in this thesis will be clearly explicated.

Chapter three discusses qualitative and quantitative approaches to case study research and the construction of this mixed method instrumental case study is the focus of this chapter. Case study as a suitable mixed methods framework for nursing research focusing on a practice issue will be supported by the current literature. Instrumental case study design will be explored. In particular, attention is paid to identification of the ‘case’ and ‘a case is’ versus ‘a case of’. The construction of the case for this study, as both a specific theoretical construct and general empirical unit
will be justified. Within the framework of this single mixed method instrumental case study, the methods chosen will be introduced.

Chapter four will justify the choice of methods and demonstrate their coherence with the pragmatic mixed methods instrumental case study framework being used in the study. Participant observations, structured observations, semi structured interviews, unstructured interviews, researcher journaling and document review will be linked to the chosen framework. This chapter will also describe and explain the applied concurrent data analysis strategy used in this study. The relevant issues of ethical conduct and consent will also be discussed. Finally, the reader will be introduced to the case study setting and the consented participants and given an overview of the data generated.

Chapters five and six present the study findings. Chapter five will introduce the five (5) findings revealed by the case study, and focuses on the first two (2) of these themes; Conveying Caring: Averting violence; and Being alert: Recognising, assessing and responding to violence.

Chapter six presents the final three (3) findings; Attributing meaning: Subjective understandings that shape responses to violence; Collegial awareness: Forming trusting relationships to help manage violence; and Fostering resilience: Resisting the negative sequelae of violence.

Chapter seven critically examines the five (5) thematic findings for their concordance or discordance with the contemporary nursing literature and offers some new insights into the phenomena of interest; violence towards ED nurses.

The conclusion chapter eight discusses recommendations for nursing practice, education and research based on the study findings. Recommendations for further research will be addressed.
Summary

Violence towards nurses is a contemporary problem in the healthcare sector. Research that explicitly examines strategies rural and regional Australian ED nurses routinely use in their everyday practice to manage violence is missing in the literature. There is also a gap in the literature with respect to qualitatively examining the initial consequences of violent events on Australian rural and regional ED nurses. This single, mixed method instrumental case study will contextually examine the ‘case of’ violence towards rural and regional Australian ED nurses providing a greater understanding of the meaning of violence towards nurses, and subsequently shed light on new specialty specific assessment and prevention strategies.
Chapter Two - Abstract

This chapter extensively reviews the current literature on violence in the health care setting, particularly violence towards nurses. The contemporary discourses regarding defining violence and understanding the aetiology of violent behaviours will also be explored. Nurses’ violence risk assessment approaches and the strategies they use to predict and prevent violent events are reviewed. The reported consequences of violent events on individual nurses are also examined. The definition of violence used in this thesis will be presented and the need for this study is argued. Parts of this chapter have been previously published (see Appendix B).
Chapter Two - Literature Review

Introduction
Internationally, nurses are the most common target of violence in the workplace (International Council of Nurses, 2005; Landy, 2005; Needham, Abderhalden, Zeller et al., 2005; Ryan & Maguire, 2006) and this is also applies in Australia (Deans, 2004; Farrell et al., 2006; Hegney, Plank, & Parker, 2003; Lau et al., 2005). Additionally there is a reported increase in the frequency and severity of violence towards nurses (see for example Carlsson, Dahlberg, Lützen, & Nystrom, 2004; Meuleners, Lee, Zhao, & Intrapanya, 2004; Noak et al., 2002). While it is widely accepted that nursing staff in any health care setting can be the target of violence, nurses working in Critical Care Areas, Mental Health, and Emergency Departments (ED) are particularly vulnerable to experiencing physical violence threatening behaviour or verbal abuse (Catlette, 2005; Hinsby & Baker, 2004; Needham, Abderhalden, Halfens, Fischer, & Dassen, 2005).

This chapter will discuss the definitions of violence used in the health care sector and nursing research. The incidence of violence and aggression towards nurses will be presented along with an overview of the traditional and contemporary theories of aggression and violence. Further, the conflicting evidence surrounding predictors and precipitators of violence and aggression will be analysed in light of their meaning for nurses. The literature discussing the reported consequences of workplace violence experienced by nurses will also be examined. The impacts of the aforementioned issues are presented as justification for the current study.

Defining violence in the context of health care settings and nursing
The term violence does not have a standard definition in the nursing literature (Adib, Al-Shatti, Kamal, El-Gerges, & Al-Raqem, 2002; Crilly, Chaboyer, & Creedy, 2004; Hegney et al., 2003; Knefel & Bryant, 2004; Whittington, 2002). Rather, violence is an umbrella term that encompasses a range of behaviours, and is often classified as being verbal, sexual, physical or emotional harm (Lanza, Zeiss, & Rierdan, 2006;
The lack of use of a consistent definition of violence in the literature means that it is difficult to compare studies, and statistical data, concerning rates and levels of violence (Hegney et al., 2003; Needham, Abderhalden, Halfens et al., 2005; Wells & Bowers, 2002) and may add to the challenge of addressing the problem of violence in nursing.

The terms assault, abuse, violence and aggression are often used interchangeably in the literature (Crilly et al., 2004; Hislop & Melby, 2003; Lau et al., 2005). Farrell et al. (2006) and May and Grubbs (2002) include physical threats, physical assaults, verbal abuse and witnessing physical threats or assaults as workplace violence. Other authors sub divide violence into two categories. Keely (2002) identifies two categories of violence; physical violence and aggression. Physical violence includes violence that is intentional and used to cause harm or injury to another person or to property. Acts of aggression are “verbal or physical actions directed toward creating fear” (Keely, 2002, p. 236). Erickson and Williams-Evans, however, define assault as “any physical contact by a patient that results in the nurse feeling personally threatened” (2000, p. 211). The inconsistency of definitions used in the literature is further highlighted by Winstanley and Whittington (2004a) who divide violence into three components, physical assault, threatening behaviour and verbal abuse.

Tolhurst, Baker, Murray, Bell, Sutton and Dean (2003) developed a definition of violence based on a thematic analysis of focus group data from rural and regional Australian General Practitioners (GP). They subsequently defined violence as “verbal abuse, property damage or theft, stalking, physical abuse, sexual harassment and sexual abuse” (Tolhurst et al., 2003, p. 233). Fernandes et al. (1999), following their survey of staff in a Vancouver ED, found that 86% respondents included witnessing physical threats, verbal abuse or assault, 92% included experiencing verbal abuse, 97% included physical threats and 92% included physical assaults in their definitions of violence. In Australia, specifically at Queensland Health facilities, both physical and non-physical violence are considered risks for the occupational health and safety of employees and Occupational Violence is defined as “any incident in which a person is abused, threatened or assaulted in circumstances relating to their work” (Queensland Health, 2002, p. 5).
The literature supports using two sub categories of violence, physical violence and non-physical violence, to inclusively define violence in the health care setting (Australian Institute of Criminology, 2004; Farrell et al., 2006; O'Connell et al., 2000). Physical violence includes any intentional injurious act, or physical force directed towards another person or facility property (Crilly et al., 2004; Keely, 2002). Non-physical violence includes acts of aggression, physical threats or verbal assaults intended to instill fear (Keely, 2002). This encompasses intimidation, humiliation, denigration, threats, and includes witnessing both physical and non-physical violent events (Fernandes et al., 1999; Nijman, Bowers, Oud, & Jansen, 2005). For the purposes of this study the use of the term violence will encompass both of these sub categories unless otherwise specified.

The position maintained in this thesis is that all types of violence against people and property is unacceptable and potentially has negative consequences. The definition of the term violence used in this thesis reflects the diversity of behaviours and actions that are considered violent, seen in the health care sector and thus experienced by nurses. Whilst violence towards nurses includes violence perpetrated by patients and visitors as well as violence perpetrated by work colleagues (Farrell et al., 2006; Keely, 2002) this study is limited to the discussion of patients, their family and friends as agents of violence towards nurses.

**Violence in the healthcare work place: Incidents of violence**

The relationship between increased violence in society generally, and violence in the health care setting has been noted by many authors, for example Jackson et al. (2002) Keely (2002), Needham et al. (2005), O’Connell et al. (2000), Rippon (2000), Wells and Bowers (2002) and Whittington (2002). Wells and Bowers (2002) add that the increased attention to the issue of violence towards nurses may be a manifestation of increasing societal concerns about the increase in violence in the community. Whilst this may be a contributing factor, there is clear evidence that nurses are at risk of violence in the workplace (Lau et al., 2005).
The literature is replete with studies that identify the frequency of violence towards nurses (Landy, 2005; Lanza et al., 2006; Nijman et al., 2005). The results of survey research exploring the incidence of violence in health care settings, and towards nurses, consistently reports high rates of violence, particularly verbal abuse. An Australian survey of nurses in Queensland found 50% (n = 215) of nurses in aged care, 47% (n = 228) of nurses in the public sector and 29% (n = 144) of nurses in the private sector had experienced violence in the preceding three (3) months (Hegney et al., 2003). Farrell et al. (2006) surveyed nurses in Tasmania Australia, and reported 68% of nurses had experienced violence in the preceding four (4) weeks. A 2002 study of seven ED’s in Victoria Australia indicated that staff, including nurses, ranked workplace safety as the most important indicator for a healthy workplace and ranked physical assault as the top work related injury (Joe, Kennedy, & Bensberg, 2002). These two findings are very much in line with the Alexander et al. (2004) rural Australia study and O’Connell et al. (2000) Australian metropolitan nurses’ survey.

Alexander et al. (2004) posted a questionnaire to 158 allied health providers, 1,299 nurses and 139 GP’s in rural eastern Australia, and reported a return rate of 72%, 62% and 62% respectively whereas O’Connell et al. (2000) report a 52% return rate from all levels of nurses working in various areas of an Australian metropolitan hospital. Alexander et al. (2004) found that compared to the other categories of health providers nurses reported the highest rates of occupational violence, most commonly verbal abuse (57%), followed by threatening behaviour. Seventeen percent of the nurses reported experiencing physical violence in the preceding 12 month period. O’Connell et al. (2000) found that 95% of the nurse respondents during the previous 12 months had experienced more than one episode of verbal aggression, and 80% had experienced several episodes of physical aggression. What can be definitively said is that research into violence directed at nurses consistently finds high rates of exposure to violence.

Keely (2002), Whittington, Shuttleworth and Hill (1996) and Winstanley and Whittington (2004a) agree that violence is a problem in the health care sector, but argue that violence towards nursing staff is not limited to those working in ED. Following their literature review of violence towards nurses in the United Kingdom,
Wells and Bower (2002) questioned that ED was the “highest priority for security provision” (p. 240) compared to other nursing areas. Landy (2005), following collation of a questionnaire completed by a convenience sample of Emergency, Intensive Care and Medical Ward nurses, found 87.5% had experienced verbal aggression, 57.5% physical violence and found there was no significant difference between the frequency of violence towards nurses in the three areas. The problems of the study included very small sample sizes, n = 13, 22 and 5 respectively. They concluded that the excessive focus on ED nurses may contribute to the belief that they are more at risk then they actually are. Alexander et al. (2004) and Winstanley and Whittington (2002) findings support this position but other authors disagree with this conclusion (Lipley, 2001; Lyneham, 1999; O'Connell et al., 2000; Ryan & Maguire, 2006; Saines, 1999) and assert that ED nurses are “the most frequent victims of violence” (Levin, Hewitt, & Misner, 1998, p. 250).

When Meuleners et al. (2004) explored staff perceptions of changes in ED’s in the Australian Northern Territory, they found that the highest ranked concern was increased verbal and physical violence. Rodger, Hills and Kristjanson (2004) sampled members of the Emergency Nurses Association of Western Australia and had a 50.4% return rate of their questionnaires. They reported that ED nurses ranked the problem of violence as one of the top three researchable topics. The results highlight that violence in Australian ED’s is considered a significant problem, and in need of ongoing research. Further, as noted by Lau and Magarey (2006), studies of violence in the ED setting are commonly retrospective surveys. There is limited research into this violence towards nurses that has reported results from studies using in-depth interview or participant observation, and these will be discussed later in this chapter. To further understand this complex issue other concerns, apart from the statistical evidence, need to be examined.

Violence in the Emergency Department: Predictors and precipitators

The agents of violence in the hospital setting are most commonly patients, their family and friends (Ferns, 2005; Hegney et al., 2003; Keely, 2002; Knefel & Bryant, 2004; May & Grubbs, 2002; McPhaul & Lipscomb, 2004; Nabb, 2000), and often men, although work colleagues, volunteers and other employees can be the
The perpetrators of violence (Farrell, 1999; Jackson et al., 2002; Keely, 2002; Stirling, Higgins, & Cooke, 2001). The antecedents of violence in health care settings can be grouped under the classifications of: patient characteristics; the institutional organisation or regime; and interactions with others (Powell, Caan, & Crowe, 1994). This schema is mirrored in the five factors that Citrome and Volavka (1999) hypothesised as possible causes for patient violence in the ED. The five factors include the three previously identified factors, and add “underlying character pathology; and (5) the chaotic environment of the ED” (Citrome & Volavka, 1999, p. 789). This model considers the precursors to violence from a patient focus and includes contextual issues that contribute to violent events in the ED.

Physical or emotional stressors are generally presumed to be precipitating factors that lead to an act of violence in the Hospital setting (Baillie, 2005; Keely, 2002). Personally stressful issues such as death, grief, divorce, retrenchment, being the victim of violence including domestic violence, are cited as examples of emotionally stressful circumstances that may initiate or contribute to an act of violence. Patient and visitors trait or state level of anger, fear, hopelessness, anxiety and their tolerance to frustration are considered internal motivating factors for violence (Keely, 2002; Mayhew & Chappell, 2003). Additionally, their feelings of vulnerability, lack of knowledge or sense of protectiveness towards each other may contribute to violent events (Bentley, 2005; Chambers, 1998; Hoag-Apel, 1998). These emotional factors are assumed to contribute to a sense of being ‘out of control’ (Whittington et al., 1996) and may be exacerbated by impatience, misunderstanding, inaccurate perceptions or intolerance and then directed toward the health care facility or staff member (Keely, 2002; Rippon, 2000). There are other presumed predictive or precipitating causes of violence specific to the health care context and nursing considered in the literature.

Winstanley and Whittington (2004b) discuss the contribution of cognitive impairment and aversive stimuli as precipitating factors for violence. It is frequently noted that patients with mental illnesses or difficulties with alcohol or substance dependence, intoxication or withdrawal, are regarded as the main agents of violence (Citrome & Volavka, 1999; Duxbury, 2002; Duxbury & Whittington, 2005; Murphy, 2004; Stirling et al., 2001). Confused and disorientated elderly patients are often
identified as agents of violence (Chambers, 1998; McPhaul & Lipscomb, 2004). Other physical or biological predisposing factors that may contribute to cognitive impairment are causes such as head injury or trauma, encephalopathy, endocrinopathy (Keely, 2002; Liu & Wuerker, 2004), pain, hypoxia, sepsis, disorientation due to medication or recovery from surgery, decreased level of consciousness and depression (Love, Morrison, & Members of the AAN Expert Panel on Violence, 2003; Whittington et al., 1996). Collectively, the above mentioned precipitating factors indicate that violence can be a symptom of disease (Duxbury, 2002; Duxbury & Whittington, 2005; Hinsby & Baker, 2004) or exogenous factors, and these socioeconomic, psychosocial, physiological, biological and demographic indicators are therefore predictors of violence (Murphy, 2004). In addition to the aforementioned precipitating issues, there are contextual and environmentally unique circumstances in ED’s that may contribute to violent events (Fernandes et al., 1999; Joe et al., 2002).

ED specialty specific issues include; long waiting times (Crilly et al., 2004; Emergency Nurses Association, 2003; Jones & Lyneham, 2001; McMahon & Fisher, 2003; Stirling et al., 2001); waiting for admission or a consultant review; the unanticipated nature of illness; 24 hour availability of services; intense interpersonal interactions (Gillespie & Melby, 2003; Lyneham, 1999; Winman & Wikblad, 2004); adverse unexpected outcomes such as death; high levels of stress (Baillie, 2005; Hoag-Apel, 1999; Levin et al., 1998); and the demands of triage (Jones & Lyneham, 2001). Further, in the ED most episodes of violence occur on Saturday and Sunday night at triage or in the waiting room (Merfield, 2003) particularly if there is an extended wait (Mayhew & Chappell, 2001a).

Despite the emphasis on waiting times as a significant contributing variable for violence in the ED, Crilly et al. (2004) observe that there is no empirical evidence to support this and suggest that most episodes of violence occur within the first hour of presentation. Schnieden and Marren-Bell (1995) in their Australian ED study found a relationship between physical violence and time of day and reported most violent events occurred between 18.00 to 07.00 hours, and this has been reported elsewhere in the literature (see for example Rippon, 2000; Stirling et al., 2001; Zernike & Sharpe, 1998).
ED waiting time, time of day, the triage process, anxiety and the multiple stressors associated with attending an ED, coupled with conflicting perceptions between the patient their family and friends and the triage nurse’s views about what constitutes an emergency, are important ED specific factors that remain misunderstood and under researched. Considerations of these specialty specific factors in combination with theories of aggression help to understand their significance in practice situations. Theories of aggression and violence will now be discussed.

Theories of aggression and violence

When considering theoretical explanations for human violence and aggression, Burton (1997) suggests the question to ask is whether aggression and violence are a consequence of the Darwinian notion of survival of the fittest, or are they socially constructed phenomena that arise from the human struggle negotiating and conforming to human institutions and structures. Broadly, biological and ethological theories of aggression and violence recognise the influence of human evolution (Boice, 1976). Violence and aggression are thus considered inherent or instinctual (Benjamin, 1999; Breakwell, 1997; Burton, 1997). The psychological and social theories of violence and aggression consider the influence of society, institutions, interpersonal and intrapersonal conditions within which violence and aggression occur. In essence, this is the perennial nature versus nurture debate (DeLaune, 2004). A third approach combines biological predispositions with social phenomena or institutions (Burton, 1997). Theories of violence and aggression are underpinned with the above three tenets and are therefore expressed in language and through constructs that are logically consistent with the underpinning beliefs. Psychological theories of violence, including the psychoanalytic and social learning perspective will be discussed, along with evidence for a genetic or biological aetiology of aggression and violence.

Psychoanalytic theory

Freud offered a psychoanalytic theory of aggression that accepts aggression as a “fundamental human drive” (Singer, 1977, p. 3), that is, every person has the
potential to be violent. This perspective presumes that aggression and violence are instincts or innate drives, akin to the biological desires of food and sleep (Breakwell, 1997). There is an inherent link between drives and the idea of natural selection. Survivors are successful because of their aggressive or competitive instincts. Further, these drives or instincts are not under conscious control. When aggressive or violent energy builds up, there will be a need for this energy to be released. From the psychoanalytic perspective, aggression is a mechanism that allows excessive intra-psychic pressure or tension to be released, thus enabling the individual to return to a state of intra-psychic homeostasis. This energy can be released in socially accepted ways, such as in sporting activities; suppressed and turned inwards, leading to depression; focused outwards leading to acts of violence and aggression. Freud’s theory of aggression is commonly referred to as the hydraulic-energy model, in recognition of the metaphor that underpins his theory (Eysenck, 1985). Criticisms of this perspective include the inability to predict aggression and violence and the lack of empirical verification of instinctual drives (Eysenck, 1985). Not all classic views of violence accept the notion of innate drives or Freud’s deterministic approach.

Social learning theory

Refutation of the acceptance of violence and aggression as instinctual drives is clearly seen in social modeling and social learning theories (Bandura, 1973; Miller & Dollard, 1967). Social learning refers to learning behaviour through direct experience and observing others (Bandura, 1977). Social learning theory acknowledges people’s capacity to be self regulating and includes the influence of the context within which behaviour occurs (Bandura, 1977). Miller and Dollard (1967) suggest that aggression is an acquired drive that can therefore be modified. The learning perspective maintains that aggression and violence are learned behaviours. From an operant conditioning learning approach, behaviours that are reinforced with rewards are more likely to be repeated. Thus social learning theorists propose that behaviour such as aggression is learned, and if positively reinforced, will be repeated (Beck, 2000).
**Behaviour /learning theory**

Learning theorists differentiate types of aggression. Bandura (1973) categorises aggression as either instrumental or hostile, and Breakwell (1997) makes a distinction between instrumental and emotional forms of violence. Both Bandura and Breakwell proposed that instrumental aggression is goal-orientated behaviour. The goal is not necessarily to hurt the victim; the goal is a positive reward. Aggressive or violent behaviours with the goal of receiving immediacy of attention or service could be construed as instrumental aggression. Hostile aggression or violence has the intent of inflicting injury or harm on others (Bandura, 1973). What is important about this distinction is that while the desired outcome is theoretically differentiated, the process and end results are not distinguishable. Interestingly, Buss (1971, 1995) suggests aggression, over time, is a relatively stable personality trait. Buss’s (1971, 1995) aggression model shares features with Bandura’s (1973) conceptualisation and Dollard et al. (1939) frustration-aggression hypothesis (Berkowitz, 1989).

**Frustration-aggression hypothesis**

The frustration-aggression hypothesis was proposed by Dollard, Doob, Miller, Mowrer and Sears in 1939 (Berkowitz, 1989; Breakwell, 1997; Marcus-Newhall, Pedersen, Carlson, & Miller, 2000). Simply stated, their hypothesis claims that frustration leads to aggression if there are no constraining factors present (Marcus-Newhall et al., 2000). Within this hypothesis, there are factors that “influence the intensity and/or frequency of aggression” (Marcus-Newhall et al., 2000, p. 670) and they include the level of frustration, the degree to which the person expects goal attainment and the frequency of variables that interfere with goal attainment (Berkowitz, 1989). Social learning theory would reject this explanation because it lacks inclusion of contextual variables and the individual’s socially learnt responses (Berkowitz, 1989). Further, the frustration-aggression hypothesis assumes that a lack of anticipated goal attainment is a sufficiently salient stimulus to elicit aggression and violence, and this is a debatable position. The frustration-aggression hypothesis is no longer seen as a strong explanatory model (Todorov & Bargh, 2002).
Personality theory

Zuckerman (1991) suggests, within the five-factor personality model, that non-conforming behaviour, receptiveness to boredom, the need for autonomy from social rules and demands, aggression, impulsivity and quick decision making, are all highly associated with a sensation seeking personality. Whilst his sensation seeking personality theory predominantly focuses on people with psychopathology, Zuckerman offers a complex treatment of the relationships between neurology, genetics, pharmacology, and personality. He suggests aggression and violence are best understood when all factors are considered. Contemporary research into aggression and violence has focused on biological etiologies either exclusively or in combination with social and psychological phenomena.

Biological theory

There is increasing evidence that supports a biological basis for aggression and violence (Liu & Wuerker, 2004; Mark & Ervin, 1970). Investigation into the biological basis of violence and aggression includes research into genetics, biochemistry, and neurobiology. Some supporters of the biological theory of violence, while agreeing that humans have instincts, disagree with the belief that violence is a learned behaviour (Mark & Ervin, 1970). The role of social influence is acknowledged, however the argument supports that “the organ of behaviour is the brain” (Mark & Ervin, 1970, p. 4), therefore, violence is a behavioural manifestation of cerebral functioning. This position is supported by studies involving biological twins and adopted children (Mednick, Gabrielle, & Hutchings, 1984). Mednick et al. (1984) reported a relationship between criminal convictions in adoptee children and criminal activity of the biological parents. They concluded that this demonstrated a genetic predisposition for some antisocial, aggressive and violent criminal activity. The finding that anti-social and aggressive behaviour has a genetic influence is supported by the work of Raine et al. (2001).

Raine et al. (2001) offer evidence from Functional Magnetic Imaging (fMRI) to support the link between brain functioning, physiology and aggression. They found that violent offenders, with a history of severe child abuse, had “reduced right hemisphere functioning, particularly in the right temporal cortex” (Raine et al., 2001,
p. 319) during a visual and verbal memory task. They suggest there are frontal or temporal lobe deficits in violent subjects and support a brain dysfunction aetiology for aggression and violence (Raine et al., 2001). Other areas of the brain reported to be associated with aggression include the amygdala, hippocampus, hypothalamus and limbic systems (DeLaune, 2004). Raine et al. (2001) elaborate on the interaction between the environment and heritable factors, supporting the work of Liu and Wuerker (2004).

Liu and Wuerker (2004) offer a complex biopsychosocial model to explain the aetiology of violence and aggression. Their model proposes that aggression and violence are the result of biological, psychological and social risk factors that are mediated by cognitive ability (Liu, 2004). They support the argument that biological risk factors, including predisposing prenatal conditions such as maternal substance use, pregnancy and birth complications, influence later aggression. Further they suggest that biological determinants such as hypo-cholesteremia; deficiencies in proteins, amino acid, iron and zinc; neurotoxins, such as trace metals; malnutrition; brain damage; neurotransmitters such as serotonin; hormones such as testosterone and physiological arousal are risk factors for aggression and violence (Liu, 2004). The work on hormones and neurotransmitters offers more evidence of the complexity of the link between biology and behaviour. Links have been established between aggression, testosterone and the neurotransmitter serotonin (see for example Book, Starzyk, & Quinsey, 2001; Burnham et al., 2003; DeLaune, 2004; Moore, Scarpa, & Raine, 2002).

**Aggression and violence in the workplace: A discourse**

Foucault’s work on discourse and power contributes different understandings of violence (Holmes & Gastaldo, 2002; McNay, 1994). Foucault considered discourse “in terms of bodies of knowledge” (McHoul & Grace, 1993, p. 26). This view of discourse includes the language used in disciplines. It also includes the underlying values and beliefs of bounded disciplines, the body of knowledge of disciplines, the practices of disciplines, and the social interactions of disciplines. In this use of the term disciplines, Foucault refers to both scholarly disciplines such as medicine, sociology and science as well as “disciplinary institutions of social control, such as
the prison, the school, the hospital” (McHoul & Grace, 1993, p. 26). A discourse includes the constraints and enablers to thinking, writing, enacting or speaking about a particular social object. A discourse also includes, therefore, the rules, conventions and procedures that regulate behaviours and assign roles and positions (Danaher, Schirato, & Webb, 2000). A discourse is thus “a form of power” (Diamond & Quinby, 1988, p.185), and a form of power that produces knowledge (McHoul & Grace, 1993).

Whilst these definitions and perspectives on discourse by no means begin to illustrate the complexities and historical constituents of knowledge, power, power-knowledge and discourse as proposed by Foucault, these definitions none-the-less reflect that violence in the health care setting, and nurses perceptions of violence, are constructed by the discourse used to define them. This is evident in the theoretical perspectives discussed thus far and re-created in the discussion of nurses as victims. The theories of psychoanalysis, personality, learning biology, flawed by their incapacity to fully explain or predict episodes of violence or aggression, nevertheless offer particular discourses on the aetiology of violence. Significantly, these discourses present the agent of violence as immune from retribution because they are unaware of their own psychological or biological reasons. This tacit understanding, a product of the discourse, is socially accepted by both the nurse and the agent of violence.

Nurses are engaged in the process of resisting the power relations within which they are located and at the same time managing the discourse of the institution (Holmes & Gastaldo, 2002). Nurses are engaged in struggle with the discourse of the discipline, both scholarly and institutional, from within circular power relations with potentially violent or aggressive patients, their family and friends. That the power relation is circular can be suggested because nurses struggle to maintain power, and so too do patients, their family and friends. It could also be argued that some patients, their family and friends manifest this struggle via aggression and/or violence. Nurses’ struggle for power is well illustrated by the literature surrounding violence prevention strategies.
Whilst considering the implications of Foucault’s perspective of violence and aggression towards nurses, it is important to acknowledge the Feminist contribution to understandings of violence. Feminists argue that violence, in particular male to female violence, is a gendered construct that is entrenched in societies where women are the non-dominant cultural group (Yodanis, 2004). Recent figures report that the nursing workforce in Australia is 91.4% female (Australian Institute of Health and Welfare, 2003). Whilst this means women are numerically the larger group, from a feminist perspective it also indicates that the majority of the workforce is subject to societal gender inequalities (Yodanis, 2004). It is of note here to recall that often the agents of violence towards nurses are men. It would be congruent, from a Feminist perspective, to argue that the gender of the nursing workforce is one variable that increases the risk of violence towards nurses. This may also have some bearing on the perspective that violence is ‘part of the job’ for nurses and can be considered when discussing the issues surrounding nurses being responsible for acts of violence and aggression (Jones & Lyneham, 2001; Lyneham, 2000; Whittington, 2002).

**Violence in the work place: Nursing prevention and intervention strategies**

There are many recommendations in the literature about workplace violence prevention and the elements of prevention, diffusion and post-trauma support have been posited as the three most important interlocking issues related to violence in the healthcare workplace (Paterson, Leadbetter, & Bowie, 1999). In her assault process model Saines (1999) proposed three intervention points for diffusing violence, the trigger, escalation and crisis phases of violence. Mayhew and Chappell (2003) offer a different model to address occupational violence which is a combination of violence prevention, protection and treatment. It is appropriate to discuss trigger phases and prevention strategies together as both concepts refer to strategies that reduce exposure to violence (Mayhew & Chappell, 2003; Saines, 1999). Similarly, the escalation, crisis and protection phases will be addressed together as they relate to issues concerning responding to, and managing, violent events. Mayhew and Chappell’s (2001a) treatment phase will be discussed in the section concerning the sequelae of violence for nurses.
Trigger or prevention phase

The violence prevention strategies that will be discussed include nursing staff education and training, management of patients, their family and friends, environmental protection strategies and facility policy and procedures.

Staff education and training

Recommendations for staff training and ongoing education about violence prevention strategies such as violence identification, response, de-escalation, diffusion, control, risk factors, self-defense and breakaway strategies are frequently recommended in the literature (Anderson, 2002; Blazys, 2001; Lipley, 2001; Martin & Daffern, 2006; Mayhew & Chappell, 2001b; Meehan, Fjeldsoe, Stedman, & Duraiappah, 2006; Nachreiner et al., 2005; O'Connell et al., 2000). These recommendations are supported by findings such as those by Fernandes (2000) who reported that 68% of respondents in an ED were in favour of violence prevention workshops including education about predictors of violence.

The call for increased education and training however, has its critics. Following a randomised control trial of the effects of training on mental health nurses’ perception, tolerance and adverse feelings towards dealing with aggression, Needham et al. (2004) found no statistically significant difference between the control group and the treatment group and concluded that the capacity of violence management training to effect changes in nursing practice was unconvincing. Badger and Mullen (2003) also reported no statistically significant difference in frequency of violent events between staff who received training and those that did not. Nachreiner et al. (2005) found no statistically significant relationship between the variable of training and the outcome of prevention of physical assault, and generalised that “empirical literature to support this recommendation has been lacking” (Nachreiner et al., 2005, p. 76).

Data concerning the efficacy of training may be skewed because nurses who engage in training are more likely to identify and report violence and, following a violent event, nurses are more likely to recall educational opportunities (Badger & Mullan, 2003; Nachreiner et al., 2005; Whittington et al., 1996). The evidence for the
efficacy of training programs and aggression management programs, particularly in the specialty of ED, remain unconvincing (Alexander et al., 2004). It is also important to note that training for violence prevention is not a substitute for other workplace related solutions (Badger & Mullan, 2003), and education and training does not lessen ED nurses’ exposure to violence, rather it prepares nurses for the event (Deans, 2004).

The patient, their family and friends

The available resources of the health care facility may be mismatched with the demands that people presenting to ED place on the service (Jenkins, Rocke, McNicholl, & Hughes, 1998). The health care sector in Australia has undergone significant changes in the last decade. Most notably, the acuity of recipients of care has increased, length of stay has decreased and there is a nursing shortage, particularly of experienced specialist nurses (Joe et al., 2002; McPhaul & Lipscomb, 2004; Meuleners et al., 2004; Robinson, Jassin, & Ray, 2004). Australian hospitals and EDs are therefore increasingly busy (Knott, Bennett, Rawet, & McD Taylor, 2005) and this is exacerbated by an increased demand for ED services.

An Australian study undertaken by Alexander et al. (2004) noted a tendency for rural and regional GP’s to encourage patients who were perceived to be violent to attend the local hospitals. Referral of potentially violent patients to hospitals or multipurpose health centres was also reported by Tolhurst et al. (2003). These findings illustrate the increased demand on ED resources, particularly in rural and regional areas of Australia, and show how patients as agents of violence may be redirected to hospital environments. The ED staff are then required to manage the patient’s violent behaviours.

In the ED, nurses have a shorter window of opportunity to establish a trusting therapeutic relationship with patients, their family and friends (Baillie, 2005) and are less likely to have information about the patient’s history. These factors, in combination with public perceptions of nursing and ED services, and negative media reports about the health care sector, decrease the capacity of the ED nurse to meet
expectations of service (Dougherty, 2005; Emergency Nurses Association, 2003, 2006a, 2006b; Gillespie & Melby, 2003; Wickett, McCutcheon, & Long, 2003)

The environment

The physical environment of the ED can contribute to violence prevention (Foley, 2004; Keely, 2002; Knefel & Bryant, 2004; McPhaul & Lipscomb, 2004). Mayhew and Chappell (2001b, p. 4) consider “crime prevention through environmental design (CPTED)” a positive, less expensive and long term violence reduction strategy. The Australian Institute of Criminology (2003a) proposes that one of the first strategies that organisations need to use for violence prevention is a pre-planned, context specific hazards audit. Worthington (2000, p. 2) concurs with this opinion and notes that this is a systems approach, rather than a “blame the victim outlook”. Hoag-Apel (1999) recommended increasing comprehensive security in EDs. Fernandes et al. (1999) found 95% of respondents endorsed the implementation of 24 hour security cover for their ED and 76.7% of respondents in May and Grubbs (2002) work supported use of trained security. Only 7% of Australian ED’s meet all 12 of the Australasian College for Emergency Medicine (ACEM) guidelines for security and 21% meet only half or less (Merfield, 2003).

Approaches including management and maintenance of entry points, locked doors with controlled admission, security personnel, security devices and surveillance, duress alarms, convex mirrors, cameras, bulletproof glass, metal detectors and staff identification cards are some of the environmental strategies that ED’s can implement to help prevent violence (Hoag-Apel, 1999; Mayhew & Chappell, 2001b). Additionally, the design of any counters can be adjusted so they have sufficient depth and height to stop people being able to reach across them or climb over them (Mayhew & Chappell, 2001b). ED’s need to be free of objects that are potential weapons, with clear exits for the staff (Australasian College for Emergency Medicine, 2006; Citrome & Volavka, 1999) and limited clutter to prevent staff from inadvertently being trapped (Hoag-Apel, 1999; Lyneham, 1999, 2000). Lyneham (1999) observe that it may not be possible to meet this condition as necessary equipment needs to be available.
Policy and procedures

Prevention and management of violence in the workplace is a shared responsibility of staff and employers (Gilmore-Hall, 2001; McPhaul & Lipscomb, 2004; Saines, 1999; Uzun, 2003). Organisations and facilities are responsible for violence prevention policies and procedures including writing and disseminating policy and procedure regarding expectations about the physical environment; providing sufficient appropriate resources; staff education and training; and policy enforcement (Keely, 2002). Australian Institute of Criminology (2003a), Brockmann (2002), and McPhaul and Lipscomb (2004) add that employers are responsible for documenting and implementing policy and procedures related to violence prevention, response, reporting and debriefing. Commonly signs are placed in clear view for patients, their friends and family outlining the ‘zero tolerance’ policy of the facility (Australian Institute of Criminology, 2003a, 2003b; Lipley, 2001; Mayhew & Chappell, 2001b; Stirling et al., 2001). These policies must be documented, detailed, clearly publicised and promoted, and available for all staff members, patients their family and friends (Mayhew & Chappell, 2001b). The complementary responsibilities of staff include awareness and adherence to the facility policies and procedures.

Human resource policies also need to ensure staff understand the facility’s policy on violence prevention, reporting, expected administrative response and available support mechanisms (Uzun, 2003). Schnieden and Marren-Bell (1995) suggest that it is the responsibility of both the facility and the staff to be informed about the common reasons people seek their health care services, including understanding the demographics of the locality within which the facility is located. Understanding the reason for health seeking behaviour and the reasons for prior violent events informs specific facility policy for violence prevention and encourages the evaluation of existing strategies (Mayhew & Chappell, 2001b).

Escalation, crisis and protection phase

Discussions about nursing behaviours, or environmental conditions that may assist when “violence appears to be eminent” (Mayhew & Chappell, 2003, p. 10) are
referred to by Mayhew and Chappell as the protection approach and by Saines (1999)
as the escalation and crisis phase. One strategy is to call for facility security
personnel or seek assistance from other staff members or the police (Whittington et
(1996) and Whittington and Wykes (1996) found that the most common initial
responses of health care staff to violent events included verbal de-escalation and not
intervening but returning at a later time. Nachreiner et al. (2005) disagree with the
finding that nurses walk away and return later. They suggest that nurses who are
more skilled with violence interventions are more likely to take an assertive role and
diffuse the situation. To a lesser extent restraint, sedation and involuntary admission
of the agent of violence are suggested as protection and response strategies
(McMahon & Fisher, 2003; Whittington et al., 1996).

A questionnaire study of 116 ED Medical Directors in Australia and New Zealand,
undertaken by Cannon, Spirvulis and McCarthy (2001), found that violence or
threatened violence (52%), behaviour related to mental illness (32%) and behaviour
related to substance intoxication (4%) were the most common indicators for restraint.
The retrospective nature of this survey and the respondents’ ability to recall events
was a reported limitation. The findings however, concluded that restraint, particularly
chemical restraint, is used as a means of both violence prevention and as a response
to violent events.

Violence in the healthcare workplace: Nursing assessment strategies
The various unknown elements of the patients, their family and friends, coupled with
the often hectic and chaotic health care workplace, supports the need for nurses to be
able to quickly and accurately assess an individual’s potential to engage in violent
behaviours (Ergün & Karadakovan, 2005; Hoag-Apel, 1999). Hoag-Apel (1998) and
Glorioso (1995) recommend assessing patients, their family and friends for their
levels of fear, agitation and feelings of loss of control that may be the precursors to
increased aggression. These emotions may manifest as pacing, increased volume of
speech, increased hostility, clenched fists, reddened face, pressured speech, rapid
breathing or a change in level of consciousness (Usher, Luck, & Foster, 2005).
Whilst this seems obvious, it is very difficult to predict violence, even subsequent to
a nursing violence risk assessment (Jackson, Veneziano, & Ice, 2005; Littrell & Littrell, 1998; Worthington, 2000). There is a gap in the literature with respect to nursing assessment tools that have focused on assessment and prediction of violence towards nurses in settings outside of the mental health specialty (Landy, 2005; Murphy, 2004).

As discussed, the literature indicates that particular categories of patients are commonly agents of violence, for example people intoxicated or withdrawing from alcohol, and people who have a mental illnesses. It is therefore reasonable to infer that these health assessment tools could be useful for violence assessment (Crilly et al., 2004). Doyle and Dolan (2002), Trenoweth (2003) and Otto (2000) label this the actuarial approach to violence risk assessment. The actuarial risk assessment, in relation to psychiatric symptoms, identifies mental health conditions that are statistically associated with violence, and thus people who fit the empirical categories are considered violence risks. This model is a predictive model for risk assessment and Doyle and Dolan (2002) claim it is congruent with moves for evidence based practice in nursing (2002). The strength of this approach is its objectivity, “presumably high reliability and known error rates” (Otto, 2000, p.1242).

Another violence risk assessment model that both Trenoweth (2003) and Otto (2000) propose is the clinical approach. In the mental health specialty, Trenoweth (2003) found that clinicians undertook risk assessments by considering; knowing the patient, their history, beliefs and background; tuning in, observing for possible signs and causes of agitation; considering the possibilities, including assessing the patient’s potential for violence; and working as a team. They identify this as the clinical approach. Doyle and Dolan (2002) state that the clinical violence risk assessment approach is the historical approach mental health professionals use to make a subjective judgment, based on the patient’s interview data and history of violence. The advantage of this subjective, unstructured clinical approach is its flexibility and recognition of the individual and context within which the assessment is undertaken. Prediction, assessment and prevention of violence in the health setting, and specifically towards nurses, are evidently complex. The actuarial and clinical assessment approaches are important for the specialty and context of mental health nursing however they do not offer guidance for settings such as the ED. Adding to
these problems are the various issues related to the consequences of violence for nurses.

Violence in the healthcare workplace: The sequelae for nurses

Discussion of the multiplicity of consequences that violence in the workplace has on nurses further illustrates the complexity of this phenomenon. The sequelae of violence towards nurses, as mentioned, is compatible with Mayhew and Chappell’s (2001a) treatment phase, thus in addition to the effects of violence, recommendations about post violence treatment will be discussed.

The individual and organisational consequence of violence in the ED does not end following the conclusion of the violent event. Violence can negatively effect subsequent job performance and productivity (Keely, 2002), job satisfaction, morale, retention, recruitment (May & Grubbs, 2002; Ryan & Maguire, 2006; Wells & Bowers, 2002; Wickett et al., 2003), and increase rates of leave including sick leave, stress leave and compensation leave (Holmes & Gastaldo, 2002; Jackson et al., 2002; Keely, 2002; Nijman et al., 2005). In addition to the possible physical consequences for the nurse such as fractures, bruising, sprains (Carlsson et al., 2004; Levin et al., 1998) and exposure to biologically hazardous or infectious materials including human blood, blood products or body fluids (Foley, 2004; O’Connell et al., 2000), there are psychosocial consequences following experiencing a violent event.

The psychosocial sequelae of violence reported by nurses include symptoms of clinical depression such as feelings of worthlessness, sadness, crying, emptiness, disturbed social and physical wellbeing, anger, burnout, withdrawal (O’Connell et al., 2000), anxiety, insomnia, post-traumatic stress disorder, impaired immune system, and increased substance abuse (Gilmore-Hall, 2001; Hellzen, Asplund, Sandman, & Norberg, 2004; Needham, Abderhalden, Halfens et al., 2005). Early and Williams (2002) and Nabb (2000) reported that some nursing staff had left their positions, in part a result of workplace violence.
All of these consequences can have a negative impact on public health care costs, including insurance claims, compensation premiums (Cutcliffe, 1999; Mayhew & Chappell, 2001a; Queensland Health, 2002), overheads for additional security personal and technology (Carter, 1999), loss of productivity (Paterson et al., 1999), lost work time, staff replacement and education and training (Levin et al., 1998; Lyneham, 2000). These consequences can further lead to a poor community image of the facility or unit (Emergency Nurses Association, 2003; Queensland Health, 2002).


**Violence: Risk factors for nurses**

Somewhat controversial is the notion that nursing staff are not “uniformly at risk of aggression” (Winstanley & Whittington, 2004a, p. 4). Interpersonal variables such as the individual nurses education level, relationship to the agent of violence, work location and level of seniority have an effect on the frequency of violent events (Adib et al., 2002; Anderson, 2002; Calabro, Mackey, & Williams, 2002). Additionally, the age of the nurse is revealed as being an important, yet poorly understood, variable (Badger & Mullan, 2003; Farrell et al., 2006; Morcombe, 1999; Needham, Abderhalden, Zeller et al., 2005) and the significance of years of experience is debatable (Arnetz & Arnetz, 2000). Gender of the nurse, is not identified as an important variable by Whittington (1997), Alexander (2004) or Wells and Bower (2002), however it is reported as significant by others (see for example Calabro et al., 2002; Keely, 2002; Mayhew & Chappell, 2001a; Nijman et al., 2005). Mayhew and Chappell (2001a) report that females tend to have higher incidence of verbal abuse and violence then males. Further, they claim, this may also reflect the female dominance of nursing and their respective positions within facilities that led
to females being concentrated in the “lower status and ‘caring’ jobs with greater face-to-face contact” (Mayhew & Chappell, 2001a, p. 3).

Roy (1999/2000) and Winstanley and Whittington (2004a) found that triggers for aggression included nursing staff initiating physical contact, for example, providing pressure area care or giving an injection. Some nursing staff may be more at risk of a violent event related to their position and role within the health care system (Winstanley & Whittington, 2004a) because of the nursing philosophy of continuity of care that leads to the same nursing staff being repeatedly assigned to the agent of violence. Nurses whose roles include exercising authority frequently experienced violent events (Roy, 1999/2000; Whittington et al., 1996; Winstanley & Whittington, 2004a, 2004b). Hegney et al. (2003) and Duxbury (2002), however, found no difference in levels of reported violence based on nursing designation. The contradictory findings of the literature may be explained by cultural and contextual differences, sample selection or the retrospective nature of the survey designs.

**Violence: The silent voice of nurses**

Having defined violence for the purposes of this study, it is important to discuss the issue of nurses’ individual desensitisation, or habituation to violence in the workplace (Deans, 2004; Erickson & Williams-Evans, 2000). It is worrying to see evidence that nurses rationalise episodes of violence, and consider that violence is part of the job (Alexander, 2001; Carter, 1999; Erickson & Williams-Evans, 2000; Jones & Lyneham, 2001; Love et al., 2003; Lyneham, 2000; McPhaul & Lipscomb, 2004; Roy, 1999/2000; Whittington, 2002; Whittington et al., 1996). Additionally, it is of concern that this perception is an institutionally, culturally and professionally “sanctioned and reinforced norm” (Alexander et al., 2004, p. 388) and speculated to be part of the reason why nurses under report violence, in particular verbal violence (Levin et al., 1998).

Many studies suggest that episodes of violence towards nurses in the workplace, and ED, are often under reported, unreported or underestimated (Crilly et al., 2004; Erickson & Williams-Evans, 2000; Ferns, Stacey, & Cork, 2006; Jackson et al., 2002; Keely, 2002; McMahon & Fisher, 2003; Ryan & Maguire, 2006; Winstanley
Further, episodes of physical violence are more likely to be reported or documented than episodes of non-physical violence and nurses who experience more episodes of violence are less likely to report the violence (Erickson & Williams-Evans, 2000). Rose (1997, p. 217), found that 49% of Irish nurses surveyed (n=27) reported being assaulted in the preceding 12 months yet “63% of all incidents and 29% of physical assaults were unreported”. Despite this, it has also been proposed that the increased incidence of violence in nursing is a sign of the success of efforts to increase awareness of violence and encourage reporting (Arnetz & Arnetz, 2000; Winstanley & Whittington, 2004a). Wells and Bowers (2002) and Hegney et al. (2003) query whether there is an increase in violence or an increase in recognition and reporting of this long term problem.

Nurses may choose not to report violent events because they believe they will be reprimanded for the violent episode because of something they did, or did not do (Schnieden & Marren-Bell, 1995). This is confirmed by Erickson and Williams-Evans (2000) who reported that only 49.1% of nurses “disagreed with the statement, ‘Nurses who take legal action against a patient are in jeopardy of losing their jobs’” (Erickson & Williams-Evans, 2000, p. 212). The onerous task of incident reporting in many facilities may be a barrier to nurses reporting violent events (Schnieden & Marren-Bell, 1995). Further, nurses may believe that there will be no positive outcome, or institutional changes to workplace practices or safety following the reporting of violent events (Alexander et al., 2004; Hegney et al., 2003; Lyneham, 1999). This perception prevails even when staff identify reporting violence to be an appropriate action (Levin et al., 1998). Nurses may also perceive reporting violent incidents as ‘rocking the boat’ and may choose to minimise the event, and subsequent emotional impact, by not reporting the event (O’Connell et al., 2000). Finally, the lack of a consistent definition in the literature may mirror the subjective interpretations of nurses concerning what constitutes violence (O’Connell et al., 2000). All of these considerations could account for, or contribute to, nurses not reporting violent events and their acceptance that violence is part of the job, particularly if they perceived that this could lead to a negative outcome for the agent of violence or themselves (Erickson & Williams-Evans, 2000).
Violence: The research methods in nursing

Commonly issues related to violence in the health care setting and violence towards nurses, have been explored using retrospective quantitative questionnaires (Anderson, 2002; Chambers, 1998; Hegney et al., 2003; Hinsby & Baker, 2004; Martin & Daffern, 2006; O'Connell et al., 2000; Winstanley & Whittington, 2004a). In ED’s survey research frequently quantifies questions such as: definitions of violence (Alexander et al., 2004; Ryan & Maguire, 2006; Tighe et al., 2006); staff stress related to violence; degree and range of violence encountered and the effect of education on workplace violence (Deans, 2004; Erickson & Williams-Evans, 2000; Meehan et al., 2006). The most common aims of nursing research is to explore and describe predictors of violence, management of violent events and incidence of violent events (Hinsby & Baker, 2004; O'Connell et al., 2000).

The strength of retrospective quantitative survey approach is the capacity to gather information about unreported violence (Levin et al., 1998). One of the major considerations when using survey data particularly regarding the emotive issue of violence is the problem of response bias, recall and memory (Alexander et al., 2004; Jackson et al., 2002; O'Connell et al., 2000) leading to over or under reporting of violence. The problem of self selection further exacerbates the methodological difficulties of representiveness inherent in survey research (Borbasi, Jackson, & Langford, 2004) and thus negatively impacts upon the generalisability of findings. Erickson and Williams-Evans (2000) noted that there was a complexity of contextual variables that related to violence toward ED nurses that could not be adequately addressed by a questionnaire that included cultural and societal norms, language and descriptions of assaults.

There are few studies on violence in the ED that have used qualitative designs (Hislop & Melby, 2003; Pryor, 2005). Levin et al. (1998) used focus groups to seek the opinions of nurses regarding what they perceived to be factors that contributed to violence towards nurses in an American ED. Hinsby and Baker (2004) used a grounded theory approach in a mental health setting to understand violence, the nurse and patient perspectives on violence, and their definitions of violence. A phenomenological study was undertaken by Hislop and Melby (2003) who sought to understand the experiences of Irish ED nurses following a violent event. Qualitative
approaches harness information that is broader than that revealed by the closed ended questions typical of survey research however they are infrequently used to address the questions posed by violence towards nurses.

The absence of research on violence towards nurses in ED that attempts to overcome the problems of recall and memory bias has been noted (Erickson & Williams-Evans, 2000; McPhaul & Lipscomb, 2004). Erickson and Williams-Evans (2000), Jackson et al. (2002) and Lau and Magarey (2006) suggest that observation of violent events could overcome the methodological problem of recall. Participant observation of violent events, therefore, could enable comment to be made on the complex interactive nature of the agent of violence, the nurse and the contextual milieu (Crilly et al., 2004). Limited research has been done regarding violence assessment, prediction and the emotional toll on ED nurses of violence in the ED.

**Justification of this study**

There is limited Australian research into violence in the Australian Health sector and the specialty of ED (Jones & Lyneham, 2001; Knott et al., 2005; Mayhew & Chappell, 2001a; Meuleners et al., 2004; Rodger et al., 2004) particularly the rural and regional Australian ED (Deans, 2004; Maskell-Knight, 2002; Tolhurst et al., 2003) where nurses are more at risk of violence than their metropolitan counterparts (Anonymous, 2003; Hegney et al., 2003). In Australia, nursing is an aging profession yet despite the evidence to suggest that less experienced nurses are more frequently the targets of violence, violence is an escalating problem (Australian Institute of Health and Welfare, 2003; Cronin & Cronin, 2006; Goodin, 2003). There is a need for further research into the problem of violence towards regional and rural Australian ED nurses that can uncover new perspectives and innovative solutions.

The escalation of violence in Australian EDs indicates that the existing preventative strategies such as education, environment management strategies and facility policy and procedures, are not working. Further, it appears that facility support for recipients of violence is poorly understood by staff and underutilised (Crilly et al., 2004). Existing mechanisms for documenting and reporting violence may not provide enough detail to enable an understanding of the dynamics and the context
within which a violent event occurs (Brockmann, 2002; Hegney et al., 2003; Jones & Lyneham, 2001; Levin et al., 1998; Winstanley & Whittington, 2004b). The literature reflects a paucity of research on Australian ED nurses’ contextual experiences, violence risk assessment skills, prevention strategies and accounts of violence (Catlette, 2005; Erickson & Williams-Evans, 2000; Hegney et al., 2003; Ryan & Maguire, 2006). Further, there is a noticeable over reliance on retrospective questionnaires to explore the topic of violence towards nurses. These issues need to be addressed and further examined to improve understandings of the contextual mechanisms that give rise to the challenge of violence towards nurses. This study will use a mixed method instrumental case study approach to gain greater insights into this ongoing challenge for nurses.

The need for ongoing research into prevention and intervention strategies for health care services and nursing is evidenced by the ongoing nature of the problem (Arnetz & Arnetz, 2000; Nolan, Soares, Dallender, Thomsen, & Arnetz, 2001; Schafer, 2005). A greater understanding of the phenomena of violence towards ED nurses, as it is manifest in the real world rural and regional Australian setting is needed to develop potential solutions for this problem. Researching violence towards Australian ED nurses contextually is a critical step in understanding and preventing violence towards nurses (Brockmann, 2002; Jackson et al., 2005; Levin et al., 1998). This study will address these gaps by exploring the contextual processes and understandings rural and regional Australian ED nurses use to assess for their risk of violence and prevent or avert violence when the agent of violence is the patient, their family or friends. This study will also examine the nature and scope of the individual consequences of violence for these ED nurses.

Summary

As this chapter has shown, violence towards nurses in the ED is an endemic, world wide, multi faceted problem. A salient feature of the problem is the lack of a consistent definition of violence. The presumed contributory characteristics of the nurse, the patient, their family and friends have been discussed in relation to violence towards nurses. The contemporary issues concerning nurses’ violence assessment and prevention strategies have been reviewed with particular emphasis on their
disputed efficacy. Importantly, there is compelling evidence to support the need for research into localised understandings of the contextual issues that surround violence towards nurses, where the agent of violence is the patient, their family or friends, in remote and rural Australian healthcare facilities. These understandings can then inform localised, specific solutions. The following chapter will explicate the mixed methods, instrumental case study design used to address the research question.
Chapter Three - Abstract

This chapter reviews the current literature on case study as a research framework. There is a focus on relevant aspects of the proposed research framework including; the types of case study designs; the construction of the ‘case of’ within case study design; and the value of generating mixed methods data using an instrumental case study design. Mixed method instrumental case study design as a framework for both quantitatively informed and qualitatively informed nursing research is addressed. Finally, the argument is presented that a mixed method case study framework, as a research design for nursing research can bridge the traditional perspectives thereby enabling the researcher to congruently choose methods from either traditional perspective. This is also supported by the proposed construction of the ‘case of’ for the current study. Parts of this chapter have been previously published and presented at conferences (see Appendix B).
Chapter Three - Mixed Methods Case Study Design

Introduction
Case study as a teaching and research tool has an extensive history in health and social sciences. Despite its suitability for many of the research questions that face nurses, nurses have not fully embraced case study as a comprehensive approach for research. The vagaries of the real life clinical setting can confound methodologically purist researchers. Case study provides a milieu in which nurse researchers can respond to these vagaries and move towards a paradigmatic openness. In this chapter it will be argued that case study offers an as yet, under-explored and under-utilised potential as a bridge across the traditional research paradigms. Further, case study has broad research application and epistemological, ontological and methodological flexibility. When used as a research approach, case study is both the process and end product of research. It provides a delineated boundary for inquiry, and a structural process within which any methods appropriate to investigating a research area can be applied.

This chapter will discuss the established approaches to case study and the discourses surrounding different approaches to case study. The definition of pragmatic, mixed method instrumental case study used in this research is presented. Particular attention is paid to conceptualisations of case study, the case, and identifying ‘a case is’ versus ‘a case of’. The phenomena of interest or the ‘case of’, explored as a general empirical unit and specific theoretical construct, will be justified. The position of the researcher with respect to the epistemology and ontology is explicated in light of the pragmatic mixed method instrumental case study design and the proposed ‘case of’.

Background of case study
Case studies are utilised in a range of social science (Ragin, 1992; Tashakkori & Teddlie, 1998; Yin, 2003) and health care disciplines involving people and programs
Case study is contemporarily applied in a broad range of disciplines; psychology, political sciences, sociology, social work, business, community planning, economics (Hammersley & Gomm, 2000; Stake, 1995; Yin, 2003), anthropology, law (Nieswiadomy, 1998), human geography, education (Mason, 2002), management (Garson, 2004), public administration (Jensen & Rodgers, 2001), medicine, and nursing (Bryar, 1999; Nieswiadomy, 1998). Social anthropologists have used case study to examine single individuals through to large groups, especially those with shared cultural backgrounds (Dempsey & Dempsey, 2000). Case study can be used as a teaching technique (Stake, 2000), for instructional purposes (Stake, 1995), as a form of record keeping to facilitate practice (Yin, 2003), and a strategy to solve practical problems (Hammersley & Gomm, 2000). Case study as a research method (Platt, 1992), and a term in the research literature, has a varied history of use (Hammersley & Gomm, 2000).

Early case study work was normatively empirical and related to social workers’ case history or case work (Platt, 1992). Case study has its American roots in the Chicago School of Sociology (Tellis, 1997), the study of life histories and case work in social work (Platt, 1992). The traditional approaches to case study identified by Platt (1992), however, highlights how the use of case study has changed. Prior to 1930’s, a feature of case study was the discovery of personal meaning. This particular characteristic was lost by the 1960’s. The historical roots in the Chicago School (Platt, 1992) and the recurrent presence of case study content in sociological texts goes some way toward explaining why the use of participant observation as a data collection method became enmeshed with case study. Following these historical movements, case study took on the prevailing features of multiple, intensive data collection strategies and rich context (Platt, 1992).

Case studies commonly explore, describe or explain the case of interest and enable holistic and meaningful, context constituted knowledge and understandings about real life events (Yin, 2003). Case study can be used to extensively study or analyse relatively common, or rarely, occurring phenomena (Borbasi et al., 2004). Further, it provides a means of “exploring the phenomena or phenomena of in their context” (Holloway & Wheeler, 1996, p. 221) and this is an accepted feature of case study (Yin, 2003). Thus, case study method is undertaken in contemporary real life
contexts where the phenomenon of interest is inter dependent, or enmeshed with the context of study (Yin, 2003).

Case studies have the capacity to offer purposive, situational or interrelated descriptions of phenomenon, connecting practical complex events to theoretical abstractions (Stake, 2000). Both medicine (Nieswiadomy, 1998) and nursing have a history of employing case study technique (Langford, 2001) though they are not as commonly seen in nursing literature as they once were (Langford, 2001). Ellis (2003) used a case study approach to enable a practical, yet theoretically appropriate approach in her study on continuing professional nursing development. The tension between rigid methodology and the practicalities of the real life setting of the United Kingdom’s National Health Service was resolved by McDonnell, Myfanwy and Lloyd’s (2000) pragmatic use of case study. These characteristics, and examples, support the argument for the application of case study research to the practice of nursing, and thus supports case study as a congruent research strategy for the nurse researcher. Contextual knowledge about violence towards nurses can be uncovered using multiple methods within a defined ontological and epistemological position, employing congruent data collection methods within a temporal and geographically defined, or bounded, context.

**Defining case study**

Although case study has some definitional problems (Bryar, 1999; Hammersley & Gomm, 2000; Stake, 2000), part of a generically accepted definition is that case study is an intensive, detailed, in-depth study, examination or investigation of a single unit - the case - (Dempsey & Dempsey, 2000), where the focus is on the particular (Bryar, 1999; Langford, 2001). Case study is most commonly defined by the choice of case rather than the choice of methods (Stake, 2000) or paradigmatic approach (Jensen & Rodgers, 2001) yet it is not sufficient to define case study by citing topic alone (Yin, 2003). The end product may be referred to as a case record but more generally the report is called a case study (Stake, 2000). The term case record does not capture the critical aspects of case study as it pertains to research. The case study can be considered the process and end product of research (Stake, 2000). Whilst case study as both process and end product clearly resonates with a
qualitative approach to inquiry, a case study may be methodologically constructed such that the process and end product offers an evaluation of the case (Pegram, 1999). Case study also has features that resonate with a quantitative approach.

The conduct and results of case studies differ (Ragin, 1992) according to the context in which they are carried out, and the philosophical assumptions that inform the particular study. Definitions of case study include case study as an empirical or theoretical inquiry (Ragin, 1992). It has also been claimed that “virtually every social scientific study is a case study or can be conceived as a case study because it is an analysis of social phenomena specific to time and place” (Ragin, 1992, p. 2). For the purposes of the flexible, pragmatic use of case study proposed in this thesis, case study is defined as a detailed, intensive study of a particular contextual, and bounded, phenomena that is undertaken in real life situations. Importantly for the researcher’s definition of case study, is their applied definition of ‘the case’.

**Identifying ‘the case’**

Akin to the difficulties defining the term case study, the term ‘case’ also carries a variety of meanings (Ragin, 1992). It is important for the researcher to define their meaning of the term ‘case’ (Ragin, 1992) and thus delineate the case study. Phenomena of interest are revealed through the case, and understandings of complex human interactions and personal meanings are developed through multiple methods including sustained engagement in the field (Creswell, 1998). Stake (2000) categorises the case as intrinsic, instrumental and collective and this categorisation reflects the potential variation in the case. Ragin (1992) argues that the changes to the use of the term case, as a basic methodological construct, represents a distortion or corruption of its use over time. There are, however, some identifiable and fundamentally accepted characteristics of the term case that are coherent with the proposition that case study is a bridge across the paradigms.

The case is a single specific phenomena (Creswell, 2003). Case study research has particular boundaries; therefore the case is a system (Stake, 2000) that is bounded by time, place (Ragin, 1992) and event or activity (Creswell, 1994) and these boundaries can assist in limiting data collection (Yin, 2003). These boundaries are explicitly set
via the description of the locale, culture, group process or institution (Stake, 2000). The case is a recognisable specific, complex, integrated system (Stake, 1995), it is purposive and “it often has self” (Stake, 2000, p. 436), that is, the case is the object of study rather than the process (Stake, 1995). Within the case, there is coherence.

The single population or single subject of the case study can be readily identified (Dempsey & Dempsey, 2000) and they are similar enough to be treated as instances of the same phenomenon (Ragin, 1992).

It may not, however, be easy to distinguish the case from the context (Stake, 2000), nevertheless what is important is that the boundaries of the case can be readily distinguishable from events, behaviour or actions that are outside the boundaries of the case (Stake, 2000). The case also describes a real situation (Yin, 2003) and is therefore well suited to naturalistic inquiry (Denzin & Lincoln, 2000). However the case is socially manifest it nevertheless shares the research driven feature that it is a single entity or single object or unit that may be studied as a whole (Pegram, 1999). Importantly, the case boundaries need to be congruent with, and explicit in, the research question asked and data collection methods used (Holloway & Wheeler, 1996).

A ‘case’ versus ‘a case of’

The boundaries of the case may be informed by literature allowing for comparison of findings with similar studies (Yin, 2003). The boundaries of the case may also be derived from the implicit boundaries of time, geography, place, and event, and are thus almost pre-existing, real and empirically bound (Ragin, 1992). A hospital ward or unit is a good example (Dempsey & Dempsey, 2000). Conversely, they may be specific or general theoretical constructs (Ragin, 1992) for example, constructs of self-neglect (Lauder, 1999), injury prevention (Hendrickson, 2003), the taxonomy of needs assessment (Cowley, Bergen, Young, & Kavanagh, 2000) and patient’s views of quality of life (Dale, 1995). What the case is ‘a case of’ does not negate the importance of understanding the case (Stake, 2000) nor does it negate the capacity of the case study to uncover contextual knowledge about the phenomenon of interest (Stake, 2000). This is controversial, however, as Ragin (1992) argues that it is important to understand what the case is ‘a case of’ (Ragin, 1992). Further, he
suggests that the discourse used to determine what the case is ‘a case of’ reflects the inquirers conception of a case. Ragin (1992) has a four cell, 2 x 2 conceptual dichotomy to answer the question “what is a case?”. A case has either empirical units or theoretical constructs and these are either general or specific (Ragin, 1992; Stake, 2000). Cases are thus either conceptualised in realist terms and exist independently, or are the consequence of theoretical abstractions or conventions (Ragin, 1992). Empirically real and bounded cases are cases that are found or cases that are objects (Ragin, 1992). For example, a case of ‘the community’ could be defined by geographical or bureaucratically defined boundaries (the case is an object) or uncovered via the definitions offered by the members of the community (the case is found) (Harper, 1992). Alternatively, cases as theoretical constructs are cases that are made, such as patient’s views on quality of life (Dale, 1995) or cases that are conventions, such as constructs of self-neglect (Lauder, 1999).

The second dimension of Ragin’s (1992) dichotomy pertains to the issue of case categories. Here, the question is of how the case categories are discovered or defined. The case categories can be defined by the process of the research (or its products) and are developed and emerge (cases are found or cases are made), and thus are considered specific conceptions. Alternatively, the case categories are pre-existing, or generic units, and are merely utilised by the researcher (cases are objects or cases are conventions) (Ragin, 1992).

In this typology, it is important that the researcher conceptualises both the case, and identifies what it (the case) is ‘a case of’ (Ragin, 1992). Becker (1992) challenges Ragin, and whilst he does not take up the position held by Stake (2000), he suggests that it is not always possible to define what is a case “or more precisely, what this – the research subject – is a case of ” (Ragin, 1992, p. 6). These two positions highlight contrasting meanings of the term case. In the first instance, the case must be a well defined ‘case of’. The researcher needs to know what the case is ‘a case of’ before the study begins. This supports the researcher identifying variables of interest and seeking causal relationships. Alternatively, the researcher adopts a position of openness with respect to the case, allowing the case to emerge inductively through an interpretative research process. Depending on the researcher’s conceptualisation of the case, issues such as generalisability, the position of theory, causal versus
narrative analysis and authority versus authenticity need to be addressed (Hammersley & Gomm, 2000). Thus there is a position for both qualitative and quantitative approaches depending on the theoretical construction of the case. Ragin’s (1992) dichotomy further defends this position as he acknowledges that the fourfold division is not mutually exclusive. The particular theoretical position of the researcher can be argued within the logic of their epistemological, ontological and methodological approach.

**Mixed methods and case study approaches**

Methods, throughout this thesis, refer to the tools, procedures or techniques the researcher employs to generate and analyse data (Crotty, 1998). There is no agreed upon set of methods for case study. Rather, methods are selected in relation to the nature of the case and the research question. Thus it can be argued that case study is more appropriately considered a research approach or strategy (Dale, 1995; Yin, 2003). Further, because any set of methods that will help to develop understanding can be used, case study is a bridge that spans the research paradigms. In addition to flexibility of method, case study acknowledges that the context shapes events in important ways. An assumption is that the variability of the case profoundly effects the issues or phenomena of interest (Marshall & Rossman, 1995). Acknowledgment of the particular characteristics of the ‘case’ such as culture, site, geography or resources, enables a detailed evaluation that is embedded in particular contextual characteristics and issues. Case study is used to gain knowledge of contextual phenomena about an individual, group, organisation, institution, social, or political event (Langford, 2001; Yin, 2003) or a situation where people, or a group, share a particular contemporary phenomenon (Dempsey & Dempsey, 2000). Thus, case study is undertaken in complex real life situations that have events, aesthetics, physical dimensions, celebrations, and politics (Stake, 2000), all situated in time and space. There is a deliberate re-searching for understanding of human knowledge and meaning in the complex social, physical and situational real-world (Stake, 2000).

In the current climate where there is openness for nurse researchers to explore paradigmatic choices, case study is a compatible vehicle for the practice based discipline of nursing. Further, Creswell (1994, p. 4) argues that the extreme
characteristics of the traditional paradigms are merely a “heuristic device”. Case studies are very broadly considered qualitative or quantitative (Yin, 2003) or both, depending on the research question, design and purpose (Jensen & Rodgers, 2001; Nieswiadomy, 1998) and thus are coherent with tenets of pragmatism. Pragmatism supports the position that qualitative and quantitative methods are compatible (Tashakkori & Teddlie, 1998). Case study is well suited to qualitative approaches with which it shares an underpinning belief of contextual holism. Guba (1990) infers that case study is a qualitative method when discussing the qualitative methods of “phenomenology, ethnography and case study” (Guba, 1990, p. 22). Quantitative and empirical methods are also used in case study designs. Case study is used to explain causal relationships between real life variables (Hammersley, 1992; Yin, 2003). Quantitative case study strength is derived from its capacity to explain causal links (Garson, 2004), to describe, to illustrate, to explore, and may be undertaken as a meta-evaluation (Yin, 2003). When used in this way Yin (2003) argues that case study is not a data collection strategy or a design alone, rather it is a method and thus can be considered a “comprehensive research strategy” (Yin, 2003, p. 14). Ragin (1992) presents a plan for case study where researchers explore variables within or between cases. This approach is congruent with the two by two conceptual map he uses to define ‘a case’ (Ragin, 1992). In this way, variables can be explored within a single case, or a comparative analysis of variables can be undertaken.

In the comparative analysis a variable, or variables, is explored across multiple cases. Ragin (1992) calls this a variable-orientated approach, while exploration of a variable, or variables, within a single case is identified as a case-orientated approach (Ragin 1992). Ragin (1992) argues the merits of the study of variables within (or between) cases, rather than supporting the study of the entire case. Despite arguments by Yin (2003) and Ragin (1992) for constructing case study quantitatively, case study knowledge may or may not be formed quantitatively or in the manner of a “working hypothesis” (Lincoln & Guba, 1985, p. 38). Stake (2000) identifies three types of case study; intrinsic case study, instrumental case study and collective case study. It is both the particularity and ordinariness of the case that the researcher is interested in understanding. Stake argues that an intrinsic case study encapsulates rich, complex meaning and describes the case with
sufficient descriptive text and narrative to allow the reader access to the phenomena of interest and context (Stake, 1995). The aptness for application to qualitative inquiry is apparent with the researcher goal of teasing out experiences and subjective understandings (Stake, 2000). There is no search for scientific or analytic generalisation or theory building. Stake (2000) claims, however, that if the end product sufficiently describes and interprets the case some degree of generalisation is unavoidable. In this sense the case is generalised through the commonality and recognition of events, contemporary and prospective (Stake, 2000). Building on these tenets Stake (2000) distinguishes the intrinsic case study from the instrumental case study. Stake’s (2000) conceptualisations are not the only possibilities for the construction of case study research.

Instrumental case study refers to an interest in a particular case with a view to examination of an issue for insights (Stake, 2000). The specific case is important as it uncovers knowledge about the phenomena of interest, which may not be the case itself. Rather, the phenomena of interest may be some other related concern. Other cases may share similarities or highlight differences nevertheless, the case is chosen for study because in some way it facilitates understanding of the phenomena of interest. Thus the difference between the intrinsic case study and the instrumental case study is not the case, but the purpose of the study of ‘the case’ (Stake, 2000). Instrumental case study offers the researcher and theorist opportunity to focus on their concerns, illustrated via the case. Instrumental case studies support the researcher taking advantage of their own knowledge about the case, or critical issues pertaining to the case, potentially enabling the use of pre conceived taxonomies or coding schemes and previously developed instruments. The third type of case study identified by Stake (2000) is the collective case study. The collective case study involves collecting data from a number of cases to understand a particular phenomenon (Stake, 2000).

From a public administration perspective, Jensen and Rodgers (2001) have a quantitative typology of case studies that include the snapshot case study, longitudinal case study, pre-post case studies, patchwork case studies and comparative case studies. Snapshot case studies are akin to single case studies and include a temporal dimension. Jensen and Rodgers (2001) claim that the snapshot
case study offers qualitative depth and richness of data. The longitudinal case studies encompass dimensions and dynamics of change and differ from the single point in time of snapshot case study because they occur over a long period of time. Longitudinal case studies can be either qualitative or quantitative. Pre-post case studies mimic the traditional non experimental pre-post test design and are thus often longitudinal and theory testing. The patchwork case study is an integration of snapshot, longitudinal or pre-post case studies, rather like a case study meta-analysis. The patchwork case study, however, needs to be focused on one entity, where an entity is defined similarly to ‘the case’. Finally, comparative case study is defined similarly to other definitions of comparative or multiple case study but can gather either qualitative or quantitative data (Jensen & Rodgers, 2001).

Researchers who support a quantitative multiple case study can also value the particularistic feature of a single case study. Yin (2003) offers five quantitatively derived reasons for a single case study. First, it is a critical case that will test a theory on its own. Second it is a extreme or unique case and third it is representative or typical, fourth it is revelatory and fifth it is longitudinal (Yin, 2003). Yin (2003) also argues for holistic versus embedded case studies. The holistic case study examines more global concepts such as phenomena of interest, whereas the embedded case study has any number of ‘units’, such as individuals (Yin, 2003, p. 42) where the individual can be construed as a single case within a comparative case study. Case study, however, continues to evolve (Yin, 2003) and may be increasingly used in conjunction with various methods.

These divergent examples serve only to highlight the paradigmatic flexibility of case study and offer further support to the position that it is fitting to construct a case study as a mixed method pragmatic research design. The work of Yin (2003), Ragin (1992) and Stake (2000) serve to exemplify the potential application of the differing paradigmatic positions to the use of case study for research. Of note is the agreement that multiple and mixed methods are all appropriate data sources for case study research (Dempsey & Dempsey, 2000; Stake, 1995; Yin, 2003). This further supports the contention that within a defined epistemological, ontological and methodological framework the researcher can congruently argue the rigour of using mixed methods.
within pragmatic case study research. Further, this can be achieved within the structure of a single or multiple case study.

**Single or multiple case(s)**

Case studies may be descriptive, explanatory or exploratory of a single case, or multiple cases (Yin, 2003). Comparative case method is sometimes used interchangeably to denote a multiple case study (Yin, 2003) or collective case study (Borbasi et al., 2004; Langford, 2001). There are, nevertheless, subtle differences. Commonly, multiple case studies have positivistic derivations and include the goal of replication, thus they are a vehicle for generalisability (Yin, 2003). The term comparative case study, when referring to a multiple case study, can be used by both the qualitative and quantitative researcher (King, Keohane, & Verba, 1994). Yin (2003) argues the merits of multiple case studies as they fulfill the conceptual requirement of theoretical or literal replication and support analytic generalisability. Collective case studies, however, can be undertaken to understand a phenomenon, a population or a general condition and may be considered an extended instrumental case study (Stake, 2000). The similarities or differences in the chosen cases are not of as much importance as the understanding of the shared phenomena of interest that can be discovered through the cases. Hence, single versus multiple case study is not a definitional distinction for paradigmatic preference, as researchers can apply both single and multiple case studies qualitatively and/or quantitatively.

**Case study and freedom of paradigm**

There may well be an arguable connection between the historic changes in use of case study research and the history of epistemological perspectives. That is, case study research practices historically mirror the ‘moments’ of research as defined by Denzin and Lincoln (2000). In particular, the traditional period, modernist phase and the third stage, blurred genres. Hammersley and Gomm (2000) also suggest that the changes over time in application and definitions of case study method may reflect the paradigmatic positions with which it has been contrasted. Both perspectives acknowledge the historical movement in definitions of qualitative research. When discussing the definition of the term paradigm, Guba (1990) suggests that “having
the term not cast in stone is intellectually useful” (Guba, 1990, 17), and allows the possibility of reshaping understandings.

The term ‘case’ is subject to varying definitions and uses (Ragin, 1992) and the term ‘case study’ is also used in a variety of ways (Hammersley & Gomm, 2000). Adopting the approach taken by Guba (1990) to the problem of defining case study may also prove methodologically useful. In particular, a flexible definition of case study may be useful for researchers interested in nurses’ knowledge, involving practical application. Flexibility in qualitatively defining case study research is coherent with Denzin and Lincoln’s (2000) seventh moment, the present. This moment endorses flexibility of epistemology, ontology, axiology, methodology and rhetoric reflected in qualitative researchers freedom to choose between canonical text, freedom of paradigm, and freedom of “strategies of inquiry, or methods of analysis” (Denzin & Lincoln, 2000, p. 18). Denzin and Lincoln’s (2000) proposal of categorical fluidity acknowledges changes in paradigmatic boundaries and resonates with other authors such as Patton (1980) who contend that rather than paradigmatic competition, it is time for “a new paradigm – a paradigm of choices” (Patton, 1980, p. 20). Patton (1980) supports using methods that may be considered traditionally atypical for a particular research design, suggesting that they can be useful, appropriate and efficacious to the research question, purpose, data collection, data analysis and research findings. The ‘paradigm of choices’ offers a pragmatic (McDonnell et al., 2000; Tashakkori & Teddlie, 1998) pathway for nursing researchers to embrace methodological openness and paradigmatic freedom, and case study offers a delineated space for inquiry. Notwithstanding this treaty for openness and flexibility, it is beholden upon the inquirer to logically justify their philosophical position, research design and include a coherent argument for inclusion of varying research methods.

**Case study: A paradigmatic bridge**

Rather than sitting comfortably within one paradigm, it has been shown that case study provides a bridge between the paradigms. As such, ‘the bridge’ is a metaphor. Like a bridge, the existing structures on either side of the bridge remain distinct
(Miller & Fox, 2004). The existing paradigms, and their assumptions, equally remain distinct. The bridge therefore offers the researcher openness to the selection of methods used to inform the inquiry, from either side of the bridge. Thus, the distinctive contributions are both respected and mutually informative (Miller & Fox, 2004). Depending on the research question, design and purpose both qualitative and quantitative methods can be applied to single or multiple case studies.

Vallis and Tierney (1999) used a comparative case study, at four hospital sites, to explore the outcomes of hip fractures from a nursing perspective. The four hospital sites represent multiple cases. Within the multiple case study design, multiple methods of data collection were used and multiple units of analysis were subsequently appropriate (Vallis & Tierney, 1999). Research data were gathered using the methods of semi-structured interviews, observations, questionnaires and statistics. Vallis and Tierney (1999) argue that their use of seemingly contradictory methods and data is justified neither as a means of combining methods (triangulation) for the purpose of validation, nor as an attempt to ensure completeness. Rather, they argue, within the flexibility of case study research, this approach offers different views, enabling the interpretation of complex inter-related phenomena; that is service management delivery and patient care. Further, Vallis and Tierney (1999) consider the traditional ontological, epistemological and methodological positions not as opposing silos, but positioned along an interconnected ‘continuum’. This perspective has similarities with the bridge metaphor proposed.

With respect to the ontological, epistemological and methodological positions, it is argued that case study approach fosters integration of research strategies (Jones & Lyons, 2004; Marshall & Rossman, 1995). Case study research can use multiple data collection methods to explore or understand the case (Creswell, 1994), enabling a rich detailed description of the single unit of interest (Dempsey & Dempsey, 2000; Pegram, 1999). Multiple methods are used depending on the research question, the research purpose, the researcher’s level of control and, debatably, the choice of contemporary versus historical perspective (Yin, 2003). Multiple methods are techniques used for data generation and include direct observations, participant observations, survey, questionnaire, documentation, archival records, documents,
interviews (both structured and unstructured), written accounts by participants, physical artefacts and researcher description of the context are all appropriate data sources for case study research (Dempsey & Dempsey, 2000; Stake, 1995; Yin, 2003). Clearly these diverse data collection methods will generate textual and numerical data. Methodological rigour can be established within the framework of the case study by using measures already accepted for the specific methods used. This flexibility of method, and potential for practical application, is one of the key strengths of case study. McDonnell et al. (2000) combined three different methodological approaches within the framework of a tailored case study design and argued the “these differences were seen as a methodological strength” (McDonnell et al., 2000, p. 385).

Philosophical assumptions and the ‘case of’ violence towards ED nurses

A single setting, such as a hospital or specialty unit, is a good location for an instrumental case study. Further, the phenomena of violence towards nurses, where the agent of violence is the patient, their family or friends, is appropriate for case study research. The context of the single ED unit combined with the complexity of the phenomena of violence towards ED nurses supports generation of data using mixed methods for the current instrumental case study. Concurrently using methods that are traditionally considered to ‘belong’ to qualitative and quantitative research, defines the current research as a concurrent mixed method case study (Creswell, 2003; Tashakkori & Teddlie, 1998) and further identifies the paradigmatic position as pragmatic, as defined by Tashakkori and Teddlie (1998). Three important philosophical issues that provide coherence for nursing research are ontology, epistemology and methodology (Creswell, 1998; Crotty, 1998; Gray, 2004; Patton, 1980, 2002). It is important to discuss them briefly to defend the construction of this pragmatic instrumental case study.

Ontology poses the question about the nature of reality. In this thesis, the position adopted about the nature of reality guides the construction of knowledge. Fundamentally, and very broadly, qualitative research acknowledges multiple, subjective realities that are meaningful holistically, and contextually, and the quantitative position is that there is a single, objective reality that can be measured.
An understanding of the personal meanings of the subjectively experienced world is ordinarily the focus of qualitative inquiry (Hammersley & Atkinson, 1983; Silverman, 2005; Streubert, 1999). The quantitative researcher, however, seeks to uncover a single, law driven, objective, truth. Both perspectives usually adopt the position that the researcher can gather knowledge of, or about, truth or truth(s) whether they are singular and objective or multiple, subjectively interpreted or socially constructed (Borbasi et al., 2004; Gray, 2004; Lincoln & Guba, 1985; Silverman, 2005; Streubert, 1999).

Qualitative research is frequently interpretative and naturalistic, attempting to uncover people’s meaning and knowledge of phenomena. In naturalistic inquiry “the inquiry is context-bound; the topic is studied within its setting” (Dempsey & Dempsey, 2000, p. 26). Not all the tenets of naturalistic inquiry were adopted in this current study, however this feature was used and will be henceforth subsumed in the term ‘real world’ research or ‘real life’ events (Gray, 2004). Qualitative ontology supports research undertaken in the real world as realities, and real life, are whole (Gray, 2004; Lincoln & Guba, 1985) and context is vital (Creswell, 1994). As discussed, case study is one type of research that can describe and interpret meaning in people’s lives in the real world (Denzin & Lincoln, 2000). Case study, defined within qualitative characteristics can utilise a variety of interpretative practices to understand the phenomena of interest using multiple methods (Creswell, 2003; Denzin & Lincoln, 2000; Stake, 2000). Case study can uncover rich, thick, complex, embedded description that is a re-presentation of the phenomena of interest. This is fitting with the real world requirement of this pragmatic instrumental case study and the emergent ‘case of’.

Violence towards ED nurses can be construed as a contextually bound, and defined, phenomenon that can be revealed via methods that provide real world, contextual, subjective meanings and understandings. The phenomena of interest were embedded in the practice of the participant ED nurses and the particular geographically bounded ED context. The ‘case of’ was a theoretical construct that was emergent as function of the process and product of inquiry. Using Ragin’s typology (1992), what the case, this case, was a ‘case of’, was emergent and answered at the end of the
research, and became known following data analysis. Violence towards nurses, however, can be constructed empirically and studied as observable and measurable variables, as discussed in chapter two.

Much nursing research has assumed the principle that violence, and the behaviours and actions related to violent events, are empirical variables. Violence in ED and mental health nursing settings have historically measured and operationalised violence in terms of variables such as; the diagnostic or actuarial classifications of the agents of violence; the precursor generalisable features of the environment; nurses behaviours; and the efficacy and the impact of staff educational programs. This assumes there are measurable, observable features of the phenomena of violence towards ED nurses that can be constructed as general empirical units. Applying knowledge about violence towards ED nurses derived from the literature, and social convention provided the framework for the definition of violence used (see chapter two). The findings from phase one of the current study, informed the construction of the structured observation guide, which measures the ‘case of’ as an empirical unit. The processes used to develop the structured observation guide are diagrammatically represented (see Appendix A), and will be further discussed in chapter four. The phenomena of interest for this study, and importantly what this case was a ‘case of’, was therefore concurrently a specific theoretical construct and an empirical unit (Ragin, 1992). The relationship between the knower and the known was predominantly that of mutual influence, however, the construction of some characteristics of the phenomena of violence towards nurses as an empirical unit involved accepting a dualist position.

At a very fundamental level, there are two dominant positions that describe the nature of the relationship between the knower and the known (Borbasi et al., 2004; Gerring, 2001; Gray, 2004; Lincoln & Guba, 1985; Patton, 1980; Polit & Beck, 2004). The first is the positivists’ dualism between knower and known where the known exists independently of the knower, and the second is the post-positivist position of interactive influence between the knower and the known (Creswell, 1994, 2003; Dempsey & Dempsey, 2000; Denzin & Lincoln, 2000; Gray, 2004; Silverman, 2005; Tashakkori & Teddlie, 1998). Qualitative researchers generally adopt the position that there is interaction between the researcher and participants and it is this
The interactive process that contributes to uncovering the meaning of what is known (Dempsey & Dempsey, 2000; Hammersley & Atkinson, 1983; Hammersley & Gomm, 2000; Patton, 2002). The qualitative researcher attempts to capture the subjective knowledge(s) of the participants who have experience of the phenomena of interest, embedded in context.

Predominantly the position adopted in this study was the acceptance of an interaction between the researcher and informant, and of the premise that the researcher was the primary data generating instrument (Creswell, 1994; Dempsey & Dempsey, 2000). The researcher was subjectively involved in the complex ED context in order to increase insight and understanding of the phenomena of interest from the participants’ perspective (Dempsey & Dempsey, 2000). This necessitated interacting with the participants and minimising the distance between the researcher and the researched (Creswell, 1994) and is coherent with the emergent instrumental ‘case of’ (cases are made). Concurrently, however, objective, quantifiable data were generated based on the assumption that some of the aspects of violence towards nurses were objectively measurable, existed independently of the knower but were nevertheless contextually constituted. The data collected that measured these objective elements reflected the components of the phenomena of interest that were constructed as empirical, general units (cases are objects). Exploring the ‘case of’ in this way means both subjective and objective knowledge are equally valued, and this is demonstrated in the processes used during phase two and phase three of the current study (see Appendix A). Discovery of the ‘case of’ in this way is also practical and is appropriate for the practice based discipline of nursing. Using an approach that accepts qualitative and quantitative methods are compatible, and that discovers knowledge by using strategies that work, defines the philosophical position of this study as pragmatic. Further, accepting the ‘case of’ as a specific theoretical construct and concurrently a general empirical unit, necessitated addressing the issue of generalisation. The two dominant positions pertaining to generalisation and transferability and the relationship to this construction of ‘the case’ will now be addressed.
Issues of generalisability and transferability in case study research

Positivism maintains the importance of the development of a nomothetic knowledge that is able to be generalised, statistically or analytically (Lincoln & Guba, 1985). The qualitative axiom broadly espouses the development of idiographic knowledge (Lincoln & Guba, 1985), that has value as it describes the individual case. There is an obvious implication for supporting the search for the particular about a case, versus searching for the generalisable. Case study, used as a quantitative methodology (Yin, 2003) or in conjunction with, and to enhance, quantitative evidence (Pegram, 1999; Stake, 2000), can be specifically employed for the purpose of analytic generalisation (Yin, 2003). This is seen when there is a focus on repetition of examples within or between cases to substantiate arguments, causal relationships and claim generalisability (Ragin, 1992).

Generalisability can be seen as a major feature that distinguishes a quantitative case study from a qualitative case study where the purpose of the quantitative case study is generalisability, and the qualitative case study research purpose is its knowledge of the particular (Nieswiadomy, 1998). Stake (2000) argues that there is value in the particularities of the case itself and it need not be justified with explanations of its exploratory focus, its typicality of other cases, its potential to lead to generalisations or restructured as an early stage of theory building. The analysis of a case study, therefore, uncovers “a ‘pattern’ of interconnected thoughts of parts linked to a whole” (Creswell, 1994, p. 94). The theory or patterns emerge inductively. Thus, the single case study is valued for knowledge and insights (Stake, 2000) about the case, and not devalued as a function of the need for an overemphasis on scientific generalisability. The qualitative case study is congruent with the purpose of qualitative research that seeks holistic, context specific meaning, that may develop a real life abstraction or theory (Dempsey & Dempsey, 2000).

Akin to experimental replication, multiple-case studies overcome some of the theoretical difficulties of generalisation via the research design and are thus generalisable to theoretical propositions rather than to populations. This Yin (2003) refers to as analytic generalisation, not statistical generalisation, and it supports the notion of a ‘typical case’. The implication here is that theories derived from the case are applicable to other ‘like’ cases (Holloway & Wheeler, 1996) and give strength
and depth to social explanation (Dempsey & Dempsey, 2000). Stake (2000), however, argues that a lot can be learnt from a specific case and these lessons need not be generalised from the specific; the uncommon may also portray the case (Stake, 2000). Generally speaking, however it is assumed that “locality and specificity are incommensurable with generalisability” (Guba, 1990, p. 22). The current mixed methods instrumental case study has many features that enable it to construed as a ‘typical case’, and these will be further discussed in chapter four.

**Limitations of case study design**

It has been argued that case studies have a lack of precision and are a weak method (Yin, 2003). Three positivistic criticisms of case study are that they lack rigour, are prone to bias, lack generalisability and “they take too long and result in massive, unreadable documents” (Yin, 2003, p. 11). Design of the case study and procedures that support rigour, however, are important ways the researcher can overcome the traditional criticism of the case study method (Yin, 2003). To address the issue of rigour, it is beholden upon the researcher to plan their case study research applying the usual caveats for rigour, or validity, that apply to their chosen methods, their theoretical propositions, philosophical position and logic of thinking (Stoecker, 1991). Stoecker (1991) further argues that accurate explanations are not guaranteed with the use of probability sampling and tests of significance, and bias is not controlled by the scientific method.

Case study has been criticised for its links with occupational practices, again on the premise that these types of case studies lack scientific characteristics. Likewise, case study evidence has been considered poor from a positivist perspective because of its limited ability to contribute to evidenced based research (Bryar, 1999). Stoecker dismisses this criticism and claims that the scientific method is not “useful for applied questions” (1991, p. 93). Importantly, case study is acknowledged for its capacity to offer a high level of contextual, detailed knowledge (Bryar, 1999; Stoecker, 1991) and ability to connect theoretical abstractions to complex practice, which is of value in nursing research. Case study underpinned with the tenets of either qualitative or quantitative research, or both, can be coherently constructed as a research strategy. As presented, case study design can use methods from either
traditional paradigmatic position and adopt the position of pragmatism. Nurse researchers strive to link theoretical abstractions to practice and therefore this is not a criticism, but a strength of the approach. Finally, as a function of the existing paradigm fluidity (Denzin & Lincoln, 2000), the positivist criticisms are less widely accepted and less common (Hammersley & Gomm, 2000). What is more widely accepted is that measures of the value of the type of knowledge gained from research need to be judged against appropriate criteria (Jensen & Rodgers, 2001).

**Structure of this mixed method instrumental case study**

Stake (2000) fundamentally agrees with Yin (2003) about the need for a conceptual structure for case study (Stake, 2000; Yin, 2003). Their notions of the organisational structures appreciably differ. Both support the need for a congruent research question and the distinct role of data collection questions. They differ regarding the degree of rigidity of the research plan prior to data collection. Regular refinement of the research project, however, is appropriate for case study research (Yin, 2003). Case study method has the flexibility (Yin, 2003) to allow in depth focus on a local, single or specific ‘case’ (Marshall & Rossman, 1995; Pegram, 1999; Ragin, 1992) with all its particular complexities (Stake, 1995). The research plan and data collection approach may only be tentatively developed and defined based on presumed issues related to the phenomena of interest (Dempsey & Dempsey, 2000; Gray, 2004). Nevertheless, proposing a methodological strategy, of greater or lesser degrees of specificity, is desirable for coherent, consistent and logical qualitative research (Mason, 2002).

The current study was constructed as a single case study. Whilst there are a number of individual participants within the case, the case, and ‘case of’ is singular. The current research is informed by the pragmatic approach outlined by Tashakkori and Teddlie (1998), the framework of a single instrumental case study as defined by Stake (2000) and the concurrent mixed methods data generation and analysis procedures of Creswell (2003). Further, this instrumental case study embraced one of the early goals of case study and sought to uncover an aspect of personal meaning related to the ‘case of’ violence towards ED nurses. The conceptual structure of the study whilst remaining flexible is coherent with the research question. Although use
of a pragmatic approach in nursing research remains controversial, the current research topic is a difficult issue for nurses and approaching this problem innovatively may enable new perspectives and insights. The constructions of the ‘case of’ further support the research design and choice of methods, which in turn are coherent with the data collection methods and questions.

The research question and purpose of this study support the use of case study as a pragmatic practical research strategy; a bridge across the paradigms. Case study as a bridge across the paradigms allows for the application of a concurrent mixed methods approach, which is congruent with the proposed ‘case of’. Having claimed this, the current study also adopts many of the shared features that generically define case study, predominantly the goal of understanding contextually constituted knowledge about real life events.

The current case study was undertaken in the real-world of an ED. The principle and vigour of multiple methods was embraced. Empirical data were collected, analysed and presented concurrently with rich textual data to present as complete a picture as possible of the phenomena of interest. The phenomena of interest were violence towards ED nurses, where the agent of violence was a patient, their family or friends. The focused object of study was the participant nurses’ violence assessment and prevention skills, and exploring the sequelae of violence for these nurses. Phenomena of interest are revealed through the case and ‘case of’, and understandings of complex human interactions and personal meanings are developed through multiple methods and sustained engagement in the field. This research, therefore, is a concurrent mixed method instrumental case study design. The qualitative data generation methods include participant observations, semi-structured open-ended and unstructured open-ended interviews, researcher journaling and document review. A structured observation tool, with closed and open-ended questions, generated the quantitative data. Data were generated within an identifiable environmental context and clearly defined and bounded instrumental ‘case of’.
The physical boundaries for this case study included the selected public hospital unit, an ED, and the inclusion and exclusion criteria for the participants. The physical boundaries were derived from the implicit boundaries of time, geography, and event. The phenomena of interest, the ‘case of’ violence towards nurses, was conceptualised as both a general empirical object and a specific theoretical construct. The boundaries of the case, and the ‘case of’ were derived from social conventions and existing definitions of violence towards nurses and were pre-existing, and empirically bound. The case and ‘case of’ were also inductively discovered, contextually constituted, and bound. The construction of the case in this manner further supports the use of concurrent mixed methods to generate data. The objects of the case and ‘case of’ were readily identifiable and this enabled a clear understanding about what was bounded by the case, and what was not. The concurrent construction of the ‘case of’ in this manner is supported by Ragin’s (1992) dichotomy.

Summary
As this chapter reveals, much about case study remains contested. There is, however, general agreement that methods from the traditional paradigms can legitimately be used together to shed light on the case of interest. The perspective offered here seeks to demonstrate how different approaches can be mutually informative rather than distinctive. What is important is that the researcher demonstrates coherence between aims, methods, methodology and paradigmatic perspective, applying these in the complex real world. In doing this, the researcher is cognisant of maximising compatible perspectives, as not all approaches are equally amenable to such linking. Additionally, the researcher is obliged to articulate ‘the case’ in light of these considerations. Case study offers a flexible, pragmatic yet rigorous approach to research that is practical and suitable for nursing research. In addition, within this practical and open framework, multiple and diverse methods can be coherently argued and applied. Case study offers a bridge across the paradigms.

The applicability of case study strategies for nursing research that seeks practical knowledge has been explicated. The position adopted for this thesis accepts that the different paradigmatic positions add value by discovering different and equally important knowledge. Further, concurrent a mixed method instrumental case study
will answer the specific research question and discover knowledge about the contextual instrumental ‘case of’. The following chapter will detail the chosen methods and their application during concurrent data generation and analysis. The setting and participants will be introduced and the application of ethical principles will be demonstrated.
Chapter Four - Abstract

This chapter details the mixed methods used in the current instrumental case study research. Attention is paid to the underlying tenets of the particular methods, and the processes used to apply these in the current research. Support for the use of the particular data generation methods, in relation to the phenomena of interest and defined ‘case of’ will be presented. Combined, the underpinning theoretical tenets and nurse researcher data generation processes illustrate and sustain the procedures used to ensure rigour. The application of human ethics principles throughout the conduct of the current study will also be described. This chapter will introduce the ED setting of interest, the 20 participants who voluntarily consented to participate in the study and explicitly delineate the data generated by each data generation method. Detailed information about the data analysis procedure, including the literal tools used for data generation and analysis, will be described.
Chapter Four -

Data Generation Methods and Analysis

Introduction

As discussed, there are no agreed upon set of methods for case study. Rather, methods are selected in relation to the nature of the case and the research question. Methods for this mixed method instrumental case study were selected according to their ability to address the research question, illuminate the case, the ‘case of’ and coherently match the researcher’s ontological and epistemological choices (Stake, 1995, 2000). Methods that enabled exploration of, and understanding about, violence towards nurses when the agent of violence was the patient their family or friends, were required. The methods chosen for data generation were unstructured participant observation, structured observation, semi-structured open-ended interviews, unstructured informal field interviews, researcher journaling and review of relevant ED documents.

In this chapter, the application of methods used in this case study will be explicated. The structured observation guide, including its development and application, will also be discussed. Further, the rationale for the chosen mixed methods, embedded within the instrumental case study approach, the emergent and empirical ‘case of’ and the particular ED context, will be substantiated. Details of the participants, the setting and the data generated will also be outlined, so too will the data analysis process. Ethical issues pursuant to the research question, the methods and the selected instrumental case will be detailed.

Mixed methods

Data were generated using the methods of structured observations, unstructured participant observation, semi-structured open-ended interviews, informal open-ended field interviews, researcher journaling and review of relevant documentation (see Table 4.1). Following the informed consent process, 20 ED nursing staff consented
to being observed during their routine nursing practice, and to audio taped interviews (for participant details see Table 4.4). There were three phases to the study.

Phase one data generation comprised; 50 hours of unstructured participant observation of consented participants, generated on 14 separate occasions; three (3) unstructured open ended interviews; and researcher journaling. Following thematic analysis of the phase one data, a structured observation tool was developed (see Appendix C). Phase two consisted of 290 hours of participant observation, generated on 51 separate occasions. Participant observation was undertaken over a five (5) month period (September 2005 – January 2006), on different days, at different times, for different lengths of time and during all shifts. Participant observation was unstructured and data were generated following observation of the 20 consented participants only. Participants were observed in the ED setting undertaking all aspects of their routine nursing practice. As a result, 16 incidents of violence towards these participant nurses were observed using the developed structured observation tool. Other violent events occurred during the field work, however only violent events that included the consented participants contributed to data for this study. Unstructured observations were characteristic qualitative ethnographic field notes that included detailed contextual data and numerous observations of routine nurse-patient interactions. In addition, 16 semi-structured open-ended, interviews of 45 – 60 minutes duration, and 13 informal field interviews of 20 – 40 minutes duration were generated. A reflective researcher journal and review of relevant ED documents complemented and completed the data generating methods.
<table>
<thead>
<tr>
<th>Phases</th>
<th>Data Generation Methods</th>
<th>Total Data Generated</th>
</tr>
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<tbody>
<tr>
<td><strong>Phase One</strong></td>
<td>Participant Observations</td>
<td>50 hours on 14 separate occasions from February 2004 – April 2004 (working various shifts, times of day, days of week and lengths of time in field). Observing only the 20 registered nurses who consented to participate</td>
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<tr>
<td></td>
<td>Unstructured open-ended interviews</td>
<td>3 interviews (45 – 60 minutes duration)</td>
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<td></td>
<td>Researcher journal</td>
<td>Journal completed following 51 field work occasions, 16 interviews and 13 field interviews</td>
</tr>
<tr>
<td><strong>Phase Two</strong></td>
<td>Participant Observations</td>
<td>290 hours on 51 separate occasions from September 2005 – January 2006 (working various shifts, times of day, days of week and lengths of time in field). Observing only the 20 registered nurses who consented to participate</td>
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<td></td>
<td>Semi-structured open-ended interviews</td>
<td>16 interviews (45 - 60 minutes duration)</td>
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<td></td>
<td>Informal unstructured field interviews</td>
<td>13 interviews (20 – 40 minutes duration)</td>
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<td></td>
<td>Observed violent events generated via structured observation tool</td>
<td>16 observed violent events generated via structured observation tool observing only the 20 registered nurses who consented to participate</td>
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<td></td>
<td>Researcher journal</td>
<td>Journal completed following 51 field work occasions, 16 interviews and 13 field interviews</td>
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<tr>
<td><strong>Phase Three</strong></td>
<td>Concurrent Data Analysis</td>
<td>Thematic analysis of all textual data – interviews, participant observation, observation, researcher journaling and institutional documents</td>
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<td>Descriptive statistical analysis of numeric data</td>
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Details of the data collection methods, data analysis, procedures for research rigour and ethical considerations will now be presented.

**Participant observation**

Participant observation can be used synonymously with the term field work “but not all field work is participant observation” (Bernard, 2002, p. 323; Russell, 1999). Participant observation is a data collection method and an analytic tool (de Laine, 1997; Hammersley & Atkinson, 1983; Wolcott, 1999). The participant observer undertaking field work enters the naturally occurring context to watch, listen, examine, experience the phenomena of interest and record these findings, usually as unstructured field notes (DeWalt & DeWalt, 2002; Fetterman, 1998; Wolcott, 1999). Data are collected in the real world or naturalistically (Gray, 2004; Russell, 2004). Data collection is therefore dependent upon the participant observer being open to finding knowledge about phenomena of interest that are embedded within situations or environments, and writing verbatim field notes about what they see, hear and experience (Russell, 2004; Schatzman & Strauss, 1973). Importantly, the participant observer does not seek to manipulate or control the context within which the phenomena are constituted (Hammersley, 1990; Mason, 2002).

In order to undertake participant observation the nurse researcher must first establish a position concerning the nature of the real world that they plan to observe (Atkinson & Hammersley, 1994; Borbasi, Jackson, & Wilkes, 2005; Hammersley, 1990). As discussed in chapter three, depending on the philosophical stance taken, the nurse researcher may accept that the real world is objectively defined, is subjectively interpreted, or is socially constructed (Borbasi et al., 2005; Brewer, 2000; Crotty, 1998; Tedlock, 2000). It is now that the objects of observation, and the position of the participant observer, become more divergent and can be viewed along a continuum. Empirical observations are situated at one end of the continuum and at the other end are interpretative or subjective observations, suitable for inductive theorising (Gray, 2004). The types of observation, and therefore epistemological position of the observer, exist along this continuum. All types of observation can be used to uncover knowledge about the phenomena of interest, but the type of data generated differs.
Participant observation is a data generation method that can be used to render the world visible to both the nurse researcher and, through the researcher, the research audience (Agar, 1986; Atkinson & Hammersley, 1994; Gray, 2004; Mason, 2002). The term data generation will be used in this thesis to locate the participant observer position and therefore the type of data collected. Data collection implicitly denotes that data are based on empirical objects. Different to this is the idea of data generation. This is the position that acknowledges that all data, structured or unstructured, objective or subjective, are already interpretations (Sandelowski & Barroso, 2002), that is, data “are already themselves constructed entities” (Valsiner, 2000, p. 100). Thus data can and does represent the underlying phenomena in different ways, depending upon what the researcher chooses to generate (Valsiner, 2000; Wolcott, 1999).

Why use participant observation?

Participant observation is used when knowledge about a phenomena can not be accessed in any other way (Atkinson & Hammersley, 1994; de Laine, 1997; Mason, 2002) and when new and additional insights can be revealed through observation (Ritchie, 2003). It is commonly used to generate data in combination with other techniques such as interviews (Borbasi et al., 2005; de Laine, 1997; Hammersley & Atkinson, 1983). This combination of data generation techniques, when applied to field work, enables a more complete understanding of phenomena than can be uncovered using observation or interview alone (Hammersley & Atkinson, 1983; Russell, 2004). In conjunction with interviews, participant observation is a method that enables tacit knowledge(s) and practices to be uncovered or known, and provides an opportunity to clarify the meanings of the observed behaviour, from the participant’s perspective, thus enabling a process that can make incongruence visible. It further permits the examination of the coherence between the participants’ stated views and their observed behaviour (Mulhall, 2003; Russell, 2004).

The focus of observation is determined by the research question and phenomena of interest. Observations are made within the real world setting with due recognition of the context and contextually constituted meanings (Fetterman, 1998; Hammersley & Atkinson, 1983). Multiple meanings can be drawn from an observed action, and
these meanings are at least partially dependent on factors such as cognition, context, cultural lens, and the individual’s position as performer or observer (Brewer, 2000; Hammersley & Atkinson, 1983). What the behaviour represents to the person performing the action, and to observer, is central to the meanings that can be drawn. To appreciate what is happening in the setting, it is necessary for the observer to attempt to understand what phenomena mean to the participants. In so doing, the participant meaning(s) render action and intention comprehensible and further, as aptly said by Charmaz (2004, p. 981), “we observe our research participants grappling with making sense of their lives, and then we grapple with them trying to do so” which eventually culminates in our own search for meaning in the situation. The context within which the behaviour occurs constructs its meaning.

‘Doing’ unstructured participant observation

Effective participant observation is dependent on the researcher remaining open, flexible, having the ability to see the usual as problematic, and a readiness to seek the unusual and render it meaningful in relation to the research question and phenomena of interest (Atkinson & Hammersley, 1994; de Laine, 1997; Hammersley, 1990). An open mindedness about the context within which the phenomena of interest are embedded is required. Ideally the participant observer approaches the real world with an “….improvisational style to meet situations not of the researcher’s making…” (Agar, 1986, p. 12). The advantage of this unstructured approach is that unexpected avenues or sources of rich multidimensional data (Mason, 2002) can be spontaneously, and often unexpectedly, uncovered in the field. This is not, however, to be confused with a lack of methodological rigour (Fetterman, 1998; Mulhall, 2003), nor with the assumption that the nurse researcher can be entirely unbiased (Hammersley, 1992; Hammersley & Atkinson, 1983). As discussed, there are many factors that will shape the meaning(s) that can be derived from any observed phenomena. The nurse researcher undertaking participant observation therefore needs to be aware of the potential effects of their own involvement in the context of interest.

The nurse researcher using a participant observer approach needs to be cognisant of their degree of involvement in the context of interest. The degree of involvement of
participant observation can be classified as a complete participant, participant as observer, observer as participant or the complete observer (DeWalt & DeWalt, 2002; Streubert, 1999). Irrespective of the level of involvement, the participant observer becomes immersed in the context, and immersed in the observational data.

Often the degree of involvement of the participant observer is presented as a ‘choice’ that the nurse researcher can make or influence (DeWalt & DeWalt, 2002; Gray, 2004; Russell, 2004; Streubert, 1999). The literature encourages researchers to enter the field and position themselves to best uncover emic (insider) or etic (outsider) knowledge (or both) (Bernard, 2002; Bonner & Tolhurst, 2002; Brewer, 2000; Gray, 2004; Roper & Shapira, 2000), however, participant observer positioning is complicated (Allen, 2004; Borbasi et al., 2005; Creswell, 1998; Gerrish, 1997; Merriam et al., 2001). The idea that the nurse researcher can adopt a particular insider/outsider position and remain firmly within it is overly simplistic and denies the interactive, flexible nature of both the world as it is lived and experienced, and the adaptability of interpersonal relationships (Allen, 2004; Emerson, Fretz, & Shaw, 1995; Gerrish, 1997). It fails to recognise how the level of involvement can change as relationships between nurse researcher and participants in the field develop over time (Allen, 2004). Independent of degree of involvement, the nurse researcher ordinarily has an active and reflexive observational role in the field (Mason, 2002) that can change over time and situation, and may or may not include an active membership role (Allen, 2004; DeWalt & DeWalt, 2002).

Within the messy hectic and often unpredictable world that is clinical nursing, the nurse researcher enters a field with multiple competing and complementary identities and becomes caught up in the complexity and fluidity of the setting (Allen, 2004; Roper & Shapira, 2000). Issues related to being a nurse play a part in the opportunities for participation and the choices made by the nurse researcher, particularly in a very busy clinical setting. Dilemmas around being a nurse or a researcher have also been noted in the literature (Allen, 2004; Bonner & Tolhurst, 2002; Gerrish, 1997; Kennedy, 1999; Mulhall, 2003). This further supports the contention that the level of participation of the nurse researcher changes according to the contextual situation. The participant observer role adopted for this research was
as a complete observer but as the study progressed, and familiarity with the ED nurse participants developed, there were times when observer as participant was most apt.

The unstructured participant observations, or field notes, were informed by ethnographic tenets and conformed to the principles and practices discussed above. They therefore included data that richly described the ED context as well as the nurse-patient interactions. Unstructured observations were generated while literally following consented nurses during their usual working routines and taking detailed verbatim descriptions of their activities, events and communications. This included participant observation during moments of intimate nurse patient interactions. These field notes were recorded on a Pocket Personal Computer, a hand held Hewlett Packard, iPAQ HW 6515 (iPAQ) using the software Microsoft Word. The iPAQ has a built in keyboard, however, when opportunity permitted, field notes and the researcher’s reflections were typed using a bluetooth enabled portable keyboard. This improved collection of verbatim data and enhanced the immediacy and intimacy of the data generated as they were typed up in the field either during the observation or as soon as possible following the completion of the observed event or nurse-patient interaction. The iPAQ was also used to generate the structured observations, in Microsoft Excel, via the observation tool. Phase one comprised 50 hours of participant observation undertaken over a four (4) month period during various shifts and limited to consented nurses. In phase two, a total of 290 hours of participant observation were undertaken over a five (5) month period, on different days, at different times, for different lengths of time, during all shifts and limited to the 20 consented ED nurses.

In addition to informing and shaping the structured observation tool, analysis of phase one data further refined and focused the research question. The broad research question of violence towards regional and rural ED nurses became focused on the issues of the ED nurses’ assessment and prevention strategies, and their initial responses to the sequelae of violence. The structured observation tool developed in phase one, and the refined research focus, were then applied in phase two of the study.
Structured observation tool

The initial, phase one data collection period of 50 hours of participant observation and three (3) unstructured open-ended participant interviews were transcribed, reviewed and thematically analysed. This data was not included in the final data analysis. Emergent themes derived from a thematic analysis of the initial 50 hour data generation period were then confirmed and informed by contemporary nursing literature, which reflects current social convention, and this developed and supported the content of the structured observation tool for violent events used in phase two. The boundaries of the ‘case as an object’ (Ragin, 1992) were, therefore, defined and defendable.

The developed tool (see Appendix C) captured empirical details about observed violent events including; demographic information about the agent of violence and participant nurse; information concerning the ED presentation; verbal communications, such as tone and volume of voice; the language used; and non-verbal communications. The observation tool also helped define the boundaries of the specific theoretical case as it was ‘made’ by assisting with the generation of thick, verbatim description of the interaction between the agent of violence and the participant nurse. The tool therefore captured detailed quantitative data, and enhanced the generation of focused unstructured qualitative observations, about the nurse-patient interaction during violent events. The observation tool increased the clarity of the boundaries of the ‘case of’, specifically the observed violent events, both as an empirical units and theoretical constructs.

The observation tool collected nominal and ordinal numeric data in addition to rich, thick unstructured data about a nurse directed violent event. There was a deliberate intent to harness the apparently common actions and demographic details of violent events in numeric form without the trade-off of loss of rich, contextual field notes. The observational tool was also used flexibly and as a ‘cue’ for a complete record of an interaction between a nurse and the agent of violence that revealed the instrumental, emergent ‘case of’. Increasing the structure of the observations of violent events acknowledged that the clinical world consisted of empirical entities, objects and events that existed independently of the observer that could be numerically re-presented. The observation tool also acknowledged that the clinical
world was constituted and interpreted subjectively, thus recognising the possibilities of multiple subjective meanings about the phenomena of interest.

The draft observation tool was trialled in the ED setting where it was to be used. During the trial stage, feedback about the observation tool was sought from ED nurse clinicians, participants and academic colleagues. Following this it was further refined. It was during this period of trial and peer review that practical changes in the design and layout of the tool were made to improve the tool’s user-friendliness and data quality. Trial of the tool brought to light problems such as ease of data entry, use of the tool in the field, and further refined the type of data needed. This also led to minor changes in the order and grouping of questions. The structured observation tool was data generation strategy used by the researcher, however, ensuring that nurse participants did not experience the observational tool as unnecessarily intrusive was also a major consideration. The practical issue of using the tool in the field was solved using the iPAQ further enabling all data to be generated in the field.

In phase two, a structured observation was completed by the researcher for each observed violent event and was recorded using the observational tool (see Appendix C). This ensured that each of the 16 observed violent events consistently generated a fundamental set of data (see Appendix D). The tool was designed to collect nominal, ordinal and demographic numeric data in addition to unstructured textual data of violent events. The nurse researcher stood at strategic viewing points, which facilitated detailed observation and generation of verbatim nurse’s comments, during collection of structured observations. No information was generated from the agent of violence. Other data included semi-structured open-ended interviews, informal open-ended participant field interviews, document review and researcher journaling.

*Interviews*

Concurrent with unstructured participant observation and structured observation, researcher journaling and document review, both semi-structured open-ended interviews and unstructured informal field interviews were used to generate data. In order to facilitate participation, informed consent and quality data, deliberate effort was placed on the processes of building trusting relationships with the clinical staff,
and so frequent opportunities arose to discuss the research and the anticipated amount of time and involvement required of participants.

As a data generation method, interviews are used by both qualitative and quantitative researchers (Creswell, 2003; Gray, 2004; Holstein & Gubrium, 2004; Nieswiadomy, 1998). Typically, quantitative interviews are structured and closed-ended and qualitative interviews are semi-structured or unstructured and open-ended (Polit & Beck, 2004). Semi structured and unstructured interviews have the purpose of revealing the typical experiences or understandings of the participant (Kvale, 2006; Melia, 2000; Silverman, 2005; Streubert, 1999). These are normally intimate face to face interactions between the researcher and participant, enabling the establishment of rapport with participants and the generation of additional information about the interview, such as the body language of the interviewee (Creswell, 2003; Fontana & Frey, 2000). Open–ended interviews are often employed when the responses of the participants are not restrained or confined (Fontana & Frey, 2000; Silverman, 2005). The researcher impacts upon the informant’s recall, information, expression and feelings. Interviews can therefore be seen as social interactions and the interaction between the researcher and the informant can strengthen the interview data by increasing depth and honesty of responses.

All interviews for the current study were undertaken in the field and were shaped by the interaction between the researcher and participant, and by contextual and temporal dimensions. Furthermore, they were held at a mutually agreed times. All interviews were undertaken during, immediately prior to, or immediately following, the participants normal rostered shift. The participants interviewed in this study were identified according to the participant inclusion criteria (Creswell, 1998; Miles & Huberman, 1994) which will be further discussed below. Interviews that were undertaken prior to or immediately following the participants usual shift were scheduled at the request of the participant. There was an ongoing relationship with the participants before, during and after the interviews, and this also shaped the meanings. At times violent events where both the researcher and the participant were present were discussed, and there was mutual disclosure about relevant issues. All interviews, semi-structured and unstructured, were digitally recorded on an iPOD. The interview processes will now be discussed.
Semi-structured open-ended interviews

Sixteen (16) semi-structured open-ended, 45 – 60 minute interviews were conducted in phase two of the study (see Appendix E). These interviews were undertaken in the field in either an infrequently used nurse education office or an unoccupied examination room so that the participant ED nurse could speak freely. There was an awareness of value of the participants’ time (Creswell, 1998; Streubert, 1999). The interviews were therefore not extended past the agreed 60 minutes.

The participants were actively engaged in the interview process and were given a copy of the interview questions (see Appendix E) prior to the interview, and each participant was asked the same set of questions. A number of participants brought handwritten notes to the interview with their answers to the interview questions, to ensure they included content that they thought was important. Further, their opinions of the questions were sought in light of their understanding of the research question, aims and objectives and they were asked if there were any other aspects of violence towards ED nurses that they thought was important but not included in the questions or revealed during the interview.

Unstructured open-ended informal field interviews

In phase one, three (3) unstructured open-ended, 45 – 60 minute interviews were conducted. These interviews were also undertaken in the field in the nurse education office or an unoccupied examination room and did not extend past the agreed 60 minutes.

The interviews were unstructured to enable an open spontaneous conversation to ensue and participants’ experiences and opinions were sought regarding the research question. Akin to the semi-structured interviews, prior participant consent was obtained for phase one and phase two unstructured interviews, and they were digitally recorded.

Thirteen (13), 20 – 40 minute informal, unstructured open-ended field interviews were undertaken following observation of a violent event and to confirm emergent, tentative research themes. These conversations often took place at the nurses’ desks,
in the tea-room or corridors but only when convenient for the participants and when confidential circumstances arose.

The informal field interviews were all spontaneous and unstructured conversations that consisted of data generation that illuminated the nurses’ behaviours, thoughts, beliefs, feelings and understandings following a violent event. These interviews also encompassed conversations where the participants’ spontaneously wanted to share their thoughts, opinions, beliefs or understandings about their subjective experiences of violence in their workplace. The third element of these interviews was their value as member checking interviews (member checking as a method for rigour will be further discussed below). During these types of informal conversations, the participants’ thoughts and opinions, validations and reflections on the researcher’s emergent themes were sought.

**Researcher journal**

Human subjectively and the interactive relationship of the knower and known, within the framework of field work, challenges the values of the researcher. Rejecting the view that any inquiry is value-free, field work inquiry acknowledges at least five ‘value’ issues that impact upon inquiry (Lincoln & Guba, 1985). The first is the influence of the researcher, the second is the researcher’s choice of paradigm, the third is the researcher’s choice of substantive theory, the fourth is the influence of the context on the inquiry and the fifth, as a function of the aforementioned four influences, is that the inquiry then is either value-resonant or value-dissonant. Self reflexive recognition of the researcher’s own values, beliefs and potentially value laden subjective perspective is important for both ethical conduct of the study (Creswell, 1994; Dempsey & Dempsey, 2000) and for auditability and trustworthiness of data analysis (Beck, 1993). This dimension is reflected in the researcher’s diligence reporting their own voice and values, and the clear separation of the data generated from the researcher journal from participant data, and the context of interest. “It is widely acknowledged and accepted that qualitative research is a reflexive process, in that the researcher has an effect on the research and vice versa” (Cutcliffe, 2003, p. 136). Further, issues of the nurse researcher’s a priori and tacit knowledge, values, beliefs, analytic self consciousness and positioning within
the contextual milieu affect the process and application of reflexivity. In phase one and two of this study researcher journaling was extensively used as a means of contributing to data generation and rigour.

Reflexivity in this research was applied by the researcher consciously and explicitly recording a detailed account of ongoing processes, feelings, thoughts, emergent ideas, hunches and questions for follow-up observation or conversation (Hammersley & Atkinson, 1983; Miles & Huberman, 1994). Further, issues pertaining to self and method were recorded and detailed therefore providing a transparent audit trail of the reflections of the human instrument (Lincoln & Guba, 1985) and a philosophical and methodological log (Cutcliffe, 2003). This was enacted using a process of record, retreat, review, reflect. This process followed each data collection event and occasion in the field. Applying this process to interviews is also valuable as a means of establishing rigour (Patton, 1980). Presenting this audit trail contributes to the credibility of the final account (Lincoln & Guba, 1985), acknowledges the insider / outsider positioning and consequently the re-presentations and interpretations offered in the findings.

Journaling was undertaken at the end of every participant observation occasion and following all interviews, and these entries were reviewed prior to the next field work opportunity. The nurse researcher journal was generated using the iPAQ and, like all field notes and observations, recorded in the field. This also ensured that the audit trail and researcher journal was chronological. As described, the journal included the feelings, thoughts, reactions, questions, uncertainties, hunches of the researcher and assisted in the process of personal debriefing. The journal was extensively referred to during data analysis.

Document review

Three relevant organisation manuals were extensively reviewed during phase two of the study (see Table 4.1). In addition, relevant State Health information, freely available on the world wide web, was referred to as needed.
Data analysis

All data analysis approaches, qualitative and quantitative, share the feature of attempting to “tell a story from the data” (Hardy & Bryman, 2004, p. 1). The common functions include answering the research question and resolving quantities of information into simpler elements, without necessarily subscribing to positivistic reductionism (Hardy & Bryman, 2004). Throughout the process of data analysis, all researchers share a concern for transparency and accuracy to maximise the veracity of their ‘re-presentation’ of the phenomenon of interest (Gray, 2004; Hegelund, 2005). For purposes of this study, qualitative data analysis refers to the processes of “coding, indexing, sorting, retrieving, or otherwise manipulating data” as well as the “imaginative work of interpretation” used to identify and illuminate the explicit links between themes, the findings and contemporary literature (Coffey & Atkinson, 1996, p. 6). The analysis process, transcript creation and the literal tools used for the study will now be discussed.

Transcripts and literal tools

The literal tools (Lee & Fielding, 2004) used in this study included the iPAQ 6515 hand held personal computer (iPAQ), an Apple iPod, and the software packages; QSR International Pty. Ltd. software package NVivo2 (NVivo2); Microsoft Office; iTunes; and Magix Audio Cleaning Lab 2005 e-version (Magix) software. Magix is a digital audio cleaning computer program. Manipulating the sound files derived from the iPod, and therefore iTunes, with Magix significantly improved the audio quality for transcription. NVivo2 is a code and retrieve, and theory-building Computer Assisted Qualitative Data Analysis Software (CAQDAS) (Lee & Fielding, 2004; Richards, 2005; Richardson & Ardagh, 2005; Weitzman & Miles, 1995). CAQDAS are regularly used for assistance with qualitative data analysis and management (Lee & Fielding, 2004; St John & Johnson, 2000; Tesch, 1991; Weitzman & Miles, 1995).(Richardson & Ardagh, 2005)

CAQDAS enhance the development of codes and their subsequent themes, partly as a result of their flexibility for multiple coding and capacity to promote complex pattern building (Boyatzis, 1998; Weitzman & Miles, 1995). This does not infer that the computer program generates the codes and themes (Coffey & Atkinson, 1996;
QSR International, 2002; Richardson & Ardagh, 2005; St John & Johnson, 2000; Tesch, 1991). Rather, the use of NVivo2, in conjunction with use of logtrail and memos linked as doclinks and databites, enhanced the production of a chronological decision making audit trail that consequently contributed to rigour (Jacelon & O'Dell, 2005; Richardson & Ardagh, 2005; St John & Johnson, 2000). This is not to suggest use of CAQDAS systems are without concern. The prevailing criticisms include the distancing of the researcher from the data, the limitations of the software package and the potential for the software to drive data analysis decision making. Further, the limits of the CAQDAS arguably places limits on what can be discovered (Coffey & Atkinson, 1996; St John & Johnson, 2000; Tesch, 1991). Prior awareness of the potential limitations of the CAQDAS led to deliberately seeking input, discussions and feedback about the raw data and emerging themes from Supervisors, therefore consciously not limiting what could be discovered from the data. Further, all digital audio files were repeatedly listened to, and transcripts read and re-read to ensure continued researcher connection with, and immersion in, the data.

*Thematic data analysis*

Qualitative data analysis is about the description, re-presentation, and synthesis of textual data (Gray, 2004) where text is analysed and interpreted in a minimum two step process (LeCompte & Schensul, 1999). Content analysis systematically uncovers ideas and themes from text (Mayring, 2000, 2004). The goal of content analysis is to interpret, explain and understand, rather than simply describe. It is a tool for summarising or reducing large quantities of text to manageable categories thus shaping themes (Gray, 2004). Data are initially de-contextualised to improve practical data management and the extraction of codes (Ayres, Kavanaugh, & Knafl, 2003). A feedback loop applies in both inductive and deductive code development (Mayring, 2000). The feedback loop allows data to be iteratively re-examined and recoded to uncover different models and themes, thereby supporting conceptual linking and interpretation (Gray, 2004). There is flexibility during development of codes, models and themes, as they can be revised based on emergent codes, ideas and new description (Hsieh & Shannon, 2005).
Thematic analysis is a form of content analysis (Boyatzis, 1998; Hsieh & Shannon, 2005). Thematic analysis is commonly used in nursing research and aims to represent the participants’ perspective of events, beliefs and experiences by systematically drawing inferences from the text (Boyatzis, 1998; Hsieh & Shannon, 2005; Park, Butcher, & Maas, 2004; Ryan & Bernard, 2000; Tesch, 1991; Weber, 1990). The goal of the descriptive/interpretative thematic data analysis (Tesch, 1991) used in this study was to understand the phenomena of interest, that is violence towards nurses, as it emerged from the instrumental ‘case of’, concurrently confirming or refuting empirical findings. This close link between data and findings is typical of qualitative studies (Coffey & Atkinson, 1996; Sandelowski & Barroso, 2002). Textual data was initially decontextualised, or reduced, then re-contextualised concurrently with the descriptive statistics, to ensure truthfulness of transferable participant meaning within the case (Ayres et al., 2003). Weber (1990, p. 22) argues that whilst thematic analysis is labor intensive, it yields “detailed and sophisticated comparisons”. Thematic analysis of this study was undertaken in three concurrent iterative stages; data reduction, data display or connecting and conclusion drawing (Gray, 2004; Miles & Huberman, 1994; Silverman, 2005; Weber, 1990).

Typically for thematic analysis, data analysis began following the initial data generation phase (Jacelon & O'Dell, 2005; Miles & Huberman, 1994), thus phase three of the study was undertaken concurrently with phase one and two, and completed following exiting the field. The qualitative data thematically analysed in this study included the field notes, interviews and researcher journal. Concurrently, quantitative data from the observation tool were generated and analysed. Throughout the data generation process, data were transcribed, tabulated and read to help guide subsequent field work. As indicated, towards the end of field work, some preliminary tentative emergent ideas and themes were discussed with participants and their thoughts were recorded as informal field interviews.

*Creating the text*

This use of the aforementioned literal tools greatly assisted with recording verbatim participant comments, allowed the reflective journal to be a chronological log, and gave the field work data an intimate immediacy that field notes may not realise if recorded after the observation.
All of the phase one data generated were transcribed by the researcher. Five (5) participant interviews, six (6) of the informal field interviews generated in phase two, and the researcher’s journal were transcribed by the researcher. All other phase two audio files were sent to a confidential transcription service in a capital city. Use of a transcription service is a common choice in qualitative research (MacLean, Meyer, & Estable, 2004; Tilley, 2003). The transcription service used has an internal confidentiality agreement with all its employees, thus further ensuring adherence to ethical requirements (see Appendix F). All audio files were repeatedly listened to, and the transcripts edited and adjusted. This process occurred on receipt of the completed transcripts, during the process of transferring documents into NVivo2, and while coding. Minimal content changes were required during the editing process of externally transcribed texts, with the exception of the need to correct specialised terminology.

In addition to engaging in data immersion and becoming re-familiarised with the content, the additional benefits of listening to the audio tapes included maintaining consistent notations, editing for consistent punctuation and checking of inaudible parts of tapes (MacLean et al., 2004; Tilley, 2003). Further, detailed descriptions of the emotional aspects of participant-researcher interactions, researcher memos and additions to the NVivo2 logtrial were made, or added to, during the editing process (Richards, 2005; Richardson & Ardagh, 2005; Tilley, 2003). Data analysis, therefore, continued during the examination and reading of the transcripts (Im & Choe, 2004; Miles & Huberman, 1994). Appropriate transcriber remuneration and confidentiality, researcher checking of all transcripts for accuracy, terminology, content and consistency of notation, decreased human error during the transcription process (MacLean et al., 2004). Further, while this choice positively affected the time taken for data transcription and therefore analysis, the additional processes ensured researcher immersion in, and intimacy with, the data.

**Coding, tabulating and developing meaningful themes**

The use of NVivo2 aided phase three data management and retrieval during data analysis in (Jacelon & O'Dell, 2005; St John & Johnson, 2000). Following the initial stage of data organisation and management, data reduction using descriptive and
topic coding commenced (QSR International, 2002; Richards, 2005). Importantly these codes were either descriptive codes containing information about events and participants, or topic codes that emerged from the data (Gray, 2004; Weber, 1990). In this use, codes denotes a list of recurring events, behaviours or narrative (Boyatzis, 1998; Sandelowski & Barroso, 2002). NVivo2 topic codes were free nodes in the first instance (QSR International, 2002; Richards, 2005). These topic codes reflected emergent preliminary ideas based on verbatim participant statements, participant observation and summarising frequently encountered ideas (Aronson, 1994; Sandelowski & Barroso, 2002). The process continued iteratively until no new codes emerged and clarity of code definition was ensured (Ryan & Bernard, 2000; Weber, 1990). Detailed descriptions of the codes, including inclusion and exclusion criteria, were developed and recorded in NVivo2 to form mutually exclusive categories that made possible useful and meaningful codes (Boyatzis, 1998; Ryan & Bernard, 2000).

Data immersion and the iterative process facilitated further examination of codes and nodes. During this flexible process some of the codes, and therefore the content coded at particular nodes, and the description of the nodes, changed. Patterns between the free codes became distinguishable resulting in categorisation of codes into ‘tree nodes’ (QSR International, 2002; Richards, 2005). That is, patterns and relationships between the codes were expounded upon and clarified, leading to the development of themes. Codes therefore developed themes. In this application of themes, they are the unifying ideas or motifs derived from the codes (Sandelowski & Barroso, 2002) and are not necessarily verbatim data extracts. Themes are conceptually developed to describe and interpret the emergent phenomena of interest (Boyatzis, 1998). Recognising the coding moments in texts consistently, was ensured through the process of comparing themes and writing and re-writing “a set of statements that differentiate” between the themes (Boyatzis, 1998, p. 48). This again illustrates the effects of the iterative process on the emergent, data driven themes and therefore ‘case of’.

The conceptual, iterative decision making and theme development, acknowledges that boundaries for codes and themes can overlap “or are fuzzy” (Tesch, 1991, p. 20). The process of clarifying potentially fuzzy codes and themes reflects the voice and perspective of the researcher (Freshwater & Avis, 2004) and the researcher’s
accepted theoretical framework (Boyatzis, 1998). Further, the flexibility of this process combined with the need to make decisions regarding distinctions between codes and themes, supports the call for intellectual entrepreneurship or creativity. In turn the process of making these distinctions contributes to data analysis and the audit trail. The influence of the researcher as “the instrument of data analysis” (Jacelon & O'Dell, 2005, p. 217) is, therefore, visible and acknowledged. Further, the technique of initially dissecting the data into smaller parts allowed more developed connections and abstracted themes to become known (Gray, 2004). The use of NVivo2 supported this process and enabled coded extracts to be easily and readily contextually understood (Jacelon & O'Dell, 2005; Richards, 2005), which is highly congruent with the tenets of this concurrent mixed methods instrumental case study.

Data display
Regularly throughout the data analysis process, reports and models were developed using NVivo2. Production of reports of all NVivo2 nodes, and therefore codes and themes, and their descriptions enabled continual review and reflexive refinement of codes, tree nodes and themes, aiding clarity and interpretation. Themes and models were synthesised to support the findings and researcher interpretations (Sandelowski & Barroso, 2002). Both qualitative and quantitative data analysis techniques were used concurrently to fully understand the phenomena of interest.

Quantitative data analysis
Importantly for this mixed method instrumental case study was the illumination of the ‘case of’ as it was constituted in the particular ED context. Quantitative data regarding violent events and the context added empirical insights into the ED and the ‘case of’. The level of measurement for the quantitative data generated was nominal and ordinal data (Borbasi, Jackson, & Langford, 2004; Polit & Beck, 2004), thus the data is presented as frequencies and in tables. Quantitative data added to the depth of contextual detail, and the qualitative and quantitative recording of observed violent events permitted concurrent data generation and analysis, contributing to credibility, auditability, fittingness and transferability of findings.
Drawing Conclusions and data interpretation

Phase three of the study entailed developing statistical descriptions concurrently with the processes of decontextualising and recontextualising, producing increasingly refined and abstract themes. Themes were then reviewed. Review of the themes was undertaken by re-reading and ascertaining consistency and logic of argument between the inductively reasoned themes, the coherence of their relationships, and the textual and numerical data. Importantly, codes and themes were continually reviewed contextually to the research question, and the empirical and emerging ‘case of’. Conceptual models and the interpretation of findings evolved from this process (Ryan & Bernard, 2000; Sandelowski & Barroso, 2002). Finally, the review included integration and contrast with the current relevant literature.

The acknowledgment and inclusion of both inductively derived, emergent themes and deductively anticipated themes is consistent with the process of discovery in qualitative case study (Stake, 1995) and the construction of the instrumental ‘case of’. Importantly, there is confirmation that the findings and interpretations are founded on sufficient evidence, and a transparent analytic process, ensuring they justifiably reflect the case and the ‘case of’. Connections between the emergent abstracted themes were made and are presented in the findings chapters (see chapters five and six).

As described, phase two and phase three, comprising generation and analysis of data, continued concurrently. Concurrent data generation and analysis strengthened the study in two ways. First, it fostered the traditional testing for consistency of findings. Testing for consistency included the scrutiny of the similarity or differences between what participants said they did and the information in the field notes (Agar, 1986; de Laine, 1997; Hammersley & Atkinson, 1983). Second, concurrent data analysis highlighted the correspondence between the quantitatively and qualitatively generated violent events and emergent themes, further authenticating the research findings and interpretations. Concurrent data generation and analysis further ensured that the findings were consistently contextualised to the instrumental case.
The setting for this instrumental case study

The geographical boundaries of this instrumental case study were defined separately to the boundaries of the case and ‘case of’, as discussed. The case boundaries can be distinguished with respect to location, geography and membership; thus physically and environmentally it is easy to determine boundaries of the case. These readily identifiable environmental features, that help contextualise the instrumental case, will now be described.

The setting of this research was an Australian Emergency Department within a rural and regional public referral hospital that services an approximate area of 40 833 square km in Northern Australia (Queensland Health, 2004c). The hospital services a large rural and remote multi-cultural community that includes a permanent metropolitan population, tourists and a transient seasonal workforce. Within this Health Service District, approximately 77% of the population are under the age of 49 years, 9.5% are Indigenous persons and 8.6% are people from non English speaking backgrounds (Queensland Health, 2004c). The Health Service District hospital offers medical, surgical, specialist and clinic services (Queensland Health, 2004a, 2004b).

The ED has 34 beds divided into five (5) functional areas (see Table 4.2). There are 51 nurses rostered in this unit comprising 42 full-time equivalent Registered Nurse positions (Clinical Nurse Educator, Clinical Nurse, & Clinical Nurse Consultant, 1996). Registered Nurses are allocated to 9 shifts, with varying start and finish times (see Table 4.3). The 1998 statistics indicate that this ED case mix included 39% adult medical, 25% trauma, 11% adult surgical, 10% paediatric with 5%, 3% and 3% Dressing clinic, Obstetric / Gynaecology and Psychiatry respectively. Of this, Aboriginal and Torres Strait Islander people comprised 19% of all attendances and 23% of all admissions (Clinical Nurse Educator et al., 1996). The Australasian Triage Scale is used in this ED setting (Australasian College for Emergency Medicine, 2006).
Table 4.2 Nurse Staffing

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of Beds = 34</th>
<th>Nursing staff allocation</th>
<th>0700 – 2300</th>
<th>2300 – 0430</th>
<th>0439 – 0700</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triage/Waiting room</td>
<td>1</td>
<td>Triage RN</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Resuscitation/ Cardiac beds</td>
<td>7</td>
<td>Resuscitation RN</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Acute Care Area 1</td>
<td>7</td>
<td>Acute Care RN</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Includes – Paediatric rooms 1 &amp; 2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Care Area 2 includes</td>
<td>8</td>
<td>Acute Care RN</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Isolation room</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seclusion room</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plaster &amp; dressings area</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure room 1</td>
<td>1</td>
<td>Team leader RN</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gynaecology/Rape crisis room 1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consult room 1– Eye room</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consult room 2 – Ear Nose &amp; Throat room</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Number of Nurses</td>
<td></td>
<td></td>
<td>7</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 4.3 Nursing Roster Hours

<table>
<thead>
<tr>
<th>Name of Shift</th>
<th>Shift times</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>EK</td>
<td>1000 – 1830 hours</td>
<td>1 Nurse</td>
</tr>
<tr>
<td>YB</td>
<td>1800 – 0230 hours</td>
<td>1 Nurse</td>
</tr>
<tr>
<td>NJ</td>
<td>2000 – 0430 hours</td>
<td>1 Nurse (meal break 2215 – 2245)</td>
</tr>
<tr>
<td>LQ</td>
<td>1530 – 2400</td>
<td>1 Nurse – ‘float shift’</td>
</tr>
<tr>
<td>E</td>
<td>0700 – 1530</td>
<td>7 Nurses</td>
</tr>
<tr>
<td>L</td>
<td>1430 – 2300</td>
<td>6 Nurses</td>
</tr>
<tr>
<td>LA</td>
<td>1200 – 2030</td>
<td>1 Nurse</td>
</tr>
<tr>
<td>N</td>
<td>2245 – 0715</td>
<td>4 Nurse</td>
</tr>
</tbody>
</table>

(Clinical Nurse Educator et al., 1996)
Entering and exiting the field

Following appropriate ethics approvals (see below), gaining physical and social entry into the field (de Laine, 1997; Hammersley & Atkinson, 1983) and the ED, began by contacting the Executive Director of Nursing (EDON) for the District Area Health Service. Introductions were then made to the key ED nursing and medical management personnel. There was an overwhelmingly warm reception offered by the senior nursing staff on the ED unit and this continued upon entering the field and meeting the nurses working in the unit. The need for long-term immersion in the field signalled a need for a nursing unit ‘culture’ that was open to nursing research (Roper & Shapira, 2000). The nurses in the selected ED unit had a reputation for being supportive of nursing research and innovation. Whilst the researcher never became a member of the ED, acceptance of the presence of the researcher, both physically and socially, quickly ensued. This is clearly evidenced by the number of interviews conducted. Upon completion of 12 semi-structured interviews, sufficient narrative data was collected and recurrent ideas and topics were present in the data. Participants, however, began to seek out the researcher to organise mutually agreeable interview times, thus a total of 16 semi-structured interviews were completed.

The decision to leave the field was based on the generation of repetitive data and the general picture was reaffirming itself (Fetterman, 1998). As a function of the remote and rural setting of the ED, and the researchers’ position in the nursing community, there was no absolute finality with the setting or the participants. This is not to be confused with the notion that the nurse researcher over identified with the participants to the extent of ‘going native’ (Hammersley & Atkinson, 1983). The participants were repeatedly thanked and acknowledged for their generosity and support, and they were frequently informed about the intended withdrawal of the researcher from the field. The ongoing nature of the collegial, community researcher-participant relationship and the aforementioned characteristics of the setting is evidenced by the mutual agreement to undertake collaborative research following the completion of the current thesis.
The participants

The demographics of the 20 participant ED nurses are shown in Table 4.4. Specific details about individual participants will not be divulged to protect their anonymity and confidentiality.

Table 4.4 Participant Demographics

<table>
<thead>
<tr>
<th>Demographics of Participants</th>
<th>Number of Participants (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
</tr>
<tr>
<td>Years Nursing Experience</td>
<td></td>
</tr>
<tr>
<td>&lt; 1 year nursing</td>
<td>3</td>
</tr>
<tr>
<td>2 - 5 years nursing</td>
<td>3</td>
</tr>
<tr>
<td>6 – 9 years nursing</td>
<td>4</td>
</tr>
<tr>
<td>&gt; 10 years nursing</td>
<td>10</td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
</tr>
<tr>
<td>Full time employment</td>
<td>12</td>
</tr>
<tr>
<td>Part time employment</td>
<td>8</td>
</tr>
</tbody>
</table>

Participant and event sampling

The inclusion criteria for participation were membership of the ED’s permanent nursing staff, ability to speak, read and understand English and competence to provide informed consent. The 20 participants were all registered as nurses in the Australian State in which they practiced, thus the latter criteria were guaranteed, as they are part of the registration standard. There were no explicit exclusion criteria. The recruitment of participants was non-probability convenience sampling (Gray, 2004; Patton, 2002; Silverman, 2005) because they were nurses who were members of the ED setting of interest.
The criteria for the violent events included any physical and or non-physical violence, as defined in chapter two, that was directed at the participant nurse during the course of her/his routine nursing practice, where the agent of violence was a patient, their family or friends. The violent events observed were those that were directed to a consented participant nurse, during the hours of researcher’s field work.

**Ethical issues**

Ethics approval was granted from three Ethics Committees; University of Western Sydney, the appropriate District Area Health Service and James Cook University (See Appendix G). The research was Category 1 research (National Health and Medical Research Council, 1999). In keeping with the principles of beneficence and non-maleficence, however, an independent and freely available support person was organised prior to entering the field in the event that any participants felt distressed as a result of the research process. The contact details for this person were included on the plain language statement (see Appendix H). No participant required this service.

Ethics concerns the morality of the researcher’s behaviour as well as the acceptability of the conduct and intent of the research (Borbasi et al., 2004; de Laine, 1997; Gray, 2004; Holloway & Wheeler, 2002; National Health and Medical Research Council, 1999). In Australia, health related human ethics is guided by the principles outlined by the National Health and Medical Research Council (NH&MRC) (National Health and Medical Research Council, 1999). The NH&MRC guidelines, in the National statement on ethical conduct of research involving humans, specifically outline the inter-related principles that underpin the ethical conduct of research including “integrity, respect for persons, beneficence and justice ... consent ... research merit and safety” (National Health and Medical Research Council, 1999, p. 11). The application of these principles during this research will be demonstrated.

Respect for person is reflected in this study via the protection of the participants’ identity and autonomy (Borbasi et al., 2004; Gray, 2004; Holloway & Wheeler, 2002; National Health and Medical Research Council, 1999). The case study setting was a
rural and regional ED accordingly particular attention was paid to ensuring that the informants’ identity remained protected in all products of the research, including this thesis. This was actioned with the use of pseudonyms and by ensuring that the data were represented collectively and thematically. Exemplars have been carefully selected to illustrate and present evidence that support the conclusions, without being specific enough to inadvertently provide disclosing information about the identity of individual participants. The intent, and practical mechanisms that serve to protect the participants’ identities, were clearly explained in the information sheet for participants (see Appendix H) and during conversations with all potential participants, and again prior to their written consent to participate. The ethical value of justice was upheld as the potential benefits of the research to regional Australian nurses outweigh the individual burden because as a function of the design, the burden was distributed across a number of self selected participants. With respect to beneficence, the goal of the research has the aim of discovering new nursing knowledge that has the potential to assist in understanding and decreasing workplace violence towards ED nurses where the agent of violence is the patient their family or friends.

The process for consent followed identifiable steps (Corrigan, 2003). Following entry into the field and researcher introductions to potential participants, information sheets for participants (see Appendix H) were distributed to any interested member of the nursing staff. Informal conversations explaining the reason for the study, the research process and the anticipated individual commitment ensued with the ED nurses, at their convenience. Explanation of their freedom to withdraw at any time were given along with details of the type of data to be collected, and the anticipated use of the data by the researcher. This verbal explanation reflected and reinforced the written materials. Written consent was sought only after this process was complete, and always during a subsequent meeting (see Appendix I). During the gathering of written consents, the participants were again informed of the study aims, their anticipated commitment, and consenting nurses were then provided with a copy of the semi-structured interview questions (see Appendix E). Consent was therefore voluntary, specific and obtained from competent persons (Borbasi et al., 2004; Gray, 2004; Holloway & Wheeler, 2002; National Health and Medical Research Council, 1999).
In addition to this process, there was a small handwritten entry in the ED’s Communications Book, including a copy of the information sheet for participants and consent form. A senior nursing staff member suggested not undertaking an in-service education session with the nursing staff. This person believed that the members of the nursing team would not see this as beneficial or acceptable. The choice to use contextually appropriate means to inform staff demonstrates coherence with the principle of respect for person and respect for collective and individual beliefs. Further, this recruitment process reflects due consideration for confidentiality and autonomy, conscientiously fully informing the participants in a contextually appropriate manner thus further enabling voluntary informed consent.

On a separate occasion, informed, voluntary consent was obtained from all participants to use an independent confidential transcription service for some of the interviews. This followed successful application for ethics amendment from the relevant ethics committees. The same process ensued regarding obtaining participants consent to send the digital audio files to a transcriber, and voluntary informed consent was obtained (see Appendix I). It is important to explicitly note that no narrative data were generated from the patients, their family or friends involved in the violent event. This was not the focus of the study and therefore there was no need to generate data or consent the people presenting to ED. Because of the position of the participant observer in the field, however, at times the nurse researcher was on the peripheral margins of intimate nurse-patient interactions. During these occasions, and if the observational positioning of the nurse researcher was not fully discrete, then the nurse researcher was introduced to the patient their family and friends, and the role of the researcher explained to the aforementioned people. Ethical approval was given for this process.

Anonymity was ensured using a transcriber service. The service used was in a capital city, not in the same city as the chosen ED, thus the transcriber would not know the participants’ voices. The employees of the transcription service signed a confidentiality agreement with their employer, further ensuring participant confidentiality (see Appendix F). Prior to sending audio files, the transcriber was told
of the high probability that the audio files could contain abusive or offensive language.

The aforementioned strategies to ensure ethical standards were adhered to during the entire research process and were implemented within a flexible research process that included dynamic relationships between the researcher and the participants. The dynamic nature of consent was acknowledged by continually informing participants of the research processes and tentative themes, as they emerged.

**Research rigour and entrepreneurship**

There is ongoing conversation and debate about rigour in qualitative research. The issue of rigour needs to be addressed by each researcher and needs to match the methodology, methods and philosophical underpinnings of their study (Silverman, 2005). The goal of establishing rigour is the legitimisation of the research findings and demonstrating credibility, auditability, fittingness, dependability and transferability. This legitimisation needs to be addressed in terms of the process of discovery as well as the product of inquiry and this is particularly relevant for alternative paradigm research such as this mixed methods instrumental case study.

From a pragmatists perspective, Patton (1980) directs the researcher to re-present the phenomena of interest in an ethical and credible manner but adds the need for “creativity, intellectual rigor, perseverance, insight – these are the intangibles that go beyond the routine application of scientific procedures” (p. 339). These same sentiments are reflected in the work of Cutcliffe (2003) who urges the qualitative researcher to be inclusive of intellectual entrepreneurship. “Intellectual entrepreneurship implies a conscious and deliberate attempt on the part of academics to explore the world of ideas boldly” (Cutcliffe, 2003, p. 144). Lincoln and Guba (2002, p. 29) refer to this quality, as it relates to case study in particular, as creativity. Cutcliffe (2003) argues that over emphasis on reflexivity discourages inclusion of the researcher’s tacit knowledge, hunches or creativity. He argues that it is contrary to the intent of exploring the subjective world of ‘other’ and further, that any reflexivity can only be incomplete, as a function of the intangible nature of human consciousness. It would seem, however, that despite the debates regarding criteria
and application of rigour that some fundamental issues prevail. First, there continues to be no agreed, set criteria for rigour in qualitative research. Second, subsequent to the first issue, that the researcher has the mandate to identify their own processes within their methods, methodology and philosophical position that substantiates the findings according to some detailed and defendable position. Third, that the notion to include tacit knowledge, creativity or intellectual entrepreneurship is an enduring quality of qualitative rigour. Fourth, and finally, that the researcher has to make explicit, in their processes and findings, their position concerning the aforementioned issues. Rigour was established and applied in every phase of the current study through the techniques of credibility, auditability, authenticity and transferability (Beck, 1993; Lincoln & Guba, 2002; Patton, 2002).

The recognition, by participants and research audience, that the research findings describe or reflect the phenomena of interest, as it is lived, serves to confirm credibility (Beck, 1993; Taylor, 2002). Credibility can be demonstrated in two ways. First, the nurse researcher shows that the conduct of the study was undertaken in such a way that the process of inquiry supports the believability of the findings. Second, the findings themselves are believable to the audience (Polit & Beck, 2004).

Strategies that demonstrate credibility include; sufficient engagement in the field; triangulation of data, time, space, person and method; member checking; searching for disconfirming evidence; and researcher credibility (Polit & Beck, 2004; Streubert, 1999). Data generation for this concurrent mixed method study adheres to these criteria for credibility including: the duration and depth of field work; the concurrent generation and analysis of mixed method data; and the researcher journaling; and NVivo2 logtrail which provided evidence of the decision trail. Researcher journaling and the logtrail processes offered by NVivo2, ensured there was an identifiable and traceable decision trail, or auditability, within the progress of the research. Further, the nurse researcher voice in the data generated was identifiable and subject to critique. The audit trail reflects the researcher adherence to consistency in method and research processes (Beck, 1993; Streubert, 1999; Taylor, 2002). The emergent themes and ideas were subject to member checking as part of the field work, meaning the emergent themes were confirmed by the participant ED nurses (Lincoln
Additional strategies that support the credibility of the findings include transferability or fittingness (Polit & Beck, 2004). The issue of transferability and generalisability pertinent to the construction of a coherent case study design, has been addressed in chapter three. As discussed, transferability and fittingness as a characteristic of rigour, encompasses the idea that the findings have some resonance with similar contexts or milieus within which the phenomena of interest is manifest. It also refers to people identifying with the conclusions (Streubert, 1999; Taylor, 2002). It is apparent that there is typicality in the ‘case of’, the participants and the context. Based on the typicality of the case and ‘case of’, and following the presentation of the findings (see chapters five and six) the fittingness or transferability of the finding of the current study will be further explored in the discussion (see chapter seven). The application and demonstration of the processes of rigour of the current study, including credibility, auditability and fittingness, or the confirmability of the results (Jackson, Daly, & Chang, 2003), however, have been clearly demonstrated.

**Summary**

As this chapter has revealed, mixed method instrumental case study design is an appropriate strategy to use to understand the ‘case of’. The three phases of this concurrent mixed methods study have been explicated. The methods of participant observation, informed by ethnographic tenets and structured closed-ended observations, informed by empirical tenets, are coherent with the instrumental case study design and exploration of the ‘case of’ used in the current study. It has been further argued that these observation strategies are compatible with semi-structured open-ended interviews, unstructured open-ended field interviews, document review and researcher journaling. The processes used for concurrent data generation and analysis have been clearly summarised. The remote and rural settings of interest and the nurse participants have been described. Finally, the application of ethical principles and intellectual entrepreneurship in the current study has been explicated.
The following chapter introduces the findings of this mixed method instrumental case study and provides detail of two of the thematic findings.
Chapter Five - Abstract

This chapter introduces the five findings for the current study, these are;

(i) Conveying caring: Averting violence
(ii) Being alert: Recognising, assessing and responding to violence
(iii) Attributing Meaning: Subjective understandings that shape responses to violence
(iv) Collegial awareness: Forming trusting relationships to help manage violence
(v) Fostering resilience: Resisting negative sequelae of violence

This chapter will focus on the first two of these findings, using excerpts of narrative from interviews and field notes to illustrate the development of the themes.
Chapter Five - Findings

Introduction to Findings

The findings from this study reveal that the participant ED nurses faced many confronting and potentially violent situations on a daily basis. Sixteen observed violent events over a five (5) month period may seem like a relatively modest number of events, however 20 people engaged in most occupations would not be exposed to this frequency of violent acts in their workplace during a 290 hour period. The 16 observed violent events were generated from observation of the 20 consented participant ED nurses. Other violent events involving non-participant ED nurses occurred during the time frame, however these were not included in the study. In addition to the 16 observed violent events, there were many other observed interactions where the patient, their family and friends demonstrated a potential for violence. The participant nurses intervened to manage these potentially violent situations in a timely manner and therefore many violent events were averted. As the findings reveal, the nurses met these challenges with professional attitudes, expertise and high levels of interpersonal skills. These ED nurses were also consistently supportive of patients, their family and friends as well as their colleagues during actual or potential violent events.

Five (5) themes were revealed following concurrent data analysis of textual and numeric data. Each of the five (5) themes, their subthemes and component behaviours and cues can be seen in Table 5.1. This chapter details two (2) of the five (5) findings revealed following the thematic analysis of 16 semi-structured interviews and 13 informal field interviews, and presents a descriptive overview of the 16 observed violent events, which further provides the context within which the themes were derived.

Overview of Observed Violent Events

Table 5.2 is a synopsis of each observed violent event including the age and gender of the agent of violence (see Appendix D).
<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being safe</td>
<td>Not admitting violent patients into the ED</td>
<td>Having a clear safe exit</td>
</tr>
<tr>
<td></td>
<td>Positioning themselves to avoid being physically hurt</td>
<td>Removing potential weapons</td>
</tr>
<tr>
<td>Being available</td>
<td>Active Listening</td>
<td>Reflective listening</td>
</tr>
<tr>
<td></td>
<td>Attending</td>
<td>Empathy</td>
</tr>
<tr>
<td>Being respectful</td>
<td>Using patients preferred name and having a calm demeanor</td>
<td>Building rapport and being assertive</td>
</tr>
<tr>
<td></td>
<td>Working harmoniously with patients, their family and friends</td>
<td>Use of non-threatening body language</td>
</tr>
<tr>
<td>Being supportive</td>
<td>Making people feel comfortable</td>
<td>Offering tea, coffee and meals</td>
</tr>
<tr>
<td></td>
<td>Welcoming patients, their family and friends</td>
<td>Assisting people to maintain their social roles</td>
</tr>
<tr>
<td>Being responsive</td>
<td>Giving people space</td>
<td>Decreasing stimuli when needed</td>
</tr>
<tr>
<td></td>
<td>Providing a comfortable and a safe environment</td>
<td></td>
</tr>
<tr>
<td>STAMP: Components of observable behaviour that indicate a potential for violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staring</td>
<td>Prolonged glaring</td>
<td>Absence of eye contact</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tone &amp; Volume of Voice</td>
<td>Sharp or caustic retorts</td>
<td>Sarcasm</td>
</tr>
<tr>
<td></td>
<td>Demeaning inflection</td>
<td>Increase in volume</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Flushed appearance and rapid speech</td>
<td>Hyperventilation</td>
</tr>
<tr>
<td></td>
<td>Physical pain, grimacing, writhing, clutching body</td>
<td>Dilated pupils</td>
</tr>
<tr>
<td></td>
<td>Expressed lack of understanding about ED processes</td>
<td>Confusion &amp; disorientation</td>
</tr>
<tr>
<td>Mumbling</td>
<td>Talking under their breath</td>
<td>Criticising staff or the institution</td>
</tr>
<tr>
<td></td>
<td>Repetition of questions or requests</td>
<td>Slurring or incoherent speech</td>
</tr>
<tr>
<td>Pacing</td>
<td>Walking around confined areas</td>
<td>Walking back &amp; forth to the nurses</td>
</tr>
<tr>
<td></td>
<td>Flailing around in bed</td>
<td>‘Resisting’ health care</td>
</tr>
<tr>
<td>Personalisation of violence</td>
<td>Violence directed toward a nurse as a person / an individual</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Violence directed toward a nurse as a symbol of the ‘system’</td>
<td></td>
</tr>
<tr>
<td>Presence of mitigating factors</td>
<td>Psycho-social, situational &amp; contextual stressors</td>
<td>Confusion and disorientation</td>
</tr>
<tr>
<td></td>
<td>Lack of understanding of ED</td>
<td>Perceived by nurses as not ‘innocent victim’ (self inflicted)</td>
</tr>
<tr>
<td></td>
<td>Perceived by nurses as ‘innocent victim’</td>
<td></td>
</tr>
<tr>
<td>Reason for Presentation</td>
<td>Perceived by nurses as an emergency/legitimate presentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Perceived by nurses as NOT an emergency/legitimate presentation</td>
<td></td>
</tr>
<tr>
<td>Colleagues’ awareness: Forming trusting relationships to help manage violence</td>
<td>Being supportive and feeling supported</td>
<td>Cooperation and sharing information</td>
</tr>
<tr>
<td></td>
<td>Protective and watchfulness</td>
<td>Accepting assistance from each other</td>
</tr>
<tr>
<td></td>
<td>Positive interpersonal relationships</td>
<td></td>
</tr>
<tr>
<td>Fostering growth: Nurturing other nurses</td>
<td>Shared learning and teaching</td>
<td>Willingness to give &amp; accept assistance</td>
</tr>
<tr>
<td></td>
<td>Presenting as a united team</td>
<td>Awareness and respect for each other</td>
</tr>
<tr>
<td>Resilience: Resisting negative sequelae of violence</td>
<td>Having hardiness and stamina</td>
<td>Avoiding violence impacting on subsequent nurse patient interactions</td>
</tr>
<tr>
<td></td>
<td>Managing violence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self care</td>
<td></td>
</tr>
<tr>
<td>Validating and debriefing</td>
<td>Not taking work related issues home and using humour</td>
<td>Reflecting on violent events and nursing practice</td>
</tr>
</tbody>
</table>
### Table 5. 2 Observed Violent Events

<table>
<thead>
<tr>
<th>Violent Event Number</th>
<th>Agent Age (years)</th>
<th>Agent Status</th>
<th>Agent Gender</th>
<th>Component behaviours</th>
<th>Location of Event</th>
<th>Name (pseudonym)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>25</td>
<td>Patient</td>
<td>Female</td>
<td>Repeating questions; no eye contact</td>
<td>Triage</td>
<td>Donna</td>
<td>Female</td>
</tr>
<tr>
<td>2</td>
<td>32 &amp; 29</td>
<td>Parents of Paediatric Patient</td>
<td>Male &amp; Female</td>
<td>Verbally aggressive and swearing</td>
<td>Paediatric room</td>
<td>Marilyn</td>
<td>Female</td>
</tr>
<tr>
<td>3</td>
<td>46</td>
<td>Patient</td>
<td>Male</td>
<td>Swearing loudly</td>
<td>Triage</td>
<td>Miranda</td>
<td>Female</td>
</tr>
<tr>
<td>4</td>
<td>54</td>
<td>Patient</td>
<td>Male</td>
<td>Verbally aggressive and swearing</td>
<td>Isolation Room</td>
<td>Miranda</td>
<td>Female</td>
</tr>
<tr>
<td>5</td>
<td>43</td>
<td>Patient</td>
<td>Male</td>
<td>Terse, raised voice</td>
<td>Resuscitation Area</td>
<td>Angie</td>
<td>Female</td>
</tr>
<tr>
<td>6</td>
<td>39</td>
<td>Patient</td>
<td>Female</td>
<td>Verbally aggressive, sarcastic, raised voice</td>
<td>Cardiac Area</td>
<td>Kel</td>
<td>Female</td>
</tr>
<tr>
<td>7</td>
<td>Unknown</td>
<td>Patient</td>
<td>Male &amp; Female</td>
<td>Verbally aggressive, yelling, aggressive body language</td>
<td>Triage</td>
<td>Donna</td>
<td>Female</td>
</tr>
<tr>
<td>8a &amp; 8b</td>
<td>34</td>
<td>Patient</td>
<td>Male</td>
<td>Verbally aggressive and abusive</td>
<td>Cardiac Area</td>
<td>Helen &amp; Dianne</td>
<td>Female</td>
</tr>
<tr>
<td>9</td>
<td>44</td>
<td>Patient</td>
<td>Male</td>
<td>Verbally hostile, rude, loud and swearing</td>
<td>Triage &amp; passageway</td>
<td>Donna</td>
<td>Female</td>
</tr>
<tr>
<td>10</td>
<td>79</td>
<td>Patient</td>
<td>Male</td>
<td>Squeezing, pinching and grabbing nurses hand. Resisting treatment</td>
<td>Acute One Area</td>
<td>Marge</td>
<td>Female</td>
</tr>
<tr>
<td>11</td>
<td>39</td>
<td>Patient</td>
<td>Male</td>
<td>Swearing &amp; yelling. History of violence in the ED</td>
<td>Triage</td>
<td>Muriel</td>
<td>Female</td>
</tr>
<tr>
<td>12</td>
<td>22</td>
<td>Patient</td>
<td>Male</td>
<td>Verbally aggressive, swearing, resisting treatment and confused</td>
<td>Resuscitation Area</td>
<td>Pam</td>
<td>Female</td>
</tr>
<tr>
<td>13</td>
<td>Unknown</td>
<td>Patient</td>
<td>Male</td>
<td>Confused, loud, swearing and incoherent</td>
<td>Waiting Area</td>
<td>Miranda</td>
<td>Female</td>
</tr>
<tr>
<td>14</td>
<td>19</td>
<td>Patient</td>
<td>Male</td>
<td>Verbally aggressive, loud, swearing &amp; abusive</td>
<td>Triage</td>
<td>Muriel</td>
<td>Female</td>
</tr>
<tr>
<td>15</td>
<td>41</td>
<td>Patient</td>
<td>Male</td>
<td>Verbally abusive and swearing</td>
<td>Acute Two Area</td>
<td>Angie</td>
<td>Female</td>
</tr>
<tr>
<td>16</td>
<td>28</td>
<td>Patient</td>
<td>Male</td>
<td>Reduced level of consciousness, verbally aggressive, swearing and resisting treatment</td>
<td>Resuscitation Area</td>
<td>Miranda</td>
<td>Female</td>
</tr>
</tbody>
</table>
Frequency analysis of observed violent events

As Table 5.2 details, 15 of the 16 events were non-physical violence and included swearing and loud verbal abuse, but no events involved personal or physical threats. Triage and Resuscitation Areas were the locale of 56.25% (n = 9) of the violent events. All of the violent events in the triage area occurred during the person’s initial presentation to ED. Further, in 6.25% (n = 2) of the violent events observed the agents of violence were female, in 6.25% (n = 2) the agents of violence were both male and female, and in the remaining observed events 75% (n =12) of the agents of violence were male (see Table 5.2).

Six (6) of the agents of violence were triaged as Category 2 patients (emergency), four (4) were Category 3 (urgent), one (1) was a Category 4 (semi-urgent), and four of the agents of violence either did not have a triage category or the category was not recorded. The agents of violence in the resuscitation area, including the patient involved in event sixteen, were triaged as Category 2, and therefore did not need to wait for entry into the ED or for treatment.

The start time and finish time of the observed events were recorded in 14 of the 16 violent events. Eleven (11) of the 14 violent events had a total duration of less than 20 minutes, with a mode time of one (1) minute. This small mode time is explained by 94% of the observed violence being non-physical (see Table 5.2 and Table 5.3).

<table>
<thead>
<tr>
<th>Table 5.3 Total Time of Violent Event</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total time of Violent Event in Minutes (n =14)</strong></td>
</tr>
<tr>
<td>------------------------------------------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Twenty five percent 25% (n = 4) of the agents of violence had a mental illness or history of mental illness and fifty six percent 56.25% (n = 9) were intoxicated or withdrawing from alcohol or other substances (see Table 5.4). The participant nurses were aware of these patients’ history, and presenting or co-morbid health issues, at the time of the violent event.
Table 5. 4 Health Characteristics of Agent of Violence

<table>
<thead>
<tr>
<th>Health characteristics of agent of violence (n = 16)</th>
<th>Mental illness or history</th>
<th>Alcohol / substance intoxication or withdrawal</th>
<th>Cognitive impairment</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

Introduction to the themes

The two (2) themes discussed in this chapter reveal how the participant ED nurses assessed for the potential for violence that was directed towards them from patients, their family and friends and they are; are Conveying caring: averting violence; and Being alert: recognizing, assessing and responding to violence. The themes also discuss the skills these nurses used to avert and respond to violence. The first theme conveying caring details the strategies, embedded in the participant nurses’ practice, which they purposefully used to avert and prevent violence. These skills embody the attitude of caring the participant nurses conveyed to people who presented to the ED and were observed during their encounters with people who were violent or potentially violent.

The second theme presented in this chapter outlines five (5) components of observable behaviour that the participant nurses identified as indicators of a potential for violence. This theme reveals the nursing violence assessment strategy the nurses used in their everyday practice. These two (2) themes, therefore, provide insight into the participant nurses’ violence management strategies and their contextualised violence assessment strategies. Excerpts of verbatim text from the participant ED nurse narratives and the researcher’s field notes will illustrate the themes. To differentiate verbatim participant narrative from nurse researcher field notes, the former is printed in italicised times new Roman font and the later indicated by single spaced Garamond font. All names used in the field note and interview exemplars in this chapter, and in chapter six, are pseudonyms.
Conveying caring: Averting violence

The participant nurses consistently used highly developed nursing skills to avert and respond to violent events and the potential for violence. These skills were embedded in their practice. There were five (5) broad attributes that they applied in their practice, particularly when patients, their family or friends showed any potential for violence, and these were revealed through their narrative and the structured and unstructured observations (see Table 5.5). These attributes were being safe, being available, being respectful, being supportive and being responsive. These attributes reflected awareness of the multitude of potential stressors placed on patients, their family and friends when they attended ED. They were also part of the initial strategy participants used to prevent and de-escalate violence. Though these approaches did not avert violence in one hundred percent of cases, as evidenced by the fact that there were still sixteen (16) episodes of violence observed over the two hundred and ninety (290) hours of observations, they did successfully avert and reduce potentially violent episodes on numerous occasions.
Table 5.5 Conveying caring: Averting violence

<table>
<thead>
<tr>
<th>Subtheme</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being safe</td>
<td>Not admitting violent patients into the ED</td>
</tr>
<tr>
<td></td>
<td>Having a clear safe exit</td>
</tr>
<tr>
<td></td>
<td>Positioning themselves to avoid being physically hurt</td>
</tr>
<tr>
<td></td>
<td>Removing potential weapons</td>
</tr>
<tr>
<td>Being available</td>
<td>Active Listening</td>
</tr>
<tr>
<td></td>
<td>Reflective listening</td>
</tr>
<tr>
<td></td>
<td>Attending and empathy</td>
</tr>
<tr>
<td>Being respectful</td>
<td>Using patients preferred name and asking the patient, their family and friends what they would like to be called</td>
</tr>
<tr>
<td></td>
<td>Building rapport and having a calm demeanour</td>
</tr>
<tr>
<td></td>
<td>Use of non-threatening body language</td>
</tr>
<tr>
<td></td>
<td>Working harmoniously with patients, their family and friends</td>
</tr>
<tr>
<td></td>
<td>Being assertive</td>
</tr>
<tr>
<td>Being supportive</td>
<td>Making people feel comfortable</td>
</tr>
<tr>
<td></td>
<td>Offering tea, coffee and meals</td>
</tr>
<tr>
<td></td>
<td>Welcoming patients, their family and friends</td>
</tr>
<tr>
<td></td>
<td>Assisting people to maintain their social roles by offering the use of the telephone</td>
</tr>
<tr>
<td>Being responsive</td>
<td>Giving people space and decreasing stimuli when needed</td>
</tr>
<tr>
<td></td>
<td>Providing a comfortable and a safe environment for staff, patients, their family and friends</td>
</tr>
</tbody>
</table>

The attributes were also observed to have a calming and reassuring effect when used during nurse-patient interactions. They were expressed in the participant ED nurses routine practices and reflected the participant nurses actions, which embodied their caring practice. Each of the attributes is further discussed below.

**Being safe**

The participant nurses wanted every person in the ED to be physically and emotionally safe, particularly during a violent or potentially violent event. They therefore viewed safety for self and others as a priority. Upholding personal safety was embedded in their nursing practice and was manifest in a number of ways including the use of environmental features, managing their physical environment and using high-quality, professional interpersonal skills.
The participant ED nurses revealed their commitment to ensuring their context was safe, and that patients, their family and friends presenting to ED felt safe. Helen and Donna explain that this was particularly important during a violent event or if there was the potential for violence;

... get through to them that they are in a safe place and they don’t have to perhaps act violent if they are frightened or scared or so out of their tree that they don’t know where they are... and just constantly sort of talk over them almost “yes, yes, I understand. It’s okay. You’re safe. We’re trying to do our best for you. We are trying to make you comfortable.” Just keep going on and on like a broken down record and try and reassure them somehow. (Helen)

... they are confused, they are scared and so you’ve got to try and figure out why they are scared and try and find some sort of strategy to make them feel safe... .(Donna)

The participant nurses maintained a safe physical environment, and used the environmental features provided by the layout of the department and those supplied by the facility to enhance safety. The physical assets these nurses used to maintain a safe environment are listed in Table 5.6.
Eight (8) of the 16 participants interviewed referred to using the physical barrier of the triage door and window. These two physical barriers prevented violent people from being able to enter the ED beyond the waiting room until permitted by the triage nurse. These barriers also kept the triage nurse safe from physical violence as s/he was sitting behind a perspex window. Six (6) participants acknowledged the personal and stationary duress alarms as effective violence intervention strategies, though only one participant, on one occasion, was seen to equip herself with a personal duress alarm.

The secure physical environment was used for violence prevention, and this included how visitors were managed. Participants used the security of the locked doors to determine who was admitted into the ED. It was also a mechanism they used to monitor and supervise the number of family and friends who were inside the secure environment.
clinical area of the ED. Managing the number of people inside the ED at a given time was a strategy that was also observed. As Bea acknowledges, tactfully decreasing the number of people can minimise or decrease tension.

_I think your environment plays a part in your approach, you know, prevention of violence … and I don’t like a lot of people around the bed, you know, because they can wind up the patient, they can wind up the relatives next door, they can pass smart remarks…. (Bea)_

The participant nurses tactfully, skilfully and empathically managed the number of visitors who were inside the ED, as the following field note indicates.

Chase walked to the bed unit of a patient where there were eight (8) accompanying people. Chase, with a really gentle manner, open body language, and pleasant smile said softly “we might just help Betty (pseudonym) get some rest”. All but one woman left, so they clearly knew what he meant and left without fuss or question. (Field note, 3 December, 2005)

Another way the participants maintained safety was to be alert to the presence of potential weapons and to remove them from the area. During event fifteen, Angie removed a knife from the patient’s pocket. She did this whilst assessing him and attending to his immediate needs. Angie was aware of the patient’s history of violence in the ED. Angie was attentive and calm and during her interaction with the patient:

_Have you got anything else in your pockets? You’re a bit sore are you? Do you want me to give you a bit of a cleanup and something for pain? You sure you don’t have anything else in your pocket? Yes that’s fine thank you very much you can put that back in your pocket. Now, nothing in that pocket, what about the other pocket? (Field note, 7 January, 2006)_

In addition to the obvious physical objects that patients sometimes carry with them, hospital equipment such as intravenous (IV) medication poles were recognised as potential weapons and were removed if they presented a threat. Participants acknowledged that this had a disadvantage because it often meant that at a later time
either themselves or their colleagues spent time looking for equipment that had been previously removed, but the participants were pragmatic about this and determined their safety, the patient’s safety and the safety of others was the priority.

During event sixteen, Miranda walked past me and said, "Clearing the environment of potential weapons". She is moving the IV pole out of the vicinity (Field note, 7 January, 2006. Event Sixteen)

Participants also used their body language and physical positioning to avert violence and this was observed both during violent events and routine nursing practice. This awareness was also part of what they encouraged and modelled to less experienced ED nursing staff. Specifically they identified the need for a clear safe exit for themselves during all interactions with patients and their accompanying friends and family members.

_I suppose just not getting yourself into a corner, that sort of thing. If you are bit suspicious … standing at the doorway and never put yourself into a situation that you can’t really get out of …and if you are unsure, always having somebody else with you…._ (Marge)

Participants also positioned themselves around the patient’s bed in such a way that they could not be physically hurt. During violent or potentially violent events, participants were observed to position themselves beside the bed, at the patient’s waist height or at the very head or foot of the bed, preventing the patients from being able to hit or kick them.

Pam is taking neurological observations from a patient located in a Resuscitation bay. The patient is now sedated, but has been violent. She is touching him gently but standing at the head of his bed, behind his head, as she works. Pam has the bed rails raised and security in attendance. (Field note, 23 December, 2005. Event Twelve)
While relating the story of a less experienced nurse escorting a patient with a history of violence and mental illness, Jane said;

…it decided to walk beside the bed with him and nearly hold his hand. I had to say to her, no, that’s not safe, that isn’t a safe practice. He’s okay ... you don’t need to be right beside him. Walk to the side away from him or to the back or to the front or wherever you want to walk, but you keep yourself safe first… (Jane)

**Being available**

Being available was an important aspect of reducing violence and participants were frequently observed offering information and comfort, because they were aware of the multitude of potential stressors associated with being in a hectic and unfamiliar ED setting. Participants conveyed their availability in a number of ways including the use of well developed, professional communication skills such as empathy, attending, listening, reflective listening, paraphrasing and repeating instructions or information using ‘plain language’.

Helen reflects her understanding that being available can be demonstrated to patients, their family and friends by using communication skills and a welcoming manner. They understood that patients their family and friends may be reticent to seek help, or frustrated when they could not see a nurse, so they frequently openly indicated their ability, as Helen states;

*I guess my way of trying to calm it then is communication, communication, communication... we’re your team, you can come and find us, put your head out. We’re listening, you might not see us, but you call and we’ll come...*(Helen)
Communication skills including active listening, positive regard, empathy, attending and using open non-verbal communication skills were important ways the participant ED nurses showed they were available to people attending the ED. The participant ED nurses were observed to be available, and reinforced their availability to patients, their family and friends during their routine nursing practice, as well as during violent events or potentially violent events. They also regularly pre-empted patients needs, again demonstrating that they were available and ‘present’ with the patient their family and friends. The following exemplifies Miranda’s availability and understanding of the patients needs.

Miranda is triaging a woman who is agitated, has lots of facial grimacing and is rocking on her chair. Miranda is sympathetic, using open ended questions, getting the patient to tell her story … Miranda clarifies and reflects the content in a factual and succinct way focusing on the patient’s reason for presentation … Miranda returns, after looking for beds, and asks a number of questions about the patient’s history and if she is in pain. She is nodding and giving the woman time to respond … (Field note, 2 November, 2005)

Overt awareness of the value of highly developed communication skills and self knowledge was also demonstrated by the participant nurses and they understood that these skills facilitated their availability for patients and those accompanying them. Through her self knowledge and by pre-empting patients needs, Jane demonstrates how she can show her availability to patients, their family and friends and avert potentially violent events.

…I just step back and calm down a bit, and calm them down and explain, and get them a drink and something to eat and they settle down once they knew what was happening; that someone cared about them, that they weren’t forgotten. (Jane)
Being respectful

Respect for people was central to the violence prevention approach adopted by these nurse participants. Respect was conveyed through courteous language, effective non-verbal communication skills, and by adopting an open and non-judgmental stance.

People can pick up by your mannerisms, your body language if you’re intolerant to them. I think it just um, perhaps comes down to respect, respect of yourself and respect that this is a person. That they have rights and they have needs and they have every right to be here. (Helen)

Rapport building was an important way of conveying respect for people and acknowledging the stress of their situation, and was frequently observed in practice. Taking the time to establish rapport showed these nurses desire for harmonious, respectful relationships with patients, their family and friends. Taking opportunities to develop and maintain rapport with patients and those accompanying them was embedded in the participant nurses practice. Rapport building was manifest while they attended to their routine nursing activities such as taking observations, administering medications, negotiating needs on admission and discharge and so on. Further, while walking around attending to their responsibilities, the participant nurses were frequently seen communicating with patients their family and friends.

I think you know, walk around, you know, converse with the patients, try to establish a bit of a rapport and just listen… (Bea)

Being respectful included being calm, speaking in a quiet calm manner, giving people space, and using non-threatening, open body language.
… so they are presented with a polite, friendly, non-threatening manner in a caring sort of comforting environment … we don’t invade their space, we stand back, we acknowledge them by their name or whatever they might like to be called by, we take them seriously … even giving them a warm blanket sometimes makes a huge difference in just making them feel a bit safe, its making them feel as I said welcomed, cared for and we’re not here to hurt them, its trying to communicate that in a way through body language and through, just through physical things that we do for them … give them a lot of respect… .(Pam)

The development of respectful helping relationships with patients included being able to set boundaries for people as to what behaviours and language were acceptable, and what were not acceptable. Fourteen (14) of the 16 participants interviewed stated that they felt comfortable clearly asserting that violence would not be tolerated.

We ... definitely don’t tolerate anything aggressive towards us because we’re here to help you and we’re not here to cop all your violence. (Dianne)

Event three entailed a participant nurse accurately assessing a patient and giving him a clear supportive message about acceptable language.

A very intoxicated male patient is sitting in the triage area, on the patient’s chair. He has been getting louder and louder and now using a lot of swear words. Most of what he is saying is loud and mumbled, however, his abusive language is said clearly and extremely loudly. Miranda is not far away in the triage area but is busy with the ambulance officers. Miranda turns to the patient, firmly and clearly says “We don’t need the bad language please”. The patient apologises and is now talking in a reasonable tone and volume. (Field note, 23 September, 2005. Event Three)
**Being supportive**

Support was shown in a number of subtle ways using behaviours and communications to convey a sense that the participants genuinely understood and cared for patients and their accompanying family and friends. As a means of decreasing stress, frustration and preventing violence participants routinely orientated patients and those accompanying them to the ED, unless workload circumstances were prohibitive. Offering the people accompanying patients support and practical comforts such as food, beverages, and use of the hospital telephones was frequently observed. These supportive strategies were an effective means of diffusing potential agitation, and therefore violence.

... *lots of use of personal communication skills and ... can I get you a cup of tea, can I make you a sandwich, are you comfortable there, you know like there's a lot of that. ... or can we do something else for you or do you want to use the 'phone or, you know, a lot of that happens.* (Donna)

The participant nurses continually recognised the frustrations of waiting times and the stressors of the unknown - unknown diagnosis, unknown prognosis and unknown treatment options. Clear unambiguous, jargon free communications were effective ways of ensuring people were able to understand the routines of the ED, especially the triage system. Providing information about all aspects of the ED presentation or admission was an invaluable strategy for averting and de-escalating violence, as it improved patients, their family and friends sense of control over their situation.

... *I keep people up to speed about what’s happening. I tell them what’s going to happen as soon as they hit the department. I advise them how long they potentially have to wait ... I advise them about what we are going to do, what they can do ...and I just continually keep them abreast of what’s happening...* (Dianne)
The concept of being supportive went beyond supporting patients and their accompanying family and friends. These participant nurses also actively supported one another. Frequently they informed each other about their location, and commented that the geographical layout of the ED assisted them to support each other in violent or potentially violent situations.

…the curtains can all go back so we can all see and hear each other. We’re not enclosed in rooms with doors closed. You’re always hearing interactions, you know, I guess there’s a privacy thing there to, but, from a staff perspective it’s quite reassuring knowing that you might only have to say, not even scream, just sort of say I need help in here and someone can actually hear you and come in. (Helen)

Being responsive

Being responsive reflected the participant nurses’ capacity to attend to their patient’s emotional and physical needs. These needs may not have been explicitly stated by the patient yet once recognised, they were responsively and pro-actively acted upon by the participants. One of the responsive violence prevention strategies was to minimise the physical and verbal communications and stimuli for people who were confused, disorientated to time, place or person, agitated or highly anxious. This not only involved removing items that were potential weapons but also minimising the number of people talking to the patient and the number of people the patient could see. During violent event twelve, involving a patient intoxicated by alcohol and disorientated to time, place and person, Pam moved people out of the patient’s line of vision as a way of creating a more calming milieu. When reflecting on her actions, Pam commented;

… can you imagine you’re lying down on this bed, and you have a lot of people touching you, in your face asking you a lot of questions? It’s quite overwhelming and if you can minimise that I think you minimise the impact
you have and reduce their stress levels and … everybody was yelling him …. I don’t think that was helping and that’s why also I went round the back. I got out of his view… the less people that were actually throwing things in his face, like verbally and also touching him… .(Pam)

Participants were responsive to patients, their family and friends by keeping people informed about the waiting times and the triage system. Providing information about the length and reason for their wait to see the doctor, or get transferred to a ward, implicitly acknowledged that this can be part of the reason why people become agitated and violent.

… I’ve always reiterated the number one reason why people get violent in the Emergency Department is the waiting times … there’s no question about it, if they have to wait, they get annoyed … like go out into the waiting room, and if you can tell people that it’s going to be forever, I’m really sorry, is there anything I can do for you, you can usually stave things off then, and people just want to know what’s going on, you know, they don’t want to be just left there and they don’t understand the hospital processes, and they don’t understand that things can’t be done immediately… .(Muriel)

**Being alert: Recognising, assessing and responding to violence.**

The participant ED nurses were alert to patients’, their family and friends’ observable interpersonal and behavioural signs that they used as indicators of a potential for violence. Their routine nursing practice predominantly featured the collection of patient’s physical observations such as temperatures, pulse rates, respiration rates and blood pressures, however these everyday practices incorporated their constant sensitivity and watchfulness for cues and component behaviours that indicated a potential for violence. The participant nurses also engaged in ongoing assessments of the emotional well being of patients, their family and friends
including assessing for characteristics that could suggest a potential for violence and once recognised, the nurses acted upon these cues to avert violence.

Five (5) distinctive elements of observable behaviour that indicated a potential for violence in patients and accompanying family and friends were identified. These components are independent and yet interconnected and together are able to be conceptualised as a nursing violence assessment framework. The acronym STAMP has been developed to define these five components. The five (5) interconnected components of STAMP are:

- Staring and eye contact
- Tone and volume of voice
- Anxiety
- Mumbling
- Pacing

Each of the five (5) STAMP components has a number of assessment cues that are identified as precursor or coinciding behaviours to violence. Identification of these behaviours or cues, triggered nurses’ responses to the behaviours in such a way as to avert, de-escalate or manage the potential for violence. Table 5.7 provides an overview of the STAMP nursing violence assessment framework and outlines the assessment cues for each component. Though each of the components was indicative of a potential for violence, findings revealed that the more assessment components observed in an individual, the greater their assessed potential for violence. For example, staring coupled with mumbling or pacing were very high indicators of violence. So too was the combination of any assessment component with co-morbid indicators such mental illness or intoxication. Each component is further described in detail below.
Table 5.7 STAMP Nursing violence assessment framework

<table>
<thead>
<tr>
<th>Subthemes</th>
<th>Components</th>
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<td><strong>Staring</strong></td>
<td>Prolonged glaring at the nurse</td>
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<tr>
<td></td>
<td>Lack of appropriate eye contact</td>
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<tr>
<td><strong>Tone &amp; Volume of</strong></td>
<td>Sharp or caustic retorts</td>
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<td><strong>Voice</strong></td>
<td>Sarcasm</td>
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<td></td>
<td>Demeaning inflection</td>
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<td></td>
<td>Increase in volume</td>
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<td><strong>Anxiety</strong></td>
<td>Flushed appearance</td>
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<td></td>
<td>Hyperventilation</td>
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<td>Rapid speech</td>
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<td></td>
<td>Dilated pupils</td>
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<td></td>
<td>Physical indicators of pain, grimacing, writhing, clutching body</td>
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<tr>
<td></td>
<td>Confusion and disorientation</td>
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<td></td>
<td>Expressed lack of understanding about ED processes</td>
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<tr>
<td><strong>Mumbling</strong></td>
<td>Talking ‘under their breath’</td>
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<td></td>
<td>Criticising staff or the institution just loudly enough to be heard</td>
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<td></td>
<td>Repetition of same or similar questions or requests</td>
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<td></td>
<td>Slurring or incoherent speech</td>
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<tr>
<td><strong>Pacing</strong></td>
<td>Repeated walking around confined areas such as waiting room or bed space</td>
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<tr>
<td></td>
<td>Walking back and forth to the nurses area</td>
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<td></td>
<td>Flailing around in bed</td>
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<td>‘resisting’ health care</td>
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**Staring**

Participants identified staring as an important early indicator of a potential for violence. It was frequently noted in the observational data, was observed in nine (9) of the sixteen (16) observed violent events and validated in the narratives. During non-physical violent events, staring at the nurse participant was common, as outlined in the following field note from event four. An intoxicated male patient wanted to leave the ED. He was later detained under the mental health act as an involuntary patient.

The patient came up to the nurses’ desk and asked when he could leave….. Miranda answered his question with “well you need to stay here because the psychiatric registrar has to come back and see you tomorrow morning”. At this point the patient began to swear at Miranda and, in a raised voice, tell her he was not staying. The patient was also staring at Miranda from across the desk. The patient continued to be verbally violent, glare at Miranda and argue about his need to leave. Miranda reiterated his need to stay.
Eventually he moved away from the desk saying he was joking, but still using abusive language (Field note, 24 September, 2005. Event Four)

Two distinct types of eye contact were identified, and both were cues of the staring component. The first was glaring, staring and looking intently at the nurses whilst they were undertaking their normal activities.

... they'll stare you ... you get completely stared out to the point where you almost have to cringe as you are walking past the patients knowing full well that they are starting to get a bit cross. (Muriel)

...back to body language, like eye contact, sometimes some people have a real staring - looking through you - eye contact that you know that there is something simmering there....(Angie)

The patient in bed five has the "stare". He is looking annoyed and agitated. As I am typing this at the nurses desk ... he has walked down to the toilet, but he is still staring at the RN’s and at me. (Field note, 31 December, 2005)

Nurses working at the triage desk were particularly exposed to being stared at. The triage desk faced the public waiting area and the triage nurse was frequently the first point of contact for those presenting to ED. Staring at the participant working at the triage desk, therefore, was frequently noted in the observational data. Frequently the participant nurse at the triage desk dealt with a combination of behaviours that indicated an imminent potential for violence, and this often included glaring or staring, as shown in the following field note.

A young male and a woman stormed up to the triage window. He grabbed the triage telephone, put it up to his ear and glared at Donna, who was busy finishing paperwork…. (Field note, 22 October, 2005. Event Seven)
Staring and glaring were observed to be used as a means of intimidating the nurses into providing more immediate attention and was associated with other STAMP assessment components such as pacing and restlessness. This combination of components was observed in five (5) of the violent events and was frequently noted in the observational data. Field notes from event eight (a) and (b) shows staring is a component of violence;

… glaring at Helen the whole time she is at the desk … and ... staring and glaring at the RNs ... shaking her fists ... shaking her head ... walking to and fro from the locker to the bed …’ (Field note, 30 October, 2005. Event Eight a and b)

When nurses were observed to respond to these cues, for example by engaging in conversation with the patient their family or friends about their concerns, escalation to violence did not occur. The second staring component was a lack, or absence, of eye contact, and this occurred in four (4) of the violent events, and Bob identified;

Yeah mannerisms as in you can, like someone who’s sitting in the bed, you know, that won’t make eye contact with you, they grunt, they, when you ask them a simple question…. (Bob)

Cultural differences in use of eye contact were acknowledged, and the absence of eye contact was not an assessment cue to a potential for violence if this was perceived to be congruent with an individual’s cultural morays, and not accompanied by other cues for violence. Reflecting on event one, Donna commented:

“no eye contact, first cue for me …but that could have been cultural” (Field note, 23 September, 2005. Event One)

Avoidance of eye contact was associated with anger and a passive form of resistance that had the potential to escalate into non-physical or physical violence. It was associated with other STAMP assessment components such as anxiety and mumbling. Like many aspects of human interaction, the level of eye contact initiated and maintained by patients, their family and friends changed according to
circumstances. During observation of event twelve, it was noted that a verbally violent young man initially gave Pam no eye contact. His violence and aggression completely abated following his recovery from IV midazolam sedation. Subsequent to his recovery the young man began to interact and maintain social eye contact with the nurse.

Participants recognised that the level of eye contact was a good cue to use to assess for patient their family and friends degree of frustration, anger and agitation. Participants endorsed observing the person’s level of eye contact as a routine part of clinical practice.

... well while you're doing the dressing look for eye contact or ... body movement or agitation or, you know, um, be brave enough to say is there something I can do to help you. (Donna)

The participants were aware of the impact of their own eye contact on patients, their family and friends and, when culturally appropriate, were observed using eye contact as a positive, non-verbal communication skill. Likewise, participants used a calm reassuring tone of voice as a communication skill and as a strategy to de-escalate potential or actual violence.

Tone and Volume of Voice

Thirteen (13) of the 16 observed violent events featured this STAMP component. In 11 of the 16 events, the agent of violence was yelling or raising their voice, and two (2) additional events involved sarcastic and caustic replies.

Any increase in the volume of the persons’ talking voice above what was required was identified as a potential precursor for violence. Raised volume of voice, or yelling, was also the most common violence assessment indicator observed and reported. Yelling or speaking in a raised voice was also frequently one of the first assessment cues presented to the nurse and interpreted by the participants as an
unambiguous indicator of a potential for violence. Bea clearly identifies a raised volume and changed tone of voice as a cue for an increasing potential for violence.

...if they are getting really wound up, usually their voices will get louder, the pitch will change, their use of language will change as well, you know, they might start off using, um normal reasonable language and it will become less reasonable and less pleasant… (Bea)

Raised volume of voice as an unmistakable manifestation of violence, or cue for potential violence, was also frequently observed.

Ambulance officers are wheeling a patient into the resuscitation bay. The patient is yelling, I can hear the patient, but not see him, and he is swearing very loudly at the ambulance officers and hospital staff. (Field note, 23 December, 2005. Event Twelve)

Frequently during observed violent events, the agent’s voice rose in volume, signaling their increasing potential for, or escalation of, violence. As their frustrations, confusion or aggression escalated, so too did the volume of their voice.

A 43 year old man, is in resuscitation bay 3. On route to the airport he was involved in a motor vehicle accident. He has already checked in his airport luggage. The patient was concerned about missing his flight and if he did, what would happen to his belongings. He was repeatedly asking these questions of Angie, who was trying to contact the airline. Eventually, Angie informed the patient that he could discharge himself against medical advice. He replied that he was just mentioning that his bags had been checked in. His tone of voice was curt, sarcastic and much, much louder than before. (Field note, 16 October, 2005. Event Five)

Assessment indicators concerning this component were not limited to increased volume of voice and they included; sharp retorts, urgency in speech, sarcastic or caustic comments and dismissing or demeaning the nurse through vocal inflections. Tone of voice is a subjective quality but the participants identified recognisable voice qualities, or tones, in people who were potentially violent and they reported this as a relevant assessment cue for violence. Miranda and Bea both clearly identify some characteristics of vocal inflections that they used as cues for a potential for violence.
If I couldn’t see them then tone of voice, they get gruff, they get short, they start to swear. (Miranda)

... they are belligerent to start with, if they are belligerent at triage, they’re belligerent when they come in, you know, they pass smart comments all the time or they are just unco-operative .... (Bea)

Helen and Nancy also confirm that these ED nurses were attuned to a variety of diverse and subtle verbal cues that they understood indicated increasing frustration or agitation and a potential for violence.

... and talking to you in this really controlled sort of manner. (Helen)

I guess it is more of a tone of voice and an attitude to … how they convey what they need. (Nancy)

Anxiety

Anxiety was frequently observed in patients, their families and friends. This was attributable to one or more of three broad categories. These were; psycho-social, situational and contextual stressors; co-morbid health issues that have the symptoms of confusion and disorientation; and a lack of understanding of ED resources and processes. Frequently more than one of these factors was involved.

Presentation to an ED is often a physically and emotionally threatening experience and people can feel apprehensive and fearful. The nurses were aware that an ED presentation can feel threatening and were sensitive to anxiety as an issue for patients and those that accompanied them. Therefore, they frequently assessed for this. As anxiety escalated for patients their family and friends, the nurses were observed to intervene. Because of this, and despite 290 hours of participant observation, only one (1) nurse-patient interaction with the feature of patient’s anxiety alone escalated to a violent incident and this was during event one.
Physical indicators of anxiety, such as looking flushed, hyperventilating and speaking rapidly were evident. Participant nurses were very aware of the myriad of possible emotional and physical stressors that may lead to anxiety for the patient their family and friends.

*I think that fright flight response, yeah rarely does anyone just sit there calmly and go yeah yeah, I’m quite happy....*(Angie)

The nurses were also sensitive to the environmental and situational stressors that presentation to an ED encompasses, including an awareness of people’s sense of loss of control. Similarly, nurses report that if a family or friend has a guardianship or a protective role and relationship with the patient, such as a parent with a child, there is an increased probability of agitation and anxiety and thus potential for violence, particularly involving a verbal dimension (as indicated by event two). These cues are revealed in many of the semi-structured and informal field interviews.

*...anything that builds up someone’s anxiety levels and inability for them to have control of the situation is going to make them potentially violent... so any critical situation is going to have family, friends, relatives, potentially getting angry. Not because they want to because they just don’t know how to deal with the situation.* *(Pam)*

*Often people with sick children are very anxious I suppose rather than aggressive, anxious about their kids so they probably react in a different manner to what they would if it was just for them, you know, they’re protective, they are wanting their kids well quickly.* *(Donna)*

In addition to the anxiety provoking environment, some patients were disorientated to time place, person or event. Participants identified patients with conditions such as; mental illnesses; intoxication by, or withdrawal from, alcohol or other substances; delirium or dementia; epilepsy or post-ictal conditions; hyper and hypo glycaemias; and head injuries, as people who could be confused or disoriented and therefore assessed these patients as violence risks.
… sometimes with their conditions you know like if they are delirious you know they might swing out and act out and it’s part of their sickness… (Helen)

And then, of course, the other thing is that people get violent and angry because of drugs, alcohol, um and also ‘cause of the stress like the stress of the situation. (Muriel)

Disorientation, therefore, could exacerbate anxiety and negatively influence the ability of the person to manage their own anxiety. Where possible in these situations, patients were nursed in a quiet area such as the isolation room because of the view that nursing these patients in a quieter area reduced their anxiety and thus their potential for violence. In these cases, violence towards the nurse was averted. Thirteen (13) of the sixteen (16) observed events of violence involved disorientated patients who were not able to be nursed in seclusion.

Anxiety was also associated with the mismatch between the patient’s expectations of services and the services provided. Issues common to the ED such as extended waiting times, and the triage system, which resulted in patients being seen on a needs basis rather in order of arrival, exacerbated an already anxiety provoking situation.

…and they will say to you, well how much longer have I got to wait. I really can’t tell you exactly how long you are going to wait but there are a few people still ahead of you. Well I’ve been here since so and so. … they won’t take an explanation, they just you know, I’m sicker than they are and I’ve seen other people come and be treated … and they don’t understand anything about the triage system and understand that they’re prioritised … and you can tell that they’re going to get angry, they start pacing up and down, and they talk to one another…. (Donna)

Mumbling

Patients mumbling ‘under their breath’ but just loudly enough for them to be heard generally preceded violent events. Frequently mumbling involved accompanying
family and friends, and regularly occurred in the triage area or while a treated patient was awaiting admission into the hospital. Eleven (11) of the sixteen (16) violent events included the agents mumbling, having slurred, incoherent speech or repeating questions or statements. Mumbling was associated with slurring and incoherent speech and could flag alcohol or substance intoxication or a mental illness. Whatever the cause mumbling was a sign of mounting frustration and considered an assessment cue for violence. While reflecting on past incidents of violence, Bea commented,

... they might be muttering amongst themselves and then they might not say anything to you for quite a while, they just do all this staring. (Bea)

Narratives revealed that mumbling was most often negative and aggressive statements about the service rather than individual nurses, especially concerning the waiting time. Under these circumstances, and in a similar way to how the participants managed anxiety, nurses regularly pro-actively responded to this assessment component thus defusing potential violent events.

... when I hear the muttering going on I usually go in and break that up quickly to let them know that I’ve heard them and I’ve noticed them and you know, if they have any problems to come and talk to me instead of just muttering away because its not going to help the problem (the waiting time), you know. (Muriel)

Mumbling and communications that the nurses could not hear, particularly coupled with staring at the nurse or physical signs of agitation such as pacing or wriggling in the bed, was a salient sign of potential violence. Participants reported, and it was observed, that people who repeated the same or similar questions were expressing their increased agitation, impatience or frustration. This could, and did escalate to violence.

Well if you come in and you, I know if you are going to be trouble because you are going to ask me a thousand questions before you or your relative hits a bed
and you know whether it’s a concerning question or whether it’s a hurry up I want to do things kind of question … you know that there’s going to be a bit of trouble. (Bob)

Pacing

Agitation was evident in many of the observations and this most frequently manifested as pacing. A typical example of pacing as a cue for violence involved an older man who kept returning to the nurses’ desk asking the same question;

Dianne is standing next to the nurses’ desk discussing nursing concerns with her colleagues. An older man is walking backwards and forwards between the nurses desk, where she is standing, and his wife’s bed. The man rudely interrupts Dianne’s conversation to ask how long the doctor will be… he was getting aggressive and agitated … (Field note, 23 October, 2005)

Pacing around the waiting room, pacing around the bed unit, or walking back and forth to the nurses’ stations were all indicative of mounting agitation and were all identified by participants as signs of potential for violence. The component pacing was indicative of agitation, and a potential for aggression, for patients their family and friends and participants identified and generalised this behaviour accordingly.

The component pacing could be identified in a number of ways, as Miranda, Angie and Dianne indicate;

Yeah, you just know, um frowns, cross, pacing, urgency in their step, that sort of thing… .(Miranda)

… their manner, alcohol and drugs, as I said their agitation, if they’re not calm, if they are actually moving around agitatedly… in the waiting room or wherever like they’re pacing or … tapping rather than just sitting watching television or sitting at the bedside… (Angie)
... or they might be physically overwhelming like standing in your personal space, stand over you, um like physically threaten you without verbally threatening you ...(Dianne)

Agitation was observed in nine (9) of the 16 events that escalated to violence. Agitation in these cases took the form of pacing and resisting therapeutic intervention. Patients who resisted medical and nursing interventions by pulling away from the nurse or rejecting therapeutic interventions were considered violent or potentially violent.

Marge and a doctor are taking blood from a very confused seventy-nine (79) year old man. The patient is grabbing at Marge’s hands. He is confused and disorientated and lashing out, trying to stop them from doing anything to him. He now has a firm grip on Marge and she says “stop that Bill (pseudonym) you’re hurting me”. Marge moved her hand so it was on top of Bill's rather than underneath his, preventing him from grabbing her. (Field note, November, 2005. Event Ten)

Other observed physical indicators of agitation included people staggering, flailing or swinging their arms around.

... the people that are non-compliant, like most of your trouble makers, will pull their drips out ... you ask them to stay in the bed, they will be out walking around, pulling things off just doubling your work load ...(Bob)

... they just turn away from you and they’ve got like a very aggressive stance well, not stance, but position in the bed. I mean, I know that seems ridiculous to say someone can be aggressive in a bed, but they can be. (Jane)

Summary

This chapter introduced the first two (2) themes revealed following concurrent data analysis. The themes provide insight into the contextualised, routine nursing practice skills that the participant nurses used to welcome patients, their family and friends to the ED, and to decrease frustrations, anxieties and avert violence. Further, these skills define the professional therapeutic caring of these nurses. Simultaneous with
the use of these nursing skills, these ED nurses observed for behavioural cues that alerted them to the potential for violence. These skills are summarised by the acronym STAMP and represent a nursing violence assessment framework. These two themes provide insight into how the participant ED nurses assessed patients, their family and friends for their potential to be violent as well as introduced some of the routine strategies they used to prevent, avert and de-escalate violence. The next chapter adds to the insights about the violence assessment strategies used by the ED nurses and their reactions and responses to violent events through presentation of the next three (3) themes.
Chapter Six - Abstract

This chapter continues reporting the findings of the current study and discusses the final three themes;

(iii) Attributing Meaning: Subjective understandings that shape responses to violence
(iv) Collegial awareness: Forming trusting relationships to help manage violence
(v) Fostering resilience: Resisting negative sequelae of violence

Again, excerpts of narrative from interviews and field notes are used to illustrate the development of the themes. Parts of this chapter have been previously published (see Appendix B).
Chapter Six - Findings

Introduction to the Themes
This chapter will discuss the final three (3) themes. These three (3) themes address the participant’s ascribed contextualised meaning(s) of violence and provide insights into the strategies they chose to deal with violence, both at the time of the violent event and subsequently. The three (3) themes sequentially move from how the nurses ascribe meaning(s) and respond to violence, how they help and support each other during and after violent and potentially violent events, and their emotional reactions to violence in the workplace.

Attributing meaning: subjective understandings that shape responses to violence is the first of the three (3) themes discussed in this chapter. This theme details the meaning(s) the participant nurses ascribe to the violent event, and the agent of violence. Their attribution of meaning(s) is significant because it determines their immediate response to, and management of, both the event and the agent of violence. Three (3) factors were identified that influenced how these nurses systematically attributed meaning(s) to a violent event through the agent of that violent event. The nurses considered whether the violence was directed at them personally or as symbols of the system, they weighed up any mitigating factors that may decrease the person’s responsibility for the violence and assessed the perceived legitimacy of the patient’s need to present at ED. The sub themes, therefore, are personalisation of the violence, presence of mitigating factors and reason for presentation.

Following attribution of meaning, a priority for the participant nurses was to support and assist each other during and following actual or potential violent events. The second theme discussed in this chapter, collegial awareness: forming trusting relationships to help manage violence is comprised of the sub themes being supportive and feeling supported and fostering growth: nurturing other nurses and these identify the ways in which the nurses actualise their support for each other. The final theme revealed by the participants provides insight into fostering resilience: resisting negative sequelae of violence and addresses the mechanisms these nurses
used to ward off the negative personal effects of violence. The two (2) sub themes are having hardiness and stamina and validating and debriefing. These components provide insights into how the participant ED nurses manage their immediate and short term reactions and the emotional affects of a violent event.

Attributing meaning: Subjective understandings that shape responses to violence

The findings show that violence towards the participant ED nurses was interpreted in a more systematic and complex way than the current definitions of violence make possible. These nurses used many sources of nursing knowledge upon which to base judgments about their experience of violence, and this influenced the meaning(s) they made of the violent event. Further, nursing knowledge, experience and the nurses’ subsequent subjective meaning(s) shaped their responses to violent events and to the agent of violence. The nurses judged violence on an episode by episode basis but their judgments were underpinned by a systematic and identifiable process. The meanings the nurses ascribed to violent events were therefore derived from this causal judgement process and the interactive nature of the component factors can be represented diagrammatically (see Figure 6.1) and this will be further discussed below. The participants’ judgments about the violent event and the agent of violence were informed by three (3) factors. These factors were:

- Personalisation of the violence – was it directed towards them as an individual or towards them as a symbol of the health service;
- Presence of mitigating factors through which the agent of violence could be excused from responsibility for the violent act; and;
- The reason that the agent of violence presented to the ED.

None of the 16 observed violent events were reported to hospital administration using existing organisational processes. Rather, findings reveal that nurses made judgments about specific violent events, and these judgments informed the nurses’ response, their management of the event including their own verbal and non-verbal responses and behaviour towards the agent of violence. In turn these factors influenced their decision to report, or not report, the violent event and the participant
ED nurse’s short term and long term emotional reaction and sequelae to the violent event.

Well you have to be judgmental you have to make the call. I mean it’s obvious that you’re being judgmental by saying ok I’ll take a bit of a slap from an old lady but if the guy next door is drunk and he slaps me I’m not going to put up with that and that’s a judgment right there. Walking from bed to bed taking it from one person and not from the next. (Leah)

Leah’s comments reflects the participants’ awareness that violent events, and the agent of violence, were judged on an episode by episode basis. The causative judgments, therefore, were based on the three (3) factors (see Table 6.2), each of which are discussed below.

Table 6.1 Attributing meaning: Subjective understandings that shape responses to violence

<table>
<thead>
<tr>
<th>Subthemes</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personalisation of the violence</td>
<td>Violence directed toward a nurse as a person / an individual</td>
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<tr>
<td></td>
<td>Violence directed toward a nurse as a symbol of the ‘system’</td>
</tr>
<tr>
<td>Presence of mitigating factors</td>
<td>Psycho-social, situational &amp; contextual stressors</td>
</tr>
<tr>
<td></td>
<td>Co-morbid health issues that have the symptoms of confusion and/or disorientation</td>
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<tr>
<td></td>
<td>Lack of understanding of ED resources or processes</td>
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<tr>
<td></td>
<td>Perceived by nurses as ‘innocent victim’</td>
</tr>
<tr>
<td>Reason for Presentation</td>
<td>Perceived by nurses as an Emergency/Legitimate presentation</td>
</tr>
<tr>
<td></td>
<td>Perceived by nurses as NOT an Emergency/Legitimate presentation</td>
</tr>
</tbody>
</table>

Personalisation of the violence

A key factor contributing to the process ED nurses used to understand and respond to a violent event was the personalisation of the violence. Violence that was directed toward a nurse as a symbol of the ‘system’ did not impact negatively on the emotional well being of the participants, and they reported that they did not take it on board (Miranda) or take it home (Helen). Donna’s narrative reveals that the nurses
distinguished violence that was directed at them personally, from violence that was
directed at them as a representative of the health system.

... not with me personally, but with the nurse who’s at the window.
Someone they can voice their opinion or their anger at. I think they’re
the person whose copping it. I don’t think they can see the big picture
about the system. (Donna)

The participants reported that violence that was perceived to be directed to them
personally was more difficult to cope with and was associated with participants
experiencing negative personal emotional sequelae. Participants reported feeling
emotionally distressed by acts of violence that they perceived were directed at them
individually.

When somebody attacks you personally - your appearance, your manner
whatever, even though you know that it shouldn’t effect you, it does at
some level. Sort of, you know, feel awful. (Jane)

Dianne reflects the perception that that violence that is directed at their personhood
is less common than violence that is directed at them as representatives of the system.

...then there’s the violence that is personal. That happens probably the
most infrequently and people do get hurt and that touches people, it’s not
about the system. (Dianne)

Violence that was considered to be aimed at a ‘system’ that made people angry, and
caused people to become violent was constructed differently to violence that was
aimed at the participant ED nurses as individuals, and participants were not
emotionally hurt by system focused violent events. Participants acknowledged that
frequently patients, their family and friends became increasingly frustrated, and then
violent, because of institutional problems such as waiting times. In these instances
the violence was really directed at the health system and because the nurses were the
most visible and approachable representatives of the system, they were used as
conduits for violence against the system. This construction of violence was based on
these nurses understanding of the Australian health care system. Event two demonstrates how Marilyn was subjected to violence from the parents of a patient because of their frustrations with the system.

At the beginning of the afternoon shift, Marilyn was introducing herself to the patients. She went into the paediatric room. The parents of the child, a female and male, were instantly and simultaneously verbally aggressive and swearing at Marilyn because they had been waiting for a doctor for more than five hours. (Field note, 23 September, 2005. Event Two)

The participant ED nurses revealed their knowledge about the Australian health care system, their role as nurses, and their understanding of violent events that were manifestations of frustrations with the system, as Miranda and Leah indicate in the following excerpts of narrative.

… its not us being slack or incompetent, this is a major systemic problem so you, you know, you can take it out on me but basically I’m not going to take it on board because its not me. (Miranda)

… it’s never about you as a person it’s about your job, and not how you do your job but what you do in your job and what your position is and who you are representing and what they’re not getting because the whole system is falling apart. We are at the forefront, we’re treating the patients and we see them before anyone else does and we can do the least for them when it comes to doctors and nurses…whereas really they should be saying thank you. (Leah)

Violent events directed at the participant nurses because they happen to be a representative of the service that was close by, was particularly applicable to the triage nurse. The triage nurse was the first person seen by people presenting to ED and was often the most visible representative of the system because s/he sat at the triage window near the waiting room. This understanding brought a different meaning to the violent event and enabled them to avoid negative personal consequences.
... because 90%, more than that, most of it, I can’t take it on board personally, because it’s not directed at Wendy, it’s directed at the person who happens to be standing in front of that drunk person or that drugged out person, and I appreciate that. I appreciate the fact that it’s not, or I haven’t been the victim of it being personal at work. (Wendy)

A typical observation from the triage area involved people in the waiting room repeatedly coming to the triage desk and, via the triage telephone, asking the nurse when they were going to be seen.

A man, who has been sitting in the waiting room, approached the triage counter and picked up the patient’s telephone. He looked very angry. Miranda picked up the triage nurse’s telephone. I can only hear Miranda’s side of the conversation and she said;
Yes Tom (pseudonym).
No it’s not possible to tell you how long it is going to be, they know you are here.
Alright.
Following the interaction Miranda told me that Tom wanted to know when he was going to be seen and he was using swear words and his voice was raised. (Field note, 6 January, 2006)

Personalisation of violence was the first component that influenced the nurses’ ascribed meaning(s) of the violent event, and agent of violence. The violence either had a personalised element or it did not. Where participants perceived they were not personally the target of the violence, then other factors such as mitigating circumstances and reason for presentation, contributed to the meaning(s) the nurses ascribed to the violent event and, therefore, the way that they responded to it. If the violence was a personal attack then this factor was the leading motivator for their response. The intent of the violence was also part of this factor. Participants distinguished between violence that was intended to hurt them personally, and violence that was not intended to personally attack or hurt. As Nancy discusses verbal abuse and swearing, without the intent of personal harm, was not experienced as verbal violence because there was no personal intent.

*Swearing, like it depends on what context you put that into … like some people would lay there and say “Oh I got a lot of effing pain, like get rid
of my effing pain” and they just go on and on about it. That to me, well
to me that’s swearing but it’s not calling someone something. Like it’s
just an adjective that they’re using to describe something. It’s not
directed to staff. Do you know what I mean? (Nancy)

The narratives and observations illustrate the distinctions made concerning the
experience of violence. When a violent event was personal, the participants reported
being emotionally hurt. Violent events that were personal, however, were infrequent.
More often violence was directed towards them because of their professional role as
nurses. This non-personally directed violence had two further explanatory and
clarifying factors that when combined, further influenced the meaning(s) nurses
ascribed to the violent event.

Presence of mitigating factors and their contribution to the nurses’ ascribed
meaning(s) of violence

Participants recognised the presence of mitigating or extenuating circumstances that
could be seen as explaining or influencing behaviour, particularly during a violent
event. Acknowledging the presence of mitigating circumstances shaped the nurses’
ascribed meaning(s) of the violence and their response to both the violent act and the
agent of violence. Mitigating factors, as identified by these nurses, referred to co-
morbid or presenting health problems, or psycho-social issues that participants
believed decreased a person’s capacity to act or respond in a rational, informed
manner. These factors were generally physiological, organic, psychosocial,
psychiatric or medical and exist along a continuum of high to low levels of perceived
mitigating factors.

As discussed, anxiety was frequently observed in patients, their families and friends
and participants pro-actively and empathically responded to this anxiety. The
previously outlined categories for anxiety, psycho-social, situational and contextual
stressors, as discussed under being alert: recognising, assessing and responding to
violence (see chapter five) were also seen as mitigating factors during a violent event,
particularly if there were exceptional or traumatic circumstances, such as unexpected,
sudden loss. The salience of anxiety as a mitigating factor was judged on an individual basis and in combination with the other two factors.

... you know losing something. Whether its loss of privacy, loss of control, its all that ... self preservation and um you can do as much as you can to help the patient to have that self preservation then you’re, I’d say more than 90% of the way there, um there’s some things that are out of control that none of us can control, like a death, you know, if its inevitable, its inevitable, we just then have to deal with the aftermath of the situation but, yeah, as I said I don’t feel threatened, I’m not emotionally drained by the violence .... (Pam)

The patient’s diagnosis and presenting or co-morbid health problems were also identified by participants as mitigating factors, especially if the agent of violence was confused or disorientated to time, place, person or event secondary to health problems. The co-morbid or presenting health problems the participants identified as mitigating factors, therefore, were identical to those accepted as causative for anxiety. Presence of these types of conditions increased participants reported and observed empathy towards people as agents of violence. Increased understanding and empathy towards the agent of violence changed the meaning the participants ascribed to the violent event. Event ten concerned an elderly patient with a dementia who was violent; he was also seen as having a high level of perceived mitigating factors. Following the event, Marge commented;

If the patient has dementia that's a bit different than a drunk patient or just a patient angry about the waiting time. So it depends on what sort of patient it is I suppose, what you do. (Marge)

The nurses’ meaning of violence considered the patient their family and friends categorisation regarding mitigating factors. If they were seen as having a high level of mitigating factors, then the meaning of the violence was interrelated to the assumed reason for the violence. The agent of violence, therefore, was viewed as having less responsibility for their actions. In these cases the violence was readily understood, and rationalised, in terms of illness or nursing practice requirements.
This modified the experience of the violence for participants and consequently they were calm, tolerant and understanding towards the violent person. This is not suggesting that the participants accepted violence as part of the job. Rather, the meaning assigned to violence was both contextualised and reconstructed as part of the agents’ illness, or characteristics based on perceived mitigating factors, and therefore viewed as understandable and tolerable. This is illustrated by Donna.

... or post-ictal people because they don’t really mean to do it, do they?... I mean it is aggression and abuse I suppose but they don’t know, they don’t know they are doing it and the hypoxic patients, you know, they don’t know that they are taking a swing at you. You know they don’t know that, so it’s the ones that are angry and aggressive I suppose, they’re the ones I’d count. (Donna)

Another mitigating factor that influenced participants’ meaning of violence was the perceived degree of responsibility the agent of violence had regarding their current health status. The meaning of violence changed for the participants if the agent of violence was seen to have no personal responsibility for their health issues, or were ‘innocent victims’ of some accidental event such as an injury in a motor vehicle accident. Under these circumstances the participants tended to be more tolerant and empathetic towards the individual despite their violent behaviours or utterances. If, however, the behaviours or health choices of the agent of violence, preceding their ED presentation, were seen to contribute to their need for health services, the participants’ tolerance towards the individual was more rigid and policy driven. For example, in these situations the participants’ response was frequently “violence is not tolerated in this unit’ or they contacted security guards and this was seen during event two (see Appendix D).

...I say look it won’t be tolerated if you are going to continue with that language I’ll get you to go outside. If you don’t go outside, security will come down and get you to go outside... (Miranda)

This mitigating factor also expresses the participants’ judgment about the patients’ perceived degree of responsibility for the reason they presented to ED. If the
person’s preceding health behaviours were positive and did not contribute to their need for ED services, then they were unmistakably seen as ‘innocent victims’ and the participants’ degree of latitude for physical or non-physical violence was high. During event five, and despite the patient becoming increasingly terse because of his concerns over his need to catch his flight, Angie continued to contact the airport and offer the man options, including eventually even giving him her mobile telephone so he could re-organise his travel. However, if the person was seen to contribute to their negative health status through behaviours such as drinking alcohol until very intoxicated, or failing to adhere to recommended diets for conditions such as diabetes or renal failure, then they were judged to be partially responsible for their need to present to ED and received less latitude for violent behaviours or utterances. There was, therefore, an element of degrees of perceived ‘innocence’ and guilt.

...dementia’s a medical condition. Intoxication is a person really isn’t it. A self-inflicted thing... I would probably be pretty angry if someone drunk hit me... (Donna)

...there is something influencing them whether it be infection or alcohol or lack of oxygen that’s twiddling their little brain cells there. I think it removes a certain degree of responsibility from them. (Helen)

Reason for presentation
The final mitigating factor for the agent of violence was the perceived legitimacy of the reason for their ED presentation. At one end of the presentation continuum are patients who were perceived by participants as appropriate ED presentations. Participants, as mentioned, were very aware of the difficulties facing the Australian health care system including poverty of human and fiscal resources. Consequently, patients who presented to ED following an acute, life threatening, urgent and ‘serious’ health crisis such as head injury, fractures, myocardial infarctions or asthma were unambiguously perceived by the participant nurses as appropriate ED presentations. At the other extreme were patients who were considered inappropriate self referrals. The latter category of patient was defined by features such as; their knowledge about alternate resources and social or financial ability to use alternate
resources such as the free services of the 24 hour medical centre, or their own General Practitioner (GP), rather than ED resources; the low urgency and minor nature of their health status or condition; the chronicity of their health coupled with poor prognosis or treatment options and the availability of more suitable services.

Similarly to mitigating factors, including responsibility for health status, this was constructed along a continuum and not as a dichotomy. The extremes of the continuum were more easily categorised by the participants than conditions and presentations that were ambiguous. That is, participants had a clear shared understanding of who met their criteria as highly appropriate or highly inappropriate ED presentations. Nurses made judgments about reason for presentation, and this impacted upon their experience of and response to violence, as illustrated by Dianne.

Like take a look at yourself, you know you’re really not that sick. You’re here with a sore toe, there’s people dying next door, there’s kids that can’t breath… . (Dianne)

Further, both the reason for presentation and the mitigating factors included a degree of participant judgment. The participant’s experience of violence, therefore, was influenced by their level of clarity regarding the ‘legitimacy’ of the reason for the agent of violence’s presentation. If the presentation was seen as legitimate, then the level of empathy and tolerance towards the person as an agent of violence was increased. If, however, the reason for presentation was deemed not appropriate, tolerance to patient frustrations or violence was limited and firm boundaries were often set.

...you know if you get someone that’s drunk and playing up and whatever, I’ll just go in and I’ll just say to them, okay, you’re in my area now and these are my rules ... I’m not interested in play acting and mucking around, because, you know, I appreciate your situation, and I’ll tell them how I feel and what I see the situation is. (Wendy)

Event seven illustrates a situation where the presenting patients were considered not legitimate ED presentations. There were two causal reasons for this judgment. First,
The patient’s preceding behaviours were seen to contribute to their current health service need as they did not attend their routine scheduled methadone clinic. Second, they had a current relationship with specific and more suitable service and indicated that they were not following these pathways for health service delivery.

A man and a woman stormed to the triage window and grabbed up the patients’ telephone. Their manner, body language and facial expressions looked angry. Donna picked up the triage nurse’s telephone. The male patient was verbally aggressive and yelling at Donna. They were seeking their opioid substitute because they missed their morning doses at the methadone clinic. They further indicated they had community mental health and community drug and alcohol support networks. Neither person was triaged. (Field note, 22 October, 2005. Event Seven)

Causal judgements, such as those seen in event seven, were modified on an episode by episode basis and considered in combination with the perceived extent of other mitigating factors. In the circumstances where the violence was clearly seen as not personalised, the causal judgements made by these ED nurses considered the level of mitigating factors combined with the perceived degree of legitimacy of the ED presentation, which is expressed in the Violence Judgement Factors model (see Figure 6.1).

**Violence Judgement Factors Model**

The meaning(s) the nurses ascribed to violence are able to be represented figuratively (see Figure 1). Non-personalised violent events were ascribed differential meaning(s), along a continuum, according to:

1. the level of perceived mitigating factors and
2. the perceived legitimacy of the reason for presentation to ED.

Non-personalised violent events, therefore, had four (4) continuous dimensions depicted by the letters A, A₁, B & B₁ (see Figure 1). Patients fitting into the categories A and B₁ at the extremes of the two components, were clearly identified by the participants. The participants’ response to agents of violence and the violent event, therefore, was homogenous. Patients their family and friends who were meet the criteria for A, as agents of violence, were consistently empathically managed and their violence was understood to be a function of their circumstances. Likewise, agents of violence that had low mitigating factors and were perceived as not
legitimate presentations (represented by B$_1$), were generally less well tolerated and the participant nurses responses were policy driven. Violence from agents assessed at the extreme ends of A$_1$ and B were not afforded as much latitude, although the ascribed meanings of their violence undeniably acknowledged their mitigating factors. These agents of violence symbolised a more difficult cohort and the participant nurse’s response to their violence was less homogeneous.

As the agent of violence’s classification approached X, that is the agent of violence fits mid way along continuums A and B, the participants’ responses to them as agents of violence became more individual. The ambiguity of the mitigating factors and legitimacy of presentation increased and participants rely on their subjective interpretations to ascribe meaning to the violent event and agent of violence. For example, a disorientated, intoxicated verbally aggressive young man with a history of mental illness, with a non life threatening injury, such as a suspected fractured radius. The hypothetical patient would be considered neither high nor low on both mitigating factors and legitimacy for presentation, since this person could use the free services of the 24 hour medical centre in the first instance. Hence he would more closely meet the criteria of X. This grey area is in part of function of the ambiguous and subjective nature of the component continuums as they move away from the extremes.
Collegial awareness: Forming trusting relationships to help manage violence

The fourth theme that was revealed by the participants was collegial awareness: forming trusting relationships that help manage violence and this describes collegial relationships that were characterised by functional, co-operative and harmonious contact, a shared sense of purpose and common direction. This collegiality was coupled with attentiveness and alertness to the overt and assumed needs of others, as well as a willingness and capacity to respond to these needs. A sense of collegial awareness was embedded in the nursing practice of participants, and enabled them to successfully support and look after each other during and subsequent to actual or
potential violent events. Observation and narratives reflected a context specific use of collegial awareness that was shared, and frequently expressed, by the participant nurses. Two (2) components comprised this theme (see Table 7.2). These are: being supported and feeling supported; and fostering growth: nurturing other nurses. These are discussed and elaborated below.

Table 6.2 Collegial awareness: Forming trusting relationships that help manage violence

<table>
<thead>
<tr>
<th>Subthemes</th>
<th>Components</th>
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</table>
| Being supportive and feeling supported | Protectiveness  
Watchfulness  
Sharing information  
Cooperation  
Positive interpersonal relationships  
Accepting encouragement, help and assistance from each other |
| Fostering growth: Nurturing other nurses | Shared learning and teaching  
Willingness to assist each other and accept assistance  
Presenting themselves to patients their family and friends as a united team  
Awareness and respect for each other, and each others skill, experience, strengths and weaknesses |

*Being supportive and feeling supported*

A high level of positive collegial support was revealed through the narratives. This was evidenced by participants expressing concern for other nurses as people and professionals. It was important for the participant nurses to be both a supportive colleague, and a colleague who accepted the support of their peers. In this context, the concept of support embodied characteristics of protectiveness, watchfulness, sharing information, cooperation, developing positive interpersonal relationships and accepting encouragement, help and assistance from peers. They consciously developed and nurtured a safe, encouraging working environment and a ‘space’ where they could talk openly with each other. Both narrative and observational data were replete with information that reflected their commitment to developing, maintaining and nurturing positive supportive relationships.

The findings reveal that the participant nurses commitment to supporting each other was complemented by their experience of being and feeling supported, particularly
during a violent event or if there was a potential for violence. That is, not only were the participant nurses supportive of each other, but they said they felt supported by their colleagues. Further, this feeling of being supported was unreserved and without evidence of negative consequences. When reflecting on her thoughts and experiences about dealing with violent patients, Nancy revealed her sense of being supported.

… when I’ve got support there I’m going to be able to feel confident that I can deal with it …I think ok maybe I should just get some advice from someone else and see how to deal with it … you’ve always got someone that you can go to … oh, he’s really flipping out. Ok. I’ll go and get someone. (Nancy)

Watchfulness about each others safety manifested when they kept an ‘eye’ out for each other with the intent of assisting each other if the need arose. Their level of cooperation and support for each other included watching each others backs (Wendy). This behaviour was also modelled through the leadership of the nursing team leader who stayed abreast of what was happening in the ED and was available to actively help and assist the nursing team when needed. Again, however, the participant nurses were confident that their colleagues were “watching their back” and “keeping an eye out” and this knowledge was shared and understood.

… if they know that’s something out of shape and they are around they’ll kind of step in next to you. So everyone, you know, everyone’s always got their ear out and they know what happens around here and how things happen so, yeah it’s pretty good. (Leah)

These nurses were particularly alert when patients and those accompanying them were agitated, and their active support for each other was very evident at these times, and sometimes took the form of supportive intervention. During Event 8a Helen was attempting to discharge a woman who did not want to leave the hospital. The patient had a history of mental illness and following medical assessment was deemed to be ready for discharge from the ED. The patient was becoming increasingly hostile, her tone of voice became terse and she was raising the volume of her voice.
Helen was talking to a patient who wants to stay in the Hospital … the patient was indicating that she has nowhere to go and wants to go to the mental health unit … and she has schizophrenia. Helen says she has an appointment for tomorrow and can’t stay in hospital ...

Dianne is walking back and forward and she is watching Helen and the patient’s interaction, but she is leaving Helen to manage the discharge. Dianne is keeping a watchful eye on what is happening.

The patient begins to use abusive language to Helen and Dianne, now closer to Helen and the patient, asks “how are you going”. Helen indicates that she would like some support and Dianne then assists Helen. Dianne finalises the discharge. (Field note Sunday 30 October, 2005. Event Eight)

Analysis of the above event reveals a number of supportive strategies Dianne used to assist Helen. The first supportive strategy was when Dianne noticed and paid attention to Helen’s interaction with the patient. Once alerted to the potential for violence, and whilst continuing with her own responsibilities, she remained in visual contact with Helen and the patient. Dianne moved closer as the violence escalated and therefore offered her physical presence and her support in the form of an open ended question that contained an implied offer of help. It was not until Helen invited Dianne to intervene that Dianne took over the management and discharge of the patient. The positive outcome of this support was Dianne protected Helen from the verbal violence, prevented escalation of the violence and the patient’s distress, and modelled violence management skills to Helen. Dianne showed support through being watchful and willing to assist, and this helped to protect Helen from the abuse and violence. Furthermore she assisted Helen without compromising Helen’s confidence. These strategies show how the participant nurses actively supported each other during violent and potentially violent events through their watchful manner and positive interactions, while simultaneously modelling effective violence management skills. In this instance the patient continued to be verbally abusive, but nonetheless was able to be discharged without further escalation of the violence.

Supportive collegial cooperation was also revealed through the sharing of information. Verbal handovers were used to communicate information about patients their family and friends who were potentially violent and this cooperative support went beyond the handover. Formal handovers occurred, as expected, between nurses at change of shift. Handovers also occurred between nurses during all inter-department patient transfers, including patient movement from the triage area into
there were additional informal handovers that occurred between nurses if a nurse recognised a patient with a history of violence in the ED. Irrespective of whether this information was formally documented, nurses shared information about patients including violence risk and patient specific violence prevention and protection strategies. Handovers were, therefore, an opportunity for participant nurses to share information and knowledge, and a way to ensure and maintain their colleagues’ personal safety.

*Usually the patient has been in here before and somebody knows them, so they say this patient is coming in with a police escort. He’s got a history of this, this, this and this so don’t go near them. So you are actually warned prior to their arrival.* (Nancy)

*… and someone else has said oh just watch this guy he has a history of violence in ED.* (Pam)

On one occasion, for a week over a holiday period, there was a difficult and violent patient who frequently presented to the ED. The woman had no acute medical or psychiatric health needs, had been fully assessed and subsequently referred to the appropriate community resources. The woman continued, however, to frequent the ED. Her presentations were loud and aggressive. She demanded care that she had already received resources for, she was angry with the staff for not providing her with meals and she was unable to accept the restrictions and limitations of the services provided by the ED. To assist each shift, particularly their colleagues at triage, the triage staff left an updated, handwritten note at the triage desk that outlined the woman’s current care plan, which was being provided through the community mental health team. This ensured that the nurses were able to give consistent messages that supported the woman’s treatment plan, and the woman did not receive conflicting messages that could have exacerbated her distress and possibly elevated her potential for violence. This was an informal strategy, but one that reflected the cohesive supportive nature of the participant ED nurses. The consequence of this informal information sharing strategy meant that in the absence of formal documentation of the woman’s history of violence, every triage nurse was informed about the treatment plan and could respond appropriately to avert and
manage the violence risk. As a result of sharing this relevant knowledge the nurses were supporting and protecting each other from exposure to a violent event whilst ensuring a quality of service to this woman.

Fostering growth: nurturing other nurses

Collegiality and mutual respect for each other, and respect for each other’s nursing skills and strengths, was frequently reported and observed. Fostering growth and nurturing each other was expressed through; their shared learning and teaching; their willingness to assist each other and to accept assistance; and their desire to present themselves in a united way in front of patients, their family and friends. In addition to creating a supportive workplace, therefore, participant nurses were contributing to building and sustaining a working environment where there was trust, and nurses felt safe being learners and teachers. The participant nurses capacity to work together in this way was supported by their high level of awareness of each other. This included an awareness and respect for each other’s differing skill level, experience, strengths, and weaknesses.

Participant nurses reported that they consciously observed each other’s skills, behaviours, and communications, especially concerning violent events, to supplement and enhance their own skills. They were keen to learn and share different techniques and skills for violence assessment, prevention, aversion, and de-escalation including developing an understanding of the conditions under which particular skills were used. The culture of the ED was such that people were happy to formally and informally learn from each other by watching and listening, and they were comfortable being observed by their colleagues. The geography and layout of the ED made it possible to hear other nurses interacting with patients, their family and friends, and the participant nurses considered this an asset. Further, the combination of the geographical layout and the collegial environment allowed them to trial the skills themselves on subsequent occasions. Marge confirms this as she discusses an occasion when she was observing, listening and learning from her colleague. Potential violence was averted via her colleague’s skills and this further promoted her confidence to reflect on her own practice and to consider using the modelled skill in her own practice.
... I suppose I’ve learnt a bit off people here like as in what to say in certain situations ... the way that Susan (pseudonym) handled the visitor the other day, she was just straight, no - you are going outside. I probably would have said, I don’t know, that’s not appropriate to speak like that ... we knew he had a history of domestic violence and was a violent person. I would give that a go now ... if it was someone like that where it was pretty clear cut that they were out of line, yeah. (Marge)

The acceptance and willingness to learn on the job included learning about sending patients their family and friends clear, short messages and instructions as well as setting clear boundaries for acceptable behaviour.

*I will say, “don’t use that language with me, that’s not right. I’m not swearing at you, would you please not swear at me. I’m here to help you and I can help you, but can you calm down”. So, and I’ve learnt that from a lot of the girls here ... (Jane)*

The collegiality of the learning atmosphere also supported nurses reflecting on their own nursing practice, skills and approach.

*I tend to talk to people too long and try and compromise a bit longer and because I am happy to kind of try and work out a good thing ... sometimes I will be talking and not getting anywhere and then, you know, one of my mates will come in and they’ll go, listen mate, this is the deal. Bob’s trying to do this, this and this for you, its not working, so we’re going to do this. And then we just leave, and I think, I should have just done that in the first place. (Bob)*

The participant nurses were keen to demonstrate their collegiality and willingness to assist each other. The recipients of assistance expressed appreciation for this assistance, and this mutually agreeable assistance in turn nurtured their shared sense of collegiality and fostered development of their nursing skills.
I love my job and I love the people I work with ... they are what makes you get through your day ... they're all so helpful and if someone's giving you a hard time they'll come and stand behind you when you are doing something just so that they [the patients family and friends] know that you're not alone, they'll come and stand up for you when someone is giving you a hard time ... it makes it worth coming in. (Leah)

The findings reveal that one way the participant nurses expressed mutual respect for each other was through their awareness that different years of experience in the specialty of ED nursing meant differing knowledge levels. In particular they were aware that Registered Nurses in their first year of practice following graduation from University were on a steep learning curve and would likely lack the skills to avert or manage violent events. They reflected awareness that these new nurses were often fully occupied undertaking routine nursing duties, such as dressings, and took longer with these duties. Because of this, they did not have the time or the attentiveness to assess for violence risk in the same way that the more experienced ED nurse could.

... using a new graduate [first year Registered Nurse] as an example ...you come in here and are overwhelmed with what we are throwing at you and what needs to be done and trying to keep on the ball, you won’t be able to read people because you’re too busy concentrating on minor tasks, which we would consider minor but they would consider a major task, they wouldn’t realise the escalation or the tension in people ...and even if you tell them they might not take it in because of their workplace anxiety of being here and having to do x, y and z within a set period of time. (Dianne)

...and the type of environment this is and I think that’s a really big challenge [for first year Registered Nurses to engage in violence assessment and prevention] and they’re still busily trying to work out how they’re going to do 5 things in the next hour. (Donna)
The first year Registered Nurses in turn validated their colleagues understandings, and commented on how unprepared they thought they were for the amount and type of violence that was directed towards them in the ED.

... it’s something you’re not prepared for, the violence, it’s that you’re not educated about it. ...even, you know, a bit more education about that it goes on and how much it goes on, you know. (Leah)

This collegial awareness allowed first year Registered Nurses, and nurses with less experience in the specialty of ED nursing, to learn from their experienced ED colleagues and gave the experienced ED nurses implied permission to teach their colleagues. This recognition of, and response to, their colleagues needs was also observed.

A first year Registered Nurse was assisting a patient who was agitated and withdrawing from alcohol. Dianne was observing the interaction. When the first year Registered Nurse came to the nurse’s desk, Dianne began to talk about, and suggest, nursing skills that would help keep the patient calm and therefore avert violence. (Field note, 23 October, 2005)

Through acknowledging that different members of the nursing team had different needs as learners, and the openness with which people were able to learn from each other, the participant nurses were able to both teach and learn about violence prevention, aversion and de-escalation. Further, they expressed comfort with both the learner and teacher role irrespective of their years of nursing experience or their age.

You just have to be astute enough to watch and look and learn from the patient and the relative and your peers. See how people who’ve had more experience ...see how they deal with the situation. (Donna)

... you learn from experience of having been exposed to potentially violent situations and also being exposed to whole load of different people in your nursing career and also looking at how your colleagues
have managed it and thinking oh they did that really well, I think I will adopt that practice as well… (Muriel)

Mutual support, teaching and learning and a willingness to assist each other and accept assistance was seen as an ongoing part of their role and part of how they demonstrated their collegiality and care for each other. Participants also reported that collegiality was reflected when they could readily ask a colleague to look after a patient that they found difficult without fear of negative consequence, particularly following a violent event or with a potentially violent patient.

... you can’t like everyone and sometimes you have to just put that aside and sometimes you know, you just say to your colleague, I can’t look after him, you know, rubbed me the wrong way already and I don’t think that’s unreasonable, (Miranda)

... if I get angry, then I’ll walk away I make the conscious decision to let someone else look after them or get security, you know, that sort of intervention stuff ...(Wendy)

... I’ve done the same for someone else as well, so you look after each other. You know someone might have better skills with that person in trying to communicate with them better than me and I might be able to talk to someone else a bit better than that person… (Nancy)

These collegially aware ED nurses protected and supported each other to avert and respond to violence. There was a demonstrable sense of positive, functional communication and support reflected in their ability to express concern for each other, both as professionals and individuals. Promoting and maintaining a nurturing working ‘space’, modelling effective violence management approaches, and watching out for each other were part of the strategies these nurses used to individually and collectively manage, avert and respond to violent events. The participant nurses were able to give and receive active support, assistance and informal learning and teaching. This milieu offers the background context within which they dealt with the sequelae of violent events.
Fostering resilience: Resisting the negative sequelae of violence

The final theme that was revealed answers the research question concerning the sequelae of violent events for the participant ED nurses. These nurses were frequently exposed to violence in their workplace where the agents were patients, their family and friends. Narrative and observational data established that the participants resisted the potential negative personal and work-related effects. Participant nurses displayed the qualities of hardiness and stamina and these characteristics enabled them to continue to optimally provide nursing expertise to patients. Observations confirmed that as a function of their hardiness and stamina, the experience of a violent event did not affect the professional manner with which they assessed, assisted or admitted subsequent patients. Further, violence in the workplace did not lead to them choosing to have unplanned days off work. The narratives also revealed details of the workplace strategies nurses used to resist the negative effects of violence. Validating and debriefing each other were the main strategies they used to reflect on violent events and systematically disclose their thoughts and feelings. *Having hardiness and stamina* and *validating and debriefing* were the strategies the participant nurses used in *fostering resilience: resisting negative sequelae of violence* (see Table 6.3) and these subthemes will now be illuminated.

**Table 6.3 Fostering resilience: Resisting negative sequelae of violence**

<table>
<thead>
<tr>
<th>Subthemes</th>
<th>Components</th>
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<tr>
<td><strong>Having hardiness and stamina</strong></td>
<td>Managing violence</td>
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<td></td>
<td>Avoiding violence impacting on subsequent nurse patient interactions</td>
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<tr>
<td></td>
<td>Self care</td>
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<tr>
<td><strong>Validating and debriefing</strong></td>
<td>Not taking work related issues home</td>
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<td></td>
<td>Reflecting on violent events and nursing practice</td>
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<td></td>
<td>Humour</td>
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*Having hardiness and stamina*

The participant nurses displayed qualities of *having hardiness and stamina* and narratives revealed the strategies they used to resist the negative effects of the violence they experienced. Hardiness and stamina are defined by the nurses’ resolute ability to withstand the frequent episodes of violence and potential for violence they
were exposed to from patients their family and friends, without loss of their ability to productively and successfully function in their nursing roles. Hardiness encompassed their robust resolve that their constant exposure to potentially violent events and experiences of violence would not deter them from continuing to work, remain well themselves and provide quality nursing services. Their ability to remain resolute with this decision and attitude, despite their prolonged and frequent exposure to violence, revealed their stamina.

The nurses showed hardiness and stamina when they managed violent events by remaining calm, applying the nursing skills outlined in *conveying caring: averting violence* (see chapter five), attending to the patients nursing care needs in the least restrictive and least invasive manner, and ensuring the best outcome for the individual patient. Following event twelve, Pam discussed her initial approach to a verbally and physically violent patient. She was referring to the specific event as well as her general approach:

... the least invasive to the most invasive, and no-one wants to be invasive but if you have to for their safety and others, and as I said then you’ve got the patients that have to be physically removed from the hospital, unfortunately they just have to be taken away. (Pam)

The participants’ stamina and ability to remain available to violent patients was frequently observed. For three weeks over the Christmas holiday season the average number of daily presentations was 100. The unit was staffed and funded for an average daily presentation rate of 80 people. Within this context, Angie was attending to a verbally very hostile and violent, intoxicated man with a head injury and laceration (see Appendix D, Event Fifteen). The security personnel were in attendance because the patient had a documented history of violence in the ED. With this knowledge Angie approached the patient:

Good evening Mr. Brown (pseudonym) I'm Angie. How are you? (Field note, 7 January, 2006. Event Fifteen)
Angie maintained her respect and regard for the patient throughout his stay, including negotiating the removal of his weapon. The patient had many outbursts of verbal abuse, but Angie remained calm and successfully and professionally completed her nursing activities with the patient, thereby demonstrating her hardiness and stamina. Angie also revealed her hardiness and stamina when she discussed her growing level of comfort with the patient, despite his ongoing verbal violence and history of violence.

… make sure he knew there was a plan in process and …his perception is he would have been in control of the situation, which I was also aware of …but I ended up feeling quite comfortable … (Angie)

Data from the observed violent events confirmed that the participant nurses had hardiness and stamina because they did not show any signs of negative emotional reactions following violent events. Frequently field notes described that their volume and tone of voice did not become elevated or terse, that they looked calm, their body language remained open to the patient, and there was no sign of distress on their faces. Further, observations were generated that deliberately focused on the nurses’ interactions with other patients following a violent event. The field notes are replete with descriptions such as the following involving Kel. This observation outlines Kel’s response following violent Event Six, which involved a verbally aggressive female patient insulting Kel and using a demeaning and sarcastic tone.

I have not yet caught up with Kel to speak to her about what happened, but I could see that she walked away in her usual manner. It was not more swiftly nor slowly than her usual pace. Her facial expression was non-threatening; there was no hint of her being upset that I could see from either her body language or facial expression. Her tone of voice was calm and at a normal speaking level. (Field note, 16 October, 2005. Event Six)

This following example illustrates how Muriel dealt with a violent patient, yet did not let the violent interaction impact upon her subsequent nurse-patient interactions.

Bill is in the Cardiac area and he has been, and continues to be, verbally violent and abusive. He has a history of violence in ED. Having completed Bill’s admission, Muriel now greets her next patient, Mr Ted Black.

"Hello I’m Muriel, what brings you into ED today?"
Muriel is as pleasant, warm and concerned as she always sounds despite Bills verbal abuse.
Her approach and kind gentle manner towards Ted would be reassuring to anyone. Her next question to Ted is “Mr Black do you have any pain now?” (Field note, 21 December, 2005. Event Eleven)

The participant nurses linked the need for self care to their hardiness and stamina. Following the interview questions regarding the supports they chose to use and their feelings post a violent event, the participants discussed support from each other and the intrinsic worth of their personal activities, outside of work, as means of self care.

... that’s what you need to do, look after yourself ... try and do a few more things for yourself on your days off, you know like I find that since I’ve been working here I go camping all the time. (Leah)

I run around and do play doh (with her children) … I do a lot of swimming and splashing in the pool … (Angie)

... and it is, its just all about self-preservation, you try and look after your colleagues but ultimately it’s up to them to look after themselves … (Dianne)

The participants acknowledged that it was up to the individual to take care of themselves. Violence alone, however, was not a sufficient reason for the participant nurses to take an unrostered day of leave. Rather, needing to take an unrostered day of leave was a response to other stressful circumstances and they reported needing additional time for self care when the unit had extended periods of being understaffed, overly busy and being negatively influenced by external factors such as no beds in the hospital.

... I know my limitations and because I work full time … or I’ve really got to slow down and just stop for the morning and yeah sometimes I do take a day off… its not because I can’t face work today … I never go ‘I can’t cope with facing another day at work’, never ever. If you do that, its time to go… no, I never felt like that. (Dianne)
Marilyn explains how a combination of factors could lead to the decision for her to have an unrostered day of leave. Marilyn states the most noteworthy issues are organisational problems such as ramping, which refers to having patients waiting outside in ambulances because there are no beds for them in the ED, in combination with a critical incident, which refers to an unexpected adverse outcome for a patient.

_I think it’s a combination. I don’t know that a solitary episode of having someone acting violent towards you would make you have the next day off, but it’s a combination of things …. so if you’re ramping and have no beds … and then had a critical incident and you’re tired and you might just go, there’s a combo._ (Marilyn)

Hardiness and stamina was one way the participant nurses resisted the negative effects and sequelae of violence. Validating each others experiences and debriefing following violent events was another strategy that was frequently used.

**Validating and debriefing**

The participants were uncertain about the particulars of the support their health service provided to staff following a violent event, and this included a lack of knowledge about the nature of the support, when the supports could be used and how to access these supports. The participants generally believed that their Nursing Manager would be the appropriate resource person should they need this information.

_... apart from the nursing staff I wouldn’t have a clue … I mean I don’t know what happens if someone knocks you flat …when you’re in emergency. It hasn’t happened yet, I guess I’ll find out when it does._ (Leah)

This lack of knowledge may be explained by their rejection of the need for formal support or debriefing. These participants felt that any need for support, validation and debriefing was most appropriately provided by people who had recent, first hand experiences similar to their own. Validation and debriefing, therefore, was sought
from colleagues who could understand what the experience meant for them as an individual and professional.

What supports do you chose to use? I choose my colleagues rather than other things because they understand. I think they understand what you’ve been through, what you are going to go through, what the situation was. The social worker really wouldn’t understand would they? I mean they might but not as much as the people you work with because they go through it too. I mean I don’t think even (the nurse administrators) would really understand because they’re not on the floor, it’s the ones who are in the floor doing the same things that you are doing day after day, they’re the ones who understand and that’s why I would go to them. (Donna)

Formal de-briefing was seen as appropriate if there was a critical incident. The violence these ED nurses experienced on a daily basis, however, did not meet their own criteria of a critical incident. The participant nurses discussed critical incidents, such as unexpected deaths in the ED, however they did not position any violent events as critical incidents.

When there’s a critical incident like young children injured, young children dying, you know critical things like that, traumatic death in the department we de-brief amongst each other but there is a service through the mental health service … to de-brief but its not widely advertised. (Dianne)

I can’t remember how long ago there was a death of a child in the Department and it did affect quite a few people and yeh there was a session run. Again I don’t recall who actually ran the session … (Angie)

In the absence of using formal debriefing, informal debriefing was observed to be undertaken mostly in the staff tea room, although participant nurses would discuss nursing practice issues at the nursing desks if time and patient anonymity and confidentiality permitted. There was a shared acceptance that it was safe to debrief
with each other about their experiences of violence as well as sharing and reflecting on violence prevention, de-escalation or management strategies.

*Just talking about how horrible it was, what could have been done better, just re-live what happened, talk about how it went, how we did, amongst ourselves ...in the corridor, in the tea room, in the procedure room, in the pan room, its not formal.* (Dianne)

Debriefing included the opportunity to reflect on their practice and learn from their experience, and the experiences of others. There was a sincere attempt to understand the circumstances around the violent event, and to honestly assess their own role in the event with the goal of improving their nursing practice and management of violence. Their informal debriefing had elements of their reflecting on their practice and teaching and learning violence prevention, assessment and management skills from each other. They also supported and encouraged each other to talk about violence in the workplace generically, and about violent events specifically, enabling themselves and each other to ventilate about their experiences. Creating a safe space to ventilate about violent events helped these nurses to deal with their emotional responses thereby minimising and preventing potential negative consequences.

*... the tea room is the best place ... most of us get on well and that helps an awful lot because you understand how they feel and you just get on with it really. We laugh a bit ... it makes you just think about what you could have done better maybe ... and I think your colleagues are the most important and as long as you can talk to them you are right ...* (Donna)

*... the only way that you really then deal with it is to tell other people. You talk to other nurses and say, you know, “God, you know, she was really horrible” to verbalise it yourself and get rid of it, you know, because you can’t just hold it all in. So, you obviously don’t mention names, just get it out and I think nurses often do that at tea or whenever, you talk to whoever’s there and say, well, this happened ...* (Jane)
The process of debriefing included the use of humour, and this also helped the participant nurses to avoid the negative affects and sequelae of violent events.

*We make light of it down in the tea room. The tea room is a wonderful place. It’s like the old confessional booth of the Church … I guess I use humour a lot to diffuse things.* (Helen)

*… its awful when it happens … but I don’t take it personally and after its happened you can actually turn it around to be quite funny … I think nurses have a sick sense of humour really. They can turn events that most people would think would be drastic into humorous occasions and I think we do that a lot …. (Muriel)*

When asked how they felt when they got home after a violent event, three (3) of the 16 participants interviewed very clearly stated they did not take work home or discuss work with any of their family members. Eleven (11) of the 16 participants interviewed said they may mention they had an unpleasant day at work, but they did not take work home. If they did mention their work at home, they restricted debriefing to partners, close friends and other nurses. Unpleasant days were not only related to violent events, however, and there were many other factors that lead to an unpleasant day such as how busy the ED was, what the staff mix for their shift was, the available hospital resources including bed availability, and if they had a death or critical incident in the ED.

*Yeah, I probably talk to my partner at home, sometimes I can’t go to sleep after work but often its because of actual work, you know you are thinking what haven't I done, I don’t think I’ve really not been able to sleep because of the way someone spoke to me* (referring to patients who were verbally abusive or aggressive) … (Marge)

Validating each other, debriefing, leaving work related issues at work and the use of humour enabled the participant nurses to manage violence without loss of function. Their ability to debrief and validate each other and be validated at work also enabled them to prevent violent events impacting upon their next nurse patient interaction.
... I don’t fester on anything, I don’t, I’ve learnt not to fester on things because it gets you nowhere, only internally damages your psyche ... and your emotional wellbeing, so there’s no point, what’s done is done and you just have to learn from your mistakes or learn from what happened, you know put it into context in the big scheme of life and get on with it and move on. (Dianne)

The majority of the participants expressed their hardiness and stamina by choosing not to repeat, recall and recount their work related experiences of violence in their home. Rather, they were validated and de-briefed at work and wanted to leave the thoughts and feelings about work related issues at work.

But overall I think it’s professional. I don’t take it home. I don’t go home at the end of the day and cry into a glass of wine because someone abused me. It just rolls off the back ... I have a theory in life ... don’t sweat the small stuff. I can’t change how these people want to act ... I try and be positive and happy all the time and if someone else wants to be cranky and angry that’s ok too. ... I go “Thank God that’s over” and I go home. It very seldom effects me. I just shed it. I think, that was an interesting shift. That was a bit full on ... I release that very easily. (Helen)

Summary

This chapter has presented the final three (3) findings revealed from the narratives and observational data. These findings provided insights into how the nurses ascribed meaning(s) to both the agent of violence and the act of violence. This further illuminated the strategies these participant ED nurses used to assess and respond to violence towards them when the agent of violence was a patient their family or friends. This chapter also addressed the research question pertaining to the sequelae of violence for these nurses. Their ability to foster resilience and resist the negative affects of violence demonstrated their immediate and short term reactions to violence in the workplace. Further, this occurred in a milieu that featured a strong sense of collegial awareness. The following chapter will discuss the findings from
chapters five and six in light of the relevant, contemporary literature on violence in nursing.
In this chapter, the five (5) findings presented in chapters five and six will be discussed with reference to the existing nursing literature on violence towards nurses. Importantly the contributions of the findings and their relevance to violence assessment, prevention and sequelae for rural and regional ED nurses are presented. In particular the contribution of these findings for the processes of nurses reporting violence, assessing for patient, their family and friends’ potential for violence, and the contribution of the finding of nurses’ resilience and hardiness to sequelae of violence are examined. Parts of this chapter have been previously published (see Appendix B).
Chapter Seven - Discussion

Introduction
This chapter discusses the findings in light of the current literature on violence assessment, prevention and sequelae of violence towards rural and regional ED nurses. While it is useful to review the findings from a wide range of literature and different nursing specialities, it is problematic simply to transfer previous findings to the ED, devoid of contextualisation or recognition of the specialty of ED nursing. Additionally, many of the studies that have explored the phenomena of violence in the health care sector and towards nurses have relied on survey methods and retrospective questionnaires. Nevertheless, the findings of this study have some resonance with a number of other studies on violence assessment and prevention strategies (Lyneham, 2000; Mayhew & Chappell, 2001a; Nachreiner et al., 2005; O'Connell, Young, Brooks, Hutchings, & Lofthouse, 2000; Whittington, 1997). For example, the literature identifies that men are most frequently the agents of violence (Stirling, Higgins, & Cooke, 2001), and feminist theory suggests that male to female violence is entrenched in societies where women are the non-dominant cultural group (Yodanis, 2004). As also discussed in chapter two, nursing is predominantly a female profession. The results of this study concur with this work, the most common agents of violence were male and the violence was directed towards female ED nurse participants. The current findings, however, offer greater depth of understanding of existing ideas, and new insights into prevention, assessment and the sequelae of violence towards rural and regional ED nurses because of the use of mixed methods. This chapter will discuss the five (5) findings sequentially in light of the contemporary literature, highlighting areas of concordance and difference. The benefits of positive nurse-patient relationships to assist in preventing and averting violence and the effects of contextualising the meaning of the violent event, and agent of violence, in light of contemporary literature will be reviewed.

Preventing violence: the value of positive nurse-patient communication
ED nurses are engaged in intense interactions with patients their family and friends, in a demanding environment (Cronin & Cronin, 2006). The findings outlined five sub themes of the theme Conveying caring: Averting violence. The sub themes
reflect the skills and behaviours that the participant ED nurses used in their routine nursing practice to avert, reduce or prevent violence. The sub themes were being safe, being available, being respectful, being supportive and being responsive. Though these attributes were used in everyday practice, they were used in particular ways to avert and reduce the risk of violence and reflected the participants’ embodied definition of ‘caring’ as it was expressed in their routine nursing practice. The use of highly developed and specialised communication skills is congruent with the existing literature on nurses’ violence prevention and de-escalation strategies, particularly from the mental health nursing literature. This research also highlights that effective violence prevention, assessment and aversion requires more than the use of micro communication skills alone (Keely, 2002; Mayhew & Chappell, 2001a).

Having a safe work environment, as discussed in chapter two includes the various mechanisms of crime prevention through environmental design (CPTED), such as secure entry and exit points, use of staff identification badges, availability of trained security personal and duress alarms (Foley, 2004; Mayhew & Chappell, 2001a; McPhaul & Lipscomb, 2004; Merfield, 2003; K. Worthington, 2000). Facility policy and its implementation, education programs and appropriate resources are also contextual environmental violence prevention and aversion strategies aimed at developing and maintaining safe workplaces. A safe work environment is an OHS mandate in Australia (Queensland Health, 1995, 2002, 2003). It is important to acknowledge, however, that these forms of security do not prevent violent events if the agent of violence is inside the secured unit (Lyneham, 1999, 2000). Further, these CPTED strategies often assume a degree of rational thinking on the part of the agent of violence thus many of these features may not be seen as deterrents (Mayhew & Chappell, 2001b). While the environmental strategies are endorsed in the literature, Jenkins, Rocke, McNicholl and Hughes (1998) reported that there was no correlation between security measures and levels of violence. The current study findings reveal that the participant ED nurses were able to use the facility design features advantageously, but it was their ability to convey caring that averted many violent events, and this was identified because of the use of mixed methods and may not have been revealed using survey methods alone.
As part of their practice, the participant nurses in this study contextualised the mandate of workplace safety for themselves and those attending the ED. This finding, and the associated components, has not been previously revealed in the ED nursing literature. The nurse’s recognition of their ability to use their environment for protection concurs with recommendations in the literature (C. Alexander, Fraser, & Hoeth, 2004; Foley, 2004; Keely, 2002; Knefel & Bryant, 2004; Mayhew & Chappell, 2001a, 2001b, 2003; McPhaul & Lipscomb, 2004), and was demonstrated through their awareness and use of their environmental assets such as the perspex window at the triage desk and the locked doors. While authors such as Catelette (2005) found that ED nurses did not trust these environmental mechanisms, this does not correspond with the findings from this current study. Personal safety, and the challenge of being close enough to monitor patients while not getting too close and therefore reducing risk of physical injury, was also part of these ED nurses practice. While the efficacy of preventative personal positioning is replete in the mental health nursing literature (Robinson, Jagin, & Ray, 2004), currently it is not evident in the discourses from ED nursing practices. Further, these ED nurses used preventative personal positioning and highly developed communication skills, and this contributes to the current nursing literature and understanding of the skills used by ED nurses.

The participant ED nurses used highly developed communication skills in their routine nurse-patient relationships to convey caring. They also used these skills to prevent and avert violence. Most of the work on the efficacy of using highly developed therapeutic communication skills in violent or potentially violent situations has been undertaken in the specialty of mental health nursing (Bond & Brimblecombe, 2003; Duxbury & Whittington, 2005; Martin & Daffern, 2006; Spokes et al., 2002). Using body language, a calm tone and negotiating assists with the prevention of violence and this has been noted in the mental health nursing literature, however direct application of these skills for violence prevention are not discussed in the emergency nursing literature. The mental health nursing literature also posits that negative interpersonal styles, controlling staff attitudes, poor communication skills and unhelpful body language contribute to violence and aggression (Duxbury & Whittington, 2005; Martin & Daffern, 2006; Spokes et al., 2002). Conversely, good communication skills, calm manner, empathy, warmth,
courtesy and clear boundaries are “personal attributes cited as lessening the risk of violence” (Bond & Brimblecombe, 2003, p. 11). Further, the literature on violence prevention education and training specifically endorses the inclusion of interpersonal communications strategies into curriculum (C. Alexander et al., 2004; Australian Institute of Criminology, 2003; Levin, Hewitt, & Misner, 1998).

Little work has addressed the real world use and adaptation of these skills outside the mental health setting or specifically in ED nursing practice. The findings of this study support those of other studies that promote the use of conscious, high level positive interpersonal communication micro skills and techniques to create safe environments and therapeutic nurse-patient relationships (C. Alexander et al., 2004; Baillie, 2005; Cowin et al., 2003; Distasio, 1994; F. Lee, 2001; Usher, Luck, & Foster, 2005). This study, however, revealed how these rural and regional ED nurses used highly developed communication skills to reduce or prevent violence, and this makes a new contribution to the nursing literature. Specifically, this work adds that preventative positioning and use of high level verbal and non-verbal communication skills are being effectively used and modelled by Australian ED nurses specifically to avert, prevent or manage violence, from patients their family or friends.

Building trust, and understanding how patients may feel, were part of the explicit recommendations made by the Department of Health in the United Kingdom to address how ED nurses could build therapeutic nurse-patient relationships (Baillie, 2005). ED nurses have been frequently maligned by critics who contend that because their practice is necessarily circumscribed by the need to maintain and save life within the context of the ‘medical emergency’, they are not fully attuned to the emotional and social needs of patients (Cowin et al., 2003; Kelly, 2005; F. Lee, 2001; Walsh & Dolan, 1999). This criticism does not take into account the breadth of skills of the ED nurses or the intensity of their interactions (Baillie, 2005; Hagerty & Patusky, 2003). It is evident from these current findings that the participant ED nurses demonstrated concern and care for the emotional and social needs of persons presenting to the ED. This current study revealed that many highly developed communication micro skills and interpersonal skills were practised, informally modelled, shared and applied during the participants’ interactions with patients their family and friends. These skills were contextually embedded in routine nurse-patient
relationships, particularly to prevent, avert, reduce or manage violence and demonstrated their applied nurse ‘caring’. While these findings resonate with aspects of the mental health nursing literature, they add that these rural and regional ED nurses are establishing positive nurse-patient relationships based on their abilities to convey caring and further, these skills are actively, contextually developed and used to manage, prevent and avert violence within their specialty setting.

Though the term ‘caring’ is contested in the nursing literature (Bassett, 2002; Coulon, Mok, Krause, & Anderson, 1996; de Raeve, 2002; D. Jackson & Borbasi, 2006; McAllister & Walsh, 2003; McQueen, 2004; Tarlier, 2004; Walsh & Dolan, 1999; Winman & Wikblad, 2004), these nurses revealed their conceptualisation and practice of nurse ‘caring’ through the enactment of the five attributes outlined in Conveying caring: Averting violence. Their caring was demonstrated by their politeness, respect, consideration, tone of voice and actions such as welcoming patients and those accompanying them to the ED (Boykin, Bulfin, Baldwin, & Southern, 2004; McQueen, 2004). This finding makes a contribution to the literature in that it identifies some of the contextually constituted behaviours and skills ED nurses used to embody caring in their routine nursing practice to prevent, avert and manage violence. The study findings show how caring can be conveyed and embodied through individual ED nurses. Definitions of the term ‘caring’ are problematic because they tend to be ambiguous and rarely defined by nursing practice. Although caring has been the focus of many nursing studies (Pryzby, 2005), often ‘caring’ is defined by economic, management and social imperatives (Gunther & Raile, 2002). Caring is also defined by the cognitive, affective and psychomotor skills nurses use when interacting with patients their family and friends (Bassett, 2002; Gunther & Raile, 2002; McQueen, 2004). These current findings contribute to the concept of nurses caring in an ED and shed light on how nurses practice caring with difficult patients, when there is violence or the potential for violence. Further, the findings reveal how these ED nurses manifest their cognitive, affective and psychomotor knowledge, and applied this to their practice. In particular, these findings provide insights into their use of their affective knowledge, which is frequently undervalued in specialities other than mental health nursing.
Their use of communications skills, underpinned with genuine regard, empathy and concern for people presenting to the ED demonstrated that they were able to respond to individual differences. Their capacity to see the patient, their family and friends as their central concern, be empathetic, demonstrate understandings about themselves, understand the circumstance of others, develop positive productive nurse-patient relationships were reflected in the components of conveying caring. McAlister and Walsh (2003, p. 40) define this as “adaptive caring” and Coulon et al. (1996, p. 823) discussed that these attributes were part of “excellence in nursing care”. These conceptualisations of caring have been discussed in the nursing literature (Bassett, 2002; Luker, Austin, Caress, & Hallett, 2000; McQueen, 2004; Pryzby, 2005), however their effectiveness when used in a violent or potentially violent nurse patient interaction in an ED has not yet been fully examined. These current findings make a new contribution to the literature on the efficacy of communications skills to prevent, reduce, avert and manage violent events, and more significantly apply adaptive caring within the ED setting.

It is important to remember that the ED nurse’s specialty is Emergency Department nursing, where a diverse range of illnesses, accidents, medical, surgical and psychiatric problems can unexpectedly present. These findings reveal that violence reduction and prevention skills are being effectively implemented by ED nurses, but not all violence can be averted using these attributes. It is also noteworthy that the interpersonal and communication skills that these ED nurses used to convey caring and avert violence are congruent with the skills identified by Carlsson, Dahlberg, Ekebergh and Dahlberg (2006). Carlsson et al. (2006) found that when there was violence, mental health patients needed authenticity, presence, an opening to talk, feeling like the carer really wanted to help, respect, positive body language, facial expressions and gestures from mental health nurses. They added that this included “an authentic personal encounter, that is a straightforward, unfeigned, and sincere engagement” (Carlsson et al., 2006, p. 291). These ED nurses demonstrated that they were available to those who presented in ED, and that the aforementioned skills were embedded in their routine nursing practice. While these current findings concur with the mental health literature, they also demonstrate that these skills are being used outside of the mental health nursing context, in a rural and regional ED. By implementing these attributes in their routine daily practice these ED nurses are
defining themselves and their practice. Further, their capacity to convey caring and apply their skills to the complex interactions that surround violence reduction, aversion, prevention and management, was achieved in circumstances where there was little time to establish therapeutic relationships (Baillie, 2005; Gunther & Raile, 2002; Walsh & Dolan, 1999).

As discussed in chapter two, one of the specialty specific contextual issues considered widely to contribute to violence in the ED is waiting times. Despite this belief there is little empirical evidence to support this (Crilly, Chaboyer, & Creedy, 2004; Knott, Bennett, Rawet, & McD Taylor, 2005). The findings from the current study reveal that ED nurses consider waiting time a factor that contributed to violence in their regional ED. Similarly to the literature, there was no evidence to support this assumption. The findings also confirmed that people presenting to ED need information including information to assist them to understand the triage system and this concurs with the findings of Crilly et al. (2004) and Kelly (2005). There was also the acknowledgment that the hospital environment, policies, processes and procedures are unfamiliar to many health care consumers and can increase the stress levels of family and friends, and these findings also resonate with the literature (Crilly et al., 2004; Ergün & Karadakovan, 2005; Pryzby, 2005). In the current study, participant ED nurses had awareness of these contextual stressors, acted upon this knowledge by using their skills conveying caring to ameliorate the frustrations of patients, their family and friends, and to assess for violence risk. Their assessment strategies and approach will now be further discussed in light of the contemporary literature.

**Being alert: recognising, assessing and responding to violence**

The Staring, Tone, Anxiety, Mumbling and Pacing (STAMP) nursing violence assessment framework considers interpersonal and psychosocial aspects of an ED presentation, which is often an acute life threatening emergency, and offers an easy, practical assessment acronym that can be used by ED nurses. Nurses need to have skills in violence assessment, prevention, aversion and management. Violence-related rating instruments, such as the staff observation aggression rating scale-revised (SOAS-R) and the Brøset Violence Checklist (BVC) have been developed and are applied in the specialty of mental health nursing (Abderhalden et al., 2004;
Bjorkdahl, Olsson, & Palmstierna, 2006; Meehan, Fjeldsoe, Stedman, & Duraiappah, 2006; Mills, 2005). These existing instruments, however, are not appropriate for ED nurses because they are specialty specific and have questionable predictive value (Abderhalden et al., 2004; Bjorkdahl et al., 2006; Mills, 2005; Nijman et al., 1999). Context and specialty specific nursing knowledge and practice are needed to inform ED nurse’s violence assessment strategies.

Theoretical knowledge of the aetiologies of aggression and violence, as discussed, encompass, but are not limited to psychoanalytic, learning, social learning, behavioural, personality and biological perspectives (see chapter two). As a function of the historical development of nursing, and the professions assumed need for input from a diverse range of discipline areas, many of these theoretical perspectives have been, and continue to be, taught in nursing curriculum (Bassett, 2002). Their application of this knowledge to the participants’ nursing practice, however, was limited to their usefulness to inform the STAMP nursing violence assessment framework.

Customarily a theory offers a systematic and generalisable explanation, prediction or description of phenomenon and their interrelated concepts (Polit & Beck, 2004). Many of the traditional theoretical perspectives of violence, however, do not provide nurses with complete explanatory or predictive models upon which violence in their working environments can be understood. There is a need for new practical, context specific explanations, descriptions and predictors about violence and aggression towards nurses.

The integration of a diverse range of knowledge(s) into nursing assessment and practice is congruent with contemporary nursing literature and practices (J. Lee, Chan, & Phillips, 2006; Marrs & Lowry, 2006). In addition to the contribution of relevant knowledge from the aforementioned theoretical perspectives, the STAMP nursing violence assessment framework was implicitly informed by other violence prevention strategies and information such as, institution policies, environmental considerations and familiarity about their health consumers. Some of the observable behavioural cues, such as staring, pacing, raised voice, tone of voice and fist clenching, have been previously identified in the nursing literature as indicators of
aggression (Bjorkdahl et al., 2006; International Council of Nurses, 1999; Littrell & Littrell, 1998; McAllister & Walsh, 2003; Pryor, 2005; Rippon, 2000; Umiker, 1997; Usher et al., 2005). Pryor (2005, p. 118) found that nurses working with acquired brain injured patients also observed for “what the patient was saying, changes in the patient’s voice, changes in the patients face, changes in the patients behaviour and nurses perception that patients were experiencing unpleasant emotions”. Pryor (2005) reveals that the rehabilitation nurses interpreted frustration, anxiety, and increased distress as the patient experiencing unpleasant emotions. The findings of the current study reflected in the acronym STAMP, however, more specifically details and organises these relevant components and their cues. What is important about the contribution of the STAMP acronym is that these knowledge(s) have not previously been collectively identified contextually to ED nursing practice nor have they been structured into an acronym to assist nurses to assess for violence risk. Further, these cues, derived from ED nursing practice, identify the component behaviours that portend to violence towards these ED nurses. Thus the STAMP violence assessment framework corresponds with both the research findings and the current nursing literature but extends what is known by providing a framework for violence assessment that originate from ED nursing practice and are based on observable behaviours.

The STAMP nursing violence assessment framework is a practical, easy framework consisting of five (5) component issues and their corresponding cues that can assist nurses to assess violence risk in the ED. It is noted in the literature that the construction and use of actuarial and clinical categories are problematic, and further, there is no assessment strategy that accurately predicts violence (A. L. Jackson, Veneziano, & Ice, 2005; Mills, 2005). The results from this study showed that these nurses considered, and applied, elements of both the actuarial and clinical violence risk assessment approaches. While these approaches were not explicitly named by the participants, the elements of their structures were expressed and were apparent in the findings. Within the framework of the STAMP components, and specifically anxiety, actuarial classifications of statistically significant co-morbid or presenting symptoms were used in a modified way by ED nurses.
Nurses were aware of the potential effects of presenting or co-morbid health issues, particularly those that were statistically associated with violence, for example; alcohol or substance intoxication; mental health status; cognitive impairment; and disorientation and this concurs with the literature (see for example Abderhalden et al., 2004; Björkdahl et al., 2006; Crilly et al., 2004; Duxbury, 2002; Duxbury & Whittington, 2005; Meuleners, Lee, Zhao, & Intrapanya, 2004). Crilly et al. (2004) study reported that 44% of the nurses stated that patients who were demanding or requesting attention were involved in violent behaviours. This is congruent with the findings for the Mumbling component of STAMP. While the participant nurses were reluctant to stereotype patients, family and friends based on these empirical categories, and rejected the presumption that these categories reflected homogeneity, they nevertheless used this knowledge to inform their violence risk assessment and their nursing practice. Further their actuarial violence risk assessment approach was coupled with a subjective clinical risk assessment approach, which was a clinical judgement based on their experiential knowledge. The STAMP nursing violence assessment framework, therefore, reflects the intent of both the actuarial and clinical risk assessment strategies but importantly contextualises this knowledge in a regional and rural ED setting.

The anxiety component of STAMP reveals itself as an important component. Anxiety was a potential motivator for violence, a component that informed nurses’ violence assessment, and considered a mitigating circumstance. Anxiety is a very broad term and can manifest in many physical ways, therefore the cues offered related to the STAMP nursing violence assessment framework are not intended to be exclusive or exhaustive however, they do reflect the cues observed and reported in this study. Additionally, the caring skills and knowledge that these ED nurses used to prevent, reduce and avert violence, as previously discussed, also offered cues for violence assessment. The participant nurses understood that physical, emotional and social situational stressors could lead to anxiety and they applied this knowledge equally to family, friends and patients. Further, participants were aware that all origins of anxiety impacted upon the individual’s potential for violence. These nurses also understood that a family member or friend with a guardianship or protective role and relationship with the patient, such as a parent with a child, increased agitation and anxiety.
This finding concurs with Bentley’s (2005) findings that parents of children in ED’s have elevated anxiety, a strong sense of responsibility and therefore a potential for violence, particularly verbal abuse and may imply that the goal of violence is the positive reward of receiving instant treatment or attention. This aligns with the behavioural theory of instrumental aggression. The participant nurses understanding of the potential emotional impact of a need for ED services further established that they considered their health care consumers psychosocial well being within the framework of violence assessment and prevention. These findings also concur with the literature that offers a relationship between anxiety and violence in the health care setting (Fernandes, 2002; Irwin, 2006; Kelly, 2005) and that nurses caring can ameliorate anxiety in the ED setting (Baillie, 2005). What is new, as this finding reveals, is the link between the participant nurses’ understanding of patients and their accompanying family and friends psychosocial needs, their embedded practice of caring, and the skills they used to assess for violence risk. The nurses’ understanding and caring practice is applied in the ED setting demonstrating how they integrate theoretical understandings from many sources into their nursing practice and embedded a sense of ‘caring’ into their violence risk assessment.

The STAMP nursing violence assessment framework is offered as a flexible schema where the cues and components have varying degrees of applicability. Further, the participant nurses demonstrated their understanding that the STAMP cues and components, when combined, had an additive relationship. That is, participants frequently discussed components or cues in a sequential manner to illustrate that as the potential for violence escaladed, the number of STAMP components and cues that were observed increased in frequency or intensity. It is not the intent of the STAMP violence assessment framework to offer a rank score for violence prediction however it does provide the user with an overall assessment that is linked to observable cues. The STAMP violence assessment framework is deliberately a flexible tool that acknowledges nurses ability to make informed subjective clinical assessments that are contextually fitting, informed by actuarial categories and relevant to individual patients their family and friends. The framework encourages nurses to integrate existing meaningful theory and to use very practical observation techniques in their nursing practice.
During data generation it was frequently noted that participants would respond to the presenting or escalating STAMP components and cues. Whilst individual differences were noted regarding the type and timing of this intervention, predominantly participants responded quickly with de-escalation skills such as their embedded sense of caring, empathy, clear communication skills, and approaching patients their family and friends in a calm, respectful open manner. Use of these skills following early identification of STAMP cues and components frequently served to avert violence. Further, these nurses attributed contextually and situationally specific meaning(s) to both the violence and the agent of violence.

Attributing meaning: Subjective understandings that shape responses to violence

The participant ED nurses did not classify violence according to the dominant discourse and definitions found in the literature (see for example Adib, Al-Shatti, Kamal, El-Gerges, & Al-Raqem, 2002; Crilly et al., 2004; Fernandes et al., 1999; Hegney, Plank, & Parker, 2003; McPhaul & Lipscomb, 2004; Uzun, 2003). While there is no agreed upon standard definition for the term violence, commonly the term is socially and theoretically defined, encompassing a broad continuum inclusive of all forms of non-physical, physical and sexual violence. The participant nurses meaning(s), and therefore definition(s), of violence were informed by theoretical knowledge(s) and derived from shared contextual, professional and individual understandings about the violent event and agent of violence. They did not emphasise differences between physical and non physical violence, or distinguish assault from aggression. What was important contextually regarding their definition of violence was their attribution of meaning(s). The participants were engaged in a dynamic process that rendered the phenomena of violence meaningful within their bounded context. This approach is endorsed in the literature pertaining to mental health nursing (Meehan et al., 2006). What is new here is the finding that ED nurses are engaged in a specialty and context specific process to render violent events, and the agent of violence, meaningful.

As discussed in chapter two, nurses co-create the discourse on violence through scholarly and institutional disciplines. That is, the scholarly discourses used to
theorise violence, implicitly re-create violence within a particular framework, and limits what can be said and done about it. The institutions within which nurses practice, both hospital and community settings, remain steeped in western medical traditions, and these institutions construct the knowledge that is considered valuable. Further, these same discourses determine the power relations that can occur between nurses and their patients. As the current findings reveal these rural and regional ED nurses did not limit their discourse about the agent of violence, or the violent event, to the possibilities available from within the current definitions of violence. This is a noteworthy contribution to the ED nursing literature, in particular adding knowledge explaining why ED nurses under-report or choose not to report violent events.

It could be argued that many of the definition(s) of violence presented in the literature are operationalised definitions, in the empirical sense, and that researchers assume nurses also use these theoretical classifications. As identified, the definition(s) of violence found in the literature are problematic because of the lack of consistency and as discussed, there are problems pursuant to assuming that nurses use the same definitions of phenomena as theorists or researchers, and this has also been discussed in the literature (Hagerty & Patusky, 2003). Operational or theoretical definitions are very functional for studies that attempt to measure levels of violence or find causal relationships. Understanding the phenomena of violence towards nurses contextually reveals a different perspective and provides evidence that nurses use theoretical understandings, including definitions, based on their merits for competent nursing practice.

Findings of this study shed light on the meanings nurses ascribed to violent acts towards them when the agent of violence is the patient their family and friends. As discussed, the meaning of violence was underpinned by a systematic and identifiable process that took three main factors into account; (1), the personalisation of the violence; (ii), presence of mitigating factors; and (iii), the reasons for presentation to the ED. The factors and parameters that contextually surrounded the participants ‘in use’ meaning(s) and definition(s) of violence contextualised the violent event, and the agent of violence. The participant ED nurses ascribing contextual meaning(s) and a definition of violence through this identifiable process adds to the current literature.
How the participant nurses informed their meaning(s) of violence within the ED context also contributes to the current nursing literature.

There is an increase in ED attendance for non-threatening conditions and conditions that are neither accidents nor emergencies and these are frequently considered ‘inappropriate’ (Koziol-McLain, Price, Weiss, Quinn, & Honigman, 2000; Malone, 1996; A. W. Murphy, 1998). There is current evidence that shows the discrepancy between the ED medical staff and the presenting patient’s understanding of the need for ED services (Koziol-McLain et al., 2000; A. W. Murphy, 1998; Padgett & Brodsky, 1992; Rassin, Nasie, Bechor, Weiss, & Silner, 2006). An Australian study into people who did not wait for ED treatment showed that one third (1/3) of patients classified their “problem as inappropriate for the Emergency Department”, 23% left because they felt they had waited too long and 13% left because their “problem subsided” (G. Lee, Endacott, Flett, & Bushnell, 2006, p. 60). An Israeli study showed that there was a significant difference between the urgency rating given by patients and ED nurses. More than 77% of patients considered their condition as urgent or most urgent whereas 78.58% of nurses considered the condition non-urgent (Rassin et al., 2006). Assessing the persons’ reasons for presentation, as the findings from the current study revealed, was part of the causal judgement process used by the nurses when they attributed meaning(s) to violent events. Their response to a violent event was different when the nurses perceived that the presentation was deemed inappropriate.

An inappropriate presentation has previously been defined as a presentation that is based on a “lack of a significant medical problem” (Koziol-McLain et al., 2000, p. 555). The authors acknowledge that this is a reductionist medical model based definition and, along with Murphy (1998) urge that subjective and psychosocial factors need to be included in defining the need for ED presentation. The categorisation of patients in terms of the legitimacy of their presentation, and the problems this has, is congruent with the literature. The nurses in this current study, however, demonstrated their capacity to attribute meaning based on more than this attribute alone and the effect of the decision making triad used by these ED nurses makes a new contribution to the nursing literature.

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As discussed, these ED nurses demonstrated their capacity to use actuarial categories and clinical knowledge during their violence assessment process. The actuarial categories identified in the anxiety component of STAMP were also seen as mitigating circumstances, thereby relinquishing responsibility for the violent event from the agent of violence. This finding is consistent with authors who found that nurses considered the degree of capacity of the agent of violence when determining level of responsibility for violent behaviour (Carter, 1999; Erickson & Williams-Evans, 2000; Saines, 1999).

The same predisposing factors thought to contribute to episodes of violence such as anxiety or cognitive impairment, may well lead to nurses considering that the agent of violence were in some way not “fully responsible for his or her actions” (Carter, 1999, p. 5). This is congruent with Erickson and Williams-Evans (2000) findings where 76% of nurses responding agreed they would take the perceived degree of patient self responsibility and capacity into account prior to considering assault charges. Further, only 32% of nurses would press charges and only 65% of nurses felt it ethically appropriate to take legal action. Saines (1999) concurs with this finding and Alexander (2001) similarly reported that following a physical violent assault, the nurse felt guilty and more concerned about the legal consequences for the patient and herself, than her wellbeing.

This study extends this finding by providing greater depth of understanding of the process participants used to determine the agents responsibility for violent events, and this has not been revealed by previous research. The most frequently reported precipitating factors for violence found by Alexander et al. (2004) include; first, service issues, including waiting time and staff shortages; second, mental illnesses; and third, substance abuse issues. Co-morbid health issues with symptoms of confusion and disorientation, as outlined in the components and cues associated with anxiety, were seen by participants as reasons for anxiety and therefore predictors of violent events. They were also seen as mitigating circumstances for the agent’s behaviour. The actuarial assessment cues were, however, only mitigating factors within the causal judgment process when considered in combination with the personalisation of the violence and the agent’s reason for ED presentation. These three factors combined to inform the meaning the participants ascribed to the violent
event, the agent of violence and therefore their response to both. The meaning of violence for participants was, therefore, not limited to the definitions offered for the operationalised terms for violence.

The participants indicated their knowledge of a broad number of terms and behaviours associated with physical and non-physical violence, such as bullying, threatening behaviour, harassment and aggression. Their knowledge of the terms related to violence however did not limit the meaning(s) they ascribed to violent events or the agents of violence. These terms do not sufficiently describe how the participant nurses conceptualised violent events and the agents of violence, or how they formed their nursing responses. The participants combined theoretical knowledge with their experiential, nursing practice understandings and knowledge to inform their causal judgement. The outcome of the participants combining the operationalised definitions with their contextual, experiential knowledge facilitated a dynamic definition of violence; a flexible applied set of parameters and understandings about violence towards nurses in the ‘real world’ context of a rural and regional Australian ED. The constituents of their knowledge set are very broad and include: medical model knowledge; ethical and legal requirements; psychosocial, biological and physiological information; and professional nursing practice issues relevant to the assessed nursing practice needs of individuals. Categorising violent events and their agents in this way enabled the nurses to make justifiable clinical decisions and respond in a defendable manner. The approach used by these ED nurses therefore share features with the claims made by Murphy (2004, p. 498) that violence risk assessment and response is not about being 100% accurate, rather it is about making “defensible decisions”.

There is an intellectual, tacitly held principle that actively discourages nurses from ‘judging’ patients their family and friends. There is also, however, an increasing pressure on nurses to use multiple sources of knowledge, within the parameters of their appropriate governing bodies ethical and legal boundaries, to make informed judgments in their practice (International Council of Nurses, 2005b) (Australian Nursing & Midwifery Council, ; Coler, 2003; International Council of Nurses, 2005a). de Raeve (2002) takes this further and argues that the mandate to make significant judgements in nursing practice helps to distinguish nursing as a
profession rather than a trade. Judgement is specifically defined as “clinical opinion or determination related to the focus of nursing practice” (International Council of Nurses, 2005a, p. 29) and therefore the patient and nursing practice are organised by some identifiable rules (Coler, 2003). Part of the rules, implicitly inferred because of nursing’s adoption of humanistic intents (Dowling, 2005), is that judgements are devoid of negative biases based on stereotyping. This fits the definition, and nursing mandate, of being non-judgemental (Kelly, 2005). Though nurses in this study were very aware of this tacit mandate to practice in a ‘non-judgmental’ manner, they struggled to reconcile this intellectual construct with their ‘real world’ work environments. This struggle included the problem of being non-judgmental to people who were openly hostile and violent. The ascribed meanings of violence were practical and based on a systematic, causal judgment process that informed their defensible decisions, and their professional responses. As discussed, these nurses used their causal judgement to contextually understand the violent event, and the agent of violence.

A significant implication of the process participants used to ascribe meaning to violent events is that the participants did not see themselves as victims of violence, nor did they accept violence as part of the job. This differs markedly from the current research that frequently states that nurses interpret violence as ‘part of the job’ (C. Alexander et al., 2004; M. Alexander, 2001; Carter, 1999; Erickson & Williams-Evans, 2000; Jones & Lyneham, 2001; Love, Morrison, & Members of the AAN Expert Panel on Violence, 2003; Lyneham, 2000; McPhaul & Lipscomb, 2004; Roy, 1999/2000; Whittington, 2002; Whittington, Shuttleworth, & Hill, 1996). If the agent of violence was considered not responsible for the violent event as a function of high levels of mitigating circumstances, participants felt violence prevention was their responsibility, but they were not responsible for the violence. While these findings differ from the current literature that suggests nurses perceive violence as part of the job there are similarities with the concept of nurses ‘tolerance’ to violence as described by Whittington (2002).

Whittington (2002, p. 820) states that tolerance to violence subsumes the idea that nurses can understand reasons for patients aggression and because of this cognitively, affectively and behaviourally they “endorse positive evaluations of such aggression”.

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These ED nurses were enacting a positive evaluation of aggression within their attributed contextual meaning(s) of violence. For example, despite recommendations that physical or chemical restraint is used when patients with mental health issues are violent (S. Lee, 2005; Littrell & Littrell, 1998) unless circumstances necessitated this action, this was not considered by these ED nurses as part of their early management options. This also reflects that tolerance is embedded in their caring practice. This is consistent with the idea that aggression “is an occupational problem and not a clinical problem: Staff are assaulted because they are at work” (Martin & Daffern, 2006, p. 91). That is, the violent events occur due to external factors such as the patients presenting diagnosis or co-morbid conditions, the structure of the environment, the resources of the health service (see chapter two) and not as a function of the nurses’ clinical practice. This position resonates with the findings from the current study that revealed the nurses could differentiate between violent events that were personal and those that were enacted on them as representatives of the healthcare system.

The constructed meaning of workplace violence for the participant nurses involved a complex process that considered more than the act of violence itself. Understanding the nurses meaning(s) of violence and the three factors that combine and underpin these contextually constructed meaning(s) may also shed light on the reasons nurses under-report, not report or underestimate incidence of violence as has been reported by Crilly et al. (2004). Despite observational data from sixteen (16) violent events in this current study where the nurse was the recipient of violence, none of these incidents were formally reported. The literature identifies factors that inhibit nurses reporting violence include; the perceived intent of the violence: violence being seen by nurses as part of the job; nurses habituation to violence; fear that they will be blamed for the violence; the additional paperwork involved; inefficient or ineffective mechanisms for reporting; and a belief that reporting violence will not impact upon organisational responsibility and resources for violence prevention (Crilly et al., 2004; Forrester, 2002).

It is worth considering the link between the negative psychological sequelae of experiencing violent events in the workplace, as discussed, and the burden of reporting violence. While nurses are encouraged to report incidents of violence, seek
medical treatment and attend a de-briefing counselling session (Gilmore-Hall, 2001) it is understandable that nurses experiencing post-violence psychosocial and professional consequences may feel stigmatised and therefore less likely to report the violent event (Rippon, 2000). Further, nurses describe limited support and feedback from institutions following reporting violence (Lyneham, 1999; Paterson, Leadbetter, & Bowie, 1999; Rose, 1997) despite the evidence that maintains nurses need appropriate and sensitive formal support and counselling to lessen the impact of the event (Mayhew & Chappell, 2001b). O’Connell (2000, p. 607) reported “that 65% of nurses did not know what support mechanisms were available in the hospital”. Similarly, Badger and Mullen (2003) found that 66% of nurses in their study were unaware of the formal support available. Studies suggest that most of the support for nurses following a violent episode comes from their colleagues and family (Gerald. A. Farrell, 1999; O’Connell et al., 2000; Rose, 1997). This does indicate, however, that nurses acknowledge the need to engage in self care and the benefits of de-briefing following an adverse event, albeit informally (Levin et al., 1998; Trenoweth, 2003). It has been suggested that nurses are inhibited because of these factors and therefore do not bring the issues “out into the open” (Forrester, 2002, p. 391). This, however, was not supported by the findings of this study. The aforementioned reported inhibitors to nurses reporting violence were not the main reasons for these nurses not reporting violent events.

The participant nurses were very open about violence, and they did not express any fears that they were to blame for violence – unless as stated they thought they did something wrong. Findings of this current study suggest another factor that contributes to non-reporting. The nurses’ understandings(s) of the violence, combined with their judgments about the event and the agent of violence, meant the violence was not construed as a critical incident. Their attribution of meaning of the violent event and agent of violence was underpinned with caring and tolerance. The resultant outcomes of this process ensured that the patient received optimal, best nursing practice within professional ethico-legal boundaries and the nurses remained emotionally and physically intact. This contributes towards explaining why these nurses determined that the violent event was not considered a significant incident that they needed to report. The finding that these ED nurses did not report the violent events concurs with the literature that states violence is un-reported, under-reported
or underestimated (Crilly et al., 2004; Erickson & Williams-Evans, 2000; Fernandes et al., 1999; Ferns, Stacey, & Cork, 2006; D. Jackson, Clare, & Mannix, 2002; Keely, 2002; Levin et al., 1998; McMahon & Fisher, 2003; Ryan & Maguire, 2006; Schnieden & Marren-Bell, 1995; Winstanley & Whittington, 2004). New insights of a contextualised explanatory process for nurses’ decision not to report a violent event is provided by this research.

The findings from this study revealed an emergent definition of violence that differs from the accepted discourses about violence. The ED nurses in this study conceptualised violence according to the personalisation of the violence, mitigating factors and reason for ED presentation. These findings show that while the nurses were well informed about the standard social and theoretical definitions of violence, and the language used to denote the varying forms of violence, the meaning they ascribed to violence was contextually bound and informed by many sources of nursing knowledge. This finding challenges the fit of the accepted constructs of violence for the nurses in the rural and regional ED.

**Collegial Awareness: Forming trusting relationships to help manage violence**

There is an absence of work on ED nurse-nurse relationships, and the significance of these relationships to violence assessment, prevention and the personal sequelae of violence. Nurses negotiate complex relationships in their workplace that require ‘intimacy’, involvement and engagement (Dowling, 2005; Luker et al., 2000; Taylor, 2001; Williams, 2001) and this includes relationships with patients their family and friends, team members and each other. Positive relationships can be defined by their mutual responsiveness and develop because of a sense of trust, respect and mutuality (Hagerty & Patusky, 2003; Peter & Morgan, 2001; Tarlier, 2004; Williams, 2001). Nurse-nurse interpersonal relationships are dynamic and are largely dependent upon the skills of the individual nurses, the socially constructed identities of those engaged in the interaction (Dowling, 2005; Kelly, 2005; Tarlier, 2004) and the context within which the nurse-nurse relationship occurs (Hutchinson, Vickers, Jackson, & Wilkes, 2006). This is most evident when reviewing the existing literature on the less positive aspects of nurse-nurse relationships that include bullying and horizontal
violence (Gerald A. Farrell, Bobrowski, & Bobrowski, 2006; D. Jackson et al., 2002; Taylor, 2001).

This study did not explicitly look for nurse-nurse relationships however at a time of crisis for nurses in ED settings, due to increased acuity, overcrowding and economic rationalism (Boykin et al., 2004; Dougherty, 2005; Emergency Nurses Association, 2003; Keough, Schlomer, & Bollenberg, 2003; Robinson et al., 2004) these ED nurses were collaborative, shared their knowledge and experience and demonstrated their ability to have responsive positive nurse-nurse relationships. This was manifest in their behaviours and communications with each other, their protectiveness, watchfulness, cooperation, mutual acceptance and ability to give and receive assistance, education, knowledge and support. Some of the constituent behaviours, therefore, of positive nurse-nurse relationships have been revealed by this study. This finding, and the consequent positive effects on violence prevention, aversion, management and personal sequelae, appreciably contributes to the nursing literature.

The participants’ nurse role expectations, during violent or potentially violent events, remained flexible and included sharing knowledge and protecting each other. The participant’s capacity to be flexible in their nursing roles during violent or potentially violent events also has similarities with the work on belonging (Hagerty, Williams, Coyne, & Early, 1996). This work emphasises the positive impact on psychological and social functioning associated with interpersonal interactions and human relatedness. Human relatedness associated with belonging includes the human experience of feeling like an integral part of a system or network (Choenarom, Williams, & Hagerty, 2005; Hagerty et al., 1996). It enables people to have meaningful, valued involvement and to have an expectation that they will have positive relationships with others. The characteristics of belongingness have similarities with the subthemes and components of collegial awareness in these ED nurse-nurse relationships. These nurses respected and trusted each other and actively supported each other when there was an actual or potentially violent event. They were confident in their sense of shared support and therefore able to give and receive knowledge, education, assistance and respect. Their sense of human relatedness was purposefully applied when there were violent events or the potential for violence. Their positive nurse-nurse relationships, therefore, also included the characteristics
of belonging. This aligns with the findings of collegial awareness, which in turns provides new insights into the constituent behaviours and attitudes that help nurses assess, prevent and manage violent events in their workplace.

Clear communications, roles and boundaries, respect, leadership or management, shared goals and understandings about the normative codes of conduct combined with team members personal integrity, cover some of the attributes of teamwork (Cronin & Cronin, 2006; Kelly, 2005; Laing, 2003; Martin & Daffern, 2006). Defined roles, clear communication and a shared sense of purpose or goals are the essential ingredients for successful multi-disciplinary ED teams (Kelly, 2005; McCallin, 2001). These ED nurses demonstrated behaviours and attributes that align with the literature on teamwork. The term ‘teamwork’ is different to the term ‘team’, as teamwork embraces the cooperative, effective performance of the group and their capacity to achieve their mutually understood goals (McCallin, 2001). The participants’ collegial awareness and the strategies they used to show support to each other included the teamwork essentials of cooperation, good communication skills, sharing of information, understanding and empathy for each others roles and their own roles. Within this milieu, the participant nurses nurtured each other and promoted professional and personal growth. Part of their approach to this aspect of their collegial awareness was; their expressed need to be, and present as a united team; their respect for each other; and their ability to manifest their shared goal(s) by allowing individuals to have the roles of teacher and learner. The shared goal of collegial awareness, in addition of course to the provision of competent, high quality nursing practice, was the management, prevention and aversion of violence. This dovetails with the shared commitment these nurses had for the safety of all people within the ED (McCallin, 2001).

Education and training is frequently recommended as an organisational strategy for violence prevention and improved staff safety (Keely, 2002; Martin & Daffern, 2006; Nachreiner et al., 2005). Education and training help nurses to feel better, boosts confidence and improves perceptions of safety in the workplace, but there is no evidence that supports a claim that it changes the frequency of incidents, or that it protects staff (Badger & Mullan, 2003; Deans, 2004; Martin & Daffern, 2006). Indeed, Gates, Fitzwater and Succop (2005) found no statistically significant long
term difference in the number of assaults on nurse assistants in Nursing Homes following education and training. While emphasis has been placed on discovering the effects of formal education and training programs on incidents, prevalence of violence, there has been no work on the efficacy of informal nurse to nurse teaching and modelling of preventative strategies. In this current study, what the participant ED nurses were doing was informally providing support and education to each other to help protect staff and people presenting to the ED from violence in their ED. Through the development and maintenance of collegial awareness, which included positive nurse-nurse relationships built upon teamwork and a sense of belonging, these nurses engaged in effective mutual informal education on skills based violence assessment, prevention and response. While the efficacy of formal education and training on violence assessment, prevention and management has conflicting evidence, this finding supports the call to encourage and resource informal mechanisms such as time and opportunities for clinical nursing staff to debrief together in their preferred locations and an increased focus on development of positive nurse-nurse relationships, teamwork and fostering nurses’ collegiality.

**Fostering resilience: Resisting negative sequelae of violence**

Much of the work on the psycho-social and physical consequences of violence on the nurse has focused on the negative effects of violence in the workplace. The physical, physiological and psychological effects of violence on the individual nurse, as well as the fiscal and human resource implications for health service organisations, has been comprehensively discussed in the literature (Ai & Park, 2005; Carter, 1999; Gilmore-Hall, 2001; Holmes, 2006; D. Jackson et al., 2002; Paterson et al., 1999; Rowe & Sherlock, 2005). The three most frequently reported, but non-quantified, non-somatic effects on nurses are “anger, anxiety (fear), and guilt (self-blame, shame)” (Needham et al., 2005, p. 288) and this is supported by Lanza et al. (2006). Again, these authors conceded that they only reviewed papers that looked at the negative sequelae of violence.

Violent events can trigger other negative feelings for the nurse such as a loss of confidence, loss of self esteem, resentment, embarrassment (O’Connell et al., 2000), disbelief, guilt (M. Alexander, 2001), self blame, feelings of powerlessness, and an increase in work related errors (Carlsson, Dahlberg, Lützen, & Nyström, 2004; Uzun,
Some nurses reported changes to relationships with work colleagues, fear of returning to work (O’Connell et al., 2000; Queensland Health, 2002) and the need to “hide their identity from patients” (Fernandes et al., 1999, p. 1247). Resolution of these negative feelings can take between six weeks to twelve months (Paterson et al., 1999) during which time the nurses’ capacity to fulfill their nursing practice demands may be altered, and their capacity to empathise diminished (Gillespie & Melby, 2003). Paterson et al. (1999) add that the negative psychological, cognitive, emotional, behavioural and spiritual impact on the victim of violence can be mediated by influences such as “the nature of the event; their previous experiences, beliefs, attitudes and expectations and training, preparation and information” (Paterson et al., 1999, p. 480). Similarly, Early and Williams (2002) suggest that ED nurses function quite well following episodes of violence as a result of their habituation to violence in their domestic and working lives. Whilst Early and Williams (2002, p. 203) wonder if “the impact of violence is not as great a previously supposed”, they also acknowledge that a proportion of nurses following a violent event will be seriously affected for decades and this may manifest in other areas of their lives (Early et al., 2002; Paterson et al., 1999). Again, it is important to acknowledge that many of these findings are based on studies that used retrospective questionnaires. Using this literature as a starting point, the differences found between the literature and the findings of this current study will be explored.

The nurses in this study did not disclose feeling vulnerable, fearful or anxious when looking after patients who were violent or had the potential to be violent. The participant nurses did not report any of the documented negative effects of violence. Rather, they were intent on ensuring that their support for each other, and collegial awareness, enhanced and sustained their sense of hardiness and resilience, and this finding adds to the nursing literature. Hardiness and resilience are two concepts from the positive psychology movement (Ai & Park, 2005). The movement offers a strengths approach to understanding how the participant nurses protected themselves and each other from the negative consequences of violent events. Perceiving resilience from a strengths approach has been recently discussed in the nursing literature by Darbyshire and Jackson (2004/5). Importantly, the strengths perspective can provide a framework within which the findings of this study, specifically the consequences of workplace violence towards these nurses, can be understood.
Resilience indicates a personal strength and an ability to cope in adversity. It is a complex quality of character and refers to the capacity to constructively process information, both cognitively and affectively, in order to adaptively respond to negative events (Agaibi & Wilson, 2005; Bowden, Morasca, & Meischke, 2003; Edward, 2005a; Leipert & Reutter, 2005) and therefore incorporates competence and coping (Greene, Galambos, & Lee, 2003). Having resilience allows an entity to “restore its original structural form, despite being temporarily altered by external forces” (Agaibi & Wilson, 2005, p. 196). This definition can be applied to stressful circumstances and denotes the individual’s capacity to maintain physical and mental health during adverse events. Resilience includes personality traits such as self esteem, self efficacy, extraversion, hardiness and internal locus of control allowing the individual to remain flexible and assertive while maintaining a high degree of affective control (Agaibi & Wilson, 2005; Leipert & Reutter, 2005; Yi, Smith, & Vitaliano, 2005).

Hardiness can be considered a feature of resilience. Hardiness, in this use, refers to a personality characteristic (Heckman & Clay, 2005; Kobasa, Maddi, & Courington, 1981). Like the concept of resilience, hardiness is usually associated with stressors and health status but often refers to mental health. Hardiness as a personality trait includes an individuals cognitive, emotional and behavioural characteristics that foster health, enrich life and improve self confidence (Heckman & Clay, 2005; Leipert & Reutter, 2005). Kobasa (1981) defines hardiness as having three interlocking components - control, commitment and challenge (Maddi, 2002). Control reflects the individual’s perceived capacity to influence events. Commitment refers to motivation and active engagement with the event and challenge reflects the individuals ability to adapt positively and effectively change (Heckman & Clay, 2005; Kobasa et al., 1981). Heckman and Clay (2005) further assert that hardy individuals can see stressful events as opportunities that they can actively engage with, and subsequently influence through problem solving.

Both of these concepts, resilience and hardiness, have their critics. The literature on resilience frequently explores the effects of trauma, such as sexual abuse, on people’s self reported resilience. Resilience is usually operationalised as having
variables and causal or co relational relationships with trauma and negative emotional and physical consequences are usually sought (Agaibi & Wilson, 2005; Bowden et al., 2003; Yi et al., 2005). Frequently the relationship explored when resilience is operationalised in this way is “high life stress and low illness” (Yi et al., 2005, p. 258). Further, both concepts are recognised as problematic because they lack construct validity and replication across types of stressors (Heckman & Clay, 2005; Maddi, 2002). Nevertheless they are constructive concepts to use to speculate why there was an absence of evidence of negative sequelae of violence for these ED nurses.

The resilience of these nurses was underpinned with hardiness, problem-focused and meaning focused coping when the violence was not personalised. They also engaged in an active process of developing resilience and hardiness as individuals and as a team, and this is congruent with the literature. Through their ability to convey caring and their collegial awareness in violent and potentially violent situations, these nurses were reflecting on their practice and actively enhancing their communication, assertion, coping and learning skills while being aware of their affective responses to patients their family and friends. Akin to the properties in the hardiness model, the participant nurses remained committed to their interaction with the agent of violence, despite the difficult behaviours. These ED nurses actively, purposefully and tolerantly assessed patients and their accompanying family and friends for their risk of violence. Then, as early as the initial assessment period, they began to control their environment, their own interpersonal interactions and their physical space and they maintained this control during the violent event. They also remained in control of the event and the agent of violence using the component skills of conveying caring, and actively supported each other and their colleagues.

The ability to reappraise self and the situation is a mechanism that improves stress tolerance and therefore fosters resilience (Ai & Park, 2005; Edward, 2005b; E. L. Worthington & Scherer, 2004; Yi et al., 2005). These nurses engaged in this positive reframing of both self and others when they reflected on their practice and attributed meaning(s) to violent events and the agents of violence. Collegial awareness and informal validation and debriefing of, and for, each other shows how the participant nurses nurtured each other in a context of high social support. Use of peer support
following a violent event has been reported to assist in reducing the frequency of violence in mental health facilities (Meehan et al., 2006). Only one published commentary could be found that suggested ‘tea-room’ chat was ineffective as a means of responding to critical incidents (Laws & Hawkins, 1995), however this was not supported by other published research findings. More frequently research suggests that nurses take advantage of organisational resources such as chaplaincy, stress management classes and formal debriefing sessions (Catlette, 2005). Studies that introduced formal debriefing sessions in ED’s highlighted the practical challenges associated with getting shift working nurses together for such events and reported little success (Morrissey, 2005). This current study revealed that formal mechanisms were not the preferred support mechanisms for these nurses. Extension and support of the existing, utilised and successful informal strategies were deemed more appropriate.

A study of mental health nurses practicing in an developmental disability setting where they endured extreme humiliations, physical, sexual and non-physical violence, reported that the nurses found it difficult to separate their private life from their work life and they responded to these feelings by “erecting a barrier between themselves and the patients” (Hellzen, Asplund, Sandman, & Norberg, 2004, p. 5). When the violence they experienced from the patients in the group home where they worked inhibited their capacity to fulfil their nursing care they were left feeling stressed and with a “bad conscience” (Hellzen et al., 2004, p. 7). Their feelings of being alone exacerbated the difficulties of nursing the violent patient and the emotional sequelae of these events. These nurses also reported feelings of being tormented, helplessness, being disrupted and reported that their experiences questioned their moral boundaries as many were challenged not to retaliate (Hellzen et al., 2004). The nurses realised they needed help and support from their organisation but also stipulated that this would need to be provided by persons who had personal experience of their situation.

The nurses in this current study also held the view that any organisational support is best from a nurse who had recent personal experiences similar to their own. Unlike the nurses described in Hellzen’s (2004) study, the findings from these ED nurses showed they were able to differentiate between violence that directed at their
personhood versus violence directed at them as representatives of the healthcare system. This enabled them to engage their interpersonal and intra personal workplace resources that supported their hardiness and resilience at work. The current findings add to the literature as they demonstrate that when violence was directed towards the participant nurses as representatives of the system, their use of the abovementioned process meant they did not feel personally distressed, were able to remain intact, and not take the effects of violence into their personal lives. The participant nurses also demonstrated tolerance towards the agents of violence in their workplace.

Whittington’s (2002) study of mental health nurses found that there was no difference in tolerance to violence between nurses who had been assaulted and those who had not. He further found that nurses who reported higher levels of tolerance also “reported less emotional exhaustion, depersonalization and a stronger sense of personal accomplishment at work” (Whittington, 2002, p. 824). The limitations of this work included a small sample size of self selected respondents. Nevertheless, these findings resonate with those of the current study. The participant ED nurse’s high level of interpersonal skills and tolerance, combined with the meanings they attribute to the agent(s) of violence and therefore the violent act, contributed to their resilience. Further this may explain the dearth of evidence that suggests these ED nurses experienced short or long term emotional negative sequelae.

One of the most obvious differences between the literature on the sequelae of violence and findings of the current study and findings was the high social support. High social support, such as ‘tea room chats’, is positively associated with resilience and belonging (Choenarom et al., 2005; Yi et al., 2005). The participants developed their own, context specific problem and meaning focused strategies to respond to violence and the sequelae of violence for them. They nurtured a shared unit ‘culture’ that supported the growth, development and maintenance of resilience to violence from patients their family and friends and this also supported their tolerance to the agents of violence. No work has been reported that explored ED nurses resilience following violent events in their workplace or the precursor environmental and psychosocial factors that need to be contextually available to support resilience and hardiness. The current work did not find that relationships with work colleagues suffered as a function of violence or the sequelae of violence. Rather, nurse-nurse
relationships enabled the participants to develop situation and contextually appropriate nurse-patient relationships, fostered resilience and nurtured hardiness, despite their experiences of violence.

**Summary**

This chapter discussed the study findings in relation to the contemporary literature on violence towards nurses. Many of the strategies used by the participant nurses in the rural and regional Australian ED share similarities with existing work on nursing violence prevention, assessment, and sequelae for the nurse. These ED nurses, however, applied many of the strategies in a context and specialty specific manner. The discussion has illuminated a real world description of the attributes and behaviours these ED nurses used to convey caring, demonstrating adaptive caring in the ED. The components and cues of the STAMP nursing violence assessment framework have also been shown to concur with the extant literature but extends understandings because of its application to the ED context. These ED nurses contextualised the meaning(s) of the violence, and therefore the agent of violence, using an identifiable causal judgement process. It has been shown that their violence prevention and assessment strategies, in combination with their collegial awareness, supported their hardiness and resilience to the negative consequences of violence. This adds new insights into the nursing literature on violence towards nursing in the ED.
Chapter Eight - Conclusion

Introduction
This chapter will discuss the strengths and weakness of the current study and the consequence of these issues on the research findings. Recommendations from the study are presented, and include recommendations for nursing education, practice and further research.

One of the recognised problems undertaking research into this topic area is the previously discussed lack of standard terminology and definitions for violence (see chapter two). This study adopted the position that all forms of violence are unacceptable; therefore violence for the purposes of this study included all forms of physical and non-physical violence. This enabled a robust and complete emergent ‘case of’ to be discovered via the research process whilst simultaneously supporting an empirically constructed ‘case of’ to inform and complement a complete understanding of the phenomena of interest.

As discussed in chapters two and seven, discourse limits what can be said and done, but these ED nurses did not limit their discourse about violent events and violence directed towards them to the bounds of existing scholarly and institutional language and concepts. Rather, the discourse(s) participants used to create meaning about violent events, and the personal consequences, were contextually developed. The participant ED nurses did not consider themselves to be victims, nor did they construct the agent of violence as perpetrators. Through an identifiable process of causal and clinical judgement, these nurses attribute meaning(s) to the violent event and agent of violence. The meaning(s) they ascribed assisted them to maintain their resilience towards violent events and contributed to their defensible decisions, behaviours and actions when there was potential or actual violence. Their clinical judgements were further informed by theories about the aetiology of violent behaviour and their nursing knowledge(s), but the participant nurses used these ideas selectively and according to their professional contextual morays, boundaries and philosophies. Attribution of meaning(s) of the agent of violence and the violent event
meant that within this discourse the agent of violence may have been immune from retribution, but this did not infer that the participant ED nurses were responsible for the violence, and it was not considered ‘part of the job’. This practice based finding, a contextual construction of the meaning(s) ascribed to violence towards regional and rural ED nurses is a new contribution to nursing knowledge.

**Study strengths and limitations of the study**

The design of this mixed method instrumental case study has many features that are new and innovative. This study has used the framework of case study as the underpinning design, and shown that case study as a research framework can concurrently use methods from the qualitative and quantitative paradigms to explore a research question. The current study applied a mixed method instrumental case study design pragmatically to a practical and challenging nursing practice issue, and demonstrated that case study design can be a bridge across the research paradigms. This was enacted using a three phase research strategy. The outcomes from phase one of the study focused the research question and developed the unstructured observational tool. The observation tool captured the phenomena of violence towards nurses as an empirical unit. The methods of unstructured participant observation, semi-structured and unstructured interviews, researcher journaling and document review inductively revealed the phenomena of interest as a theoretical construct. Both qualitative and quantitative knowledge were concurrently and equally valued and theoretical abstractions were connected to nursing practice. The connection of theoretical abstraction to practice is a recognised strength of case study research. The deliberate concurrent search to understand phenomena of interest as both a theoretical construct and empirical unit has not been reported in the literature. This study constructed a mixed method instrumental case study in this manner and this advances the knowledge and potential application of case study as a research design.

There are other strengths of this instrumental case study, and therefore the findings. First, the instrumental case study and findings are contextual and directly reflect rural and regional ED routine nursing practice. Second, the findings are derived from mixed method data generation strategies including participant observation. Third, the complex nature of the ‘case of’ has been recognised, acknowledged and revealed.
The findings add to the literature about violence towards ED nurses because of the depth and complexity of the subsequent understandings uncovered by the findings. For example, the study contextualises the cues and components summarised by the STAMP acronym to the ED setting, and reveal the ED nursing practices that enable conveying caring. Further, these findings are derived from the ED nurses’ routine practice. The findings have shown that as a function of exposure and experience, ED nurses actively adapt and re-conceptualise theory and skills related to violence assessment and prevention, to render them meaningful to their nursing specialty and context. These ED nurses contextually constructed their nursing practice to manage, avert and respond to violent events in a way that preserved both themselves and the agent of violence.

The mixed method instrumental case study design robustly answered the research question and aims and revealed more about the phenomena of interest than could be discovered using a single method. The complexity of the problem of violence towards nurses was acknowledged by defining it through its contextual manifestations and generating data from direct participant observation. This differs from the previous research into violence towards nurses have predominantly used quantitative retrospective questionnaires. The acknowledged problem of nurses’ recall, common to retrospective questionnaires, was overcome as violent events and nurses meaning(s) of violence was directly observed and discovered using multiple methods. The research design enabled the nurse researcher to compare what the participants said they did, with their observed behaviours and practices, and this is a well recognised strength of field work. The selected mixed methods further enhance the transferability of these findings.

As discussed in chapter three, the typicality of the ‘case of’; the rural and regional ED nurse participants; the rural and regional ED; and the violent events observed, increases the transferability of the findings to similar rural and regional ED nurses practice. The transferability of these findings is enhanced by the processes of rigour applied in the study (see chapter four). Whilst the research framework and chosen
methods clearly added strength to the findings, there are also limitations to the
design and therefore findings.

Akin to other studies that use non-probability convenience sampling, one limitation
was that only violent events involving the self selected consented participant ED
nurses were included in the data. It was not possible to generate data from participant
observation and structured observation 24 hours a day and 7 days a week therefore
only violent events that occurred when the nurse researcher was in the field
generated data. These constraints are common to fieldwork methods. Another
potential limit was the unknown impact of the researcher in the field. The presence
of the nurse researcher may have altered or increased the participant nurses
sensitivity and awareness about violence directed towards them by patients their
family and friends.

Finally, there is an obvious contradiction concerning the contextualised ‘case of’ as
revealed by the participant rural and regional ED nurses and the issue of
transferability. The emergent ‘case of’ was defined by the practice and discourse
used by the participant ED nurses, and it could be argued that this limits the
transferability of the findings. Whilst this issue is an acknowledged limitation, there
is nevertheless sufficient evidence that supports the transferability of the findings to
similar rural and regional ED contexts, including the aforementioned issues of
typicality, the chosen data generation methods and the applied processes for rigour.

Recommendations

The findings from this study, as discussed in chapter seven, differ in many ways to
the current conceptualisations of violence toward ED nurses, particularly the
consequences of workplace violence for nurses. There are potential areas where
recommendations derived from this study could enhance and improve nursing
education, practice and research. These recommendations will now be presented.

Recommendations for Nursing Education

Education about the efficacy of using highly developed communication skills and
capacity of nurses to convey caring as a way of assessing for and averting violent
events needs to be reinforced in nursing curricula. The findings of this study support increasing nursing education about the need for nurses to be alert, recognise, assess and respond to violence and potential violence.

Nurses need to be informed about the components of the STAMP nursing violence assessment tool to enhance their ability to be alert to the subtle behaviour cues of violence and the potential for violence.

Implications for Nursing Practice

It is recommended that organisations understand and provide support for the successful localised strategies used by their nurses to prevent, avert and manage violence and the sequelae of violence. Following identification of these localised strategies, facility resources need to be made available to improve and enhance the successful aspects of these approaches. For example, time for nurses to informally debrief violent events.

This study has shown that ED nurses attribute meaning(s) to violent events and the agents of violence and strongly implies that there is a link between their attribution of meaning(s) and incidence of reporting. It is recommended that organisations acknowledge and understand the constructs and meaning(s) of violence used by nurses in their facilities and use this to inform organisational reporting policies. This would involve both further research and changing some aspects of the existing reporting structured to remove attributions of guilt, blame or retribution. ED nurses could record and report violence in the same manner that they report other aspects of their everyday nursing practice.

It is recommended that there is an increase in education and resources that skill ED nurses to avert and deescalate violence rather than continuing to prioritise reactive management and response strategies. This includes enhancing and encouraging ED nurses to use the skills of conveying caring and their specialty specific environmental assets.
The findings from this study recommend increased education for the general public about hospital and emergency department process, especially the triage system. Information could be available in the waiting area via television. De-identified statistics about the ED such as; the current status of the department; number of beds available in the unit and the facility; number of people waiting; triage category of people waiting; and number of ambulances arriving could be provided and updated in the waiting area. This strategy, of course, targets people who are cognitively alert.

Implications for Nursing Research

Violence continues to challenge nurses and other sectors of the health care setting. It is recommended that prior to implementing the traditional strategies to respond to violence that further research is undertaken. Research that repeats this work in contexts other than rural and regional Australian EDs is needed to shed further light on the significance and applicability of these findings.

Findings suggest a need for further research into ‘real world’ adaptation of highly developed communication skills as a way of conveying caring and averting violence in other ED settings, and other nursing specialties. The effectiveness of conveying caring when used in a violent or potentially violent nurse-patient interaction in an ED has not yet been fully examined.

Research is needed that further explores the generalisability of the revealed meaning(s) of violence towards nurses in the specialty of ED. It is recommended that a similar study is undertaken in other nursing specialties to uncover the similarities or differences of the nurses’ ascribed meaning(s) of the agents of violence and violent events.

Further research is recommended to discover the causal or correlation relationships between nurses’ ascribed meaning(s) of violence and the challenges of nurses under-reporting or not reporting violent events.

It is recommended that further work is conducted on the STAMP nursing violence assessment framework to establish its validity and reliability as an assessment
instrument. Following this, research can be undertaken to investigate its usefulness, and generalisability as a violence assessment tool in other ED settings. In particular, further research examining the construct and content validity and reliability of the STAMP framework is needed. Further research could also entail exploring the application of the STAMP nursing violence assessment tool in nursing specialties other than the ED.

The study reveals that there is a lack of work that has explored positive nurse-nurse relationships and collegial awareness in rural and regional ED contexts. Research needs to be undertaken on the significance of positive nurse-nurse relationships and collegial awareness on violence assessment and prevention and the personal sequelae of violence.

The findings show that no work has been reported that has explored ED nurses fostering resilience following violent events in their workplace or the precursor environmental, educational and psychosocial factors that need to be contextually available to support nurses’ resilience and hardiness. Further research into mechanisms that can assist ED nurses to cultivate supportive environments and foster resilience to the consequences of violence in the workplace is needed.

Summary
The findings from this concurrent mixed methods instrumental case study extend current knowledge about the phenomena of violence towards rural and regional ED nurses when the agent of violence is the patient, their family and friends. The deliberate use of the mixed method instrumental case study as a flexible research framework enabled the research to connect the abstraction of the ‘case of’ to rural and regional ED nursing practice, shedding light on subtle aspects of the phenomena of violence towards ED nurses. The mixed methods research framework and the construction of the ‘case of’ as both an empirical unit and theoretical construct substantiated the research findings and enabled a complete picture of the practice based phenomena of interest. This contributed to understanding the complex nature of violence towards regional and rural ED nurses as it was observed. The emergent ideas from phase one findings were used to develop the structured observation tool and focused the original broad research question. The study focused on the issues of
the ED nurses’ assessment and prevention strategies and the initial sequelae for the ED nurses to violence in the ED setting. The developed tool confirmed the typicality of the observed violent events, and ensured that the same set of data was collected for each observed violent event. Phase two used the developed structured observation tool and contributed to the finding that the phenomena of interest could be constructed as both a theoretical construct and empirical unit within the same research study. Phase three entailed concurrent analysis of data, and revealed that the quantitative and qualitative findings were mutually supportive. This combination of types of knowledge is congruent with the pragmatic paradigm that informs the current study.

The findings revealed that the violence prevention strategies used by Australian rural and regional ED nurses integrated conveying caring and being alert, which encompassed the ability to recognise, assess for, and respond to, violence when the agent of violence was a patient, their family or friend. The study further found that the participant nurses had a positive sense of collegial awareness that enabled them to develop skills to manage or avert violence and this contributed to their resilience and hardiness. The participant nurses’ initial responses to violence evidenced their resilience and hardiness to the affects of workplace violence. The insights gained, from the real practice world of ED nursing, will enable the development of local, specific solutions to violence towards ED nurses.
References


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Appendix A

Single Concurrent Mixed Methods Instrumental Case Study Design

Phase ONE

- Procedures: Unstructured participant observation, Unstructured open ended interview, Researcher Journal
- Qualitative Data Generation
- Qualitative Data Analysis

Phase TWO

- Procedures: Concurrent Thematic analysis of Text
- Product & Results: Structured Observation Tool & Semi Structured Interview Questions

Phase THREE

- Procedures: Concurrent Thematic analysis of Text
- INSTRUMENTAL CASE
- Qualitative Data Generation
- Quantitative Data Generation
- Qualitative Data Analysis
- Quantitative Data Analysis
- Document Review
- Unstructured participant observation, Semi structured open ended interview, Unstructured open ended interview, Field notes, Interview transcripts, Structured Observation Tool

Products
- Codes, Themes, Descriptive Statistics

Results
- ‘Case of’ violence towards rural and regional ED nurses

Empirical ‘case of’

Theoretical ‘case of’

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Appendix B -

Publications and Professional Seminars to date

Journal Articles


Conference Papers
2005 Advances in Qualitative Methods, International Conference Edmonton Canada
2006 Applying the instrumental case study design Advances in Qualitative Methods, International Conference Brisbane Australia
### Appendix C – Structured Observation Tool

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<tr>
<th>Observation Number</th>
<th>12. Why did the incident end</th>
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<tbody>
<tr>
<td>Date &amp; Day</td>
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<tr>
<td>Participant</td>
<td>Agent Left</td>
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<tr>
<td>EVENT</td>
<td>Intervention Nurse</td>
</tr>
<tr>
<td>Total Time of Incident</td>
<td>Intervention Dr</td>
</tr>
<tr>
<td>1. start</td>
<td>Intervention Family</td>
</tr>
<tr>
<td>2. finish</td>
<td>Intervention Friend</td>
</tr>
<tr>
<td>3. Est. total time</td>
<td>Security</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>4. Triage Category</td>
<td>AGENT</td>
</tr>
<tr>
<td>5. Type of Presentation</td>
<td>13. Agent of Violence</td>
</tr>
<tr>
<td></td>
<td>1. Expected</td>
</tr>
<tr>
<td></td>
<td>2. Unexpected</td>
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<tr>
<td></td>
<td>Via ambulance</td>
</tr>
<tr>
<td></td>
<td>Walked in</td>
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<tr>
<td></td>
<td>Referred</td>
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<tr>
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<td>Helicopter</td>
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<td></td>
<td>Other</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Location</td>
<td>14. Gender</td>
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<tr>
<td></td>
<td>Triage</td>
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<tr>
<td></td>
<td>Waiting area</td>
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<tr>
<td></td>
<td>Resus</td>
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<tr>
<td></td>
<td>Cardiac Beds</td>
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<tr>
<td></td>
<td>Acute 1</td>
</tr>
<tr>
<td></td>
<td>Paeds Rooms</td>
</tr>
<tr>
<td></td>
<td>Acute 2</td>
</tr>
<tr>
<td></td>
<td>Fast track</td>
</tr>
<tr>
<td></td>
<td>Isolation Rm</td>
</tr>
<tr>
<td></td>
<td>Gynae Rm</td>
</tr>
<tr>
<td></td>
<td>Room 1 eye</td>
</tr>
<tr>
<td></td>
<td>Room 2 ENT</td>
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<tr>
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<td>Safe Room</td>
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<td></td>
<td>Other</td>
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<td>7. Violence Category</td>
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<td>Non-Physical Violence</td>
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<tr>
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<td>Slap</td>
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<tr>
<td></td>
<td>Pinch</td>
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<td></td>
<td>Spit</td>
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<tr>
<td></td>
<td>Other</td>
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<tr>
<td></td>
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<td>9. Use of weapon</td>
<td>18. If yes to above, is it the reason for this attendance</td>
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<tr>
<td></td>
<td>Y</td>
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<td></td>
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<td>10. Weapon</td>
<td>19. Any Relevant Agent History</td>
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<td>(field note)</td>
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<td>21. Emotional response</td>
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<td>22. Physical response</td>
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<td>24. Gender</td>
<td>26. Nurses’ Assessment cues for risk of violence</td>
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<td></td>
<td>F</td>
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<tr>
<td></td>
<td>M</td>
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<tr>
<td>27. Other Assessment Cues</td>
<td>28. Time Arrived in ED</td>
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<td></td>
<td>(ie body language whilst waiting, number of approaches to staff, pacing, agitation etc) (field note)</td>
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<td>CONTEXT</td>
<td>29. Time of Triage</td>
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<td>Details of ‘Waiting time’ of agent</td>
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<td>31. Time seen by Staff</td>
<td>30. Time first moved into ED</td>
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<td>31. Time seen by Staff</td>
<td>30. Time first moved into ED area</td>
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<td>Open ended observational data</td>
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Appendix D -

Summary of Observed Violent Events

Event One
Donna triaged a 25 year old woman who was verbally aggressive, uncooperative, annoyed and anxious. She kept repeating questions. The young woman gave Donna no eye contact, but was giving eye contact to her male companion.

Event Two
At the beginning of the afternoon shift, Marilyn was introducing herself to the patients. She went into the paediatric room. The parents of the child, a female and male aged 29 and 32 years old respectively, were instantly and simultaneously verbally aggressive and swearing at Marilyn because they had been waiting for a doctor for more than five hours.

Event Three
A 46 year old intoxicated male patient, during the process of his triage, began swearing loudly at the triage nurse.

Event Four
A 54 year old intoxicated male, admitted as an involuntary patient, was telling Miranda he wanted to leave. He had a history of mental illness. The patient was verbally aggressive, abusive and used swear words. Because he was an involuntary mental health patient, two hospital security officers were present.

Event Five
An agitated 43 year old male patient was being treated following injuries he sustained in a motor vehicle accident. He was agitated, terse and raised his voice because he wanted to leave the ED to catch his booked domestic flight.
**Event Six**

A 39 year old woman with chest pain and a history of mental health illness, was in a bed in the Cardiac area. The female patient was verbally aggressive, sarcastic, had a raised voice, a demeaning tone and insulted Kel when she spoke to her.

**Event Seven**

A man and a woman stormed to the triage window and grabbed up the patients telephone. Their manner, body language and facial expressions looked angry. Donna picked up the triage nurses telephone. The male patient was verbally aggressive and yelling at Donna. They were seeking their opiate substitute because they missed their morning doses at the methadone clinic. They further indicated they had community mental health and community drug and alcohol support networks. Neither person was triaged.

**Event Eight (a) and (b)**

A 34 year old woman who presented with chest pain was angry because, following medical review, she was being discharged. The woman had a history of mental illness and wanted to be admitted to the mental health unit. She was verbally abusive and aggressive towards both Dianne and Helen.

**Event Nine**

A 44 year old female patient, in handcuffs, was being escorted by police from the triage area to the isolation room. The woman had inflicted self-harm whilst in police custody. The triage nurse was trying to get some information from the woman and the woman was rude, loudly swearing and verbally hostile.

**Event Ten**

A 79 year old confused and disorientated elderly male patient with a dementia was physically resisting treatment by the nurse and accompanying doctor. The male patient was squeezing, pinching and grabbing Marge’s hand.
**Event Eleven**

An aggressive, confused, intoxicated 39 year old male patient with a head injury was yelling and swearing at Muriel. The patient had a history of violence in ED and was escorted by police officers because he had been violent towards the ambulance officers in transit. The ED team was notified of the patient, and his en-route behaviour, prior to his arrival therefore, there were two hospital security officers present during the entire event.

**Event Twelve**

An aggressive, confused, intoxicated 22 year old male patient with a head injury was brought in via ambulance. The patient refused to move from the gurney to the bed, and eventually got off the gurney and indicated he was leaving. The patient did not respond to any non-invasive de-escalation or intervention strategies and was verbally swearing, abusive and resisting treatment. Two hospital security officers arrived shortly after the patient was wheeled into the resuscitation area and eventually they physically held the patient while he was sedated with midazolam intravenously. The patient had a history of violence in ED and was wanted by police. Upon recovery from the midazolam, the patient was a very pleasant, co-operative man.

**Event Thirteen**

Two hospital security officers brought a man into the waiting area, and subsequently into triage. The very intoxicated man was assaulted on the street outside the ED. The man was confused, noisy, swearing and at times incoherent. The man did not stay for treatment following assessment.

**Event Fourteen**

An intoxicated 19 year old man accompanied by two friends was being assessed by the triage nurse. He was verbally aggressive, loud, swearing and abusive. He did not stay for treatment.
**Event Fifteen**

A 41 year old intoxicated man, with an open head injury and a history of violence in the ED was verbally abusive and swearing. Angie called security and two security officers were with her when she introduced herself to the patient, and they remained near the patient’s bed unit for most of his stay. The patient said he was not happy being in the ED. Angie asked him to empty out his pockets and she removed the knife he was carrying. She locked the knife and his other personal belongings in his bedside table. The patient did not use the knife, or threaten to use the knife.

**Event Sixteen**

An aggressive, confused, intoxicated 28 year old male forensic mental health patient with a head injury was moved from the ED isolation room into the resuscitation bay as his oxygen saturation levels were rapidly dropping. The patient had also consumed and unknown quantity of unidentified psychotropic medications. He had moments of reduced levels of consciousness but when he roused, he was verbally aggressive, swearing and resisting treatment. Two security officers were present when he was in the isolation area and they escorted him to the resuscitation area.
Appendix E -

Semi-Structured Interview Questions

Question One - Contextual violence prevention strategies
What violence prevention approaches do you think are used by nurses in this ED?
What do nurses do to avoid violence in ED?

Question Two - Contextual assessment skills for predicting risk of violence
Do you believe it is possible to predict or foresee whether a patient or their family or friends will be violent?
If yes how?
If no, why not

How do you assess patients or their families and friends for their risk of violence towards you or your nursing colleagues?

What signs (behaviours, language, attitudes) would you look for?

What skills do you think you have that help you to see a patient or their family or friends potential for violence? (please be as specific as you can)

What skills do you use to manage this potential – (irrespective of whether the person becomes violent) (please be as specific as you can)

Question Three - Nature and scope of sequelae of violence
What are your reactions following a violent event (physical, emotional, spiritual)

How do you feel following violent events?
What do you do?

What supports are available for you?
What supports do you choose to use?

(for all of these question, Why?)

Question Four – Stories of Violence
What experiences have you had with violence directed towards you

How did the incident begin?
Why did the incident end?
Who was the agent of violence – their characteristics, health, history of violence?
CONFIDENTIALITY AGREEMENT

This Confidentiality Agreement is made the day of 2002.

BETWEEN: Miss Organisation (ABN 4078 1938 991)
6/26 Wellington Street
Coorparoo Qld 4151

"Contractor"

AND: (Insert party) (ABN )

[address]

"Sub-contractor"

RECITALS:
A. The Contractor has supplied or is considering supplying the Information to the Sub-contractor to carry out the Work.

B. In order to assist the Sub-contractor carry out the Work for the Purpose, the Contractor has supplied or agreed to supply the Sub-contractor with the Information upon the terms contained in this Agreement and on the basis that the Sub-contractor shall at all times maintain the confidentiality of the Information.

OPERATIVE:

1. DEFINITIONS AND INTERPRETATIONS

1.1 Definitions

"Confidential Information" includes, but is not limited to, all information concerning the existing and future clients and the methodology, affairs and procedures arising from or in connection with the existing and future clients of Miss Organisation, including:

(a) information concerning marketing and promotional procedures and activities, surveys, techniques, data, formula, research and development, know-how and trade secrets, software, engineering data, plans and specifications, marketing plans and information, processes and formula, together with any accounting procedures, financial information or other proprietary information; and

(b) the contents of any computer software programmes developed or implemented by the Contractor whether such information is in writing, conveyed orally, stored or recorded by electronic, magnetic or other means whether in original form or re-compiled.

2. ACKNOWLEDGMENTS AND COVENANTS

The Sub-contractor acknowledges and covenants:

(a) that the Information is and shall be the sole and exclusive property of the Contractor;

(b) that, subject to the preceding clause, the Sub-contractor shall not at any time hereafter, disclose the Confidential Information;

(c) that the Sub-contractor shall not at any time hereafter except with the Contractor's prior consent use the information for any purpose; and
Appendix F – Transcription Service
Employee Confidentiality Agreement

3. OWNERSHIP OF CONFIDENTIAL INFORMATION

3.1 Contractor the Owner
As against the Sub-contractor, the Contractor, is and will, to the full extent and for the full period permitted by law, remain the owner of the information.

3.2 Consent Required
The Sub-contractor will not hold itself out as owning being a licensee or in any way entitled to deal or purport to deal with the Information without the prior written consent of the Contractor.

4. CONFIDENTIALITY

4.1 Disclosure
The Sub-contractor covenants in favour of the Contractor that it will not without the prior written consent of the Contractor:
(a) copy, communicate, publish or disclose the (Information); nor
(b) cause or allow the (Information) to be copied by or communicated, published or disclosed verbally, in writing, by electronic means or by any other means or medium; or
(c) use the (Information) for any purpose or application other than the stated Purpose;
to any person.

5. CONTACT WITH CLIENT
The Sub-contractor covenants in favour of the Contractor that it will not, without the prior written consent of the Contractor:
(a) telephone, email, fax, write, or contact in any way, any potential or existing client of Miss Organisation
(b) meet with potential or existing client of Miss Organisation

Should the Sub-Contractor no longer perform Work for Miss Organisation in its capacity as Sub-Contractor, then the Sub-Contractor covenants NOT to approach any existing or potential clients, by any means, with a view to securing that client’s future business or work.

The sub-contractor covenants that it will not, at any time, now or in the future, take what information, material or other knowledge, it has obtained from Miss Organisation and use it to commence the same or similar business for a period of 12 months.

6. INDEMNITY
The Sub-contractor indemnifies each of Contractor for and against all costs, Claims, losses, expenses and liabilities suffered or incurred by the Contractor as a direct or indirect result of the Sub-contractor failing (whether intentionally or not) to fully comply with the its covenants and obligations under this Confidentiality Agreement including by virtue of any act of any employee, researcher, consultant or agent of the Sub-contractor.

Should any clause in this Agreement deem to be invalid, then it will not make invalid the remainder of the Agreement.
Appendix F - Transcription Service
Employee Confidentiality Agreement

SIGNED by CAROLINE HORNER in her capacity as principal of Miss Organisation and Contractor this day of 2002 in the presence of:

Witness: ________________________________

SIGNED by ________________________________
this day of 2002

Witness: ________________________________
Appendix G – Ethics Approvals

Appendix G1 - James Cook University Approval

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<tr>
<th>ETHICS REVIEW COMMITTEE</th>
<th>Human Research Ethics Committee</th>
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</thead>
<tbody>
<tr>
<td>PRINCIPAL INVESTIGATOR</td>
<td>Lauretta Luck</td>
</tr>
<tr>
<td>SUPERVISORS</td>
<td>Professor Kim Usher (Nursing, Midwifery and Nutrition); Professor Debra Jackson (University of Western Sydney)</td>
</tr>
<tr>
<td>SCHOOL</td>
<td>Nursing, Midwifery and Nutrition (Sch)</td>
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<td>APPROVAL DATE</td>
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<td>EXPIRY DATE</td>
<td>30 Jun 2006</td>
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<td>CATEGORY</td>
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This project has been allocated Ethics Approval Number with the following conditions:

1. All subsequent records and correspondence relating to this project must refer to this number.
2. That there is NO departure from the approved protocols unless prior approval has been sought from the Human Research Ethics Committee.
3. The Principal Investigator must advise the responsible Ethics Monitor appointed by the Ethics Review Committee:
   - periodically of the progress of the project;
   - when the project is completed, suspended or prematurely terminated for any reason;
   - if serious or adverse effects on participants occur; and if any unforeseen events occur that might affect continued ethical acceptability of the project.
4. In compliance with the National Health and Medical Research Council (NHMRC) "National Statement on Ethical Conduct in Research Involving Humans" (1999), it is MANDATORY that you provide an annual report on the progress and conduct of your project. This report must detail compliance with approvals granted and any unexpected events or serious adverse effects that may have occurred during the study.

<table>
<thead>
<tr>
<th>NAME OF RESPONSIBLE MONITOR</th>
<th>Leggat, Professor Peter</th>
</tr>
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<tbody>
<tr>
<td>EMAIL ADDRESS:</td>
<td><a href="mailto:peter.leggat@jcu.edu.au">peter.leggat@jcu.edu.au</a></td>
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<tbody>
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<td>Date: 16 May 2002</td>
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Professor Peter Leggat  
Chair, Human Research Ethics Committee  
Tina Langford, Ethics Officer  
Research Office  
Tina.Langford@jcu.edu.au  

Date: 22 December 2005
Your request to amend the current ethics approval that we have agreed to formally note was considered and approved.

regards

Kay Buckley
Human Ethics Officer
University of Western Sydney
Locked Bag 1797, Penrith Sth DC NSW 1797
Tel: 02 47 360 883
http://www.uws.edu.au/about/adminorg/devint/ors/ethics/humanethics
Dear Kaye,

Please find attached a letter seeking an amendment for my current ethics approval. Also attached are modified consent forms and information sheets.

I am diligent about my project continuing to abide by all ethical standards and look forward to your comments. If the committee, or Chairperson’s decision is to request a re submission, I am very happy to submit this by the 29 April, 2005 for consideration.

I look forward to your comments and suggestions.

Kind regards

Lauretta

Ms Lauretta Luck
Deputy Head of School / Clinical Director
Senior Lecturer
School of Nursing Sciences
James Cook University
PO Box 6811
CAIRNS 4870 Qld

Telephone Number 07 4042 1441
Email Address Lauretta.Luck@jcu.edu.au
Appendix H – Information Sheet for Participants

Dear Participant,

I am interested in undertaking a study that looks at the prevention and assessment strategies, and consequence of violence towards nurses in the workplace. Across Australia and in Far North Queensland, there is an increase of violence towards nurses. Violence, for purposes of this study, includes verbal threats, aggression and any physical harm. It is a shared concern for us that we provide the best possible nursing practice for all patients whilst remaining safe in our workplace. This study is attempting to understand how nursing staff, on this unit, prevent, assess and deal with an episode of violence.

To gather information for this type of study, I will need to follow you around, observe your nursing, interview you and ask you about what you do and why. What this means is that you do not need to do anything differently to what you would normally do in your working day or night. The data that will be recorded for this research will be predominantly observations and interviews. Observations will be made of your normal working activities and during any episode of violence directed at you. The other important component of this study will be the information that you share with me. This means it will be important to talk with you about your nursing practice and experiences with patients, their family and friends who are agents of violence, and take notes of our conversations. The only additional request may be to find a mutually convenient time when you agree to be interviewed and this interview, with your consent, will be audiotaped. It is expected that this interview may take up to 60-90 minutes of your time.

Your confidentiality is most important. Should you choose to participate in this research project, you will be given a pseudonym (for data collection, analysis and any written publications). You will not be identifiable in any way in this research project or any resulting publications. The focus of this research is to understand nursing violence prevention, assessment and consequences, and not to look at individuals. There will be no way of identifying you in any of the products of this research, i.e. the doctoral thesis or any following journal articles.

There are no physically invasive procedures associated with this research project. There is no reason for me to make requests for personally uncomfortable disclosures or to place you in a political, social or personally difficult situation. If, however, you have any concerns about the research project, at any time, you are most welcome to contact me on the numbers listed at the bottom of this information sheet. If you feel any distress as a function of the research, you can confidentially contact Ms Melinda Staunton, Social Worker in Charge (telephone number 07 40508096). If you have serious concerns about the manner the research is being undertaken, you can contact the University of Western Sydney Ethics Committee through the Research Ethics Officer (telephone number 02 4570 1136).

It is your right to make your own decision about participating in this research project. You are free to change your mind and withdraw your consent at any time if you choose. There will be absolutely no adverse consequences to you changing your mind, without giving a reason, at any time, and withdrawing your consent to participate.

You are most welcome to contact me:

Lauretta Luck
Doctoral Candidate
Senior Lecturer

Telephone 07 4042 1441
Email Lauretta.Luck@jcu.edu.au
CONSENT FORM

I __________________________ agree to participate in the research project being conducted by Lauretta Luck. I understand that this research project is undertaken by Lauretta Luck as part of her Doctoral studies at the University of Western Sydney, and in conjunction with Cairns Health Service District and James Cook University.

I understand the purpose of the study is to explore, from a nursing perspective, the issue of violence towards nurses. I understand that the focus of the study is the prevention and assessment strategies I use in potentially violent situations, where the agent of violence is the patient, their family or friends. Information will be gathered via direct observation of, and conversations with, me and other members of the nursing staff working at the Unit. I understand that the study will explore my understandings of how and why I use particular violence prevention and assessment practices and how I deal with these episodes. I also understand that I may be asked to read the data gathered via observation and interview and asked to comment on how accurate or correct I feel these records are. I understand that some interviews will be audio-taped.

I understand that my participation in this research will involve being observed engaged in nursing practice whilst working at the Unit. I understand that I will be engaged in conversations about violence prevention and assessment practices, and the consequences of an episode of violence. I also understand that I will not be personally identified in any way in any of the products (thesis, articles) of this research and that I will be given a pseudonym to protect my anonymity and ensure my confidentiality. I am aware that I will participate in the study whilst I am rostered on duty at the Unit.

I am aware that I am at liberty to contact Lauretta Luck, at any time, if I have any concerns about the research project. I also understand that I am free to withdraw my participation from this research project at any time I wish, and without giving a reason. I am aware that there will be no adverse consequences to my employment, or relationship with Lauretta Luck, should I exercise my right to withdraw from this research project.

I agree that Lauretta Luck has answered all my questions fully and clearly. I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

NOTE: This study has been approved by the University of Western Sydney Human Research ethics Committee. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Research Ethics Officers (telephone number 02 4570 1136). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Signed by __________________________ (signature)
(please print name) __________________________
Date __________________________

Witness __________________________
(signature)
(please print name) __________________________
## INFORMED CONSENT FORM

**PRINCIPAL INVESTIGATOR**  Ms Lauretta Luck  
**PROJECT TITLE:**  A case study of violence in an ED: nursing assessment, strategies, and sequelae  
**SCHOOL**  School of Nursing Sciences  
**CONTACT DETAILS**  Ms Lauretta Luck  
  Telephone Number 4042 1441  
  Email Lauretta.Luck@cu.edu.au

I have agreed, and consented, to participate in the research project being conducted by Lauretta Luck. I understand that this research project is undertaken by Lauretta Luck as part of her Doctoral studies at the University of Western Sydney, and in conjunction with Cairns Health Service District and James Cook University.

I understand that this study involves the audio taping of my interview with the researcher, and have signed my consent to audio tape the interview. I give consent for the tapes to be transcribed by an independent confidential transcription service. Further, I understand the digital audio files are stored in a password protected file, on a password protected computer in the University office of Lauretta Luck. Neither my name nor any other identifying information (such as my voice) will be associated with the audiotape or the transcript nor will they be used in presentations or in written products resulting from the study.

**NOTE:** This study has been approved by the University of Western Sydney Human Research ethics Committee. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Research Ethics Officers (telephone number 02 4570 1136). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

The aims of this study have been clearly explained to me and I understand what is wanted of me. I know that taking part in this study is voluntary and I am aware that I can stop taking part in it at any time and may refuse to answer any questions.

I understand that any information I give will be kept strictly confidential and that no names will be used to identify me with this study without my approval.

| Name: (printed) |  |
| Signature: | Date: |

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