‘Violence is Not Part of Our Job’: A Thematic Analysis of Psychiatric Mental Health Nurses’ Experiences of Patient Assaults from a New Zealand Perspective

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This paper describes psychiatric mental health nurses’ (PMHN) experiences of patient assaults within mental healthcare settings using a thematic analytical approach. The aim of the study was to explore and describe psychiatric mental health nurses’ experiences of patient assaults. The major findings of the study related to the nature and impact of assaults and supportive strategies associated with violence perpetrated by patients against psychiatric mental health nurses. Perpetrator risk factors for patients include mental health disorders, alcohol and drug use and the inability to deal with situational crises. The injuries sustained by nurses in the context of the study include lacerations, head injuries, dislocations and bruises. Psychological harm has also occurred, including quite severe mental health problems, such as post-traumatic stress disorder. Protective strategies for combating negative consequences of workplace violence include practice of self-defence, social support and a supportive and consultative workplace culture with access to counselling services and assistance in all aspects, including finances. The paper concludes that while healthcare employers need to provide better support services to the healthcare professionals who are assaulted, the legal system also needs to acknowledge that assaults against nurses are a violation of human rights and violence should not to be tolerated as part of working in mental healthcare settings.

INTRODUCTION

Violence, which is prevalent in every sphere of social life, in all races and cultures, is defined as any physical, emotional or sexual behaviour that harms individuals physically and/or emotionally (Anderson & West, 2011). Workplace violence, on the other hand, is an incident where the worker is abused or assaulted by a person or people during situations related to their work (Dillon, 2012). Violence in healthcare institutions includes any incidence of threatening behaviour, verbal threat, physical assault and sexual assault inflicted by the patient, the patients’ relatives or any other individual, which constitutes a risk for health staff (Anderson & West, 2011; Martin & Daffern, 2006). Violent behaviours directed at nurses can be either direct violence or take a more indirect form. Threatening behaviour is a very common form of indirect violence and can include yelling, swearing, property damage, threatening with lawsuits and to go to the press, threats to family, public humiliation and sexual harassment (Opie et al., 2010; Gates & Kroeger, 2002). Direct forms of violence include punching, shoving, hitting, kicking, spitting, biting, scratching, using a weapon like a gun, edged weapon or blunt object and rape (Opie et al., 2010; Gates & Kroeger, 2002).

There is no one right way to intervene therapeutically with disturbed behaviour. Psychiatric mental health nurses (PMHNs) assess mood, mental state and presentation of patients, follow guidelines or standards of care, search for more effective interventions and measure the outcomes of interventions (Johnson, 2004). The stressors experienced by PMHNs are considerable. Intervening daily with individuals whose behaviour is disordered or maladaptive requires a great deal of personal and professional resources and exacts a heavy toll (Johnson, 2004; Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Mealer, Burnham, Goode, Rothbaum, & Moss, 2009). Aggression is the most difficult behaviour that nurses have to contend with in the workplace. The fact that nurses are often assaulted underscores the difficulty they experience in providing care for patients who exhibit aggressive behaviours (Anderson & West, 2011; Lanza, Ziess, & Rierdan, 2006; Ryan et al., 2008). Moreover, the aggressive patient challenges the right of the nurse and other patients to be free of fear of threat or assault (Anderson & West, 2011; Richter & Berger, 2006). Violent behaviour is a source of concern to both patients and staff in healthcare settings (Johnson, 2004). Anxiety escalates, adrenaline flows and the human responses of fright, flight and
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fight are manifested: the therapeutic environment is suddenly challenged, loses stability and is temporarily thrown off balance (Lautyr, Noustad, & Palmstierna, 2009; Lu, Wang, & Liu, 2007; Rossberg & Friis, 2003; Stone, McMillan, Hazelton, & Clayton, 2011). It is a sad reality that nurses need to prepare themselves with the skill and knowledge to deal with aggression and violence in the workplace, when the fundamental notion of nursing is caring (Stone et al., 2011).

Literature Review

Violence and aggression have different meanings depending on the situation and group of people to whom they are referring (Royal College of Nursing, 2003). The World Health Organization (WHO) defines violence as: ‘the intentional use of physical force, or power, threatened or actual, against oneself, another person or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation’. Workplace violence is any act of physical assault, threatening or coercive behaviour that occurs in a work setting and causes physical or emotional harm (Rippon, 2000). It includes incidents of verbal abuse, threats, obscene gestures and sexual harassment. Verbal abuse primarily involves humiliation, derogatory comments, threats and deprivation, which creates negative perceptions, increases apprehension and stress, and diminishes self-confidence and self-esteem (Rippon, 2000; Paterson, Miller, Leadbetter, & Bowie, 2008). Types of physical assault include pinching, biting, hitting, grabbing, kicking or being struck by a weapon (National Institute of Occupational Safety and Health, NIOSH, 2006). Workplace violence also includes acts of sabotage on worksite property (NIOSH, 2006). Workplace aggression is not much different from domestic violence. It is abuse of power and control, and it can involve psychological and emotional abuse, threats, intimidation, sexual assault and coercion (Johnson, 2004; Needham et al., 2005a).

Workplace violence is an occupational hazard in healthcare settings that has serious health, safety and legal consequences (NIOSH, 2002). The American Psychiatric Nurses Association (2007) recognises that violence in the workplace is a pressing occupational concern for all registered nurses and for PMHN in particular. Nurses worldwide typically experience more fatal violence than virtually any other occupational group (Archer-Gift, 2003; Brennan, 2000; Nau, Dassen, Needham, & Halfens, 2009; Peek-Asa et al., 2007).

Psychiatric mental health nurses are frequent victims of workplace violence, most of which is perpetrated by patients almost on a daily basis. This is due to the nature of the populations they serve, the culture and demands of the institutional environments, the shortage of trained staff and the limitations of the treatment services provided (Stone et al., 2011; Janocha & Smith, 2010). Due to long exposure and numerous security functions, PMHNs are assaulted more frequently than other members of the multidisciplinary team (Hatch-Maillette, Scalora, Bader, & Bornstein, 2007). Staff surveys show that 75–100% of nursing staff on acute psychiatric units have been assaulted during their careers (Caldwell, 1992; Hatch-Maillette et al., 2007). Poster (1996) reported that 75% of psychiatric nursing staff experienced an assault at least once during their career. Caldwell (1992) also found that 62% of psychiatric clinical staff and 28% of non-clinical staff reported that patients assaulted them at least once. From the same study, 28% of clinical staff and 12% of non-clinical staff reported an assault within the last 6 months (Caldwell, 1992; Janocha & Smith, 2010).

Although all international literature repeatedly state that workplace violence has a major impact on the emotional and psychological lives of the victims, New Zealand literature on the topic is minimal. Literature from the UK and Australia throws light on the predisposition of nurses’ exposure to violence perpetrated by patients and/or their families. Because of the similarities in the healthcare systems between the former countries and New Zealand, it is likely that violence against nurses in New Zealand is a problem on a par with the UK and Australia.

Mental Health Care within New Zealand

In the 1840s, mentally ill people were held in prisons, as there was nowhere else to care for them. The first ‘lunatic’ asylum was opened in 1854. From the 1860s, large asylums were built around the country. The initial treatment included physical work, exercises, and restraints when violent. From 1911, attitudes to mental illness changed and asylums became mental hospitals and voluntary admission was possible for treatment. From the 1950s, new drugs were available to treat mental illness and psychotherapy was used more often. Institutions became psychiatric hospitals. Different professionals, such as occupational therapists were employed to prepare patients for life and work outside hospital. From the 1970s, there was a move to care for mentally ill people outside of large institutions. By the 1990s, almost all psychiatric hospitals had closed and patients moved into the community. In the 2000s, Non Governmental Organizations (NGOs) were becoming more involved in providing mental health services. At present, the District Health Boards (DHBs) provide the primary, secondary and tertiary levels of mental health services within hospital and community settings.

METHODS

The aim of the study was to explore and describe mental health nurses’ experiences of patient assaults.

The study was conducted within the mental health services of a large regional DHB in New Zealand. The mental health service of this large regional DHB provides many services and approximately 60% of staff in the mental health services are nurses. The participants in the study included both registered and enrolled nurses (Licensed Practical Nurses, i.e., LPNs, in the USA), whose scope of practice permitted them to work within the mental health services. The areas of practice of the
participants included both community and inpatient settings and their positions were either as clinical staff or in managerial roles.

The research method adopted for the study was thematic analysis. Boyatzis (1998) describes thematic analysis as a process of encoding qualitative information where the researcher develops codes, words or phrases that serve as labels for sections of data. Thematic analysis was the most appropriate methodology, as it is a more flexible method that allows easier communication of findings, interpretation of meanings and comprehensive understanding of the phenomenon. Thematic analysis can be inductive or deductive as the researcher moves back and forth between new concepts and the data. Thematic induction creates themes, while deduction verifies them. An inductive approach was adopted as the exploratory power of this technique enabled the researcher to begin analysis with the minimal conceptual understanding of the topic not being an expert on the same.

The research study was approved by the Ethics Committee, Maori Research Division and the DHB. After gaining approval, posters were displayed in all areas of mental health care of the DHB inviting participants. A purposive sampling method was adopted to gain the data required for the study because the participants selected had all experienced some form of violence from patients and would best answer the research question (Ritchie, Lewis, & Elam, 2003). The specific inclusion criteria were that participants were nurses (registered and enrolled/LPN) working within the mental health services of the DHB in a specific province in New Zealand and who had experienced some form of assault from patients at any point in their career. This meant that the participants were registered with the Nursing Council of New Zealand and practised under the HPC Act (2003) with a scope of practice permitting them to work in mental healthcare settings. In total, 13 registered nurses and one enrolled nurse/LPN working in different nursing positions within the DHB confirmed their willingness to participate in the study within the set time frame.

**Data Collection**

Data were collected using semi-structured interviews that were audio-taped and transcribed verbatim. With reference to qualitative studies being more effective with a smaller number of participants for higher volumes of rich data, the researcher interviewed the 14 participants to obtain the data for the study (Denzin & Lincoln, 2000). Interviews took an average of 30–40 min each. Participants confirmed they were happy for the researcher to approach them for a follow-up interview if required to clarify or obtain more information, although this was not necessary.

The interview style took an individualistic approach and the flow of prompts and follow-up questions were dependent on previous responses and information to seek clarification when appropriate (Friesen, 2010). Most participants chose to share more than one experience of having been assaulted. Some interviews were stopped for short periods, due to the strong emotional and sensitive nature of the topic of the interview and the need of the participants on an individual basis.

**Data Analysis**

The interviews were transcribed verbatim and possible sub-themes were identified using Boyatzis’ (1998) three stages of theme development. The next phase of the analytical process involved the grouping of related sub-themes to develop themes. The ongoing reflective analytical process of thematic analysis resulted in the emergence of three overarching themes with 24 sub-themes. The three themes identified proved robust and their core meanings and titles were maintained throughout the study with only subtle changes. Another important aspect of this phase of analysis involved the allocation of sub-themes to only one theme. This was promoted by the clear definitions and refinements in the meanings attached to the sub-themes.

**FINDINGS**

Theme 1: Nature of Assaults

The participants found that the increase in aggression and violence was related directly or indirectly to numerous factors, such as personality traits, professional expertise, clinical roles, static and dynamic factors. There was the common acceptance that violence and aggression are ever present within mental healthcare settings, for example:

> Violence is something that you do not like to have happen but it is a possibility it may happen. That is the nature of what you look after when you do psychiatry.

The experience of assaults as shared by the participants stated that there was a perceived violation to personal safety irrespective of the nature of the assault. This threat to safety crossed boundaries of work and invaded social circles and personal spaces. The risk of workplace violence was significant in both hospital and community settings with an evident increase in the incidence of violence in the community over the recent years.

When you’re in the community you are very much on your own. So you have to anticipate that things could happen a lot more but in the inpatient unit the patients are usually a little bit more acute. So they’ve both got their issues. I don’t know whether you could say one was more likely to pose issues than the other, they’re about the same.

Despite the ever present nature of violence and non-acceptance of aggression as part of the job, participants agreed that verbal abuse was the most prevalent form of abuse. The participants perceived verbal abuse to be expected on a day-to-day basis and identified this could be used therapeutically to role model appropriate behaviours for clients.

> It’s funny because I think we are all subject to verbal abuse, working in mental health. It comes and goes.
Theme 2: Impact of Assaults

Workplace violence against mental health nurses is a significant problem that impacts on the different facets of life. Workplace violence can have an impact on the emotional lives of individuals and these consequences include fear for self, anxiety, frustration, vulnerability, grievance, distress and anger. Emotional consequences are very often the first effects to emerge, which pave the way for more profound and long-term personal and professional changes.

I was very resentful, quite angry and ended up sort of saying to my colleagues that I did not want to work with her at this stage as I was a bit too angry and it wouldn’t be therapeutic.

Personal and professional changes are very often interlinked because of the nature of the work of mental health nurses with involvement of self in the therapeutic process. A few participants highlighted the impact to be the beginning of a new learning process where skills were re-learned and there was enhanced practice and expertise gained.

Well I took it as learning experience. It did enhance my practice and my awareness of keeping myself safe and that my actions can have a reaction to the individual I’m talking to or to the group.

The negative consequences of violence included loss of self-esteem, confidence and burnout. The impact of workplace violence extended beyond the workplace and caused strained family and social relationships as shared by a few participants:

I was absolutely exhausted and it showed in the house. Luckily I had a husband who just took over the care but on one occasion it came to a crunch. One night I came home and I lifted my daughter by her hair, I couldn’t cope any longer with the general parenting role.

The physical consequences were described on a continuum of mild effects, such as bruising, abrasions, pain and swelling, to more serious conditions, such as head injuries, asphyxia and sensory deficits.

Probably as a nurse, the worst thing was the memory loss, but what I started doing was just carrying pieces of paper and writing things down, because it was the only way sometimes I could remember.

The physical consequences had indirectly paved the way for financial constraints in terms of loss of regular income, cost of medical treatments and long-term leave from work for the recovery process. The participants also shared their views on facing the patients who perpetrated the assaults.

Mixed responses were expressed with most participants highlighting the lack of remorse among patients and continuing intimidation towards targeted staff members. A few participants also reinforced the need to break the ice of fear for self and lower the threshold of impact of workplace violence among mental health nurses.

Theme 3: Support Strategies

The participants highlighted the importance of supporting assaulted nurses in all aspects of life in their road to recovery.

Peer support was identified as the most common support strategy for various reasons, which include closeness and the immediate availability for injured staff. Management support was clearly acknowledged to be better than yester-years but the participants also brought to the fore the lack of input from management on a personal stance.

I think they’re (management) is a bit come and go; I’m not sure whether they’re that supportive. I think it is more supportive now but I don’t think it’s perhaps as strong as it could be.

The positive influences of clinical supervision and critical incident stress debriefing as support strategies, related to factors, such as time of occurrence, appropriate utilisation and interaction between individuals involved in the processes, were reinforced.

Debriefing is definitely useful but the person has to be in the right frame of mind to talk about it because the natural human instinct is, each time something happens somebody comes up and goes, “Are you all right?”

Legal implications brought to light the clear lack of support in proceeding with charges against assailants both from management and the police. This was based on the perception that nurses had to expect violence as part of working within the mental health services.

And I kind of felt like that from the Police as well, “You’ve got to expect to be hit, you work in mental health”.

The participants also expressed that being more personally supported would ease their recovery and return to work.

We can’t avoid it, how we deal with it is important because if we don’t get back on that bike, the fear takes over and it gets blown out of proportion.

DISCUSSION

This study found that the experience of being assaulted as shared by the participants is an interlinked relationship of the three overarching themes, which are the main findings. The integrated analysis of the three themes identified four preordaining components of the workplace violence cycle, which are precedents, nature of abuse, defining elements and aftermath. These four components are interlinked to each other and it is this combined simultaneous occurrence that eventuates as the workplace violence cycle, as shown in Figure 1 and explained below.

Component 1: Precedents

The precedents of workplace violence include organisational culture, nursing culture and perpetrator variables. The concept of culture refers to the way things are done within a specific location and with reference to healthcare practice; it is culture at individual, team and organisational levels that determine the same (McCormack et al., 2002). Organisational culture is a system of shared values and beliefs that moulds an institution’s employees, organisational structure and control systems.
"VIOLENCE IS NOT PART OF OUR JOB": A THEMATIC ANALYSIS

When conflicting cultures operate within an organisation, these lead to sub-optimal working relationships (Flanagan, 1995). Moreover, high job demands coupled with lack of managerial support result in poorer outcomes in managing aggression and violence (Biton & Tabak, 2003; Atan et al., 2013). Nursing culture embraces values, such as aesthetics, altruism, equality, human dignity, justice and truth (Faithfull & Hunt, 2005). In the context of workplace violence, this is where the dilemma arises of whose needs come first – the patients’ or their own. The New Zealand Nurses Organisation (NZNO) Code of Ethics (2010) outlines the fundamental values one should have, as a nurse, towards clients, colleagues, organisation and society. However, this does not balance the need to care for self in comparison to caring for others (Healy & Tyrrell, 2013). This further accentuates the ethical dilemma of nurses when faced with workplace violence.

The perpetrator variables that accentuate the occurrence of workplace violence include limit setting, denial of services and sensory overload by high levels of ward activity (Chou, Lu, & Mao, 2002; Stone et al., 2011). Perpetrator characteristics are not limited to personality disorders, a past history of aggression, stress, pathological condition, insecurity, a sense of powerlessness, poor impulse control and communication skills, fear and anxiety (Crowner et al., 2005; Brewin, Andrews, & Valentine, 2000). All these impair the perpetrator’s ability to apprehend and thereby increase the likelihood of aggression and violence.

Component 2: Nature of Abuse

The findings of the study reported verbal, physical and sexual abuse. Verbal abuse was the most common and frequent type of violence experienced that is difficult to recognise because most nurses accept it as part of the job. It is also recognised that verbal violence along with physical violence is often perpetrated through repeated behaviour, of a type which by itself may be relatively minor but which cumulatively can become a very serious form of violence (Duncan et al., 2001; Duncan et al., 2003). Although the existence of physical violence at the workplace has always been recognised, the existence of the impact has long been underestimated and only now is receiving due attention (Hartley & Ridenour, 2011). Even although workplace violence is receiving more attention today, sexual violence within the work environment still remains unexplored, due to...
lower reported rates and the sense of shame with which it is associated.

Component 3: Defining Elements

There are three core elements crucial to the occurrence of workplace violence. They include nature of relationship, power and behaviour (Daffern, Mayer, & Martin, 2006). These are interlinked and it is the combined effect that results in violence and aggression. The primary aim of nurse–patient relationship is to meet the needs of the client by mutual consensus in a therapeutic manner. The nature of the nurse–patient relationship has the ever-present potential for violence because of the imbalance of power and personal attributes of both the perpetrator and the victim (Chen, Hwu, Kung, Chiu, & Wang, 2008; Levin, Hewitt, & Misner, 1998; Hills, 2008). Power can be used, misused or abused in an attempt to disempower an individual to elicit a favourable response from an individual or maintain power (Beech & Leather, 2003). When the patient perceives disempowerment, the occurrence of workplace violence is compounded (Tschamnn, 2004). There needs to be trust, choice and reciprocity within any relationship to be therapeutic. When there is a slight alteration to these elements, violence evolves with devastating effects (Gillies & O’Brien, 2006).

Component 4: Aftermath

Although a single incident can suffice, workplace violence consists of repeated, unwelcome, unreciprocated and imposed upon action, which has a devastating effect on the victim. The consequences not only involve the individual but also extend to include the workplace and wider community (Gates, Gillespie, & Succop, 2011). The suffering and humiliation resulting from violence usually leads to lack of motivation, loss of confidence and reduced self-esteem. Workplace violence causes immediate and often long-term disruption of interpersonal relationships, the organisation of work and the overall working environment, usually leading to deterioration in the quality of service provided (Atan et al., 2013; Sofield & Salmon, 2003; Stadnyk, 2012; Stone & Hazelton, 2008). The cost of violence includes healthcare and long-term rehabilitation, reintegration of victims, unemployment and retraining costs of victims who lose or leave their jobs as a result of such violence (Gates, Gillespie, & Succop, 2011). It also includes disability and invalidity costs, where the working capacities of the victims are impaired by violence at work (Atan et al., 2013; Chambers, 1998). If at any point the rehabilitation process is compromised, it will accentuate the potential for the individual to be subject to workplace violence again and resume the cyclic process of workplace violence, with more pronounced individual, workplace and community consequences (Jacobowitz, 2013; Javidi & Yadollahie, 2012).

Workplace Violence Cycle

The relativity between the four components of the workplace violence cycle is an interesting point. One should consider them as a continuum, but to do so would disregard the symbiotic relationship that exists. This clearly highlights the importance of all the factors and the process that is collectively formed. The differentiation between them is that the first three components are judged to result in the fourth; the aftermath of workplace violence. The strong link between the precedents and defining elements of workplace violence determine the nature of abuse, which subsequently marks the intensity of the impact. There is always the possibility of a cyclical process with regard to the four components of the workplace violence process. If at any point, timely precautions or interventions are implemented, this enables the minimisation and elimination of the occurrence of workplace violence and its aftermath. However, if the combined occurrence of the four components is pronounced with zero effective interventions, this will result in the potential increase in the occurrence and resumption of the workplace violence cycle. This cycle is displayed in Figure 1.

The study by Duxbury and Whittington (2005) reflects on the above discussion, stating that the role of personality in relation to violent and aggressive assaults should not be underestimated. This relates to both the perpetrator and staff characteristics. Staff member personal characteristics, attitudes and communication styles may result in staff being targets of violence (Bowers et al., 2006; Ray & Subich, 1998). The immediate environment can either raise or lower an individual’s level of dangerousness, and nursing staff function as antecedents and consequences to aggression (Love & Hunter, 1996; Walsh & Clarke, 2003). Work-related characteristics, such as type of care setting, form of employment, working hours, work conditions and activities, organisational change, understaffing and workload, are factors that may increase or decrease exposure and risk of workplace violence in mental healthcare settings (Baron & Neuman, 1996; Bowers et al., 2006). This clearly emphasises the interrelation between various precedents in eventuating as aggression and violence in various forms.

The integral aspect of addressing workplace violence includes the recovery and review process of employees who have been violated (Handa, Krantz, Delaney, & Litz, 2011). This can be elaborated to include what nurses do when faced with violence, development of user-friendly responsive procedures, backed up by adequate training and provision of ongoing support (Leather, Brady, Lawrence, Beale, & Cox, 1999; Hahn, Needham, Abderhalden, Duxbury, & Haflens, 2006). Therefore, understanding the organisational culture through the context of the nurses’ practice is essential to comprehend how to bring about changes in managing workplace violence. Nurses need to be supported to cope with ongoing violence with interventions, such as timely debriefing, training of advanced skills to manage violence and regular resilience building meetings (Jacobowitz, 2013).

Nurses function within increasingly complex workloads, hostile environments and with diminished resources. Workplace violence has penetrated every inch of the healthcare system and this affects the nurses’ physiological reactions, cognition and
emotions, including their social and group behaviours (Findorff-Dennis, Mc-Govern, Bull, & Hung, 1999; Needham, Halfens, Fischer, & Dassen, 2005b). Role conflict, in terms of their professional role and as a victim, further complicates the picture. Divided loyalties exist between allegiance to the professional mandate of putting patient needs first and attending to their own needs as a victim (Chapman, Styles, Perry, & Combs, 2010; Leather et al., 1999; Tehrani, 2011a).

The obligation ‘to do good’ is so basic to nursing that it is almost taken for granted. As a result, nurses often wonder when ‘enough is enough’ regarding patients who are demanding, angry and uncooperative (Gallagher, 2003). When a patient threatens to become violent however, the question of the limits of the nurses’ duty to help the patients comes into much sharper focus (Chapman, Styles, Perry, & Combs, 2010). Simply put, there is no ethical obligation for a nurse to put herself/himself in danger of serious harm, regardless of the patient’s needs or status. While nurses are obligated to treat all patients with dignity, they are not obligated to perform heroic acts of self-sacrifice (Gallagher, 2003; Olson, 1998; Tehrani, 2011b; Thrasher, Power, Morant, Marks, & Dalgleish, 2010).

Possible Implications

Clinical Practice

The Occupational Health and Safety legislation has necessitated that organisations must adhere to policies and procedures to ensure safety of the employees as outlined in the New Zealand Health and Safety in Employment Act 1992. This legislation clearly states in Part 2: General Duties of Employers that: ‘Every employer shall take all practicable steps to ensure the safety of employees while at work; and in particular shall take practicable steps to provide and maintain for employees a safe working environment’. Policies form an essential element in providing guidance for both management and employees. Therefore, for policies to be effective, these need to be driven by the identified needs of nurses. Nurses who offer direct patient care need to be involved in decision-making that affects the clinical setting and patient care delivery. Similarly, clinical nurses need to be willing to participate when asked to share their insights, experiences and problem-solving skills within the workplace.

Education

Violence-related content is sparse within the current nursing curriculum. Attention needs to be given to clinical issues and competence in dealing with aggression and violence. While current challenging behaviours and risk minimisation programmes offer training in dealing with aggressive behaviour, they possess limited scope, as they do not account for the complexity and variability in situations within the work setting. The overall aim must be to provide a high quality programme, which disseminates knowledge about identifying, preventing and managing workplace violence that nurses are likely to experience. Moreover, employees need to take responsibility and be prepared to deal with violence perpetrated by patients, rather than rely on employers to provide education about prevention and management of violence.

Research

The strategies to recognition, prevention and management of workplace violence are ongoing challenges within the nursing profession and the lack of research regarding workplace violence within New Zealand intensifies the issue. Further research with regards to workplace violence is suggested to provide a holistic picture of violence against nurses in different cohorts and its impact. It is necessary to provide a sound and meaningful framework to assist our understanding of the complex phenomenon. Development of policy and management programmes that are relevant to the problem must be based on strong links between the cause and effect of workplace violence.

Limitations

This study was a small qualitative study, limited to 14 participants and was confined to one DHB. However, the intent was never to conduct a generalisable study. All the participants in the study were currently working in the mental health services sector. It would have been interesting to have captured the experiences and views of nurses who have left the profession due to violence, not necessarily for reasons of comparison, but to obtain a complete picture of the intensity of the problem.

CONCLUSION

This study has offered an exploration of nurses’ experiences of assaults perpetrated by patients and has proposed potential solutions to the problem. Nurses have a vested interest in addressing workplace violence and should be committed partners in the campaign against workplace violence, if violence and its negative consequences are to be reduced. It is hoped that this research will convey important insights and meaningful connections that will help keep the issue of violence towards nurses to the forefront and assist in shaping our understanding of workplace violence, specifically within the context of nursing.

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