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The Aftermath of Violence: The Lived Experience Phenomena of Assault in Nursing

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Dissertation Submitted in Partial Fulfillment

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Abstract

Despite the high incidence of violence directed at registered nurses while on duty, there is limited qualitative data that explores the lived experience of returning to the workplace after an assaultive incident. This phenomenological study sought to explore and analyze the phenomena of registered nurses who are employed in high-risk settings. The research questions considered the detailed descriptions of the experiences of nurses returning to the workplace. The conceptual framework was resiliency, as these participants continued to survive and thrive after the adverse assaultive events. Data were collected using in-depth interviews from purposeful sampling. Nine registered nurses working in the high risk areas of inpatient psychiatry and emergency departments provided detailed descriptions about the phenomena. Data management was an inductive, iterative analysis completed and facilitated by the use of NVivo 10 software program. The study found that participants had a brief emotional response post assault mitigated by the community of nursing personnel from their immediate surroundings and felt that assault was "part of the job." Providing a true culture of safety would include enhancements to the internal community of bedside nursing practice. In addition, research is needed on interventions that can effectively enhance the internal community after assault by patients. This study contributes to positive social change by providing registered nurses, an oppressed group, a voice to mitigate negative consequences associated with assault in the hospital setting.

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Dedication

This study has been dedicated to my father, William A. Berth, who passed away in 2011. A brilliant man with no formal education continually focused on assuring his children's success, despite being unable to read, he guided me in a love for continuous inquiry. I also dedicate this accomplishment to my husband David Clark, who believed in me, when in times I doubted myself.

Acknowledgments

I would like to acknowledge and thank Dr. Hoye for assisting me along my journey as both a mentor and faculty chair. Dr. Hoye consistently guided me in accomplishing my goals, even during times when I thought that I could not. He continued to my aid in me evolving as both a researcher and a person always holding me to the highest standards as set forth by Walden University.

I would also like to acknowledge the members of the research forum, who have journeyed with me throughout the years. Their accomplishments and support have been inspiring.

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Chapter 1: Introduction to the Study

Nurses in the hospital setting are the front line staff caring for patients. Their duties include helping, promoting, healing, and alleviating the suffering of those in their care. The Nursing Code of Ethics in the Professional Standards of Practice states that nurses, in all professional relationships, practice with compassion and respect for all individuals regardless of social, personal, or health related indices (ANA, 2010). Nurses are also the victims of violence perpetrated by the same individuals who they are caring for.

The issue of violence in health care is of concern for nursing practice. Ensuring safety and minimizing risk to all hospital staff is paramount. Nurses are the most victimized group in the health care setting accounting for approximately 80% of all assaults with this number being under estimated (Findorff, McGovern, Wall, Gerberich, & Alexander, 2004). It is not that this epidemic has gone unrecognized. Violence prevention strategies remain a focus, although the violence at the bedside continues. There is also supporting evidence of the adverse effects and aftermath of violence in the workplace and its impact personally, professionally, and organizationally for nurses (Findorff, McGovern, & Sinclair, 2005). However, there is limited evidence of the lived experience, professionally, and personally for nurses who return to their workplace after they have been assaulted. This study is necessary as I seek to provide the lived experience for nurses who have returned to work after an assault.

The findings of this study may impact the health care industry as I acknowledge a demonstrated understanding of the phenomena of nurses returning to the workplace after

an assault while engaged in professional practice at the bedside. I conducted phenomenological research of the lived experience of physically assaulted nurses who returned to practice in the same workplace. The findings indicated the voice of the nurses after their experience and the resiliency tools that were effective or recommended after the incident. In chapter 1 of this study, I have outlined the background of violence in health care and the challenge that nurses face within high risk areas. I also discuss the purpose of this qualitative study, the conceptual framework of resiliency, and overcoming adversity, assumptions, scope, delineations, limitations, and significance of this study in relative to the impact of social change. Finally, I conclude with a summary of the main points presented in this chapter and provide a transition statement that leads into Chapter 2.

Background

Violence in the workplace is a serious and relevant problem for the American worker. The United States Department of labor estimates approximately 2 million workers are victims of violence every year (DOL, 2010a). Health care is one of the largest industries in the United States. Health care workers are often victims of violence from the same individuals they are trying to care for. Nearly two-thirds of all nonfatal victims of violence are health care workers, placing them at a risk five times greater than the entire work force (NIOSH, 2013a). Nurses who are at the grassroots and front line of health care are often victims of violence.

Nursing, as a profession, places individuals at a high risk for violence in the workplace. In 2008, the overall incident rate of injuries from assault on nurses was 20.4

for every 10,000 workers (NIOSH, 2013b). Among health care occupations, the nursing profession has the highest percentage of workplace violence (Harrell, 2011). The experience of nurses being physically assaulted is on the rise. In a survey completed in 2012, 42% nurses reported episodes of workplace violence from patients or family members as compared to 11% in 2011 (Duffin, 2013). The research has indicated that an estimated 80% of nurses do not feel safe in the workplace (Peek-Asa et al., 2009).

Evidence has demonstrated that workplace violence has a serious impact on the health and well-being of nurses. It is documented that exposure to violence may have serious psychological consequences (Findorff, McGovern, & Sinclair, 2005). Research supports that nurses who experience workplace violence suffer from posttraumatic stress symptoms including distressing emotions, difficulty thinking, and withdrawal from patients, absenteeism, and job changes (Gates, Gillespie, & Succop, 2011a). Other psychological consequences include anger, irritation, sadness, and depression (Findorff, McGovern, & Sinclair, 2005). The work related violence in the health care environment can lead to work related stressors that include intent to leave practice, burnout, and low job satisfaction (Winstanley & Whittington, 2002). The correlation between incidence and the impact of violence in the workplace puts the professional nurse at serious risk. The overall well-being of nurses is placed at risk whenever they are subjected to potential violence.

The finding of this research adds to the existing body of knowledge for nurses that experience violence in the workplace. The findings also provide recommendations from

the nurses on strategies that were both a hindrance and helpful to maintaining resiliency when faced with an episode of violence in the workplace.

Statement of the Problem

The recognition of violence in health care has been demonstrated throughout the literature. The National Occupational Safety and Health a subsidiary of the Occupational Safety and Health Administration (NIOSH) has established guidelines to address workplace violence in health care that include prevalence, risk factors, violence prevention programming, and organizational commitment that address this epidemic (NIOSH, 2004). There is also a plethora of research on workplace violence and nursing. Spector, Zhou and Che (2013) completed a systemic review of nurse exposure and violence and stated that there have been over 100 articles published on the incidence of workplace violence. It is also well established that the highest incident of workplace violence in nursing is in the areas of psychiatry, emergency medicine, and geriatrics (Spector, Zhou, & Che, 2013). Most outcome based research has focused on violence prevention. The effectiveness of workplace violence intervention programming that includes the training and techniques utilized when dealing with combative patients has been most often evaluated (Wassell, 2009). Although meaningful, the focus on incidence and protective measures by organizations does not account for the impact that work place violence has on the lives of nurses.

There are common contributing factors that go unaddressed after an incident of workplace violence. Related factors to workplace violence include the environment and the impact on the individual that is accompanied by a lack of administrative support

(Wolf, Delao, & Perhats, 2014). There is limited literature that addresses the experience of returning to the workplace after an assault from the perspective of the victim. Research was needed to uncover the meaning and essence of returning to the same workplace after an assault by a patient in health care.

Purpose of the Study

The purpose of this qualitative, phenomenological research study was to gather an in-depth understanding of the lived experience of returning to work as a registered nurse, employed in a high risk area, after being assaulted by a patient while on duty in the hospital setting. Using the lens of an oppressed group, the focus was on the experience of returning back to the same contextual space in which a traumatic event was experienced. The high risk setting utilized in this study was in-patient psychiatric and the emergency room setting. The study has provided significant insight into the experience by nurses of workplace violence and returning to the work place as a registered nurse after being assaulted by a patient.

The phenomenological approach was applied as it is concerned with the experience from the perspective of the individual (Moustakas, 1994). According to Van Manen (1990), phenomenological questions are meaning questions that cannot be solved, but can provide a better understanding so that we are able to act more thoughtfully and tactfully in certain situations. The lived experience can never be grasped in its immediate manifestation, but only through reflection which provides a contextual essence of the totality of the experience (Van Manen, 1990). My aim with the phenomenological approach is to gain a deeper understanding of the meaning of the real world events in

order to gain plausible insight and bring the profession to a more direct contact with the real world (Van Manen, 1990). Through interpretation of the lived experience, I was able to provide reflective interpretation and meaning to the experience of workplace violence for nurses.

Findings from this study add to the body of knowledge and address the gap in the research relative to managing work place violence after a physical assault of nursing personnel. This study provides a voice for the nurses after the negative work experience of assault. Based on these findings, I have also provided recommendations for organizations on the management of nursing staff after violent episodes in the hospital setting in Chapter 5.

Research Questions

RQ1- Describe in detail what it was like when you returned to the work after the assaultive incident?

RQ2-What are the positive experiences when returning to the work place after an assaultive incident?

RQ3-What are negative experiences when returning to the workplace after an assaultive incident?

RQ4-How have the assaultive incidents affected nursing practice?

Conceptual Framework

In order to gather an in-depth understanding of how nurses were able to survive and thrive in the workplace after a negative experience I used the conceptual framework of resiliency. Resiliency is the positive adaptation or the ability to maintain health in spite

of experiencing diversity (Herrman et al., 2011). Resiliency is forged through negative experiences. The outcome of resilience can be a self-reported, positive well-being, or external adaptation to the stress, or a reported combination of the two (Masten, 2001). The negative experience of assault in the workplace and the ability to return to the same environment and working with a similar patient population was examined in this study. How nurses recover after an assault can be affected by the way they perceive the event, their problem solving skills, and the support they may receive. All of these attributes encompasses the resiliency framework (Masten, 2001). The meaning of this experience for nurses has provided a deeper understanding of the gestalt in the profession and for organizations.

Resiliency as a conceptual framework is dynamic. It consists of two elements that place an individual at an increased probability of negative outcomes after an event which includes risk and vulnerability (Johnson & Weichelt, 2004). Risk refers to the group of the individuals that can be impacted personally, socially, or economically and has measurable variables including environmental issues or critical events that can hinder normal functioning (Johnson & Weichelt, 2004). The employment of nurses in high risk areas for assault is congruent with risk. The element of vulnerability is considered a personal construct of coping behaviors that affects the quality of adaptation (Masten, 2001). Vulnerability refers to the personal attributes of the individual elicited through personal identification and interview through a phenomenological approach. This conceptual model is based on the view that individuals that are facing insurmountable odds can and do survive with positive outcomes (Greene & Graham, 2009). Nurses that

return to work after an assault by a patient have demonstrated a level of resiliency. The meaning and the essence of these resiliency characteristics were examined in this study.

There are multiple constructs of positive outcomes when faced with adversity that are implicit in the resiliency framework. The constructs have multiple pathways to resilience that interconnect including biological, psychological, dispositional attributes, social supports, and other attributes of a social system (Herrman et al., 2011 p. 259). Personal psychological attributes are consistent with resiliency. Qualities of resiliency include high-hardiness traits with problem-focused coping strategies, self-efficacy, self-esteem, positive cognitive appraisals of events, optimism, and hope (Simmoni & Patterson, 1997). These personal constructs and others, including social relationships, demographics, and life-stage specifics, may operate across the lifespan indicating aspects of human development (Herrman et al., 2011). The qualitative approach in this study has identified the most pertinent personal attributes that contribute to resiliency after assault. Although exploration of evidence continues, most definitions include similar domains based on an ecological framework in regards to resiliency.

The other significant construct within resiliency is the environment. In this study, the environment was the workplace that, according to the resiliency framework, can enhance overall well-being through social relationships that are a part of positive coping attributes. To overcome adversity the social connection of positive role modeling, unobtrusive monitoring of the well-being, coaching, and goal setting components are needed to be met (McAllister & McKinnon, 2009). This study exemplified the construct of environment. The environment construct has been considered a protective factor

against the adverse effects of stress or trauma. The complex approach and connections between resiliency concepts and constructs are further defined in Chapter 2.

The current response to assaults of nurses in the workplace in the literature falls short of adequately understanding the resiliency demonstrated by nurses who return to work after an assault. The accrediting bodies of hospitals have recognized the seriousness of workplace violence and its influence on both employees and patients. The Joint Commission on Accreditation of Hospitals (JCAHO) suggestions for follow-up after an assault include reporting the crime to appropriate authorities, recommendation of counseling, and reviewing the events to prevent a reoccurrence (JCAHO, 2010). Hospitals are required to abide by these recommendations and demonstrate how they meet this goal. The limitation of assault follow-up does not take into account demonstrated resiliency or what factors could enhance adaptability and overall continuous well-being for nurses in the hospital organization. The current focus on workplace violence in health care has been time limited and factual. By examining the experience of returning to the workplace after assault, this study has provided meaningful understanding into the impact the event had on the individual and on their return to the workplace. This study may also lessen the organizational burden that violence in the workplace has on employees through recommended follow-up based on this research.

Nature of the Study

This was a qualitative phenomenological study. I conducted in-depth interviews of nurses who were assaulted in the hospital setting using purposeful sampling from the high risk areas of emergency and psychiatric nursing settings. The focus of this study was

to gather an in-depth understanding of what it was like to return to work to care for patients after being assaulted by a patient. Data was transcribed verbatim and analyzed using NVivo 10. NVivo 10 assisted in the formulation of themes from the nurses' experience when returning to work to gather an understanding of the phenomena. An essence may only be intuited through a study of particulars or instances as they are encountered by the lived experience (Van Manen, 1990). According to Creswell (2003), identifying the essence of the human experience will develop patterns and relationships of meaning. Using a transcendental phenomenological approach a fresh perspective, as if for the first time, can be provided on workplace violence and the approach to its aftermath (Moustakas, 1994).

Definition of Terms

Employee Assistance Program (EAP): A professional assessment, referral, and short-term counseling service available to all employees and, in some situations, to their family members to help with personal problems which may be affecting work performance. EAP services are voluntary, confidential, and provided at no cost to the employee. (DOL, 2010b)

Nursing: The professional practice that alleviates suffering promotes health and provides interventions and advocacy in health promotion of individuals, families and communities. (ANA, 2014a)

Resiliency: Resilience refers to a class of phenomena characterized by positive outcomes in spite of serious threats to adaptation after traumatic events. (Masten, 2001)

Physical Assault: The unwanted physical contact with the potential to cause bodily or emotional injury, pain, and/or distress. The physical assault involves the use of force and may involve the use of a weapon including objects such as pens, chairs, or equipment, and includes actions such as hitting, punching, pushing, poking, or kicking. (DOL, 2010b)

Tolerance: The attitudinal dimension defined as expressed awareness and endorsement of positive evaluations. (Wittington, 2002)

Workplace violence: An act of physical aggression that is intended to control or cause harms, death, or serious bodily or psychological injury to others. (DOL, 2010b)

Assumptions

The following are assumptions that were made in this study as being true and that impacted the design, findings, and conclusions without validation or proof:

1. The most important factor when entering into a research study is to do no harm. The most significant assumption is that the nurses in this study have gained mastery over the assault experience by returning to the workplace and by doing so they have developed some sense of resiliency. Nurses that return to work resuming professional duties and meeting job performance expectations should not be actively experiencing potentially harmful antecedents of the event and should be able to articulate the experience upon returning to the workplace. This was indicated in the purposeful selection of participants. An informed consent was provided to all participants prior to initiation.

2. If it is determined that there is a potential for adverse reactions to discussing what happened after the assault, the participant will be immediately provided an EAP referral and excluded from the study. The participants were informed that they can withdraw from participation at any time during the interview process (Appendix A).
3. The assumption that the participant will be openly sharing their actual experience and describe any experience that may have occurred.
4. When analyzing a phenomenon, researchers try to determine the themes, the experiential structures that make up the experience (Van Manen, 1990). As the researcher, I assume that the underlying experience is similar in nature between all participants so that information can be synthesized and themes can be drawn to provide a broad understanding.

Scope and Delimitations

The scope of this research was to develop an in-depth understanding of the experiences of nurses who have been assaulted while on duty in the hospital setting. Although there is a significant amount of outcomes research related to violent events in health care, there has yet to be an examination of the experience upon returning to work that can ultimately lessen the impact of the adverse event for the professional nurse.

The literature has characterized registered nurses as demonstrating oppressed group behavior (Greenfield, 1999). Prior evidence suggests that violence in nursing has its origins in the context of being excluded from the power structures that are dominant in todays' health care organizations (Dubrosky, 2013). The current gap in the literature is

evidence of the voice of the powerless in the health care organizational structure and the care for the care provider by the organization after trauma in the workplace.

The population and environment were significant to this study. To identify resiliency in nursing, the participants had to experience a violent episode and return to the current organizational structure, not once but twice. The work place environment was also crucial to this study. The workplace environments were selected because they offer an Employee Assistance Programs (EAP); the organization has a workplace violence policy in place, and has a designated tracking or reporting mechanism of adverse events. This would indicate that this organization is providing due diligence as a health care institution.

Health care organizations that are Joint Commission accredited abide by standard guidelines that include proficiencies for workplace violence (JCAHO, 2010). In order to be funded by both Medicare and Medicaid, a health care facility is required to be Joint Commission accredited (JCAHO, 2010). The findings from this study will be transferable to any health care setting meeting the same study criteria that employs registered nurses and is supported by the United States' government medical programs.

Limitations

There are several potential limitations in utilizing a phenomenological approach for this study. As the sole researcher, completing all interviews analyzing data alone increases a potential threat to credibility. I was able to suspend all assumptions about the nature of the reality of assault in the hospital setting. To mitigate the potential for researcher bias, I initially conducted an in-depth reflection to remove any potential bias

from the data. During the interview process, questions were open-ended with no interruption by me as the participants told their story. During the interview I clarified any unclear meanings immediately with the participants and reviewed the information as it was presented in order to obtain the essence of the experience. I also provided the participants the opportunity to review the transcripts for accuracy.

A second limitation to the study is the setting. The design setting was in one urban hospital organization that meets inclusion criteria for workplace safety and adheres to the voluntary guidelines set forth by the Occupational Safety and Health Administration (2004). This allows for generalizability to other similar health care institutions.

The limitation of trustworthiness in data must be addressed when completing a phenomenological study. I expected truthfulness in data. There were several safeguards implemented to assure truthfulness. The first was selecting participants within the organization for the study that had no relationship with me as the researcher. Study members may view participation in relation to professional employment and assume it may have a negative impact; therefore no participants can be under the direct supervision of this researcher. The second was by assuring confidentiality and informing participants prior to the study of the strategies set forth that would maintain their confidentiality. The third safeguard was done by obtaining Institutional Review Board approval from University of Pennsylvania, Pennsylvania Hospital Institutional Review Board (Appendix C) and a letter of cooperation from the organization (Appendix B).

The small sample size is also a potential limitation within qualitative studies. The task of phenomenological research is to construct possible interpretation of the nature of

a certain human experience (Van Manen, 1990). In order to address this potential limitation, I conducted interviews until data saturation was met. I also completed an additional two interviews to assure accuracy of information. This strategy was implored in order to assure that the theory holds true for additional participants (Creswell, 2012).

Significance of the Study

Providing nurses a voice in relation to an adverse event in the workplace empowers nurses. The experience provided a meaningful venue to empower nurses who have been identified as an oppressed group. The literature has described nurses as an oppressed group in response to the domination of the health care organizational structure and physician power (Matheson & Bobay, 2007). Violence as a dimension of oppression gains legitimacy if tolerated and unchallenged (Dubrosky, 2013). Placing the victim in the framework of violence diminishes the exploitation of nurses by the institutions at which they are employed. The results of this study can have a significant impact on the lives of nurses working in high risk areas of health care.

The results of this study will provide the health care industry with meaningful insight to the post assault needs of nurses. Identifying the experience as a resiliency concept can assist organizations in their ability to develop resilient nursing employees and provide a venue for healthy adaptation to traumatic events. Opening a dialogue surrounding the experience of returning to work after an assault can promote social change through empowerment of the oppressed group and impact both nurses and their patients.

The impact and scope of violence in health care is clearly demonstrated. Nurses have an unequal position in the hierarchy of the health care team (Greenfield, 1999). Evidence will suggest that the more unequal the society the greater the risk for violence (Williams & Donnelly, 2014). Violence in health care and its effects are related to issues of justice and the issue distinguishes itself with a complex array of determinants with multiple layers of influence (Williams & Donnelly, 2014). It is important to determine what can be done in the aftermath of violence to negate effects if possible. Survivors of assault in the workplace have been provided a voice in this complex issue.

The idea was that a collective voice increases a sense of confidence to nurses who have returned to work after assault. Workplace violence and nursing epitomizes social injustice and oppression towards nursing as a group. Oppression is the understanding within a system that a phenomenon lacks empowerment (Crossley & Crossley, 2001). Providing a voice articulates the experience, moves towards a collective identity, and is a beginning step in making social change (Crossley & Crossley, 2001).

A phenomenological approach to workplace violence is transformational as the true life experiences will ignite a movement within the health care hierarchy to promote positive social change.

Summary

Violence directed toward nurses is a significant issue in health care. Although there is a significant body of literature that describes the incidence, interventions to prevent violence, and the impact that violence has on both nursing and health care organizations, there is little evidence that allows nurses to describe the experience of

returning to the workplace after an assault. The following study provided a deeper understanding of the human experience of living through the traumatic incident of assault in the workplace.

Chapter 2 will provide evidence of the magnitude and impact that violence in health care has on nurses and organizations. The concepts and constructs of a conceptual framework of positive adaptation known as resiliency are examined. Supportive evidence and its application to nursing and violence in health care will produce logical connections.

Chapter 2: Literature Review

Introduction

The purpose of this study was to develop an in-depth understanding of the experience of returning to work as a registered nurse after assault by a patient in the same high risk hospital setting. This chapter reviews the current literature on the prevalence of assault towards nurses, associated risks, and the impact on nurses, organizations, and practice. The professional practice of nursing has been described as demonstrating oppressed group behavior (Dubrosky, 2013; Matheson & Bobay, 2007). Recognizing that the return to workplace setting in which an assault occurs for an oppressed group of individuals has challenges, the conceptual framework of resiliency and the notion of positive outcomes despite adversity were examined. Identification of factors that can accentuate positive outcomes despite adversity is vital for nursing practice and quality patient care. Some key words used to access literature included *nursing and violence, nursing and assault, resiliency, resiliency in nursing, oppression and nursing, workplace violence interventions, hardiness and nursing,* and *workplace violence in health care*. Sources include Medline, CINAHL (Nursing and Allied Health), Pubmed, EBSCO, Academic Research Premier, Psychinfo, Cochrane Library, and additional databases such as Proquest. Only relevant studies were sought and identified, regardless of publication status (in press, or published). The literature revealed hundreds of related articles with a majority of the studies based on international research findings. All sources were related to violence in health care or violence in its relation to nursing and resiliency factors.

The first section will review the prevalence, incidence, and associated risk factors related to violence directed toward nurses. The second section discusses the effect that violence has on nurses individually, including associated risk factors. The direct construct of the impact of workplace violence on practice will be explored. The impact workplace violence has on both organizations and nursing practice will be identified in this chapter. Following the impact, the exploration of nursing as a profession and oppressed groups will be examined. The third section will review the conceptual framework of resiliency. Constructs that assist in defining resilience as positive outcomes when faced with adversity will be identified for relational themes in returning to the workplace after the adverse event such as assault (Gillespie, Chaboyer, & Wallis, 2007; Kobosa, 1979; Maddi & Kobosa, 1984; Masten & Powell, 2003). An in-depth understanding of the experience of overcoming an adverse event and returning to nursing is imperative for future practice. This researcher has identified positive indicators after experiencing workplace violence in this specialized population of care providers in order to influence empowerment and social change in nursing. Ultimately, knowing positive outcomes and factors that can assist in overcoming adversity benefits not only the nurses individually, but organizations and their patients which can result in significant positive social change.

Workplace Violence in Nursing Research

Violence in the health care industry is well recognized and remains a serious concern for health care providers in the United States. The Bureau of Labor and Statistics (BLS) reported that health care workers were victims of approximately 11,370 assaults in 2010 which was a 13% increase over the number reported in 2009 and 19% of which

occurred in nursing (National Institute for Occupational Safety and Health (NIOSH), 2012). Nurses are at highest risk for violence in the workplace (Harrell, 2011). Among all health care workers, nurses have the highest rate of violent victimization with over 30,000 reported incidents of violence reported in the United States (Harrell, 2011). These numbers account for reported workplace violence and the actual number of violence in nursing may be considerably higher. The number of incidences of assault may be 80% higher because research suggests that individuals in the health care area underestimate the incidence of violence they experience while on duty (Findorff, McGovern, Wall, Gerberich, & Alexander, 2004).

The prevalence of workplace violence presents a concerning picture. There are several reported forms of violence. The NIOSH (1996) provides a range of definitions for workplace violence that includes but is not limited to physical assault, threatening behavior, or verbal abuse occurring in the work setting (NIOSH, 1996). A large study conducted by Hader (2008) concluded that 80% of those surveyed from the United States, Afghanistan, Taiwan, and Saudi Arabia had experienced violence within the work setting. The study noted that 25.8% experienced physical violence with 92.8% of respondents being female; the number is consistent with the national percentages of registered nurses (Hader, 2008). Out of the reported episodes of violence 53.2% were committed by patients towards nurses (Hader, 2008). The consistent prevalence of workplace violence demonstrates the threat that nurses face. Hader (2008) reported that 73% of nurses experienced some form of violence occasionally, 17% reported violence often, and 1.7% described workplace violence as always being experienced. The evidence clearly

identifies that exposure to violence in health care is common with half of all workers reporting exposure (Findorff, McGovern, Wall, & Gerberich, 2005; Winstanley & Whittington, 2004). The prevalence of the magnitude of incidents of workplace violence is clearly presented throughout the literature.

Evidence suggests that workplace violence in nursing is under reported. A large study of more than 4,700 Minnesota nurses revealed that only 69% of physical episodes of violence were reported (Gerberich, et al., 2004). Findorff, McGovern, Wall, and Gerberich (2005) identified that 60% of nonphysical acts of violence were never reported and when violent incidents were reported, 86% of those incidents were verbal only and lacked adequate follow-up. The evidence for non-reporting contributes a noteworthy view of a possible additional problem related to violence in health care and the impact on nurses.

The causation of under reporting workplace violence is abundant and dynamic. Evidence suggests that nurses consider that aggression and violence is part of their job (Findorff et al., 2004). In a survey of emergency rooms nurses, 76% stated their decision to report a violent incidence is based on whether or not the patient was perceived as being responsible for their actions (Erickson & Williams-Evans, 2000). The determination of causation of assault then falls on the nurse who self-determines if the assault was warranted. Research has indicated that in the aftermath of violence in the workplace nurses' self-perceptions surrounding the incidents include blame, punishment, fear, poor morale, vigilance, and distrust of the organization (Kindy, Peterson, & Parkhurst, 2005).

This evidence provides insight into some possible causes of non-reporting of workplace violence by nursing professionals.

Institutional culture may also be a factor in under reporting of workplace violence. A survey conducted by the Massachusetts Nursing Association (2001) concluded that the majority of incidents of violence that were reported to management had had no follow up, and in 6% of the reported cases, nurses felt management intimidated or discouraged them from reporting the incident to the police, and in 4% of the cases the management blamed the nurse themselves for the incident (Commonwealth of Massachusetts, Board of Registration in Medicine: Policy 01-01, 2001). The lack of organizational response regarding written incident reporting should not leave nurses feeling that their documentation is pointless (Ferns, 2012). The lack of reporting provides some insight into the magnitude of the issue, however further clarification is needed to provide insight into the issue.

Workplace violence in nursing is a complex phenomenon. There are several types of reported workplace violence. The definition of workplace violence by the National Occupational Safety and Health Administration (OSHA) under the U.S. Department of Labor is “any physical assault, threatening behavior, or verbal abuse occurring in a work setting” (OSHA, 2004 p. 4). Workplace violence is further defined as physical, sexual, or verbal (Copeland, 2007 p. 2). NIOSH (2006) has documented that definitions of workplace violence are not consistent among government agencies, employers, workers, and other interested parties. In order to maintain clarity of the definition of violence in the

workplace only physical violence will be the focus of further discussion throughout this study.

There are also certain areas of the health care industry that are notorious for increased risk of violence towards nurses. The compelling research for this project examined what is considered the highest risk areas in nursing. The typology of the perpetrator will be a customer/client/patient that becomes violent while being under the care of a registered nurse. A focused exploration of current research has identified physical assault, in emergency rooms, and psychiatric inpatient hospital settings with the perpetrator being the patient as a high risk environment.

The prevalence of workplace violence with physical aggression and assault towards nurses as an identified type of workplace violence has several common themes. The first is the professional area in which the nurse is employed. Physical violence is the most prevalent in psychiatric units, emergency rooms, and geriatric areas (Spector, Zhou, & Che, 2013 p. 76). One study of 113 nurses found that 50% to 85% of nurses working in psychiatric or emergency departments reported incidents of physical aggression exposure (Chapmen et al., 2009). Further examination of the factors that cause increased violence in these identified high risk settings will provide a unique perspective into the phenomena.

Psychiatric settings are considered a high risk area for physical aggression and workplace violence. One study indicated that 76% of nurses reported mild physical aggression and 16% experienced serious physical aggression (Nijmen, Bowers, Oud, & Jansen, 2005). Often nurses experience more than one episode of physical assault in the

workplace. In the psychiatric care setting, one study found that 62% of clinical staff were assaulted at least once with 28% reported being assaulted in the 6 months prior to the study (Caldwell, 1992). Another study determined that 34% of clinical staff was physically assaulted and again less than 50% reported the incident (Privitera et al., 2005). One research study had found 94% of psychiatric nurses had been assaulted at least once in their careers with 54% stating that they have been assaulted over 10 times (Poster & Ryan ,1994). Further research has indicated that eight out of ten nurses experienced some form of physical violence in the past 12 months (O'Connell et al., 2000). These findings represent physical assault only; threatening, intimidating, or verbal aggressions is not represented and are often a prelude to physical aggression.

Exposure to physical aggression in psychiatric units is due to the mental disorders of the patients (Johnson, 2004; Quintal, 2002; Flannery, Irvin, & Penk, 1999). Research has indicated that 90% perpetrators of physical violence are patients (Gerberich et al., 2004). A consistent finding throughout the literature is that patients with a diagnosable mental illness including schizophrenia, mania, psychosis, and certain types of brain syndromes including dementias, substance abuse, and personality disorders have a direct correlation with aggression (Johnson, 2004; Quintal, 2002; Flannery, Irvin, & Penk, 1999). Positive psychiatric symptoms such as hallucinations and delusions accounted for 20% of assaults (Nolen et al., 2003). Comorbid medical conditions and social factors of patients seeking mental health services including inadequate pain management, gang violence, autoimmune deficiency syndrome, pancreatitis, or tuberculosis have also been attributed to increase acts of violence (Carney, Love, & Morrison, 2003). The most at risk

populations for exhibiting violence and aggression have been identified as male (75%), with a mean age of 39, carrying a diagnosis of schizophrenia (100%), with a history of violence (93%), and substance abuse (56%) (Flannery, Irvin, & Peck, 1999). Patient related factors in the psychiatric setting are uncontrollable variables that nurses are exposed to in the nature of their work duty.

Psychiatric units inherently place nurses at risk for workplace violence. Inpatient hospital settings for psychiatric patients provide a structured, supportive environment. The inpatient psychiatric units have restrictions that often infringe on the patients' personal freedoms, such as locked doors, and no smoking areas which are universal patient safety guidelines. The unit environment process including the structure, level of stimulation, patient autonomy, and safety provisions can impact the occurrence of aggression (Hamrin, Iennaco, & Olsen, 2009). The enforcement of unit rules, denial of privileges, and involuntary commitment for treatment has positively correlated with aggression in the psychiatric setting (Flannery, 2005; Johnson, 2004). The structure of the environment has an impact on the propensity of aggression in the inpatient psychiatric setting.

The emergency department is also considered a high risk area for assault. Exposure to physical aggression in emergency departments has been reported to be as high as 67% (Iennaco et al., 2013). In a study by Crilly et al. (2004) 79% of nurses in the emergency department experienced workplace violence by patients that were believed to be under the influence of drugs or alcohol (57%) or mentally ill (40%). A study examining conflict in one emergency department found 50% of the incidences were

direct physical assault between staff and patient with 16% involving medical equipment used as opportunistic weapons such as canes, crutches, tables, or chairs (Ferns, 2012). The nature of the patient population and environment of emergency departments are similar in scope to psychiatric units with some describable differences.

The environment and patient population in emergency departments, although similar has some unique differences. Environmental risks factors in an emergency department includes working directly with potentially dangerous patients, poor security, uncontrolled movement by the public, delays in service, crowding, and an overall uncomfortable setting (Taylor & Rew, 2010). The first point of contact with the patient and the service provider that determines the wait time process in an emergency room is known as triage (Lavoi et al., 1988). It has been identified that 78% of violent incidents occurred within one hour of triage to an emergency department (Lavoi et al., 1988). Those familiar with emergency departments recognize that wait time is an inherent issue and the process of triage is an accepted practice in emergency medicine. Other inherent risks in an emergency department include ease and accessibility from the public, 24 hour access, perceived environmental chaos, increased stimulation, and a high stress environment (Howerton, Child, & Mentes, 2010). All known risk factors are identified but remain salient in emergency departments.

There is acknowledgment in the literature, that certain risk factors in relation to the staff themselves pose a risk for violence against nursing personal. Certain nursing staff characteristics such as young age, places a nurse at increased risk for violence (Estryn-Behar et al., 2008). In the mental health setting, male nurses are more likely to be

assaulted, but others studies have reported that female nurses are more likely to be assaulted, predominately because nursing itself is a female dominated profession (Howerton, Child, & Mentes, 2010). The likelihood that experience and training has some impact on decreasing violence has been implied in the research (Johnson, 2004). This alone may demonstrate that resiliency is formed with experience; however limited research on this subject has been identified. Another personal identified risk factor that pertains to nursing is increased contact with patients. Evidence has suggested that nurses' interpersonal communication and attitude toward working with a particular population is a potential risk factor. A hostile provocative staff member or those who are fearful has been associated with an increased risk or violence (Quintal, 2002). The nature of nursing duties, including lifting of patients, holding patients, inadequate staffing, and increased patient workload is reported to be implicated to violent behavior (Lawoko, Soares, & Nolan, 2000; Oztung, 2006). The combination of risk factors including the nurse, the environment, the patient, variable definitions of violence, and under reporting make workplace violence a complex occurrence.

The risk and the propensity of under reporting makes workplace violence a significant issue for nurses employed in identified high risk areas. The evidence in prevalence lacks uniformity due to self-selected reporting and centralized reporting systems of occurrences. Exposure to potentially violent perpetrators may be unavoidable by these care givers. Although significant attention has been brought to the prevalence and potential preventive strategies, the fact remains that psychiatric and emergency room nurses are at significant risk of physical violence in the workplace. The need to further

explore the consequences of violence in the workplace towards nurses requires further examination to fully understand the impact that aggression has on nurses and the profession.

Consequences of Workplace Violence towards Nurses

The consequences of workplace violence are multi-factorial impacting the individual nurse, the organization, and the profession. The impact of physical injury is self-explanatory resulting in mostly minor injuries (Caldwell, 1992). However, from 1997 to 2009 there were 130 documented workplace homicides in the health care and the social assistance industry (NIOSH, 2012). Evidence suggests that physical assault is the strongest predictor for the use of sick time, on average 3.7 days as compared to the average use of time by nursing personnel (Nijman et al., 2005). Physical injury alone has an obvious impact on health; however the psychological impact can be equally as devastating.

The psychological impact that workplace violence has on the individual nurse has been well examined in the literature. One study that examined psychiatric nurses post assault in the workplace found that 17% met criteria for Post-Traumatic Stress Disorder (PTSD) immediately after the assault and after 6 months 10% met the criteria for a diagnosis of PTSD (Richter & Berger, 2006). Seventy eight percent of workers exposed to work related violence experienced at least one adverse symptom that included anger, irritation, sadness, or depression (Findorff, McGovern, & Sinclair, 2005). O'Connell et al. (2000) found that the most frequent emotional responses to violence in the workplace included frustration, anger, fear, and emotional hurt. Long term stress and trauma after an

assault can have a cumulative effect leading a nurse to experience symptoms including apathy, flashbacks, crying spells, intrusive thoughts, and nightmares (Phillips, 2007). This emotional response also has an effect on low morale, decreased productivity, and increased errors (Ozge, 2003). This can lead to a compromise in job related duties and performance in care.

Nurses who are exposed to violence in health care may compromise their ability to care for patients appropriately. Exposure to violence can promote fear of future episodes that enhance somatic symptoms and cause intent to leave an organization in which the violent episode took place (Rogers & Kelloway, 1997). One study reported that 12.4% of nurses working in environments with the potential for violence had caused fear that perpetuated mental and physical distress and 6.4% reported a decrease in productivity in practice (Budd, Avery, & Lawless, 1996). The propensity for workplace violence can impact patient care by limiting a nurse's ability to practice.

Limitations on practicing nurses can not only affect patients, but the health care organization. The communication and coherence between colleagues in the health care setting is instrumental in caring for patients. Hospital employees who have been exposed to violence in the workplace have reported more stress reactions and a weaker sense of coherence with colleagues as opposed to non-exposed employees (Hogh & Mikkelsen, 2005). The literature also has identified that exposure to workplace aggression causes decreased job satisfaction, decrease satisfaction with family support, trauma, and occupational stress known in nursing as "burnout" (Nijman et al., 2005; Inoque et al., 2006; Maguire & Ryan, 2007). Burnout has been correlated with high work demand with

low levels of resources to cope that increases emotional exhaustion (Winstanley & Whittington, 2002). The "burnout" syndrome is also related to depersonalization that manifests itself as withdrawal from work, both emotionally and behaviorally, and can affect the quality of patient care (Winstanley & Whittington, 2002). These individual stress reactions have a significant impact on organization.

An individual's response to workplace violence can have far reaching effects on care and perception of their hospital organization. Reactions to aggression in the workplace included sick leave (20%) of staff and the use of alcohol or drugs (20%) by employees after an incident (O'Connell et al., 2000). Nurses exposed to violence may be ill prepared to care for patients. Compounded with the emotional strain, workplace violence can negatively affect an organization. It has been estimated that 80% of nurses do not feel safe at work (Peek-Asa et al., 2009 p. 166). The lack of institutional support and sense of abandonment particularly surrounding inadequate staffing levels, unfulfilled promises of workplace safety, ignored concerns, insufficient education, lack of support by peers, and administrators can lead to nursing dissatisfaction (Gacki-Smith et al., 2009 p. 341). Even in organizations that provide EAP for violence exposure, research has found most employees did not receive the resources (Caldwell, 1992). The evidence further exemplifies the significance of a culture of safety and support in high risk environments. Hospital organizations are inherently impacted by workplace violence. The cost of institutional violence within an organization can be dramatic. Absenteeism, productivity, and dissatisfaction with the work environment are losses that are not easily accounted for when reviewing the impact on an organization. Research by the

International Labor Organization reported that the cost of violence and stress in the workplace represent 1.0-3.5% of the gross domestic product over a range of countries (Waters, et al., 2005). The impact on individual employees overall well-being that include mental and physical health, job satisfaction, and morale are closely tied to organizations productivity and overall cost (Hatch-Maillette & Scalora, 2002). In a presentation by Colonel John S. Murray, President of the Federal Nurses Association, it was estimated the cost of violence in the workplace is at $4.3 million annually or approximately or $250,000 per incident, excluding hidden expenses experienced by the victim or their families (Murray, 2008). Unidentified costs to an institution are often not included in the impact of workplace violence. The organizational level may also experience legal liability cost, employee turnover, and resource allocation to hiring and retaining employees (Hatch-Maillette & Scalora, 2002). Maintaining qualified personal is a significant financial issue for the profession of nursing. Emergency department nurses reported that they were unable to work in the emergency department after a violent incident (Howerton, Child, & Mentes, 2010). The occurrence of workplace violence continues to be an issue that impacts individuals, organizations, and the profession of nursing.

There is clear and compelling evidence that workplace violence in health care has numerous effects. Twenty years of research has indicated that this is not only a health care problem but a social concern. In light of the many challenges that health care is currently experiencing, workplace violence should be considered a priority. As a public

concern, a preventative framework has been instituted. The effectiveness of preventative strategies continues to be another challenge in mitigating workplace violence.

Preventative Strategies to Workplace Violence

Evidence clearly demonstrates the risks and consequences associated with workplace violence in health care amongst nurses. The impact that workplace violence has on individuals and organizations is considerable. In view of the impact, governmental agencies, and accrediting bodies have enacted recommendations and regulations to combat the workplace violence issue.

In spite of the significance of workplace violence in health care, the United States government has been slow to respond. Currently, there is little legislation that is enacted to specifically protect nurses. In many states it is not a felony to assault a nurse as a health care provider; however this is changing at a slow pace. There are no federal laws that require workplace violence prevention program as a mandatory requirement for organizations. The Occupational Safety and Health Act of 1970 mandated that employers have a general duty to provide their employees a workplace free from recognized hazards likely to cause death or serious harm (National Advisory Council on Nursing Education and Practice, 2007). The guidelines that have been issued include preventative strategies for health care organizations. The Occupational Health and Safety Organization (OSHA, 2011) enacted enforcement procedures for inspecting agencies that have workplace violence incidents in order to review incidents and provide a generalized enforcement of the policies and procedures that they have been recommended (OSHA, 2011). The Occupational Safety and Health Administration recommended strategies include;

management commitment, employee involvement in violence prevention, worksite analysis, hazard prevention and control, safety and health training along with record keeping (OSHA, 2004 p. 10). Although slow in response, the trend of regulation has been moving consecutively forward in addressing violence in the workplace.

Several other organizations invested in health care and nursing have taken steps to address a culture of safety. The Joint Commission on the Accreditation for Hospitals (JCAHO) has taken some significant steps to address workplace violence. Joint Commission Standard LD.03.01.01 stipulates that leaders need to create and maintain a culture of quality and safety throughout the system by developing acceptable codes of conduct, managing undermining behaviors, and placing processes in place to ensure a safe culture (ANA, 2014b). Voluntary guidelines, recommendations and position statements regarding workplace violence have been addressed by the American Nurses Association (ANA), and the American Psychiatric Nurses Association (APNA). A culture of safety has been recommended with specific strategies. These guidelines have provided organizations with a framework as an approach to violence prevention based on principles set by the U.S. Department of Labor and OSHA in 1996 and 2006 (McPhaul & Lipscomb, 2004).

Health care organizations have in turn applied recommendations for strategies in preventing workplace violence. The cultural shift is to support a safe workplace, with little empirical evidence on the most effective strategies to address workplace violence. Most organizations have policies that include preventative strategies. However, there is

little evidence that addresses the best strategies in decreasing the incidence of workplace violence.

The U.S. Department of Labor and OSHA have utilized a conceptual framework model, known as the Haddon Matrix, on an injury prevention epidemiological perspective method. The Haddon Matrix has been designed to include the essence of transition awareness between relationships, between man, and his environment, human ecology, and man's relationship with certain potentially or actually hazardous physical attributes of his environment (Haddon, 1999 p. 231). The Haddon Matrix is comprised of three distinct phases; the pre-event phase, event phase, and post-event phase (Gates et al., 2011b). The application of the Haddon Matrix for violence prevention includes the host as the health care worker, the vehicle as the injury vector, the agent as the patient, and the environment that includes physical and social structures in the health care setting (Gates et al., 2011b). The event phase aims at instructing personal on preventive measures to minimize assault and prevent injuries including training of workers in protective strategies (Runyan, Zakocs, & Zwerling, 2000). Utilizing a primary, secondary, and tertiary model, the Haddon Matrix is able to encompass the experience of workplace violence. In the aftermath of a violent incident, one study demonstrated a consistent theme. After assault in the workplace evidence suggests that administrative support, development, and enforcement of policies, procedures, and resources must be provided to nurses (Gates, et al., 2011b). Although most employees are aware of supportive mechanisms in place such as EAP, they do not use the service following an episode of violence in the workplace (Findorff, McGovern, & Sinclair, 2005). The conceptual

framework has been applied in several health organizations, however there has been mixed results of effectiveness due to variations in stakeholders.

The main focus of employee based strategies for workplace violence has been focused on prevention. One of the first and most frequently recognized are zero tolerance policies toward workplace violence in health care. Tolerance is considered an attitudinal dimension that is defined as an expressed awareness and endorses positive evaluations (Whittington, 2002). Research has indicated that tolerance for workplace violence was strongly correlated with length of experience and nursing burnout (Whittington, 2002). The theoretical concept of zero tolerance against violence is admirable, however, there is wide variation on individual nurses' concepts of mastery and control in challenging situations. The education of prevention and management has been instituted in order to assist in mastering violent events in the workplace.

Workplace violence prevention programs have shown to be a consistent component of organizational approaches to managing violence against nurses. However, workplace violence prevention programs have not shown to be effective consistently across all health care organizations (Ferrell & Cubit, 2005). The basic evidence is the continued prevalence of reported violence in the workplace against nurses. One significant issue with violence prevention programs in health care is that there is no consistency within programs. It has been found that physicians were not required to attend training in 75% of California Hospitals and 55% of New Jersey hospitals (Peek-Asa et al., 2009 p. 171). Another significant issue is that the training curriculum is inconsistent across intuitions. Some organizations focus on the identification of

aggressive factors, verbal de-escalation, and physical methods to diffuse aggression while others focus on identification of characteristics of aggressive patients, and factors that predict aggression (Peek-Asa et al., 2009 p. 171). It is virtually impossible to examine the effectiveness of aggression management programs in health care as there is no standardized curriculum or intervention that has proven effectiveness across institutions. Whichever curriculum is used a system evaluation of the training and outcome is required, as many programs do not incorporate the orientation of staff to the environment and polices and reporting system that can lend to poor data on effectiveness (Farrell & Cubit, 2005). The lack of rigorous design in education for the prevention of workplace violence inhibits effectiveness. Although evaluation of effectiveness for individual training has not been proven as a standard, there may still be some inherent benefit to employees.

Education and training in preventative strategies for workplace violence has had some positive outcomes. Although there is not a reduction in assaults, research has found that preventative programs increase knowledge and confidence to deal with aggressive or assaultive patients (Kowalenk et al., 2012). Training may also benefit employees in their ability to cope with the aftermath of aggression in the workplace. One aggression management training program that included recognition of aggression, interaction with the aggressive individual, and the skills and techniques to prevent potentially threatening events from occurring demonstrated improvement on individuals' insight into aggression and increased the ability to cope with adverse situations (Oostrom & Van Mierlo, 2008).

Training as a preventive measure therefore has value in management of workplace violence.

Another element that is significant in workplace violence is the structure of the workplace environment. Modifying the physical department by implementing security methods such as metal detectors, manual patient searches, and the visibility of security officers has potentially promising results (Kowalenk et al., 2012). Although the mere presence of a metal detector has not been fully evaluated in the health care arena, other industries have demonstrated an increased perception of safety when in use (Kowalenk et al., 2012). Other safety measures that have been implemented into the environment includes surveillance cameras, restricting access to certain areas, the use of panic buttons, proper lighting, visibility, and alarm systems (Lee et al., 1999; Ayranci et al., 2006). In contrast, research has indicated that physical assault was actually increased when environmental measures were put in place (Gerberich et al., 2005). This may demonstrate that environmental strategies do provide a sense of safety for employees and they are more likely to report if a violent incident occurs. The structure of the workplace environment alone is not insignificant without the support of management and the organization at large.

The continuum of the management of violence in the workplace as outlined by the Haddon Matrix includes the event and post event stages. Administration and management are crucial during these phases. Research has found that most safety initiatives are patient centered instead of employee centered (Kowalenk et al., 2012). Organizational administration needs to commit to promoting a culture of safety. One such commitment

would include adequate staffing ratios. Bowers et al. (2007) found a significant relationship between lack of adequate staff and the incidence of violence. Administration needs to continue to support and follow policy and guidelines. Managers should conduct work site analysis to determine the specific needs within their own organization. Action plans for improvement can be developed by gathering the best evidence and engaging all stakeholders to reduce violence in the hospital setting.

Workplace violence in health care towards nurses is a complex issue. This literature review has demonstrated that assault in the workplace is not only prevalent but has a significant impact on nurses as individuals and professionals. Although some strides have been made from a legislative, policy, and organizational standpoint there remains a pervasive and lingering effect on nurses as evidenced by the existing problem. The incidence and occurrence has been clearly established and it is now time for researchers to examine other aspects of the phenomena. The culture of safety within an organization is inherent in the policies created. Nurses who have the most frequent contact with perpetrators and who are the most frequent victims should be at the center of all workplace violence initiatives.

The Position of Nursing in Health Care

Nurses play a vital role in health care. Nursing is defined as the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations (ANA, 2014a). This places nurses in the forefront of human suffering and a mainstay in the

health care of our population. A change in the safety of health care is dependent on the response of the nursing work force. However, nursing is wrought with many negative social characteristics that identify them as an oppressed work group (Dubrosky, 2013). An examination of the current state of the profession is needed in order to fully demonstrate the need for empowerment and social change.

One of the most lingering issues in nursing today is the lack of qualified personal to complete job duties. Despite the current easing of the nursing shortage due to the recession, the U.S. nursing shortage is projected to grow to 260,000 registered nurses by 2025 (American Association of Colleges of Nursing (AACN), 2014). A shortage of this magnitude would be twice as large as any nursing shortage experienced in this country since the mid-1960s (AACN, 2014). There are several factors that contribute to this immense shortage. A lack of qualified nursing faculty combined with the projection of 1 million nurses reaching retirement age within the next 10-15 years has a significant impact (AACN, 2014). Aiken et al. (2002) found that nurses reported greater job dissatisfaction (15%), and emotional exhaustion, or burnout (23%) when they were responsible for taking care of more patients than they can care for safely. The nursing shortage has led to a significant amount of nurses (93%) reporting that they do not have adequate amount of time to maintain patient safety and detect early complications or collaborate with team members (American Colleges of Nursing, 2009). This consistent upheaval in the profession has only embodied the position that nursing maintains within health care.

Nurses provide the service of health care. This service is significantly driven by financial determinants. The services provided to consumers or patients are strained by many variables. The most prominent concern of these is the cost of health services. The structural issue includes increasing cost of health care, as well as the lack of ability to pay for the totality of services demanded by the public has presented an unequal supply and demand. This consumer driven profession is demanding the highest quality of care, and nurses are not available to meet the demand.

Nurses are therefore placed in an unequal position within health care organizations. This hierarchical structure within health care organizations has led nurses to a subordinate role with a lack of power and control within a hospital based system (Roberts, Demarco & Griffin, 2009). The word "nurse" alone has long been associated with a subservient role that has been rooted in the historical dominant role of the physician over the nurse since Nightingale and has continued to be reinforced by gender, education, and remuneration (Greenfield, 1999). Registered nurses exhibit oppressed group behavior (Dubrosky, 2013). An oppressed group feels devalued and the leaders within the oppressed group are often supportive of the more powerful dominating group (Roberts, Demarco, & Griffin, 2009). Submissive behavior of nurses has evolved throughout history in response to a more dominating powerful group within hospitals such as administrators and physicians (Matheson & Bobay, 2007).

Oppressed group behaviors are highly correlated with the response to violence in the workplace. Violence is considered a social justice issue of oppression because it is directed at members of a group simply because they are members of that group

(Dubrosky, 2013). Violence gains further legitimacy within a group when it is tolerated. Research has indicated that nurses are ambivalent about violence, particularly the notion of zero tolerance, suggesting that a degree of violence be, if not acceptable, is tolerable (Lovell & Skellern, 2013). A dominant culture that allows other groups to maintain control and not challenge the existing status quo perpetuates oppression. Nursing remains exploited in regards to workplace violence and remains powerless in the current health care structure.

Powerlessness is a significant indicator of oppressed groups. Powerlessness is exemplified in workplace violence as the lack of decision making with limited capacity to make changes in regards to major decisions that are made by regulators and administrators based on what's best for the health care organization rather than what's best for the nursing employee (Dubrosky, 2013). Nursing leaders tend to promote the agendas of health care institutions, and administrations rather than promoting the agenda for employees (Roberts, Demarco, & Griffin, 2009). Throughout the evidence, there was little research regarding the nurses' voice in workplace violence, outside of reporting of prevalence. Giving nurses a voice assists in empowerment and provides a forum of respect that allows nurses to be a part of the decision making process and can promote social change (Roberts, Demarco, & Griffin, 2009).

Nurses are at the forefront of experiencing violence in the workplace. There are many variables that place nurses in harm's way as potential targets inherent in the profession. Nurses are the frontline care providers for patients that may be angry, afraid, in pain, or anxious. It is a nursing response to provide care. Nurses tend to be more

tolerant of inappropriate behavior and often put the needs of others above their own (Phillips, 2007). It is nurses that often provide uncomfortable treatments such as insertion of intravenous catheters or wound dressing changes. The nurse is also the individual that places individuals in isolation, prohibits smoking, and sets limits on patients that can lead to patient frustration and resentment. Knowing that these incidences prevail as part of the job it is apparent that the nursing response to violence has become in a sense acceptable.

There are several recommended strategies that address oppressed categorical behaviors. The first is to understand the cycle of oppression in order to alter the silence and inaction (Roberts, Demarco, & Griffin, 2009). The significance of workplace violence needs to come to the forefront of the profession and health care institutions. Groups cannot correct their state of awareness without recognition of the problem. Organizations have focused on the patient with the expectation of nursing staff to tolerate violent behavior (Gates et al., 2011b). There is a need for nurses to share their voice on the experience of returning to work after assault.

This research study has explored the experience of nurses when returning to work after assault and has provided an oppressed group the voice to break the complacency of tolerance and indifference to the phenomena and can lead to social change. The literature has clearly demonstrated limited resolve to the issue by both nurses and health care organizations as reflected in the absence of reporting and the implementation of guidelines that have been regulated from an authority basis. The phenomenon of workplace violence has a significant impact on nurses as reflected in the literature. The in-depth investigation, authored by nurses as to what the experience of returning to work

after an assault in the workplace has been examined. The management and strategies that have been implored to direct this issue have been presented from the hierarchy in health care in the literature and the need for strategies for post violence has now been explored in this research by the individual victims, the nurses.

Conceptual Framework of Resiliency

An in depth understanding of the strategies that nurses use to maintain and enhance emotional well-being in response to workplace violence may assist in positive adaptation. Nurses need to capitalize on the strengths and resources when faced with the significant unending challenge of workplace violence. The conceptual framework that was used for this dissertation is based in resiliency. Resiliency is characterized by good outcomes in spite of a serious threat to adaptation or development (Masten, 2001 p. 228).

The resiliency framework identifies risk as a base predictor of high probability of undesirable outcomes. The terms risk and vulnerability in the model can be used interchangeably (Johnson & Weichelt, 2004). The major difference between risk and vulnerability is that risk refers to groups of people and vulnerability refers to the characteristics of those individuals (Johnson & Weichelt, 2004). The framework corresponds with the tenants of violence in the workplace against nurses.

Risk has been operationalized in different ways. Risk has been described as socioeconomic measures, tabulations in the number of life events that have occurred in recent months or a lifetime, massive community trauma, divorce, or combinations of different kinds of potential factors (Masten, 2001 p. 228). Risk factors are not uniform. Multiple definitions of risk have emerged including family issues, or any critical event

that hinders normal functioning (Johns & Weichelt, 2001). Vulnerability is considered an individual's personal constructs of coping behaviors that impact the quality of adaptation (Masten, 2001). Constructs that assist in defining resilience include self-efficacy attributes, hope, and coping (Gillespie, Chaboyer, & Wallis, 2007). A study of Holocaust survivors noted that threats of survival were continuous and unpredictable, however survivors' ability to face risks and exhibiting the self-righting nature of human development aided in positive outcomes (Greene & Graham, 2009).

The previous evidence presented in this chapter would suggest that the prevalence of workplace violence places nurses in a high risk category within this framework. Vulnerability can also be equated as the adaptation of the oppressed group of nursing as the negative response to violence as part of the job as demonstrated in this literature review.

There are several pathways to resilience. Resilience has been described as interplay between biological, psychological, dispositional attributes, social supports, and other socially based concepts (Herrman et al., 2011). The domains of resiliency remain salient and linkages between the conceptual model of resilience and violence in the workplace towards nurses will be applied in this section.

One of the first factors that contribute to resiliency is personal attributes. Internal locus of control, mastery, self-efficacy, self-esteem, positive cognitive appraisals of events, and optimism can contribute to resiliency (Herrman et al., 2011 p. 260). Evidence suggests that positive coping and the presumption of locus of control has been found to increase well-being when managing stress (Arslan, Dilmac, & Hamart, 2009). Self-

efficacy is a defining characteristic and may be developed over time when an individual is faced with uncertain outcomes and failure, and is still able to persevere (Gillespie, Chaboyer & Wallis, 2007). The attribute of hope encompasses the belief that an individual has some degree of control over the goals that have been set and that these goals are achievable (Gillespie, Chaboyer, & Wallis, 2007). Achievable goal setting provides the opportunity for success in attainment and increased hope. Positive coping is also a characteristic of resiliency. Increased exposure to stressful events assists in the development of problem focused strategies that ameliorate consequences and assist in adaptation (Gillespie, Chaboyer, & Wallis, 2007). Given the theoretical underpinnings of resiliency, the applications of resiliency constructs have already been applied to workplace violence in health care. The implementation of administrative guidelines, the education of the management of aggression and the institution of mandatory reporting with the hope of follow up are already considered the benchmark within a culture of safety. Resiliency research has indicated that some individuals emerge from adversity with stronger capacities once challenged (Gillespie, Chaboyer, & Wallis, 2007).

The social environment also has a significant impact on the resilient individual. Social support that includes family and peers with secure attachment and positive reformation from peers is associated with fewer behavioral issues and overall psychological well-being (Herrman et al., 2011). Communities represent attachment, social networks, and support to its members. Evidence suggests that resilience can be improved through the provision of protective factors that have positive high expectations, and provide a positive environment that is strong, supportive, and offers peer

relationships (McAllister & McKinnon, 2009 p. 373). Organizations can promote and contribute to resiliency. Studies have suggested that individuals who report greater satisfaction with support, also report greater use of adaptive ways of coping with stressful situations (Delongis & Holtzman, 2005 p. 1646). The notion of organizational support, in the provision of culture of safety has also been identified as a determinant in current workplace violence improvement guidelines.

The concept of resiliency is dynamic in an ecological framework that correlates to overall personal well-being. Personal characteristics of individuals are highly correlated with resiliency. The three personal attributes or characteristics that can be identified that contribute to resiliency are control, commitment, and challenge. Individuals who perceive that outcomes are within their control believe they are more responsible for their own destiny and perceive adversity as a challenge (Arslan et al., 2009). Evidence will further stipulate that when individuals see themselves as able to influence their everyday life as a challenge rather than as a threat they report less depressive symptoms, anger, anxiety, and cognitive disturbances (Harrison, Loiselle, Duquete, & Semenic, 2002). This belief in ones' capabilities to mobilize cognitive resources assists the individual in a course of action to successfully execute a specific task within a given context (Avey et al., 2010 p. 24).

Inherent in the resiliency framework is the concept of self-efficacy. There is a strong statistical association between self-efficacy and resilience (Gillespie et al., 2007). Individuals who believe they are effective and do not imagine their own failure and have increased self-efficacy are empowered (Simoni, Larrabee, Birkhimer, Mott, & Gladden,

2004). This is an imperative notion in the work of resiliency for nurses who experienced workplace violence. Research has indicated that nurses who regained control of their situations by employing strategies such as attending counseling, reporting events, initiating restraints, and avoiding similar situations after an assault rebuilt confidence (Chapmen et al., 2010). If an individual perceives mastery and control in challenging situations, they will encounter less distress if they were to potentially encounter a similar event. This resiliency characteristic is a key element in the exploration of returning to work after an assaultive incident.

The conceptual framework of resiliency also identifies positive coping as indices. Active coping is characterized by problem-focused coping and seeking social support (Ming-Hui, 2008). Problem-focused coping is correlated with less psychological symptoms when faced with a stressful encounter (Folkman et al., 1986). This form of adaptive coping begins with the cognitive appraisal of an event followed by interpersonal efforts to alter the situation and a rationale deliberate effort to problem solve using available resources (Folkman et al., 1986). An individual's positive psychological state of development characterized by self-efficacy, positive thoughts about the future, persevering towards goals, and when necessary redirecting paths to meet goals, and sustaining through adversity are consistent with over all well-being (Avery et al., 2010; Luthens, Youssef, & Avolio, 2007).

The conceptual framework of resiliency is based on human capabilities and adaptive systems that promote overall well-being. Resilience focuses on a strength based strategies and the building onto existing capabilities including an individual's inner

strength, competence, optimism, and effective coping patterns (Wagnild, 2009). The outcome of resiliency can be self-reported positive well-being or external adaptation to the stress, or a reported combination of the two (Masten, 2001). An essential feature to resiliency is that the individual needs to overcome adversity. The process of resiliency is activated through adversity and the introduction of interventions that reduce the difficult situation (Gillespie, Chaboyer, & Wallis, 2007).

The resiliency framework correlates appropriately to the phenomenon of returning to workplace after experiencing violence. Twenty years of research on assault in health care exemplifies the risk associated with an identified vulnerable population. Although the resiliency framework provides a broad base of adaptive measures such as control, commitment, support, self-efficacy, and positive coping little is known about how or if any resiliency constructs are implored when returning to the workplace after an assault. The notion is that returning to work alone after an adverse event represents resiliency in some manner. The experience of returning to the workplace after an assault and how this is described has been examined in this study. Strategies that emphasized resiliency have been explored and then applied in various high risk settings in order to lessen the impact of adversity. As health care is wrought with the challenge of violence, it is imperative to positive social change to examine the indices that can maximize our human potential in the face of adversity.

Review of the Current Literature Exploring Resiliency and Workplace Violence

Currently, there is an expansive body of literature on violence in the workplace and nursing. Most studies examine occurrence and prevalence, staff, organizational

interventions, and consequences. There are limited studies that have been identified that relate directly to nursing and workplace violence within a resiliency framework. Furthermore, there is a gap in the literature, as there are few studies that explored the human experience of returning to work after assault. The literature search revealed evidence that examined the antecedents to violence as well as nursing characteristics and perpetrator profiles correlated to preventative measures. There is little consensus to the effectiveness of preventative measures, as previously mentioned as there has been no standard or benchmarked intervention that prevents workplace violence universally. There were also no studies found in this literature review that examined resiliency specifically with returning to the workplace after a violent incident in nursing.

There are several studies that apply the constructs of resiliency and adaptive coping without citing resiliency directly. A literature review by Jackson, Firtko, and Edenborough (2007) reviewed constructs of resiliency such as positive and nurturing professional relationships, maintaining a positive attitude, and achieving balance with spirituality. The literature found correlates to resiliency, nursing, and adversity, specifically noting resiliency as a framework (Jackson, Firtko, & Edenborough, 2007) The examination of nurses' perception to adaptation as being a recipient of violence was examined and the adaption when returning to work was implied (Chapman et al., 2010). One study found that avoidance of effective coping strategies leads to persistent traumatic symptoms after aggression in the workplace (Niiyama et al., 2009). Buurman et al. (2011) examined the coping strategies of nurses after assault. The research indicated that active coping was a protector against traumatic stress, with the exception of social

support. This study found that those seeking social support as a coping mechanism were associated with higher chances of developing traumatic stress (Buurman et al., 2011). However the authors did site this may be a causal effect because those that sought social support may have had higher indices of trauma. However, the incidence and occurrence remain the focus for most of the literature.

Resiliency has been studied in a variety of settings, few in health care at this point. There was study that applied the model of resiliency directly to nursing. The study by Gilliespie et al. (2007) examined the relationship between perceived competence, collaboration, control, self-efficacy, hope, coping, age, experience, and years of education as the resiliency framework as applied to operating room nursing. The study found that five variables were statistically significant; hope, self-efficacy, coping, and resilience were contributed to resiliency (Gillespie et al., 2007). One study by Van Heugten (2013) examined social workers in the health care environment, who identified themselves as being bullied in the workplace. The study found that in the aftermath resiliency was enhanced with a greater sense of control and the participants expressed increased resilience (Van Heugten, 2013). Resiliency was applied to educational programing for health care professionals. This study suggested that a program that integrates self-caring in a resiliency framework denotes lower self-reported levels of stress while simultaneously increasing one's ability to cope with life's challenges (Tarantino, Earley, Audia, D'Adamo, & Berman, 2013). Although there is an increasing body of literature on resiliency in the health care arena, there were no direct studies

identified that correlated to overcoming the adversity of assault in the workplace for nurses.

Conclusion

Violence in health care directed at nurses is a significant issue. Nurses assaulted in the workplace experience multiple negative consequences. The literature has demonstrated that post assault nurses may not only experience physical trauma but long lasting psychological trauma that can impact them both personally and professionally. Although evidence clearly identifies the magnitude of this issue, the response has been met by regulating agencies that require a culture of safety.

A culture of safety has been determined by organizations and regulating bodies and not by nurses themselves. Nurses have long been considered an oppressed group, lacking a voice in the hierarchy of health care. Providing nurses the opportunity of sharing their voice on the real world experience of returning to work after assault in the workplace can promote social change for this at need oppressed group. Chapter 3 will provide a description of the research design for this study. In that chapter, the introduction of study methods, justification for the design, and the application of the conceptual framework will be presented. A full description of the population of study, the data collection process and the qualitative approach to analysis will be addressed.

Chapter 3: Research Methods

Introduction

The purpose of this chapter is to justify and present the methodology used in this study. The literature review presented a compelling picture of work related violence towards registered nurses. Among all health care workers, nurses have the highest rate of violent victimization with over 30,000 reported incidents of violence reported in the United States (Harrell, 2011). Research has indicated that nurses may perceive aggressive interactions as part of the job (Findorff et al., 2004). The literature illustrates the need for additional research, and this study was designed to provide an in-depth examination of the experience of nurses who have been assaulted in the workplace. I have examined the consequences of work related violence towards nurses and the current interventions that are in use. There remains a gap in the literature that provides a descriptive account of the experience of returning to work after assault.

There has been a considerable amount of research, from various disciplines, on the antecedents to overcoming adversity. The resiliency framework has provided a broad range of conceptual themes. The concept of resiliency includes the capacity to transcend adversity and transform it into an opportunity for growth which offers a valuable framework for individuals who may face high stress environments (Gillespie, Chaboyer, & Wallis, 2007). Nurses facing a continued high risk environment who have returned to the work place have demonstrated resiliency. However, the in-depth exploration of the themes in this resilient group needed to be examined.

Current literature lacks the empirical research to the experience of the phenomena of violence in the workplace, its essence, and the real world experience. The experience of workplace violence, the behaviors, and the perceptions are inseparable relationships and are not a sum of its parts. A qualitative approach is needed to provide meaning to the experience of workplace violence in nursing.

The research aim was to provide nurses a voice in the experience of returning to work after an assault by a patient. Exploration of the lived experience has provided meaningful insight into the needs of nurses to overcome adversity.

Chapter 3 will describe the research design, rationale, and the role of the researcher in this qualitative study. A description of the research methodology along with recruitment procedures, participation, and data collection will be presented. I will also describe the data analysis procedures as well as any pertinent ethical issues related to this study.

Research Design

In Chapter 2, I reviewed the literature and the need for additional inquiry into the experience of returning to the workplace after an assault in nursing. The purpose of this study was to gather the meaning of the lived experience of returning to the workplace as a registered nurse employed in a high risk area, after an assault by a patient while on duty in the hospital setting. The design selected that was the most appropriate for this study was a qualitative, phenomenological research design. Phenomenology, described by Creswell (2012), is the methodological approach that describes the common meaning of an experience. The basic purpose of phenomenology is to reduce the individual

experience to obtain a description of the universal essence (Van Manen, 1990). As a human science, phenomenology will progress human beings to become increasingly thoughtful and better prepared to act tactfully in situations, and produce action-sensitive knowledge to manage violence in the workplace (Van Manen, 1990). Philosophical in nature, phenomenology seeks to gather the essence of an experience consisting of what the experience was like and how the select study group experienced it (Moustakas, 1994).

Defining characteristics in a phenomenological study are (a) a group that has all experienced the same phenomena, (b) how the group subjectively experienced it, and (c) a researcher that has, in some cases, a personal experience with the phenomena (Creswell, 2012). A transcendental or psychological phenomenological approach was utilized. This approach, described by Moustakas (1994), identifies a phenomenon of study; brackets the researchers own personal experience, and data collection. Analyzing the data is reduced to identifying textural descriptions of the person's experience and structural descriptions of their experience to convey the true essence (Moustakas, 1994). The goal of this phenomenological research study was to capture an in-depth understanding of what it is like for nurses who return to the workplace after an assault by a patient.

The phenomenological research design has a constructivist's worldview and is the rational for the approach to this study. A phenomenological design is the best design methodology to describe the phenomena and place interpretations to its meaning. In Chapter 2, the complexity of workplace violence towards nurses was emphasized. Understanding the meaning of the experience of returning to work after an assault is a

complex issue with a limited scope of categories that previous research has already examined. To remain true to phenomenology, the question of knowledge always reverts back to the real world experience (Van Manen, 1990). The pedagogy question shows what it is like to have returned to work after an assault without further researcher interpretation. The central phenomenon is to provide the universal essence of the experience of returning to the workplace after being assaulted by a patient. This original study adds to the body of knowledge so nurses can construct their own meaning and essence of returning to work after assault and in turn inform the health care industry of the experience.

I utilized the conceptual framework of resiliency for this phenomenological study. Resiliency is the characterization of positive outcomes despite a serious threat to adaptation or development (Masten, 2001). There are several constructs from resiliency inherent in this study. This study was designed in order to apply the resiliency framework and determine the outcomes through the lived experience. The first resiliency concepts are risk and vulnerability that are exemplified in the high risk population in this study. The process of resiliency is activated through adversity and the introduction of interventions that reduce the difficult situation such as a violent episode in the workplace (Gillespie, Chaboyer, & Wallis, 2007). The activation of resiliency has been applied in the selection of the participants with overcoming two episodes of physical assault in the workplace. The conceptual framework of resiliency was identified and applied throughout this research process.

Role of the Researcher

It is essential in a phenomenological study for the researcher to examine their own ideas and experience with the phenomena in question. Knowing that there are broad philosophical assumptions the researcher should identify their assumptions prior to the initiation of research (Creswell, 2012). It is wise for researchers to frame their own feelings, attitudes, biases, and understandings of the phenomena prior to undertaking the research (Simon, 2010). An examination of personal assumptions was required prior to the initiation of this study.

My interest in workplace violence does stem from a personal perspective. As a practicing registered nurse for over 20 years, I have been the victim of assault by patients. Similar to the research findings, I believed that is was part of the job. Progressing in my nursing career as a leader, I have witnessed and worked with several nurses who were also assaulted in the workplace. Never fully understanding their experience, outside of the usual reporting and referral to an employee assistance program as defined in my role, it was unknown what the experience was like for nurses when returning to the work setting and to the same or similar patients after experiencing a trauma by a patient's hand. I set to explore the human experience of returning to work after an assault in order to care for the care giver. It was my role to suspend my understanding of the phenomena in order to implement accurate interpretations.

My role as the researcher did not have an impact on the study participants. The organization, by which I am employed, is a large health system consisting of four hospitals. Prior to conducting research within the workplace I obtained a letter of

cooperation from the director of research and evidenced-based practice at the University of Pennsylvania (Appendix B). Care was taken to assure ethical concerns were eliminated. No nurses under my direct supervision were recruited in this study. There was also no assistance by other nurse managers or leaders within the organization involved in the recruitment process in order to remove any potential bias or coercion. Institutional Review Board approval was obtained from the University of Pennsylvania with protocol number 82275, review board IRB #8 (Appendix C). This organization was selected because a culture of safety is implied within the organization as identified later in this chapter. Workplace cooperation and IRB approval was included on my approved Walden University IRB approval number 06-01-15-0106256. University of Pennsylvania also supports active research that enhances a safe culture. No incentives were used in this study. A $10 gift card as a thank you gesture for participation was offered.

Methodology

The population of this study was registered nurses employed in high risk areas for workplace violence that included psychiatric mental health inpatient units and the emergency department. Each participant was self-selected according to the pre-established criteria. The first criteria for inclusion in this study was that the registered nurse had to be employed at the same institution in which at least two episodes of physical violence had occurred while on duty and returned to the same workplace area. The registered nurses also needed to have maintained full time employment at the same institution at which the episodes of the assault had taken place. Seven nurses were immediately excluded because although they have experienced episodes of violence, it

did not occur within their current institution the University of Pennsylvania where this study was taking place. All participants had to return to full time employment after the violent episodes. The most recent episode of violence could not have occurred within the preceding three months which excluded two participants. The episode of workplace violence in this study was defined as physical violence. On more than one occasion within the recruitment process, I had to define physical assault according to the study definitions so that participants had a clear understanding. The workplace chosen for the study had to adhere to voluntary guidelines set forth by the Occupational Safety and Health Administration (2004). The University of Pennsylvania Health System, Pennsylvania Hospital meets the inclusion guidelines that are required by OSHA including (a) an active, organizational violence prevention plan with training of key personnel in aggressive management and de-escalation, (b) a zero workplace violence policy, (c) a reporting system available to all staff members in a computerized database for tracking with encouragement to report and (d) an employee assistance program if a nurse requires counseling or other services.

Recruitment was conducted on an individual basis. I met with registered nurses to discuss the phenomena of study and elicit interest, at which point if interested, I provided a recruitment flier approved by Walden IRB. I set time to meet with each interested recruit to evaluate appropriateness with inclusion criteria and discussed the research project. I then asked participants who met criteria to set up with me a time and location of their choosing to conduct the interview. Selection was based on the participant's availability to conduct the interview. Potential recruits were asked to plan a time and

place to conduct the interview of their choosing. If participants were not able to plan a date and time for the interview, the recruit was asked to contact me to arrange availability. If I was not contacted by the recruit, it was assumed they were not interested in moving forward with participation.

The sample was self-selected purposeful sampling and many participants approached this researcher with the request to participate. Once recruitment was started, nurses began approaching this researcher asking specifically to participate. The sample size for this study was nine participants, two from the emergency department and seven from the inpatient psychiatric area. The recommended sample size for some phenomenological studies has been between 5-25 samples (Creswell, 2012). I continued recruitment of participants until saturation was met. Saturation refers to the point in data collection where no new themes emerge (Mason, 2010). I believe that saturation was met after seven interviews, but an additional two interviews were conducted to assure data was sufficient. This strategy of gathering additional individuals, different from those initially interviewed can determine if the theory holds true for additional participants (Creswell, 2012). Interviews were conducted until enough information was established to fully develop the understanding of returning to the workplace after assault.

Data Collection Procedures

The populations for this study were registered nurses, working in high risk for assault areas that included mental health inpatient units and the emergency department. Physical violence is the most prevalent in psychiatric units, emergency rooms, and geriatric areas (Spector, Zhou, & Che, 2013 p. 76). The registered nurses had to have

reported at least two incidents of physical violence, not within the previous three months. The process of resiliency is built through adversity (Gillespie, Chaboyer, & Wallis, 2007). The nurse participants who have met this criterion were recruited for this study. Recruitment was conducted at the University of Pennsylvania, Pennsylvania Hospital division, where inpatient psychiatry and an emergency department are located within the hospital system. The University of Pennsylvania, Pennsylvania Hospital, met the criteria for established work environments that address workplace violence.

Following IRB approval, I proceeded with recruitment. Significant care was taken in the recruitment process to assure that individuals met established IRB approval. Once participants were identified, I scheduled to meet with participants at a time and location of their choosing. The data collection process took approximately two months. During the summer months, it was at times difficult to schedule participants surrounding work and family obligations for a convenient time and location to meet. Uninterrupted space outside of the employee's department was sequestered for the interviews at the choice of participants. I met with the individuals during an initial interview, and then reviewed the interview data to assure that the participants relayed the information that was intended to answer all study questions.

Before the interview commenced, I collected a brief amount of demographic data. The demographics were directly related to resiliency and did not reflect major individual attributes. This was purposely collected to obtain information related to resiliency concepts. The data included area of expertise, years employed within the current hospital

setting, timing of first physical assault, and timing of second physical assault. No personal data was obtained for the purpose of this study.

The interview began with a scripted introduction (Appendix A). Included in the script was an introduction to the purpose and structure of the study. It was emphasized during the introduction that the participant could stop the interview at any time if they felt uncomfortable. After the initial introduction of the script I reviewed verbatim the informed consent and asked the participant to sign, offering them a copy for their records. Informed consent for participation in the study was established. Referral information to employee assistance programs, sponsored by the institution was available and provided upon request, however no participants requested this information. Each participant's interview was assigned a code, for example; participant 1, participant 2, participant 3, and so on in the study. I informed the participant that once the recordings began, they would be referred to from that point moving forward in the interview by participant code. Recordings were initiated with the first question. The interviews were reordered using an Olympus DM-620 digital voice recorder. The data collection method was in-depth personal 1:1 interviews conducted by myself as the researcher. The interviews themselves were semi-structured. The open-ended questions were memorized in order for content flow of the lived experience. At times, it was requested for the participant to explain what was meant by their response in order to obtain the essence of the phenomena. Each participant interview lasted between 8.15 minutes to 16.45 minutes in duration.

The research questions were open-ended, general, and focused on gathering an understanding of the phenomena (Creswell, 2012). The research questions were focused

on the real world "what it was like" to return to work after an assault. Phenomenology asks the simple question of what it is like to have a certain experience (Van Manen, 1990 p. 44). The following interview questions were used:

RQ1- Describe in detail what it was like when you returned to the work place after the assaultive incident?

RQ2-What are the positive experiences when returning to the work place after an assaultive incident?

RQ3-What are negative experiences when returning to the workplace after an assaultive incident?

RQ4-How have the assaultive incidents affected nursing practice?

The questions were formulated based on Moustakas (1994) providing detailed descriptions on regards to two elements, "what" the individuals have experienced and "how" they have experienced it. Open-ended questions are used to focus attention on gathering data that will lead to textual and structural experiences and intimately provide a thorough understanding of the experience (Creswell, 2012). At no time did I impart any personal experiences related to workplace violence during the interview process to maintain truthfulness in data. I continually remained reflective in maintaining active listening skills throughout the interview. At the conclusion of the interview the participants were thanked for their participation and a review of content was completed.

The most significant issue with the data collection process was scheduling individuals for interviews. Although several individuals demonstrated interest, several did not meet criteria, while others had requested to participate and then were unavailable

for interview. This required follow-up with individuals who were interested, met criteria, but could not clear their schedule to participate. Initially I considered the willingness to be open to the experience and engagement as a potential limitation. I was surprised by the nurse's willingness to share their experience and the openness they provided. Some of the nurse participants sought me out to participate in this study, noting the importance of the research.

The participants were assured confidentiality during the consent process. All interviews were transcribed verbatim in Microsoft word. All contact information is secured in a locked and coded computer drive that is protected by anti-virus software. All consents and participant codes are maintained in a secured lock box located in an area away from the workplace. This data will be maintained for no longer than five years. Upon dissemination of research findings, all contact information will be destroyed. No names, hospital locations, or any such identifiable information will be utilized in the dissemination of the research.

Data Analysis

Data analysis was conducted in order to obtain both textural and structural descriptions of the experience of returning to the workplace after an assault in nursing. I began data analysis by reading and re-reading the transcripts to familiarize myself with emerging themes. The phenomenological data analysis procedure known as horizonalization was used and consists of highlighting significant statements, sentences, or quotes in order to provide an understanding of how participants experienced the phenomena (Moustakas, 1994). Phenomenological themes are best understood as the

structures of the experience (Van Manen, 1990). I extracted significant statements to cluster into themes for development of meaning. This allowed me to fully prepare to review completed results and synthesize findings into a computer software program.

There are several software packages available to organize data. Software programs readily organized storage data and provides the location of ideas, statements, phrases, or words used in the analysis process (Creswell, 2012). The program that was utilized in this study was NVivo 10. NVivo 10 provides secure storing of data and it enables researchers to easily manipulate data and graphically display codes and categories (Creswell, 2012). The data collection from the transcribed interviews was sorted under each question. I imported the transcripts using sources under the documentation tab within the NVivo 10 program. I was then able to create nodes to keep track of information and to look for emerging patterns, creating codes as I continued. I summarized nodes in summary detail utilizing case nodes in column format for review.

The identified themes from the research were used to write descriptions of the participants' experience of returning to the workplace after an assault. These themes were used to describe the context or setting that influenced how the participants experienced the phenomena known as structural description (Creswell, 2012). Moustakas (1994) further recommends that the researcher writes about their own experience and the context and situations that have influenced their experience that will be addressed in Chapter 5.

The data analysis consisted of a composite description of the phenomena known as the essence. The essence of returning to the workplace after an episode of physical violence was clearly and similarly articulated throughout this study. This essence is a

descriptive passage that focuses on the common experience of the participants identified in the research (Creswell, 2012). No single statement can capture the experience of a phenomenon, however it can provide the structure that will serve as a starting point for the experience of workplace violence (Van Manen, 1990). These passages will provide insight into the experience of returning to work after assault in the hospital setting.

Issues of Trustworthiness in Data

Assuring issues of internal validity and external validity in research is essential. Some researchers have reported that external validity is irrelevant in phenomenology because the data is unique to the individuals describing it and therefore cannot be generalized to other similar studies or even other samples (Corben, 1999). The detailed methodological approach outlined has assisted in the ability for replication transferability of this research to other organizations to assure some sense of generalizability. The detail outlined would require that the organizations meet the same setting standards as found in this study. This study can be repeated in other organizations, however the lived experience encompasses the nature and number of possible human experiences that are varied and infinite as is human life itself (Van Manen, 1990). Although phenomenological experiences are unique, the essence of the experience has been conferred.

Internal validity was incorporated into several aspects of this research. Trustworthiness and credibility rests in the richness of the description (Corban, 1999). This technique was conducted through the detail in the description provided by the participants. During the interview process, I presented the interview without interruption

or opinion to gather the full essence of the experience. I created a relaxed atmosphere, of the participant's choice, in order to promote open and honest dialogue. Detailed description of the phenomena was provided by the participants that elicited several themes. The description involved recounting the general ideas to narrow terms, interconnecting the details using strong action verbs and quotes (Creswell, 2012). Credibility in the research was conducted through member checking. This technique is considered the most critical for establishing credibility (Creswell, 2012). Any response that was considered non-representative of the actual experience was revisited with the participant at the time of interview. When asked if participants wanted to review the transcripts, no participant requested review or revisions.

Dependability was assured through quality digital recordings and verbatim transcripts that were reviewed on several occasions. A second element was to listen to the audio recordings repeatedly to confirm that transcripts are accurate and create the essence of the experience. As previously noted, member review for clarity was conducted. The use of NVivo 10 software assisted in providing in-depth summary data. In order to achieve the maximum results I used both electronic and manual data for this study. The transcript narratives reflect the hesitation and nuances in the participants' responses.

The concept of reflexivity is inherent in me as the researcher to place myself in a position of neutrality within the research. Reflexivity is the concept in which the interviewer is conscious of biases, values, and experiences that they bring to the qualitative research (Creswell, 2012). This process had begun prior to the initiation of this research through thoughtful reflection of my past experience with the phenomena of

workplace violence. I was continually conscious of how my personal experience may have shaped my perceptions throughout the research process. Any personal reflections that may have potentially shaped findings will be reflected in Chapter 5. A good characteristic of qualitative research is when the inquirer makes his or her position explicit (Creswell, 2012).

Ethical Procedures

A strict code of ethics was maintained throughout the research process. Potential risk and burden to the participants was addressed through the sampling procedure. All participants were informed of the nature of the study as well as sampling questions prior to consent being obtained. The participants were informed that they can withdraw from the study at any time and EAP material was available at each interview if requested. I am a psychiatric mental health clinical nurse specialist with specialization in adult mental health and special populations. With over 20 years of psychiatric mental health experience, I am considered an expert in the field of mental health nursing and am able to clinically evaluate for signs and symptoms of stress. No participants demonstrated stress during the interview.

Accuracy in data interpretation was assured utilizing two methods. The first was clarification during the interview of unclear meanings. The second was participants were asked to review conclusions for accuracy of statements. No participants requested to change the information provided.

The role of the researcher was clearly established in the recruitment process. I initially completed a self-reflection prior to initiating the study so that there was no

external influence in results. In order to assure no undue influence within the setting, I had no participants that were employed in my work area and no association with participant's management in the recruitment process.

High ethical standards are expected at the University of Pennsylvania. Institutional Review Board approval was obtained from the workplace setting (Appendix C) and a letter of cooperation was obtained (Appendix B) prior to Walden University IRB approval number 06-01-15-0106256. Within the criteria, the participants were to be employed in an institution that addresses violence in the workplace and adheres to a culture of safety and have zero tolerance policies. As participants have experienced an episode of violence as inclusion criteria for this study, the workplace setting selected has available detailed information on reporting procedures for workplace violence. Participants have this readily available as a workplace practice standard. The hospital setting for this study was selected because it has provisions consistent with OSHA recommendations including EAP incident reporting and a zero tolerance for violence policy.

Confidentiality in research was assured. Data collection included coding participants with no names being used in any audio recording or verbatim transcription. All data collection will be stored in a secure locked location away from the work site. Electronic information will be maintained on a locked passcode protected computer drive by this researcher. Paper consents, participation coding, and letter of cooperation will be maintained in a locked secured area away from the workplace and housed for no longer

than a 5 year period according to Walden standards. After the 5 year period, the data will be destroyed and shredded.

Summary

Qualitative research provides a world view that supports the reality of the individuals who have experienced phenomenon and elicits their perceptions and derives meaning from the context (Simon, 2010). Phenomenology was the only appropriate methodology for examining the experience of returning to the workplace after an assault towards a nurse by a patient and how their reality was interpreted. The only reliable sources for this inquiry on the real experience are the nurses themselves. The procedures for conducting qualitative research on the phenomena required thorough detail and the inclusion of active reflection by me, as the researcher, in order to suspend all previous assumptions. The focus of this qualitative inquiry allowed me to capture the meaning and essence of the experience. Previous research has focused on the prevalence and outcome of workplace violence for nurses. This study is focused on the inquiry of the experience of returning to the workplace after assault and how that is interrupted. The goal of this study was to inform the health care industry of the lived experience of its employees. Chapter 4 will present the findings in rich detail of the phenomena.

Chapter 4: Data Analysis

Introduction

The purpose of this qualitative research study was to gather an in-depth understanding of the lived experience of returning to work as a registered nurse employed in a high risk area, after being assaulted by a patient while on duty in the hospital setting. Four specific research questions were formulated in an attempt to detail the lived experience for nurses returning to work after assault and what factors were inherent in their resiliency to return to their employment and thrive. The research questions were formulated as open-ended questions to determine the lived experience itself and provide the opportunity for detailed descriptions. In Chapter 3, I reviewed the research methodology, the appropriateness of the research design, the steps taken to assure ethics in this research, and the qualitative approach taken for this study. I included the recruitment methods and the sampling strategy and size in Chapter 3. I also described in detail the analysis plan. In chapter 4, I restate the research questions and the methodology in order to provide detailed results of the study along with the findings from the study.

The setting of the study was the University of Pennsylvania, Pennsylvania Hospital. Participants were recruited and IRB permission was granted by the setting institution to complete the study (Appendix C). A letter of cooperation from University of Pennsylvania, Pennsylvania Hospital was also obtained (Appendix B). Institutional Review Board approval from Walden University was also obtained approval # 06-01-15-0106256. Both IRB applications were identical when granted permission to initiate the study. There was no conflict of interest in the recruiting methods and participation in the

study was completely voluntary. There was no identified undue influence of participants that may have influenced the results of this study. Recruitment from the emergency department was less than expected. There were five registered nurses that demonstrated interest from the emergency department but did not meet the criteria for inclusion. My understanding is that there has been a recent turnover of staff, and many nurses are new to the department, negating them from the study. No recruitment was conducted prior to IRB approval.

Sampling Strategy

There were nine participants in this qualitative study. Purposeful sampling was utilized for individuals that met inclusion criteria for participation. Criteria for inclusion was registered nurses, who work in a high risk area, either the emergency department, or the inpatient psychiatric setting. The registered nurses would need to have experienced two episodes of physical violence while on duty in the workplace. The latest violent episode could not have occurred within the previous three months of the interview. The participants for inclusion were also required to be employees within the same work area for both episodes of physical violence and remain in current full time employment to the date of the interview. Several nurses expressed an interest in participation in this study; however few met the full criteria for inclusion.

Once selected for interview, I worked with the registered nurses to determine the time and place of their choosing for the interview. I randomly assigned codes as Participant 1, ranging from Participant 1-Particpant 9. Each participant completed a demographic form and an informed consent (Appendix A). Participants were given a

copy of the consent with my contact information for further follow up if requested. As outlined in Chapter 3, interviews were conducted in accordance with the methodology.

Data Collection

Data was collected in an interview format using a series of open-ended questions. The questions were formulated to provide detailed descriptions on regards to two elements, what the individuals have experienced and how they have experienced it (Moustakas, 1994). I memorized the interview questions to add in engagement and transitioning of questioning in order to fully explore and develop the essence and the experience. Each participant interview was reordered via digital recorder. Interviews lasted from 8.15 minutes to 16.45 minutes in duration. The recordings began with the first interview question and after the participants were presented with the nature of the study. Participants had the ability to discontinue the interview at any time. During the interview, additional probing questions were asked to clarify information provided by the participants.

Interviews were conducted over a 2 month period. The place and time of the interview was determined by the participants and were done at their discretion. Although themes emerged universally, an additional 2 interviews were conducted to assure saturation. The gathering of additional individuals different from those initially interviewed can determine if the theory holds true for the additional participants (Creswell, 2012).

All data information was transcribed verbatim into a word document for review. Each recorded interview is maintained on a locked hard drive that is password protected.

All consent forms, hard copies of transcripts, and demographic information is stored in a secured locked area and will be maintained for a 5 year period according to IRB approval. There were no variations from proposal or unusual circumstances presented in the data collection.

Demographic Profiles

The participants in this study included seven registered nurses from the psychiatric mental health inpatient setting and two registered nurses from the emergency department. There were seven female participants and two male participants. The length of practice as registered nurses on average was 12.5 years. The average length of service at University of Pennsylvania, Pennsylvania Hospital was 5 years. The timing of the physical assault was pertinent to this study. The first reported physical assault for the participants on average was 2 years ago and the second average length of time from a secondary assault was 11.4 months. The following table reflects the resiliency characteristics of the registered nurses in this study

Table 1

Resiliency Demographics of Sample

Category	Frequency
Length of time as a Registered Nurse	2- 46 years
Full time employment current position	1-11 years
First physical assault within organization	1-5 years ago
Second physical assault within organization	3 months-3 years ago

The preliminary questions were based on resiliency characteristics. A significant characteristic of resiliency is problem-focused coping strategies that are identified in the data narratives (Simmoni & Patterson, 1997). No individual personal data was collected, as the purpose of the study was to examine the phenomena, not individual characteristics. Personal characteristics have been indicated in the risk for assault towards registered nurses; however the focus was on the aftermath of the assault, not the risk (Estryn-Beher et al., 2008; Quintal, 2002).

Research Questions

The purpose of this qualitative research study was to gather an in-depth understanding of the lived experience of returning to work as a registered nurse employed in a high risk area, after being assaulted by a patient while on duty in the hospital setting. The aim of this approach was to focus on the real world experience of returning to work after an assault. Phenomenology asks the simple question of what it is like to have a

certain experience (Van Manen, 1990). The research questions were open-ended, general, and focused on gathering an understanding of the phenomena (Creswell, 2012).

The following interview questions were used:

RQ1-Describe in detail what it was like when you returned to the workplace after the assaultive incident?

RQ2-What are the positive experiences when returning to the work place after an assaultive incident?

RQ3-What are negative experiences when returning to the workplace after an assaultive incident?

RQ4-How have the assaultive incidents affected nursing practice?

Evidence of Trustworthiness

The following data analysis provides detailed in-depth data through descriptions to achieve credibility in the data. There were no adjustments to the strategies throughout the research process. In the following narratives, I provided in-depth detailed transcript information to provide a voice for the registered nurses and the lived experience of being assaulted and returning to work in the hospital setting. Creditability focuses on the truth in the findings. This has been clearly demonstrated in the data analysis. The real world experience was demonstrated in the reciprocal responses that were both positive and negative. The data is logically connected throughout the themes. These logical relationships are identifiable in the data presented. The participants had input in reviewing and clarifying information for accuracy.

Reflexivity was also applied. Reflexivity is the concept in which the interviewer is conscious of biases, values, and experiences that they bring to the qualitative research (Creswell, 2012). As the researcher I reflected on my role in the process, maintaining ethical standards, and allowing the data to reveal the lived experience without assumptions or biases. The data is written and reflects the voice of the registered nurses in their own words.

There was significant detail in the design that confirms trustworthiness in data. This detail lends itself the ability to be replicated across other health care institutions with similar criteria. This study is therefore transferable and generalizable to other organizations and populations. These findings also indicate that there is a need for further study in relation to both a better understanding resiliency and workplace violence towards nurses.

Data Analysis

I began the data analysis process by spending time reading the transcripts and listening to the audio recordings to extract themes. This raw data was placed on an excel spreadsheet to track patterns within the themes. I hand-transcribed each interview verbatim. This allowed me to fully immerse myself in the data. I continued this process until no new themes emerged. Any response that was considered non-representative of the actual experience was revisited with the participant during the interview. No participant requested revisions to information presented. I also utilized NVivo 10 to assist in the organization of data utilizing nodes for continued review. This allowed for a comparison of responses most frequently cited in the texts. This assisted in achieving the

maximum results. Although no new data emerged after the seven interviews, I collected an additional two interviews to assure saturation. This strategy of gathering additional individuals different from those initially interviewed can determine if the theory holds true for additional participants as was the case in this study (Creswell, 2012).

Presentation of Themes

The format of open-ended questions were formulated based on Moustakas (1994), providing detailed descriptions in regards to two elements, what the individuals have experienced and how they have experienced it. Open-ended questions were used to focus attention on gathering data that can lead to textual and structural experiences, and intimately provide a thorough understanding of the experience (Creswell, 2012). The goal of this study is to gather an in-depth understanding of the lived experience of returning to the workplace as a registered nurse after a physical assault by a patient. The themes elicited in this data are essential themes to the phenomena. In determining the essential aspects or qualities that make a phenomenon the concern is to discover aspects or qualities that make a phenomena what it is, and without the phenomenon could not be what it is (Van Manen, 1990 p. 107). The following presentation highlights the essence of the experience and culminates in themes related to the experience.

Themes Associated with Research Question #1

The first research question was set to examine the lived experience of what it is like when the registered nurse returned to the workplace after the assault. The open-ended question was “Describe, in detail, what it was like when you returned to the work after the assaultive incident” This opening question enabled me to explore further the essence

of the experience. Probing questions for clarification were utilized to fully develop the experience. Five themes emerged regarding returning to the workplace after an assault.

Theme 1: An initial emotional response. Eight of the nine participants reported that they had an emotional response. Although the emotional response was not universal, eight of the participants went into detail on the feelings as the strongest indicator of what it was like returning to work after being assaulted by a patient. The participants focused this question on one of the two assaults when returning to work, indicating that one of the two assaults had a more significant impact. The most frequented response was anxiety. Participant 1 described the experience as:

> I think I returned the next day after my assault a little anxious because the patient was still here hoping not to agitate the patient or get into another situation with the patient. I found myself thinking, how I go about my normal day and help the patient but not upset the patient pretty much.

The universal experience of identified anxiety continued in the responses, the following demonstrate anxiety as a significant factor on registered nurses upon their return to the workplace. Participant 2 described the experience:

> I felt a little anxious. I was a little more vigilant about watching patients. I felt like things were more unpredictable than I had thought. I've worked a long time on the psych unit and I thought - it sort of reinforced the thought of you just never know. Somebody will come in who you think, oh, they're pretty agitated, people could be at risk from this person, and they never do anything and then somebody comes in and it doesn't look like they ever will have a behavioral problem and

> then that person might do something, so I felt sort of, yikes, you just never know what could happen; just more anxious.

Participant 5 described the experience as a nervous response. She stated

"I was ok coming back to work then when I saw the patient I got a little nervous, I was a little, not nervous I shouldn't say nervous I was just apprehensive to approach him."

Participant 6 described the immediate response when returning to work as afraid:

> I was immediately afraid to come back to work thinking, okay, this was a very traumatic incident and I wasn't sure. I wasn't feeling safe. I was feeling a little unsettled and more on high alert with my surroundings than I usually am when I come to work, and thinking about the incident a lot and replaying it back in my head.

Other initial responses related to a feeling of powerlessness. Two of the participants described powerlessness and what it was like when they returned to the workplace. Participant 4 recounted the experience as

> We were able to understand what it felt like that day because we all felt very powerless and we were able to support each other and talk about it, and understood that feeling of helplessness, because we were all assaulted; it wasn't just me.

Participant 7 clearly verbalized helplessness as an emotional response when stating:

> The main feeling I remember is, especially when you wear glasses and you can't see, the feeling of like you depend on your glasses and the whole bit. I've had surgery since so I can get by without glasses; I see very well, but that feeling of

> total - I can't even describe it. You feel like you're totally helpless and the whole bit, like helpless is a better word, and also anger. I remember telling them I always treat you good and the whole bit - this is to the client who was really psychotic - and you kind of take it personally.

The last emotionally charged response elicited from the participants was the feeling of embarrassment and frustration. Participant 8 described the aftermath as:

> Yeah; it was hard to separate the incident or isolate the incident and continue on because in the incident I felt embarrassed and stupid and unprotected by my environment, unprotected by my coworkers, angry about that. It was just hard for the, I don't know…ten minutes after it have people constantly ask me if I was okay, while it was meant in a good interest the whole incident could have been prevented if people actually were concerned about things happening versus after the fact. That's not as helpful, and then I guess frustrating and that's why I was upset.

Only one participant did not respond with an emotional response regarding the return to the workplace after an assault. From the participant response, this divergence is embedded in the fact that the registered nurse did not consider the physical attack as a significant incident. Participant 3 explained the limited response to the impact as:

> I felt that I was there to be a nurse. They were there because they were sick. I don't hold an assault against them because this isn't personal; this is professional. So if I had to care for that patient again the next day I would consider it a fresh start and I would always explain that to the patient so that they didn't feel bad or

> feel like they needed to apologize or feel like we had bad vibes between us; just to reestablish rapport.

The majority of responses remained consistent in the data that physical assault by a patient had an emotional impact on registered nurses after the assault.

Theme 2: Lingering emotional response is patient dependent. A second theme was connected to the emotional responses. The participants quantified the emotional experience in relation to the patient that committed the assault. The responses were directly related to seeing or working with the patient again and were time limited in regards to patient care.

Participant 1 described the continued emotional response as,

> I definitely pulled back. Oh; until the patient was gone; until that patient I was involved with the altercation was gone, so it was about a week I want to say. I remember well, it was about a week until I felt like I was back to myself.

Participant 2 described the experience as, "the patient was still here but I think I was vigilant about everybody else too; sort of like, "gee, he might be somebody."

Participant 9 stated that,

> I think in the emergency department you always know that
> that patient's not going to still be here so I think, to me, it's the physical threat of that specific patient, and so kind of knowing that they have moved onto the next step or we because I know that that physical person isn't there. So I think to me the next shift later, I don't have a problem with it.

The theme of a charged emotional response was not only dependent on the presence of the patient, but how their treatment had been after the violent outburst.

Participant 5 descripted this in detail for the management of the emotional response.

> After I saw him for the first time I was fine, you know I just needed that initial get through that initial reaction you know of seeing him again um… but once I saw him after that I was fine because I don't think that he realized it was me you know the same person that he had hit the day before in the crisis center so I don't think he realized it was me.

The cognitive appraisal of the incident in relation to the patient also assisted in negating the emotional response after an assault in the workplace. The perception of the patients' illness and treatment in regard to assault behavior had assisted in minimizing the emotional response.

Participant 7 described his understanding of the patient treatment as,

> I think it passed when I realized the boy was really sick and the whole bit, and it's not personal It was voices telling him to hit someone and I just happened to be the person. It's the same thing; you're not going to last in psych; it's not personal regardless if I always treated him well or gave him an extra sandwich, its incidental.

Participant 3 described managing the emotional response as "we're here to care for them. If they're assaultive that's okay; they're sick and we understand and we're still here to help them."

The essence of returning to the workplace, from this study exemplifies an emotional response that is sustained dependent on the interaction between the perpetrator and victim. The emotional response became manageable for these participants that were in direct correlation to the patient.

Theme 3: Coping through Peer Support. Peer support is mentioned frequently throughout this data in regards to several aspects of the phenomena. For question 1, peer support or lack thereof, had a significant impact on post assault in the workplace for registered nurses. The interactions amongst peers in the workplace as a community were mentioned by every participant, in varying ways. Participants most frequently discussed talking to peers immediately after the incident as a coping strategy. Other frequented responses included knowing the team was there to assist.

Participant 1 articulated the response back to the workplace as,

> Everybody offered very good support like, "Are you okay? Do you need anything?" If the patient would come up to ask for something if somebody else was around they would run interference, "hey, I've got it," you know? Or the nurse that was assigned to the patient that day would be like, "hey, I'm your nurse today, how can I help you?" as opposed to you having to go to the patient. Everybody kind of ran interference I guess.

Participant 2 stated;

> Well, I remember talking about it with several people feeling like I needed to say what happened and that it was scary and kind of just venting. I felt supported; it validated that other people felt the same way, other people felt the same sort of

> extra vulnerability and the unpredictability of what could happen. So it's easy to get kind of lulled into a state of You know, things don't usually get that bad, but it felt good to know that other people felt really the same way.

Participant 5 described the return to work experience as,

> I don't blame the staff in any way that it happened you know I think that everybody did their job and that made me feel more comfortable coming back to work but I didn't feel that anybody did not help me you know what I mean everybody supported me and helped me and grabbed him away from me as soon as they could, ya know…. I was so, like that made it easier for me to come back to work…. because if I thought that at any point that the staff were somewhat not to blame but not helping but I probably would have been more apprehensive, but I didn't feel that way at all I felt that I had good staff support.

When asked about returning to the workplace, after an assault by a patient other interactive coping strategies emerged in relation to peer support. Participant 4 described her coping mechanism in the aftermath. She stated, "it took, I would say, several weeks but laughter really helped. We would laugh and joke about the incident and that seemed to helped, the ones who had experienced it."

One participant went in to detail utilizing talking with peers as therapeutic response after assault demonstrating a catharsis and sense of coherence in talking with peers after violence in the workplace. He told the story of community support in response to workplace violence and the essence of this factor was eloquently stated.

Participant 7 responded with,

> I think when you talk to people I think it makes you feel better. There's a sense like community… I know that sounds weird, but there's a strong sense of community that you're alone maybe. That if someone says…hey, you know what? ….even if it was a different hospital… that happened to me last year… or this happened to me then or there. Just a chance to express your feelings and also kind of like vent with your peers. I don't know; I think that's important.

There were two respondents that provided a negative response in regard to peer support. The participants clearly identified, that the lack of peer support was a negative aspect of returning to the workplace after assault. Participant 4 stated,

> So after work, coming back the most interesting finding that I noticed was that those who weren't there didn't have much to say about it except for, "if I was there that assault would not happen." I felt as if the group of nurses that were there, and the techs, were blamed for the fact that it even happened, for not preventing it. It wasn't preventable because the patient did get PRNs and we did everything we needed to do, medication wise to prevent it, and it was totally out of the blue what happened. I was surprised by that, like the lack of concern or empathy and the feeling that, "well, if we were working that day it would have never happened.

Participant 8 also provided a negative response immediately after the incident that articulated the theme of peer support as coping. This data reflects that no or minimal support is contrary to what is believed to be the needed after an assault. Participant 8 described the negative peer response as,

> Yeah… it was hard to separate the incident or isolate the incident and continue on because in the incident I felt embarrassed and stupid and unprotected by my environment, unprotected by my coworkers, angry about that. And it wasn't difficult all taking care of the same patient; I was fully able to do that. It was just hard for the… I don't know …ten minutes after it to have people constantly ask me if I was okay, while it was meant in a good interest the whole incident could have been prevented if people actually were concerned about things happening versus after the fact.

Theme 4: Keeping a distance. The final theme that emerges from the research question, "describe in detail what it was like when you returned to the work after the assaultive incident?" surrounds space. The lived experience included keeping a physical distance or being on guard between the registered nurses and the patients was elicited. This theme was not isolated to the perpetrator, but resonated from the emotional response to all patients under the care of the registered nurse. The distance was relational to the experience within the phenomena.

Participant 1 responded by,

> It was rough that day and we had a lot of patients with similar behaviors, so I was on guard hoping to not get into another altercation with someone else. I just not myself, a little apprehensive. I just found myself being a little more reserved, just more vigilant of my surroundings just because I was just assaulted. I definitely pulled back.

Participant 2 described this as, "a little more vigilant about all patients; a little more

careful about distance; being close to patients."

Participant 6 described in more detail the actions related to distancing from patient care. Participant 6 noted,

> I was more cautious with the patients. I was asking them more questions, seeing how delusional they were, being more hyper vigilant with everything I was doing with them on a one to one level and giving PRN medications.

The other general reflection regarding the experience was being "on guard." Participant 7 talked about the experience in detail regarding the return to work and the impact it had on him. Participant 7 described the phenomena as;

> I think you're on your guard. Your guard is much higher because once you get hit it's like the worst thing that can happen. I don't know if you let your guard down but you're hyper vigilant almost. There's a sense of like being hyper vigilant because when nothing happens for a long time and you haven't been hit or anything and things are running smoothly then… I can't say you let your guard down but you're just like different, but then after an incident I think you're more hyper vigilant, that type of thing.

Participant 2 described this distance as; "I think I probably looked at everybody slightly differently; looked at everyone sort of like, "do you have more potential than I thought you did to be violent?"

Participant 5 described the phenomena as,

> Um… Just coming to work knowing where you work and that you work in this environment and that it could happen again and that um…just being more aware

> of your surroundings and the people that are around you… just the knowledge that it could happen again at any time, that this is something that …this is where we work this is what we do and you know you just have to be aware of your surroundings.

The first question in this study focused on the essence of the experience within phenomena as demonstrated through the emotional responses. The broad open-ended question intention was met, by providing consistent data related to "what" it was like to return to work after being assaulted by a patient.

Themes Associated with Research Question #2

For Research Question #2, I sought to answer the following question: What are the positive experiences when returning to the work place after an assaultive incident? This question was meant as a reflection of the phenomena and intended to gather insight in positive attributes that were identified after an assault in the workplace. A positive affirmation from a negative situation required some probing and reflection on the part of the participant. Four consistent themes emerged in the data.

Theme 1: Knowing you're supported. One theme consistently described as a positive experience after an assault, is the resource that one has in the community workplace. Every participant described a level of community or peer support after an assault in the workplace setting. Whether the support was viewed positively or negatively, it remains a focal point of the experience. Although participants were asked what was viewed as positive, a consistent theme was the working of the team. Participant 1 stated,

> The only positive I could take from it was the support I got from my coworkers. Everybody offered very good support like, "are you okay? Do you need anything?" If the patient would come up to ask for something if somebody else was around they would run interference, "hey, I've got it," you know? Or the nurse that was assigned to the patient that day would be like, "hey, I'm your nurse today, how can I help you as opposed to you having to go to the patient? Everybody kind of ran interference, I guess.

Participant 5 identified the positive of peer support. She stated,

> I think that everybody did their job and that made me feel more comfortable coming back to work but I didn't feel that anybody did not help me you know what I mean very body supported me and helped me and grabbed him away from me as soon as they could, ya know.

Participant 9 described how she felt more secure with support. She stated,

> I would say knowing security is there when we need them. We're very fortunate to have a great working relationship with the security team, so in the event that something does happen, knowing that they're there and that they come quickly when we do need them and they usually come with more than one person so that's always nice. So I think in regards to the incident where the girl threw things at me and was verbally aggressive security was immediately in the department with multiple people and kind of then took the situation over to de-escalate the patient, so the feeling of security because of security's reaction to the situation.

> When you know you are supported in negative circumstances it decreases isolation.

Participant 4 described how peer support was a positive for her after an assault. She stated,

> We were able to understand what it felt like that day because we all felt very powerless and we were able to support each other and talk about it, and understood that feeling of helplessness, because we were all assaulted; it wasn't just me. The whole staff was assaulted.

Participant 2 reported that, being supported,

> Validated that other people felt the same way, other people felt the same sort of extra vulnerability and the unpredictability of what could happen. It felt good to hear other people say, "we get kind of used to things - nothing like that happens for weeks on end and then suddenly it happens." So it's easy to get kind of lulled into a state of, you know, things don't usually get that bad, but it felt good to know that other people felt really the same way.

The feeling of support resonated into further probing about the positive experience of returning to the workplace after assault. The following theme parlayed on the theme of positive peer support.

Theme 2: Post working with peers. The participants throughout the study verbalized the impact a post event team discussion had on the victim of assault in the workplace. This post peer interaction was the focal point on what "is needed" for registered nurses who are victims of assault in the workplace. The post event peer review

was expressed in various ways by participants. The continued need for this level of support and enhancements to this process was described in detail in the narratives. Participant 2 alluded to a working peer group. She stated,

> I can't remember if we had this sort of thing at the beginning of the shift; it may have happened but I can't remember it…for there to be a sort of after report before everybody gets up and starts the work of the day. I think it's a good idea and I don't remember if it happened to just generally say…a lot of us were involved in an upsetting experience and I know we're all vigilant… just some words of encouragement and support… we're all pretty good at watching for signs that somebody is getting upset but let's keep our eyes open and I will too. I guess maybe… is everybody okay, is everybody feeling all right?

Participant 3 also described the team approach to support. She stated that,

> A positive experience would be, to make sure that the whole team knows what happened, the whole team being your coworkers, and just to look out for if there is any bad vibes or if the patient seems to be focused on you for any reason, just to try to prevent it from happening again.

Participant 6 also went in detail as to what should take place for a positive experience after an assault in the workplace. She stated,

> Having counseling with everybody that was on and having a therapy session. It doesn't necessarily have to be a therapy session; just so we can vent and to see what to do, how everybody is feeling, what we could do differently. Yeah, kind of like a therapy session but that's probably not the right word. Just to see how

> everybody is feeling about it and what everybody else was thinking and what could have been done differently and what could we have done to help each other.

Some of the participants that experienced a review session made recommendations that they believed would enhance a positive outcome for the victim. Participant 5 stated

> I think that, if you just come to work I mean it's nice if we sat down and debriefed it not only immediately after the incident but maybe a day or 2 later or when the person returns back to work just to make sure that everybody is ok everybody is on the same page, what we could have done differently. The staff that was involved in the assault-that were there, what could we have done differently… did anybody see anything or signs that nobody else saw… just some debriefing like I said right after the incident is one thing, but I don't know if you really think about it as clearly until a day or two later you know when it happens your adrenalin is up so think if you did it a day or two later verses right after the incident might be helpful because I think it gives time for people to put it into perspective.

Participant 8 also provided an in-depth narrative on the post assault peer review. She stated,

> I guess after the return to work a debriefing episode, contributory sessions, something like that occurring, scheduled after. I don't agree with the idea of debriefing immediately after events; I don't think it's helpful for anybody involved. I get the theory behind it; I just don't think in practice you're going to get meaningful feedback immediately after these things. So if something were scheduled, "hey, we heard you were assaulted, let's set up a time to talk about it

> so that we can prevent future things like this happening," would have been lovely, but it didn't happen that way.

Participant 4 described what the team did that "helped after the incident. She said,

> We drew artwork and pictures of what happened. It was very comical but it really helped. We actually drew and we wrote certain things that we heard patients say. It was very therapeutic but we had to laugh about it because it was such a terrible ordeal that that was our release.

Participant 4 also identified a post review session as a positive experience.

> I think there should have been staff meetings. We had a debriefing with the people that were there but there should have been debriefing with all the other nursing staff so they can understand what happened, how we worked as a team to solve the problem, so it would give them a framework to understand how they could respond in future situations. I think there should have been staff meetings, not just the people that were there but all the staff should have been involved in what happened and maybe give their input in a nonjudgmental way because things can happen at any time because we're all vulnerable. And things are not predictable in psychiatry, of all things; things are not predictable.

Participant 9 summed up the theme by stating,

> I think the debriefing was a huge help…kind of hearing security's side of the story and talking about what happened, why it happened, how did it escalate, how did it de-escalate? I think that was hugely informative and helpful.

Theme 3: Acknowledgement. The third theme for Question #2 is acknowledgement of the negative incident. The participants of this study described the aid of a positive acknowledgment and the reciprocal tenant of not acknowledging the event as having an impact on the registered nurses. Nurses that received positive affirmation noted that was a helpful experience after the assault.

Participant 2 stated that,

> It validated that other people felt the same way, other people felt the same sort of extra vulnerability and the unpredictability of what could happen. It felt good to hear other people say, "we get kind of used to things - nothing like that happens for weeks on end and then suddenly it happens.

Participant 4 described validation of the experience as the acknowledgment of the experience. She stated,

> I think what made it easier is for those that weren't there to validate that that was a terrible ordeal. That would have made it a lot easier. For people to admit… yeah, that's pretty wrong what happened… but it seemed like it was more like brushed under the carpet.

The acknowledgment of experiencing a traumatic event did not necessarily have to come directly from a peer working side by side with the staff member. Other participants noted that they felt validated from family members, physicians and management.

Participant 3 described the acknowledgement as;

> This might sound weird but talking with the family members of the patient who was assaultive and when they find out that you were the one that was assaulted

> they feel really bad and feel like they need to apologize for the patient. But as a professional nurse you just explain to them, I know this isn't your loved one's personality, it's their illness and accept everything is fine. We're here to care for them. If they're assaultive that's okay; they're sick and we understand and we're still here to help them. And the family seems to be really reassured by that; that other people accept them for who they really are and not for this illness that they're going through.

Participant 8 said, "Let's see. I suppose the physician who was responsible for the patient that assaulted me acknowledged it again and apologized."

Participant 1 described validation of the negative experience by his manager. He stated, "The manager I had at the time was really great with seeing something wasn't right and was like, hey, if you need to talk my door is always open."

Theme 4: Knowing your environment. Several participants discussed having a keen awareness of the environment was helpful. The implementation of environmental measures that were readily available was mentioned as a positive antecedent to returning to the workplace after an assault. The environment was described in the physical sense, from space allocation, doors and locks, and supplies that may be needed during an unpredictable episode. Participant 2 stated that,

> I think it was after one incident we actually got...we never use to have an emergency button. It doesn't sound here on the unit but it sounds really loud on six, and the same for up there, so that people would just come right away. There is

> always security, of course, which everybody uses but I think that's when we got an emergency button.

Other participants discussed the many changes that occurred to the environment after an assaultive patient incident. Participant 4 stated,

> Some good things that came out of that is now we have a special box for those kinds of emergencies with protective equipment near the nurse's station, because one of the things we realized was that, gosh, if we ever have this kind of emergency again everything we need is in the back hallway… and the other thing yourself in and be safe; like you're really at risk. So certain changes were made because of that situation. We had a lock put on one door. We have an emergency bag behind the nurse's station with protective equipment if there's ever an emergency. Another issue we had was that the restraints that we needed were in the hallway.

Participant 6 again went into detail regarding the positive outcome and environmental need changes. Participant 6 verbalized,

> We made policy and procedure changes. We made the unit where, if and when it happened again, we were going to be more prepared. When security came up on the unit there were no gowns available, there were no goggles, none of that, so we made sure that that is available in the back, so when we call for help it's readily accessible, actually for all of us; not just security but for all of us.

Participant 9 talked about knowing your environment and the ability to access information when needed in an emergency. Participant 9 stated,

> Knowing the phone number to security, it's right on the telephone if I'm ever in a situation where it's like, "oh crap, I need security." Knowing that my charge nurse is going to be there right when I need her or in the event of something happening, the tools that I need to perform my job are at my fingertips and at my disposal. Not feeling left alone; I think that sense of comfort that I'm not alone when this happens that someone will help me when I need help.

The physical environment and space was also noted as an awareness tool for positive outcomes. Participant 1 stated,

> Giving patients more space when they're upset, but it's hard because if they're upset here and they're loud and they're banging stuff you have to respond. It would nice if they had a place where a patient could just be angry for a few minutes and then come and try to express their anger verbally as opposed to physically acting out. I'm giving people a little more space; I let people talk more aggressively for a little longer before I try to interject I guess.

Themes Associated with Research Question #3

For Research Question #3, I sought to answer the following question: What are negative experiences when returning to the workplace after an assaultive incident? This reflective question provided an opposing view to the previous question in order to obtain an in-depth understanding of the phenomena of returning to the workplace after an assault. Although the event itself was negative, this question was in opposition, after positive reflections were identified in order to gather depth on the perspective of violence in the workplace. There were three themes that emerged from this question. Each theme

was reciprocal to the positive experience as described in question one; however it provided the opportunity for full reflection of the event and provided trustworthiness of data.

Theme 1: Negative response. In question 2, a universal response after assault in the workplace was the positive impact on peer support. Several participants noted this as one of the most imperative aspects upon returning to the workplace after assault. However, it was also identified that a negative peer response is counterproductive within the phenomena. Participant 4 discussed that as the provider, she was blamed by her peers for the incident. Participant 4 stated,

> Blaming the staff for the incident; that was negative. In other words we had to explain what our interventions were prior to that, like what happened prior to that incident? Well, I'd say initially the way that I felt was that we were held responsible for a patient's bizarre behavior, assaultive behavior; that we were blamed for it. I think peers should not be judgmental towards those that are assaulted. I think a lot of times the victim is blamed; just like in domestic violence the victim is blamed and I think it's similar and I think that that's how I felt. That nursing staff was blamed for not doing something to prevent that. I think that's what is, blame the victim.

Participant 6 said, "It's going to be he said, she said, and even if somebody wasn't there they're going to hear about the event so it's probably good for everybody." Participant's verbalized that talking about the assault at certain times is not professional when working with other patients. Participant 3 stated,

> Coworkers bringing it up in front of other patients that could hear. Maybe being at the nurse's station and a coworker says… hey, I heard what happened yesterday when such and such hit you, are you okay?... and then other patients hear; other patients may say… oh, such and such hit you… that's horrible; are you okay… and then they start telling other patients. That professionalism that you try to have with the patients, no matter what happens, it gets kind of blurred. You just want to maintain that professional environment.

Participant 8 described the negative aspects of peer involvement. She noted,

> Multiple staff members kind of gossiping… not gossip; I don't think anyone was intentionally being gossipy, but just spreading the word about the incident and what had occurred and people asking me if I was okay and drawing attention to it. Drawing attention to it made it difficult to continue working.

Participants reported the lack of empathy surrounding the event as a negative outcome of the phenomena. The derived lack of empathy was from their surrounding peer group Participant 7 stated,

> That doctors don't seem to care and ask like… how you doing... or whatever are. Like it's presented to them in treatment rounds that are done Monday through Friday and I've had this happen twice, like an attendant won't go up and just say, "oh, how are you doing," or something or, "I heard you got hit." It seems almost like the cost of doing business or you're like my little soldier out there in the field. I tried to get past that but I do have that feeling. I think that doctors are like a little cold, without a doubt.

Participant 4 articulated the negative experience as summation

> You know what? There wasn't blame… no, there wasn't blame then because a lot of us get smacked around a lot every now and then. You get smacked on your head or you get your hair pulled, and that happens, but this was different. This was like the whole unit assaulted. All the nursing staff was assaulted. The patients were in lockdown. It was a real severe situation. It was a critical situation. We've all been slapped on the arm; all of us have or had our haired pulled.

Participant 4 also verbalized a lack of empathy stating,

> That even the physicians; like even the physicians didn't acknowledge what happened because one of the nurses overheard, who was there at the incident, heard one of the attendants say, "wow, I got that call on my birthday." So you know, it's like, well…

Theme 2: Questioning nursing practice. The responses to Question 2 clearly identified the need for staff to review the incident, during a time when they could cognitively process the event. This peer evaluation was emphasized by all participants in the study. One pertinent response to the potential negative outcome of the event was the registered nurses or their peers questioning their practice or their management of the assaultive incident. Participant 4 recounted her perception of the event as well as peer perception. Participant 4 said,

> Well… we were asked questions like, was the patient given PRNs? and…well, why didn't notice the patient was agitated?... and basically what happened, the patient, because he wouldn't take medication, was denied a smoke break which is

> our practice here so if you don't take your medication you're going to lose your smoking privilege. That's what provoked the patient to, you know? They questioned that we missed the signs. What we did, when we saw the patient was upset about missing the cigarette we thought, well, let's give him … I forget which nurse gave him the medicine, but one of the nurses gave him medication, so we thought, okay, let's monitor, and we didn't see any further signs that he was agitated because he was quiet.

Several other participants questioned themselves when it came to their practice decisions prior to the event. Participant 1 stated, "I was more angry at myself because I kind of saw the situation bubbling up and I didn't make some of the necessary adjustments to avoid the altercation."

Participant 6 questioned

> And this is really, really dramatic but the thought came and went, that I should look for another job what am I? I must be crazy? What am I doing in psych all these years? Why don't I look for another position as a registered nurse? What am I thinking putting myself at risk like that? And I have days like that; that's just when there's an incident.

Participant 7 questioned his actions stating,

> I knew he was volatile and walking on back to the quiet room where he was I think you're…. like your radar goes up or something in the next situation, because we had known he was volatile and taking him out on the smoke break was

> actually… the charge nurse said it's up to you, or whatever, but maybe not to be as lax.

Theme 3: We are vulnerable in health care. Theme 3 of Question 3 really exemplifies the essence of the experience for registered nurses. Several participants discussed their vulnerability in their current role. This aspect of the phenomena lends to the feelings surrounding post assault nurses experience. The expression of vulnerability was presented in various ways, each citing that in nursing practice; you never know what can happen and the practice environment is unpredictable. Participant 4 stated,

> Well I would say I felt vulnerable to a degree because you don't really know what to expect, and as time went by that feeling passed, as the shock passed. Well, it's not so much an action because you're still going to behave as a nurse and practice as a nurse. I think it's more of what kind of attitude do you not come to work with; it's more of an attitude thing, so I would say don't come with the attitude that you're going to be assaulted again, something bad is going to happen, it's all your fault. Come with the attitude that being in a helping profession you make yourself vulnerable to other people, to patients. You're vulnerable to the behavior of others. In health care you are; you're vulnerable.

Some participant described what makes a registered nurse vulnerable. They gave examples of their vulnerability to unpredictable situations. Participant 5 said,

> I would not recommend acting apprehensive around patients. Umm that that you're nervous or you're scared because I think that they just feed on that and I think that that's a bad thing. I think you have to have confidence in what you are

> doing.… I would... I think you have to be on guard, but I wouldn't let the patients see that that you're nervous or you're scared because I think that they just feed on that and I think that that's a bad thing. I think you have to have confidence in what you are doing.

Participant 2 well described the essence of vulnerability by stating,

> Well just that there was always the unpredictability, you know? We all know what signs of impending agitation are, when people start to get worked up and activated and what kind of signs to watch for. We all know about those things but sometimes there aren't signs, and I think that was a little bit more of a worry, that sometimes it really seems to come out of the blue and you can't be prepared. You're not prepared because there weren't any signs ahead of time.

Participant 6 recanted,

> Worrying about, okay, what I am going to do the next time this happens or what am I going to do the next time a patient assaults me, so I guess that would be the negative experience. Like are we going to be prepared the next time this happens? It's the uncertainty that I didn't have before the assault.

Participant 7 stated,

> Not that I thought I was lax but just more prepared or whatever for the situation based on someone who had been so volatile and unpredictable. That's probably the biggest thing with the patient, was the unpredictability of when he would swing out.

Themes Associated with Research Question #4

For Research Question #4, I sought to answer the following question: How have the assaultive incidents affected nursing practice? The response to Question #4 was based on the personal factors that were created from the lived experience after assault in the workplace. Three themes emerged. Overall, the responses reported that the assaultive event did not affect their nursing practice with patients, but how they practice within a risk area for assault in the workplace.

Theme 1: Focused on safety. Several participants in this study provided generalizations regarding practice as maintaining a level of safety. The theme of nursing practice centered on safety was evident. Participant 2 said "well, I was going to say that it made me a little more worried about, worry is the wrong word…. but a little more concerned about safety."

Participant 4 reported that, "you have to think quickly; you have to think quickly because I know when that happened we had to make the unit safe because there is a lot you can't control, and we had to focus on certain elements after that assault."

Participant 9 reiterated "just that like that feeling of security, that feeling of the team working together and making it less stressful. I think ensuring their own safety."

Others under this theme described what practice interventions a registered nurse could implore to ensure safety. Participant 8 suggested that

> I think it could in general be made easier by department wide, hospital wide support in those incidences particularly for patients because, in theory often the emergency department what will happen with patients is, that they get 302'd, go

> to CRC, 302 is not upheld, get discharged from there. So if there was any legitimate threat to the nurse, the patients walking around on the street a block away, security could say… hey, do you want for me to walk you out?

Participant 9 suggested education to ensure safety. She stated,

> We had the MOAB training, the Managing Aggressive Behavior, and that was kind of helpful learning how to keep myself safe, learning de-escalation concepts, so I think just that whole education and knowing who to call, when to call and being aware, kind of recognizing aggressive behaviors before it gets too out of control.

Participant 1 also provided strategies. He stated,

> That way we have handled the care as a practice to safely handle patients, knowing your environment. I've been in a lot of situations where it has worked so I fully believe in it. When you go to these classes pay attention. The verbal de-escalation works. That stuff works so be vigilant. Do your mandatory yearly stuff because it works. I've been in bad situations and security comes over; everybody has had the same training and you feel confident going into a situation, even though you try to avoid it, but you know you're prepared if it happens because of the training.

The last participant summarized the two incidents of workplace violence and described what the essence of the experience. Participant 4 stated, "You know; you feel vulnerable when that happens but it didn't feel dangerous and unsafe. What happened with that other incident, we felt trapped; I felt trapped and unsafe."

Theme 2: Awareness. The notion of increased awareness and vigilance as an outcome after assault was also reverberated in various ways. Awareness is another sense of knowing, related to being increasingly aware of the potential dangers that registered nurses are facing in the workplace. Awareness as a general theme underscores the impact of the assault on the continued practice of registered nurses.

General comments regarding awareness of surroundings were embedded throughout the transcripts. Participant 4 stated,

> Because you know, actually all the patients and we say no to so many things… they can all do that at any time and things are not predictable in psychiatry, of all things; things are not predictable. I feel okay now but I do realize that in this field we are, in a general sense, vulnerable because anything can happen, even in the main hospital. Everyone is vulnerable because it's a caring profession, it's a helping profession and things happen, and we could be target.

Participant 8 described awareness as "being more keyed into the triggers of when violence can happen." Participant 1 stated,

> I'd tell people if your gut is telling you something is off then it probably is, and call some for the appropriate backup. If you don't feel good about a situation and it looks like its going bad call for security because a show of force hopefully will help calm things down before someone can be assaulted or staff gets hurt.

Other participants of this study presented the general awareness as a learning experience that enhances ones' practice. Participant 5 stated,

> I learned from it. It affected it no but I think I learned from it… to just know that every time something like this happens I think it's a learning experience for everyone, just to know it's an awareness tool. It's an awareness tool that makes you aware to what's happening around you and what can happen to you at work because you just never know so I think it just makes you more aware.

Participant 2 described awareness by saying,

> I think it made me a little more… on in a verbal sort of way… but I think it made me a little more proactive about checking in with patients, doing more than just noticing, but just making a couple of extra contacts in a day of… how has the day been?... everything is okay?... anything happened that I need to know about that maybe you think I didn't notice about how your day was or how people treated you?

Theme 3: It's part of the job. When discussing practice, the registered nurses who had experienced an assault in the workplace acknowledged that this was part of their job duties. Assault, does not affect practice, as it becomes a part of the practice environment. Several of the participants demonstrated an understanding that the potential of assault is inherent in the work that they do. Participants in general had a very reserved response to assault and violence as part of their job duties and described it as an acceptable risk. Participant 1, in response to change in how one practices he stated,

> No; just the feeling working, I know it's a possibility that these things happen and I think around here we're like… hey, it happens… so you just keep pushing. You still want to help everybody; I still want to help everybody get better, take your

> meds, stop coming to the hospital as frequently as they do, so I think my practice is the same.

Participant 7 stated,

> I guess in a sense realize its part of the job, unfortunately, that its part of psych, anyone who works in psych knows. Luckily I should…I've been doing this for 20 years and I've only been hit a few times so I think that's pretty decent, like a good record, knock on wood, but I think that you accept the risk.

Participant 3 reiterated that "I don't think I really even thought about it when I returned to work. It didn't affect how I felt about returning to work. I accepted it as part of my practice and I felt safe. One participant summarized the themes from Question 4 in a broad statement. Participant 5 said,

> Just the knowledge that it could happen again at any time, that this is something that… this is where we work this is what we do and you know you just have to be aware of your surroundings and being able to talk to your peers about it and knowing that you know what happened and let other people learn from it knowing what the experience would be like that at any moment in time someone can go off on you without any warning.

Summary

The purpose of this qualitative research study was to gather an in-depth understanding of the lived experience of returning to work as a registered nurse employed in a high risk area, after being assaulted by a patient while on duty in the hospital setting. The population of nurses that were recruited for this study included 9 registered nurses

from high risk areas including inpatient psychiatry and an emergency department. The registered nurses that participated in this study consented to be interviewed and were forthcoming with in-depth detail surrounding the phenomena of returning to the workplace after an assault by a patient.

The interviews provided relevant significant statements regarding the lived experience. The sampling method, research questions, data analysis procedures, trustworthiness in data, themes, and in depth narratives presented by the participants were outlined in Chapter 4. The majority of the statements were personal statements and opinions of how the participants experienced returning to the workplace. Significant observations were incorporated into the results.

The data analysis process consisted of an extensive review of the transcripts. The transcript review provided insight into the generated themes. NVivo 10 was used to further extract themes creating nodes based on the responses of the patients that were maintained on an excel spreadsheet. References had to be cited a minimum of 5 times within the data analysis process in order to generate a theme. A total of 14 themes in total were generated.

The themes represented the phenomena of returning to the workplace after an assault by a patient for registered nurses. Research Question #1 was a broad based question requesting the detailed account of returning to the workplace after an assault. Four themes emerged from Question #1: An emotional response, lingering emotional response is patient dependent, coping through peer support, and keeping a distance. Four themes emerged from Research Question #2 and they included: knowing your supported,

post working with peers, acknowledgement, knowing the environment. Research Question #3 had three themes: Negative responses, questioning nursing practice, and we are vulnerable in health care. The last Question #4 also had three themes emerge: Focus on safety, awareness, and it's a part of the job. The relationship between the responses was congruent throughout the data and evidenced through the narrative writings. Throughout Chapter 4 the registered nurses in this study clearly articulated the lived experience of returning to the workplace after assault and resiliency strategies in the workplace.

In Chapter 5 I will present, discuss, and evaluate the research findings presented in Chapter 4. I will also discuss limitations and implications for social change within health care with recommendations for further research.

Chapter 5

Introduction

The purpose of this qualitative, phenomenological research study was to gather an in-depth understanding of the lived experience of a registered nurse employed in a high risk area returning to work after being assaulted by a patient while on duty in the hospital setting. The objective of this phenomenological approach was to provide a voice for this recognized oppressed group, with the focus on the experience of returning back to the same contextual space in which a traumatic event was experienced. The lived experience can never be grasped in its immediate manifestation, but only through reflection which provides a contextual essence of the totality of the experience (Van Manen, 1990). Chapter 5 will provide interpretation and reflect on the essence of the experience from the findings illustrated in Chapter 4.

This study is imperative to nursing practice. Among health care occupations, the nursing profession has the highest percentage of workplace violence (Harrell, 2011). The research has indicated that an estimated 80% of nurses do not feel safe in the workplace (Peek-Asa et al., 2009). The study of workplace violence towards nurses has been well researched. There have been over 100 articles published on the incidence of workplace violence and a systemic review conducted that reviews nursing exposure to violence (Spector, Zhou and Che, 2013). However, there is limited research on the lived experience phenomena of returning to the workplace for nurses after an assault.

Interpretation of Findings

In analyzing the findings of this study, I identified 14 themes related to four research questions that emerged.

Answers to Research Question #1

There were four themes that were identified for Question #1: Describe, in detail, what it was like when you returned to the work after the assaultive incident. This question revealed that participants experienced an emotional response when returning to the workplace after being assaulted by a patient. This was the first theme identified in Question #1. The emotional response varied between individuals in the study. The most noted emotional response was anxiety; however other responses included embarrassment, frustration, helplessness, anger, and fear. The majority of these findings are consistent with previous research. The most frequent emotional responses to violence in the workplace in the aftermath of violence included frustration, anger, fear, and emotional hurt (O'Connell et al., 2000).

The second theme identified in Question #1 was the lingering emotional response was dependent on the patient. Several participants described the anxiety or fear remained with them with continued exposure to the perpetrator. The emotional responses were time limited. There was no corresponding evidenced that linked the patient with length of time of the emotional response. This is a new finding generated by this research. Research has previously noted that 17% of nurses post assault in the workplace met criteria for Post-Traumatic Stress Disorder (PTSD) immediately after the assault and after 6 months 10% met the criteria for a diagnosis of PTSD (Richter & Berger, 2006). There was no

evidence of PTSD in any of the participants who volunteered for this study. The sample selection for this study had overcome at least two episodes of violence in the workplace in accordance to the sampling criteria. Resiliency research has indicated that some individuals emerge from adversity with stronger capacities when challenged which may account for the time limited response (Gillespie, Chaboyer, & Wallis, 2007).

The third theme identified in Question #1 was coping through peer support. The participants reported a significant impact on positive peer support in the workplace post assault. Every participant in the study discussed the notion of peer involvement in the experience in returning to the workplace after assault. Peer support was reported as a positive indicator that assisted registered nurses with the ability to survive and thrive in the workplace. This is consistent with previous research. Social support that includes family and peers with secure attachment and positive reformation from peers is associated with fewer behavioral issues and overall psychological well-being (Herrman et al., 2011). Key indicators toward resiliency include high-hardiness traits with problem-focused coping strategies (Simmoni & Patterson, 1997). Registered nurses verbalized that peer support was significant and utilized; this indicated that active coping was utilized in the aftermath of violence. Positive outcomes are related to active coping that is characterized by problem-focused problem solving and seeking social support (Ming-Hui, 2008).

The fourth theme identified in Question #1 was keeping a distance. The distancing was referred to in various forms. Some of the participants term the distance as vigilance, while others referred to the distance as “on guard.” The essence of this finding

is that distance is an identified emotional response in the workplace after assault. Research supports that nurses who experience workplace violence suffer from posttraumatic stress symptoms including distressing emotions, difficulty thinking, and withdrawal from patients (Gates, Gillespie, & Succop, 2011a). This finding may indicate why the evidence suggests that patient care can be interrupted after violence in the health care setting and can be correlated with distancing oneself from patients. This data is consistent with previous findings that work productivity, disturbed mental health, and headaches are the most frequently reported effect by nurses after violence in the workplace (Ozge, 2003).

Question #1 developed the essence of the experience for registered nurses who returned to the workplace after assault. The narratives provided the voice of the participant nurses who experienced violence who returned to work after assault. The nurses stated that they had an emotional response on return to the workplace that continued for a brief period, particularly if they had further expose to the perpetrator. They also reported that peer support was a significant venue for alleviating symptoms. Lastly, the nurses demonstrated a secondary coping response that including distancing themselves or being "on guard."

Answers to Research Question #2

Four themes were identified for Question #2. Question #2, what are the positive experiences when returning to the work place after an assaultive incident? This reflective question was poised to provide insight into the phenomena of resiliency factors that were identified after a registered nurse returned to the workplace after assault. Finding

meaning during stressful situations is an essential factor for individuals who have undergone adversity (Graham, Furr, Flowers, Thomas-Burke, 2001). Identifying a positive affirmation to a negative incident required true reflection on the part of the participants.

A significant theme again emerged surrounding peer support. It was considered a positive experience when victims in this study felt supported by peers or other outside sources. The participants reported that knowing they had the support of their peers assisted them in feeling comfortable in acclimating back into the workplace. This notion of social support aided in overcoming feelings of powerlessness experienced by the registered nurse. Violence is an issue of oppression because it is directed at members of a group simply because they are members of that group (Dubrosky, 2013). Peer support empowered the staff. Research has clearly indicated the impact of social support in resiliency. By improving the provision of protective factors that includes a positive environment that is strong, supportive, and offers peer relationships, resiliency can be enhanced (McAllister & McKinnon, 2009). Further research had suggested that that individuals who report greater satisfaction with support, also report greater use of adaptive ways of coping with stressful situations (Delongis & Holtzman, 2005 p. 1646). This clearly articulates the lived experience of peer support after experiencing violence in the workplace and is consistent with evidence. Opportunity for further research in this area is needed and will be offered in Chapter 5.

The second theme identified in Question #2 was after working with peers. The majority of respondents in this study identified that reviewing the event with peers was

necessary to gather a better understanding of the incident. The participants further noted that this review should not be done immediately after the incident, but at a time when the staff is better able to process the information. Several of the participants included ideas for the structure of the post assault review with peers. The structure included a review of what may have led to the incident, a check up on the employees involved, and what could have been done differently. The participants reported that this is needed.

The idea of critical incident debriefing is not new. The participants of this study requests for debriefing correlates with known critical incident debriefing literature that includes the nature, intensity, and duration of the traumatic event; pretrauma vulnerability and preparedness; post trauma experiences; and individual differences, reactions, and perceptions of the event (Campfield & Hills, 2001). The purpose of critical incident debriefing is to facilitate the normal recovery process (Campfield & Hills, 2001).

The registered nurse participants verbalized that nurse's need critical incident debriefing after an assault by a patient in the workplace. The implementation of critical incident debriefing after assault is an opportunity for development that includes, process, procedure, and tools. Currently this is not included in the Occupational Safety and Health Administration recommended strategies for workplace safety (Occupational Safety and Health Administration, 2004).

The third theme identified in Question #2 was acknowledgment by others that the incident was stressful. The participants identified acknowledgement as a positive antecedent after assault in the workplace. This acknowledgement within relationships may influence coping by turning to others in the face of adversity for a sense of direct

provision of information regarding efficacy and coping strategies (DeLongis & Holtzman, 2005).

The fourth theme identified in Question #2 was the thought of knowing the environment. Several of the study participants discussed the physical space in relation to positive outcomes after assault by a patient. The environment was not only expressed as physical space, but the controls within the environment that created a positive outcome. First, it is important to note that environmental changes as described in the study were prompted by the assaultive event. This is consistent with the literature that notes individuals who believe they are effective and do not imagine their own failure add increased self-efficacy and empowerment which was an objective of this study (Simoni, Larrabee, Birkhimer, Mott, Gladden, 2004).

The nature of the environment has been examined in the literature. Providing provisions to the environment, such as a metal detector, demonstrated an increased perception of safety when in use in some industries (Kowalenk et al., 2012). In the hospital setting safety measures that have been implemented include surveillance cameras, restricting access to certain areas, the use of panic buttons, and proper lighting and visibility, and alarm systems for provision of patient safety (Lee et al., 1999; Ayranci et al., 2006). Similar safety measures were implemented in the workplace environment for the registered nurses who participated in this study. As noted by this study, they have identified this as a positive outcome post assault in the workplace.

Answers to Research Question # 3

Three themes were identified in this study from Question #3. I sought to answer the following question: What are negative experiences when returning to the workplace after an assaultive incident? The three themes identified were in direct opposition of the positive experience of returning to the workplace after an assault. This would indicate trustworthiness in the study as data remains consistent throughout.

The first theme identified in Question #3 was negative responses. The participants in this study reported that a negative response from the peer group was counterproductive. The registered nurse participants reported that the negative outcomes were in response to a loss of control by the participant that may have added to the event. The participants were quick to mention that this reflects blaming the victim. This finding is consistent with the literature. The literature has indicated that the sense of abandonment particularly surrounding inadequate staffing levels, unfulfilled promises of workplace safety, ignored concerns, and lack of support by peers can lead to nursing dissatisfaction (Gacki-Smith et al., 2009). The finding that the participants expressed dissatisfaction with negative responses from peers may be in relationship to the coping strategies utilized by the nursing staff. An effective coping strategy that has been identified presumes that locus of control increases well-being when managing stress (Arslan, Dilmac, & Hamart, 2009). The implication in negative responses by peers assumes the loss of control over the stressful event, therefore is viewed as a poor outcome.

The second theme identified in Question #3 is questioning nursing practice. A negative response was that the nurses were questioned regarding the management of the patient either by themselves or a peer. This is an interesting finding as the participants had stated that they felt the need for a review with their peers as imperative after an assaultive incident in the workplace and noted this in Question #2 as a positive. This reflection may indicate that the need for nurses to believe in their individual capability to manage patients. The belief in ones' capabilities to mobilize cognitive resources assists the individual in a course of action to successfully execute a specific task within a given context and be reflective of perceived self-efficacy (Avey et al., 2010). When the course of action is in question, there is a risk to perceived self-efficacy.

The thirds theme identified in Question #3 was that nurses are vulnerable in health care. This was an interesting finding and directly correlates with nursing as an identified oppressed group. This reflects research that indicates that it has been the expectation of nursing staff to tolerate violent behavior (Gates et al., 2011b). Nurses have long been placed in subordinate roles with a lack of power and control within a hospital based system (Roberts, Demarco & Griffin, 2009). Vulnerability within the workplace directly correlates with an oppressed group and the participants of this study recognized this notion. This will be further discussed in research Question # 4 themes.

Answers to Research Question # 4

The final question in this study elicited three themes. Research question #4 how have the assaultive incidents affected nursing practice? This question did not elicit any significant data regarding practice; however the focus of the participants in the study was

identified by their own personal developmental changes after the assault relational to the practice setting. The first theme identified was the focus on safety.

The participants of this study reported that concerns and maintaining safety were enhanced after the assault in the workplace. The safety strategies identified in this study were objective in nature with some noting a re-enforced focus on education. Antidotal evidence has suggested that education has limited impact on assault rates; it has been shown that preventative programs increase knowledge and confidence to deal with aggressive or assaultive patients (Kowalenk et al., 2012). Some of the literature supports educational programs that included recognition of aggression, interaction with the aggressive individual and the skills and techniques to prevent potentially threatening events from occurring demonstrated improvement on individuals insight into aggression and increased the ability to cope with adverse situations (Oostrom & Van Mierlo, 2008). This response by the participants of the study may be correlated with gaining mastery and an effective coping mechanism.

The second theme from Question #4 was an increased awareness. This generalized theme resounded that their workplace is considered at risk for violence. The participants identified the unpredictable nature of the work environment in which they practice. The evidence clearly supports this notion. The patient population in and of itself causes a risk. The literature reveals that patients with a diagnosable mental illness including schizophrenia, mania, psychosis, and certain types of brain syndromes including dementias, substance abuse and personality disorders have a direct correlation with aggression (Johnson, 2004; Quintal, 2002; Flannery, Irvin, & Penk, 1999). The

emergency department also has inherent risks toward violence. Ease and accessibility from the public, 24 hour access, perceived environmental chaos, and increased stimulation, and a high stress environment pose a risk for increased violence (Howerton, Child, & Mentes, 2010). It is interesting to note that this awareness was demonstrated under the question, how has this incident affected your nursing practice? The risk associated within this work setting has been well documented so the interpretation would include limited awareness prior to the assaultive incident.

The final theme from Question # 4 is that "it's part of the job". The participants of this study had clearly identified that working with patients pose a risk of safety. The literature acknowledges the same and suggests that nurses consider aggression and violence as part of their job (Findorff et al., 2004). The narrative data clearly identifies that participants of this study had tolerance for workplace violence. Tolerance is considered an attitudinal dimension that is defined as an expressed awareness and endorses positive evaluations (Whittington, 2002). Therefore, this is not a new knowledge, but emphasized the importance of managing the aftermath of such incidences and the need to implement change to address this issue.

The majority of current violent in the workplace policies focus on preventive measures. The Joint Commission on the Accreditation for Hospitals (JCAHO) has taken some significant steps in addressing workplace violence by implementing standard LD.03.01.01 which stipulates that leaders need to create and maintain a culture of quality and safety throughout the system by developing acceptable codes of conduct, managing undermining behaviors and placing processes in place to ensure a safe culture (ANA,

2014b). However, this broad based definition does not address actions to be implemented by organizations post violent incident.

This research study has identified divergence from the current literature. The first issue of divergence is the role of leadership in a culture of safety. Lack of institutional support particularly surrounding inadequate staffing levels, unfilled promises regarding workplace safety and in insufficient support from management can lead to nursing dissatisfaction (Gacki-Smith et al., 2009). The evidence from this study had no mention of the organization or leadership in response to the management of the experience, but focused on the culture of peer support.

The second divergent characteristic from current research is the implementation of zero tolerance policies as a means to minimize workplace violence. The zero tolerance campaign expects that clinical staff view violence as unacceptable (Whittington, 2002). This research has identified that workplace violence is part of the job. Zero tolerance for workplace violence and promotion of polices surrounding this notion is not realistic to the duties that registered nurses perform. This may lull registered nurses into a false sense of security, thus the increased awareness of violence potential which was another outcome of this study.

Conceptual Framework and Implications

One of the most powerful outcomes of this study is the direct application of the conceptual framework of resiliency identified throughout this study. Resiliency is characterized by good outcomes in spite of a serious threat to adaptation or development (Masten, 2001 p. 228). The sample selection was based on resilient features including

remaining in the workplace after at least two episodes of violence while on duty. The sample exemplified a population that meets the criteria for an at risk population. There are multiple definitions of risk, but for the purpose study the risk was identified a critical event that hinders normal functioning (Johns & Weichelt, 2001). The application of resiliency as a notion in returning to workplace violence has clear implications for further development.

The findings of this study were consistent with the model of resiliency. Most significantly was the continued reverberation of peer support as an effective strategy post assault in the workplace. Social relationships may influence coping by turning to others in the face of adversity for a sense of direct provision of information regarding efficacy and coping strategies (DeLongis & Holtzman, 2005). Resiliency research suggests that individuals, who report greater satisfaction with support, also report greater use of adaptive ways of coping with stressful situations and this was correlated in the findings (Delongis & Holtzman, 2005).

A second correlation with the resiliency framework was the role of self-efficacy and a sense of coherence. The registered nurses in this study reported both positively and negatively, that acknowledgment and conversely, negative peer responses were inherent in returning to the workplace environment after an assault. Resiliency attributes have been measured through the example of self-efficacy, self-esteem, and sense of coherence (Wagnild, 2009).

Another characteristic inherent in resiliency that was found in this study was the questioning of one’s practice and the frequented requests to review the incident with

peers. Resiliency has demonstrated that belief in ones' capabilities to mobilize cognitive resources assists the individual in a course of action to successfully execute a specific task within a given context (Avey et al., 2010). This also corresponds with research that has indicated that cognitively adapting to experiences is enhanced with strategies such as finding meaning, gaining mastery and enhancing self through social comparisons (Chapman et al., 2010).

The registered nurses in this study demonstrated an active coping approach when it came to adversity. The coping strategies implored by the participants included, seeking support, and problem focused strategies to create a change in environment. The single significant characteristic that encompasses resiliency is in the coping approach that includes high-hardiness traits with problem-focused coping strategies (Simmoni & Patterson, 1997).

The application of resiliency was demonstrated in this research study. The process of resiliency is activated through adversity and the introduction of interventions that reduce the difficult situation (Gillespie, Chaboyer, & Wallis, 2007). There has been limited application of resiliency when returning to the workplace after assault in nursing. The participants in this study identified resiliency correlates that assisted in helping them overcome adversity. Although resiliency correlates and risk groups have been clearing described in the literature, there remains a lack of understanding of the integration of resiliency into practice (Avery et al., 2008).

Limitations of the Study

There were several limitations to this study. The setting of this study was an urban, teaching hospital within a health care network. This facility has resources that may not be available to other organizations with similar structures. The setting also had both an emergency department and psychiatric inpatient setting. Some organizations do not have both specialties within the same campus location.

Another limitation was related to the population chosen to participate in this study. The study design recruited nurses who were physical assaulted, at least twice, not within the previous three months and returned to the workplace. The findings indicated that there was a level of intensity and severity related to the physical assault. Seven of the nine participants chose to participate due to an obvious increased level of severity related to the violence in the workplace. Equal levels of severity related to the physical assault were not a part of the inclusion criteria. The sample size is a limitation to the quality and credibility of qualitative research findings. However, when saturation was reached as per the data, an additional two interviews were conducted to assure accuracy of information. This strategy was implored in order to assure that theory holds true for additional participants (Creswell, 2012). A limitation of the sample also included the disparity in actual number of participants from each work area. There were only two participants from the emergency department, due to recent turnover of nursing staff. Although this did not affect findings equal representation would be more desirable.

Acting as the sole researcher in a study is also considered a limitation. I alone completed all interviews, formulated data, and organized findings into themes.

Credibility was reinforced by providing the opportunity for participants to review transcripts after the interview. This provides the opportunity to add any additional information to the data. No participants wished to edit their transcript, however acknowledged that they appreciated the interview. Another potential limitation is possible researcher bias. In order to counteract that bias, I instituted constant reflection to suspend all assumptions about the nature of the reality of assault in the hospital setting.

Lastly, truthfulness in the data is correlated with the interview responses. All attempts were made to assure an atmosphere of open honest communication during the interview. I proceeded with broad open ended questions, not injecting any personal assumptions or beliefs throughout the interview process, using a script for guidance. I am under the assumption that all participants were truthful when providing detailed descriptions of what is was like to return to the workplace after an assault.

Recommendations

The evidence from this study represents a powerful message from registered nurses who have been assaulted by a patient while on duty in the hospital setting. This research presents the voice of registered nurses after a critical incident in the workplace, and primarily that voice needs to be heard. The evidence presented several themes that were consistent across participants. The themes included; an emotional response, that lasts for a brief period that is dependent on interaction with the perpetrator, keeping ones distance, awareness, acknowledgement, peer support, negative peer response, interactions with peers post assault, knowing ones environment, and sensing safety, questioning practice, feeling vulnerable, and knowing it’s a part of the job. The research described the

essence of the phenomena which is a linguistic construction and description that structures the lived experience (Van Manen, 1990). The essence within the phenomena of this study was based on feelings and coping. The registered nurses told their story of living through a traumatic event at work. These feelings and essence were not quantitative, but even more powerful as feelings can be transformational.

My first recommendation builds on the purpose of this study, to provide a voice for an oppressed group. In order to understand the cycle of oppression, one must first alter the silence and inaction (Roberts, Demarco, & Griffin, 2009). The registered nurses have provided an understanding of the phenomena. I previously stated that I will be presenting this information at the University of Pennsylvania, Pennsylvania Hospital for the nursing team and leadership, but I do not believe that is sufficient. I further recommend presentation of the findings for local, regional and national conferences. I will make definitive plans to disseminate this information by writing their stories for a journal article. The goal is to break the silence of inaction.

This study correlated with resiliency concepts that aid in overcoming adversity in registered nurses practice. I believe there is a further need to examine a more inflexible or rigid sample of registered nurses. A corroborating sample of nurses who left nursing practice after a critical incident or assault is suggested. This understanding assists in the full development of antecedents that a registered nurse may experience after an assault. The examination of the level of assault can also be more fully developed. This study did not define severity or intensity of assault. A follow up study that examines nurses that left the workplace with a high intensity critical assault injury may provide even more insight

into the phenomena. A similar methodology could be applied, with extreme caution to do no further harm. Implementing a resiliency scale prior to participation or having an extended period of time between the critical event and the interview would be my recommendation.

There is certainly opportunity to develop more insight on the role of peer support in the workplace, particularly after a critical incident or assault. Social relationships may influence coping by turning to others in the face of adversity for a sense of direct provision of information regarding efficacy and coping strategies (DeLongis & Holtzman, 2005). The evidence from this study presented several venues for further research on peer cultures for nurses in the hospital setting. Organizations need to recognize the need for peer support. Nursing leaders tend to promote the agendas of health care institutions, and administrations rather than promoting the agenda for employees (Roberts, Demarco, & Griffin, 2009). Initial steps in creating this true culture of safety includes defining a critical incident with the registered nurse employee at the center of the definition. The second is to utilize the voice provided in this evidence to develop a critical incident tool or narrative that meets the employees' need for support. The employee critical incident tool needs to be developed and tested to assure reliability and validity. Set policies for organizing peers to implement supportive measures, that are time based are needed to review critical incidents for professional development. The bedside registered nurse needs to be empowered to make change. Powerlessness is exemplified in workplace violence by lack of decision making, limited capacity to make changes in regards to major decisions, that are made by regulators and administrators,

and that are based on what's best for the health care organization rather than what's best for nursing employee (Dubrosky, 2013).

I recommend that a campaign for acceptance, that violence is part of the job for nurses is launched. Violence in health care towards nurses is indisputable. A large study conducted by Hader (2008) concluded that 80% of those nurses surveyed from the United States, Afghanistan, Taiwan, and Saudi Arabia had experienced violence within the work setting. We can no longer have zero tolerance for violence in health care because it is cognitive dissonance.

The application of resiliency as a conceptual framework demonstrates considerable promise in the workplace setting after adversity for employees. Resilience focuses on a strength based strategies and the building onto existing capabilities including an individual's inner strength, competence, optimism, and effective coping patterns (Wagnild, 2009). The resiliency strategies identified in the study need to be fostered. Resiliency can be supported when it is learner-centered, has positive and high expectations in the environment, and provides a strong social, supportive community (McAllister & McKinnon, 2009).

Implications for Social Change

Results of this study can have a positive impact on registered nurses personally and professionally. The registered nurses in this study provided the story of the lived experience of returning to the workplace after being assaulted by a patient. Their words were powerful expressions of feelings and the essence of the incident that is transformational in the way we think the experience is like. Providing a voice articulates

ones experience, moves towards a collective identity and is a beginning step in making social change (Crossley & Crossley, 2001).

Registered nurses have been described as an oppressed social group. Submissive behavior of nurses has evolved throughout history in response to a more dominating powerful group within hospitals such as administrators and physicians (Matheson & Bobay, 2007). This is reflected in the evidence when the registered nurses reported feeling vulnerable and that workplace violence is a part of the job. To understand the cycle of oppression and alter the silence and inaction, it must first be recognized (Roberts, Demarco, & Griffin, 2009). To alter the silence of registered nurses, the voice of the registered nurse needs to be heard for empowerment. This can have an impact on the lives of those who care for others. Giving nurses a voice assists in empowerment and provides a forum of respect that allows nurses to be a part of the decision making process and can promote social change (Roberts, Demarco, & Griffin, 2009). This study is empowering evidence that can begin to alter that power of oppression.

Hospital organizations that have a hierarchal system in decision making need to refocus efforts to the decision making at the bedside and areas where the interaction with the patients take place. This hierarchical structure within health care organizations has led nurses to a subordinate role with a lack of power and control within a hospital based system (Roberts, Demarco & Griffin, 2009). Health care leaders have identified preventive measures that can alter violence in the workplace, but there are limited post interventions that can enhance organizational structures in a culture of safety post critical violence incidents. Registered nurses have identified that violence is “part of the job.”

Health care organizations and leaders need to recognize and accept this tenant and provide the resource of time and availability to staff in order to meet the needs of individual employees that have experienced violence in the workplace for social change.

The evidence from this study can also assist in social change through the application of the resiliency model. Successful strength focused outcomes after a negative event could open the door for several researchers to examine the positive results from negative circumstance in order to survive and thrive. Everyone has the potential for resiliency. Resiliency is a process of human development that is activated by adversity and the introduction of interventions that reduce difficult circumstances (Gillespie, Chaboyer & Wallis, 2007). Interventions have been identified in this study that includes a culture of safety that encompasses the response of the community and the support provided. This alone can enhance the lives of nurses working in high risk areas.

Conclusion

This qualitative phenomenological study provided powerful evidence of the experience of registered nurses returning to the workplace after being assaulted by a patient. The stories presented a voice for registered nurses and provided needed reflective insight into the tenants that assisted them in surviving and thriving in a high risk environment. The essence of these stories reframes the notion of the culture of safety in oppressive hospital organizations and validates the need for enhancement to the internal bedside community as an effective measure to counteract the impact of violent events. This study has provided insight into the need for social change in high risk environments.

The powerful results of this study has already produced social change in one health care leader, me.

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Appendix A: Script

Demographics

Please write your responses in the space provided. All information will be kept strictly confidential and will not be used to identify you in any way.

What is your area of employment?

How long have you been practicing as a Registered nurse in your area of employment?

How long have you been a full time registered nurse at UPHS?

How long ago were you assaulted by a patient while on duty in the hospital the first time?

How long ago were you assaulted by a patient while on duty in the hospital a second time?

Script for Interviewer

Script to be stated before proceeding with the interview:

Thank you for agreeing to meet with me today. My name is Kathleen Clark, and I am a researcher and Ph.D. student in Health Sciences at Walden University. I want to understand what is like to return to work after having experienced a physical assault by a patient while on duty. The purpose of this project is not to discuss the assault itself, but to help me understand what it is like to return to the same workplace after you had been assaulted by a patient. It will also help to understand what can be taken away from such as experience when this happens to other nurses. Please know that you can stop this interview at any time. This interview and the information gathered from it are confidential and will not be shared with anyone.

RQ 1: Describe in detail what it was like when you returned to the work after the assaultive incident?

What was your first shift back to work like when working with patients?

RQ 2: What would you consider a positive experience when returning to work after the assaultive incident?

What would you recommend as helpful when returning to the workplace?

RQ 3: What would you consider a negative experience when returning to the workplace after the assaultive incident?

What would you not recommend to an employee who has returned to work after a similar incident?

RQ4: How has the incident affected your nursing practice?

How have preferred the return to the workplace to be?

Appendix B : Letter of Cooperation

Sample Letter of Cooperation from a Research Partner

Pennsylvania Hospital
University of Pennsylvania Health System
800 Spruce Street
Philadelphia, PA 19107

4/22/15

Dear Kathleen Clark,

Based on my review of your research proposal, I give permission for you to conduct the study entitled: The aftermath of violence: The lived experience phenomena of assault in nursing within the Pennsylvania Hospital. As part of this study, I authorize you to recruit nursing participants employed in the emergency department and the inpatient psychiatric units 4 & 6 Spruce, conduct interviews of employee participants and disseminate results. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: access to registered nurses, available space to conduct interviews upon request and supervision that the partner will provide in compliance with the research department. We reserve the right to withdraw from the study at any time if our circumstances change.

The student will be responsible for complying with our site's research policies and requirements, including IRB approval and completion of CITI program training.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Dr. Linda Hatfield PhD, NNP-BC
Pennsylvania Hospital
Director, Research and Evidence-Based Practice
Basement Pine East, B75

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the

Appendix C : University of Pennyslvania IRB Approval

University of Pennsylvania
Office of Regulatory Affairs
3624 Market St., Suite 301 S
Philadelphia, PA 19104-6006
Ph: 215-573-2540/ Fax: 215-573-9438
INSTITUTIONAL REVIEW BOARD
(Federalwide Assurance # 00004028)

20-Apr-2015

Kathleen Clark

Kathleen.Clark@uphs.upenn.edu

PRINCIPAL INVESTIGATOR : Kathleen Clark

TITLE : The Aftermath of Violence: The Lived Experience Phenomena of Assault in Nursing

SPONSORING AGENCY : NO SPONSOR NUMBER

PROTOCOL # : 822275

REVIEW BOARD : IRB #8

Dear Dr. Clark:

The above-referenced research proposal was reviewed by the Institutional Review Board (IRB) on 19-Apr-2015. It has been determined that the proposal meets eligibility criteria for IRB review exemption authorized by 45 CFR 46.101, category 2.

This does not necessarily constitute authorization to initiate the conduct of a human subject research study. You are responsible for assuring other relevant committee approvals.

Consistent with the federal regulations, ongoing oversight of this proposal is not required. No continuing reviews will be required for this proposal. The proposal can proceed as approved by the IRB. This decision will not affect any funding of your proposal.

Please Note: The IRB must be kept apprised of any and all changes in the research that may have an impact on the IRB review mechanism needed for a specific proposal. You are required to notify the IRB if any changes are proposed in the study that might alter its IRB exempt status or HIPAA compliance status. New procedures that may have an impact on the risk-to-benefit ratio cannot be initiated until Committee approval has been given.

If your study is funded by an external agency, please retain this letter as documentation of the IRB's determination regarding your proposal.

Please Note: You are responsible for assuring and maintaining other relevant committee approvals.

If you have any questions about the information in this letter, please contact the IRB administrative staff. Contact information is available at our website: http://www.upenn.edu/IRB/directory.

Thank you for your cooperation.

Sincerely,

Renee Crews

Digitally signed by Renee Crews
DN: cn=Renee Crews, o=ORA, ou=IRB, email=rcrews@upenn.edu, c=US
Reason: I attest to the accuracy and integrity of this document
Date: 2015.04.20 15:56:40 -04'00'

IRB Administrator