Are we ready yet?:
New graduate nurses’ experience of workplace violence and aggression and their sense of readiness

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ABSTRACT

Aim:

The aim of this study was to explore new graduate nurses’ experience of WPVA and their sense of readiness for responding to such events.

Background:

Considerable evidence exists indicating that workplace violence and aggression (WPVA) is a concern for nurses working in all sectors of health. The impact of exposure can be far reaching for nurses themselves, those they care for and for organisations that employ them. There is a need to prepare nurses adequately to enable them to respond safely and competently to WPVA.

Method:

This study used a qualitative descriptive approach to explore the experience of seven new graduate nurses who were employed in a range of sectors, including Mental Health and General Medical units. Data was collected using semi-structured interviews which were recorded and transcribed by the researcher. Thematic analysis was used to analyse the data which generated three themes and associated subthemes.

Findings:

The themes identified were labelled ‘Part of the Journey’, ‘Towards Self Efficacy’ and ‘Maintaining Integrity’. The themes reflect the diversity of experiences and challenges these nurses faced when exposed to WPVA. ‘Part of the Journey’ captured the nature of the experience including physical and verbal assaults, and exposure to horizontal violence. Factors that influenced this experience and how participants made sense of them were identified. ‘Towards Self-Efficacy’ captured the effects of exposure which were mostly negative and psychological. These included lowered self-esteem and confidence, fear and reduced engagement with clients. Only minor physical injuries were sustained. However, positive effects that contributed to the nurse’s self-efficacy, such as increased risk awareness, and improved understanding of client centered care and duty of care were also identified. ‘Maintaining Integrity’ captured the vulnerability participants felt with several aspects of WPVA. Vulnerability was associated with trying to ‘fit in’ with colleagues by not
complaining and attempting to deal with WPVA as competently as more experienced staff. However, the new graduates also identified coping strategies used to maintain integrity and counteract the vulnerability they experienced. They described entering into processes of reconciliation with clients or staff involved, reflective practices and supervision and seeking the support of others.

**Conclusion:**

While a large body of literature on WPVA in the health sector exists, less of it focuses specifically on new graduate nurses’ experience and their readiness for responding to it. This study provides insight from nurses who are at the most vulnerable stage of their career and includes suggestions on how they could be better prepared. In addition it contributes to the understanding of WPVA by providing a contemporary, New Zealand perspective.
ACKNOWLEDGEMENTS

Firstly and fore mostly, I wish to acknowledge the support of my family and friends on the long journey undertaken to complete this thesis. The support of work colleagues and my respective employers has been invaluable. Finally, the wisdom, encouragement, interest and patience of supervisors Virginia Maskill and Sandra Richardson (University of Otago) has been a key component in completing this work.
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<th>Full title</th>
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<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Corporation</td>
</tr>
<tr>
<td>AVIS</td>
<td>Acknowledge, validate, inform, support</td>
</tr>
<tr>
<td>C &amp; R</td>
<td>Calming and Restraint</td>
</tr>
<tr>
<td>CHDSCR</td>
<td>Code of Health &amp; Disability Services Consumers Rights</td>
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<tr>
<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>EAP</td>
<td>Employee Assistance Programme</td>
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<tr>
<td>ED</td>
<td>Emergency Department</td>
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<tr>
<td>H&amp;DSS</td>
<td>Health &amp; Disability Support Services</td>
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<tr>
<td>H&amp;SEA</td>
<td>Health &amp; Safety Employment Act</td>
</tr>
<tr>
<td>HPCA</td>
<td>Health Practitioners Competency Assurance Act</td>
</tr>
<tr>
<td>HV</td>
<td>Horizontal Violence</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MHAct</td>
<td>Mental Health (Compulsory Assessment and Treatment) Act.</td>
</tr>
<tr>
<td>NCNZ</td>
<td>Nursing Council New Zealand</td>
</tr>
<tr>
<td>NESP</td>
<td>New Entry to Specialist Practice</td>
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<tr>
<td>NETP</td>
<td>New Entry to Practice</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
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<td>NZ</td>
<td>New Zealand</td>
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<tr>
<td>NZCMHN</td>
<td>New Zealand College of Mental Health Nurses</td>
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<tr>
<td>NZNO</td>
<td>New Zealand Nurses Organisation</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
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<tr>
<td>SIR</td>
<td>Special Incident Report</td>
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CHAPTER ONE: Introduction

Introduction

There is overwhelming evidence to indicate that workplace violence and aggression (WPVA) is a significant worldwide phenomenon for nurses regardless of the context in which they work (Hegney, Tuckett, Parker & Eley, 2010; Spector, Zhou, & Che, 2014). The effects and consequences of WPVA can be far reaching. Nurses can become fearful, disillusioned and burnt out with many considering leaving the profession after frequent exposure to WPVA (McNamara, 2010). There is the potential for care to be compromised violence and aggression occurs in the health setting (McNamara, 2012). This thesis is the result of a qualitative research study that explored the experience of WPVA of a cohort from a specific population; that of new graduate nurses who were in their first year of practice as Registered Nurses in a small provincial town in New Zealand (NZ). This chapter provides an introduction to the thesis, outlining the objectives and rationale for the study and presenting a brief overview of the seven chapters that make up the thesis.

Objectives

The question underpinning the study was twofold. Firstly, what are new graduate nurses’ experiences of WPVA and secondly, what is their sense of readiness to respond to WPVA? The aim of this study was to explore the experiences and sense of readiness of seven new graduate nurses who had been exposed to WPVA. Drawing on a qualitative descriptive approach the specific objectives were to:

- Establish the nature of WPVA new graduates experienced in clinical practice (such as physical, verbal, horizontal, sexual)
- Identify those involved in WPVA (such as nurses, patients, visitors)
- Understand the effect of WPVA on the new graduate (such as physical and psychological impact)
- Establish what happens after an incident of WPVA in terms of follow up and support (such as the response from the new graduate, other nurses, management)
- Determine new graduates’ sense of readiness for dealing with WPVA and possible improvements in how new graduates are prepared
**Rationale**

The idea for the study emerged following a review of the research and literature related to WPVA in a range of clinical practice areas such as Emergency Departments (ED), care of the elderly, Mental Health (MH), in client and community settings. Preliminary reviews of the literature are useful in determining ‘gaps’ and trends in research and for considering recommendations for further areas of research (Houser, 2008). As a result of the review, several factors influenced the development of the research question and the decision to study new graduates.

There is a large volume of literature on this topic already in existence and given that nurses make up a significant part of health workforce, it is not surprising that much of the literature is either generated by nurses or based on nurses’ experiences. This suggests that WPVA has been and is likely to continue to be an area of concern for nurses. As nursing has become more specialised, literature and research has also become more specific and this is reflected in the fact that most studies relate to a particular context such as ED or MH. This has the potential to limit the understanding of WPVA, limit the strategies to manage WPVA to certain areas and could imply that WPVA is an issue in only some areas. Therefore, a study that draws participants from a range of areas could provide a useful perspective.

Predominantly the literature is internationally based indicating that WPVA directed at nurses is a global issue. Most of the literature reviewed was from northern hemisphere, less from the southern hemisphere and significantly less from NZ. However, a recent study on client aggression experienced by health professionals in a secondary care facility in NZ indicates that WPVA is an issue in NZ with 93% of participants having experienced verbal abuse and 65% physical aggression (Swain, Gale & Greenwood, 2014). Furthermore, the New Zealand Nurses Organisation (NZNO) has identified workplace health and safety in clinical environments as a current priority (NZNO, 2014). When considering the impact of WPVA, much of the research is quantitative so provides information that is statistical and impersonal making it all too easy to dismiss and become desensitised to the full impact. Burns (2014) asks; what does the face of violence against nurses in NZ actually look like? The author relays the personal stories of several experienced nurses who endured serious assaults while conducting their work and is a reminder of the human impact. These factors indicate that a NZ based study that draws on a qualitative descriptive approach could make a timely contribution to current understanding of WPVA.

New graduates are particularly vulnerable to the effects of violence, which can lead to decreased retention in the first year of practice and the adoption and perpetuation of violent
behaviours and abuse (Thomas, 2010). For new nurses, workplace ‘readiness’ includes being competent to provide safe client care in the ever-changing context of health services, including dealing with violent and aggressive behaviour (Wolff, Regan, Pesut & Black, 2010). The need for research to explore how nurses can be effectively prepared and so ready to respond to WPVA is supported by Chapman, Styles, Perry and Combs (2010) who recommend this happen at undergraduate level. In addition, involving new graduates in research has also been found to be beneficial to their future utilisation and generation of research (Wangensteen, Johansson, Björkström & Nordström, 2011). Finally, while the risks to participants are acknowledged it is anticipated that the experience of participating in this study will contribute to professional and personal growth of the participants (Soti, 2012).

To generate a research question, Roberts and Taylor (2002) recommend that the novice researcher consider areas that are of interest and excite or spark curiosity, areas where there is some clinical expertise and connection to the researchers’ area of practice. Interest for this topic stems from the researcher’s previous work history in the MH sector including clinical experience, management, undergraduate education (mental health) and current leadership role where the incidence of WPVA is evident. The impact of exposure to WPVA on nurses and the effectiveness of educational and employer programmes to prepare them for understanding, recognizing, responding to and reducing its occurrence has been an on-going area of concern.

These factors, combined with the opportunity to work in collaboration with a New Zealand regional District Health Board (DHB) that delivers the New Entry to Practice Programme (NETP) and New Entry to Specialist Practice (NESP) for new graduates, resulted in the decision to research experiences of WPVA in this cohort.

**Outline of chapters**

This thesis is presented in seven chapters. The first chapter provides an introduction to the thesis and includes the objectives, rationale and an outline of each chapter. Chapter two presents the background to the study. An overview of existing literature and research on WPVA including the specific context of mental health, population specific (new graduate nurses) and more generic studies which consider wider health professionals experience of WPVA was conducted. A search strategy that included an identified process, inclusion and exclusion criteria and identification of key themes and trends was employed. The key themes identified by the literature search are presented and include definitions of WPVA, prevalence, contributing factors, the impact and consequences and approaches to the prevention and
management of WPVA. A profile of the new graduate nurse, including undergraduate and entry to practice education is provided.

The descriptive, qualitative approach that the study drew on is presented in chapter three. The first section of this chapter provides a background to the choice of methodology and includes a broad discussion on qualitative and quantitative research approaches and the rationale for choosing a descriptive, qualitative approach. The second section provides background to the researcher and includes a discussion on the theoretical positioning of the researcher and the application of reflexivity. The final section addresses ethical considerations including ethical principles that guided the study and methodological rigour.

Chapter four outlines the methods used to conduct the research including the sampling and recruitment strategies employed and the collection and analysis of data. A purposeful sampling strategy where the researcher intentionally targeted individuals who had experienced WPVA and were new graduate nurses was employed. Recruitment was undertaken by way of presentations and ‘snowballing’ and included the management of potential risks. Data was collected by way of semi structured face-to-face interviews, which were recorded and then transcribed by the researcher. Data was analysed using thematic analysis: a step-by-step process to identify codes, categories and themes.

Chapter five presents the findings of the study in four sections. Firstly, the introduction to the findings provides a summary of demographic and relevant contextual data. Following this the findings are presented in three sections with each section focussing on a specific theme including a detailed presentation of the categories and subthemes making up each theme. Direct quotes from the transcription have been used to illustrate and provide evidence to support each theme and to give voice to the new graduates who participated.

A discussion of the findings is provided in chapter six. It includes a summary of the three key themes which were titled: Part of the Journey, Towards Self-Efficacy, and Maintaining Integrity and the associated subthemes. These are discussed in relation to current literature and research and the study’s aims and objectives. The strengths and limitations of the study associated with the sample size, self selection, participants recall and subjectivity, inconsistencies in data and researcher bias related to relationship with participants are highlighted. Implications for nurses, education providers and employers to ensure the ongoing preparation of the nursing workforce are included as well as recommendations for future research. Chapter seven is the final chapter and provides a conclusion to the thesis. It includes a summary of the key points of each stage of this study.
CHAPTER TWO: Background

Introduction:

This chapter presents an overview of the existing research and literature focusing on workplace violence and aggression (WPVA). A broad range of literature was reviewed including context specific (such as mental health settings), population specific (such as new graduates) and more generic studies (such as health professionals’ experiences of WPVA).

An outline of the search strategy employed in undertaking a review of the relevant literature is presented. The identified literature was analysed using a thematic approach which resulted in the production of five themes: ambiguity surrounding WPVA, prevalence of WPVA, contributing and predisposing factors, impact of WPVA and prevention and management strategies. The final section presents information about new graduates, including their undergraduate and postgraduate education.

Search strategy

A search strategy was employed to locate, review and manage relevant data from the large volume of information available on this topic which ensured the review was comprehensive and minimised researcher bias (Houser, 2008). Components of the strategy are outlined, including the search process, inclusion and exclusion criteria and identification of key themes.

Search process

The search for literature was guided by a step by step process recommended by Houser (2008) to ensure the review of literature was comprehensive, effective and that the potential for researcher bias was minimised. Firstly, key words were identified from the research question: workplace violence, workplace aggression, new graduates and undergraduate education. A large number of results were obtained so Boolean operators and wildcards were used to refine the search: workplace violence AND nurs*; violence and aggression AND nurs*; violence OR aggression AND nurs*. This reduced the number of results considerably and provided some further key words: incivility AND nurs*; verbal abuse AND nurs*; lateral violence AND nurs*; clienthostility AND nurs*; personal safety training AND nurs*. Many of the articles located provided useful links to other literature specific to the population and context: new graduate nurses AND violence OR aggression; violence and aggression AND NZ; new graduate nurses AND NZ.
Primary electronic data bases accessed were CINAHL, Proquest, OVID, Index NZ, Cochrane Library, KRIS and Google Scholar. The search also included other sources of information: library catalogues and e-journals provided links to other articles, texts and unpublished theses. Several official websites were accessed and monitored for the study including worldwide sources such as International Council of Nurses website of Workplace Violence in the Health Sector (2008, 2010, and 2012). National websites included: NZ Nurses Organisation (NZNO), Nursing Council of NZ (NCNZ), Te Ao Maramatanga: The NZ College of Mental Health Nurses (NZCMHN), Te Pou o Te Whakaaro Nui (Te Pou) and Worksafe NZ. While the research was being undertaken, a media watch was maintained with reports and articles accessed to inform the study on an ongoing basis.

Literature was managed using Zotero a free reference management system that assists in the collecting, organising and citing of references (www.zotero.org). This system enabled electronic copies of information and citation details to be stored in one, widely accessible repository supporting flexibility in working on the study and tracking and checking of sources at a later date.

**Inclusion and exclusion criteria**

Sources were assessed according to inclusion and exclusion criteria (Houser, 2008). Articles needed to be peer reviewed, English only publications and available in full text. Date range was from 2005 – 2016, with the exception where the publication was regarded as being influential on current thinking, as evidenced by being referred to extensively or which provided valuable contextual perspective (such as from NZ). Similarly, primary sources (original research) were preferred, however, significant systematic and integrative reviews completed by topic experts were also included. The literature needed to be relevant to nursing. Most sources were international: predominantly from United States of America, United Kingdom and Australia. Every attempt was made to access NZ studies and although these were small in number they provided pivotal background. These included the work of Mckenna, Poole, Smith, Coverdale and Gale (2003); Rolls, (2006); Ventura–Madanfeng and Wilson (2009); and Swain, Gale and Greenwood (2014). Articles that were not peer reviewed, were not in English or were not available in full text were excluded. Articles that were not relevant to nursing were also excluded. If the article met the inclusion criteria, the abstract was reviewed to ensure relevance and the full text of the article was obtained.

Websites accessed needed to be developed by professional organisations (for example NZNO, NCNZ), the web address an official site, the information needed to have been posted or
updated within the last five years and the site to be professionally presented (Jesson, Matheson & Lacey, 2011). If the website met inclusion criteria it was saved as a favourite site and visited periodically to keep abreast with any new developments.

**Identification of key themes and trends**

Once the full text was obtained it became apparent that different types of literature were available including theoretical, research, practise and policy literature (Aveyard, 2010). Publications were critically appraised to determine strengths, limitations and relevance utilising a generic critical appraisal tool, which guided this process to ensure a consistent approach (Aveyard, 2010). The tool’s criteria consisted of who wrote the paper and what their professional qualifications were, how the research was carried out and / or what the theoretical basis of the work was, where and when the work was published and how this work was relevant to the topic (Aveyard, 2010).

**Ambiguity surrounding WPVA**

Despite the growing body of literature and research the concept of WPVA remains ambiguous and contentious (Holmes, Rudge & Perron, 2012). This section presents key aspects of the debate including possible explanations for ambiguity, the concepts of ‘violence’ and ‘aggression’ and a proposed definition for use within this thesis.

**Explanations for ambiguity**

There are several factors contributing to the ambiguity surrounding WPVA. Firstly, it occurs within a variety of contexts including health and social services, and the criminal justice system (Holmes et al., 2012). In some of these contexts violence is expected and to some degree tolerated and in others it is not acceptable (Waddington, Badger & Bull, 2005). The result is different understandings of what constitutes WPVA and a plethora of terms used to describe and define aspects of the concept. Terms used encompass a range of behaviours from mild verbal abuse to more serious life – threatening assaults (Dickens, Piccirillo & Alderman, 2013). Some definitions emphasise ‘intent’ but this is unclear in many individuals such as those with mental impairment or under the effect of substances and is open to interpretation (Dickens et al., 2013).

Those involved in incidents are likely to have subjective rather than objective interpretations of their actions and those of others. In an earlier study, Rippon (2000) defined aggression and violence within the health setting, which was often referred to by other scholars and suggested that aggression and violence are emotive, sensitive topics in the health sector. The effect of
this is two-fold; experiences tend to be highly subjective, and there is a greater chance of information being withheld (Rippon, 2000).

Finally, WPVA is an occupational hazard that is complex and often present in the health sector. The relationship between an incident of WPVA and the impact this has on those involved, particularly the recipient, is often unclear and complex. Notably, the psychological trauma is not necessarily correlated to physical injuries and may be experienced for a prolonged period of time (Waddington et al., 2005). Although many assaults can be deemed minor, as the physical effects are relatively insignificant (such as mild bruising) repeated exposure can, over a period of time, result in severe psychological consequences (Rippon, 2000)

**Concepts of ‘violence’ and ‘aggression’**

The terms ‘violence’ and ‘aggression’ are at times used interchangeably and in other instances distinctions are made (Holmes et al., 2012; Rippon, 2000). When used in English, ‘aggression’ has a broader meaning than ‘violence’ and is more commonly associated with events in the health sector (Holmes et al., 2012). ‘Violence’ can be regarded as the physical expression of aggression and is more often used in the area of criminal justice or criminology (Holmes et al., 2012). Rippon (2000) states that while violence is synonymous with aggression, it is used to describe actions that are regarded as more intense, heinous and reprehensible. Therefore, a single act of assault may be regarded as aggression while a repeated act of torture is deemed as violence. In addition, the increased use of ‘violence’, especially in the media, can be attributed to the belief that it evokes a stronger emotional response and that society has become de-sensitised to ‘aggression’ (Rippon, 2000).

Research has led to the identification of different forms of violence and aggression in the health sector (Clark, Olender, Cardoni & Kenski, 2011; Dickens et al., 2013; Hegney et al., 2010; Holmes et al., 2013). Aggression directed at health professionals that is premeditated with the intention of obtaining something, rather than to harm the victim, has been labelled instrumental (Dickens et al., 2013). Aggression directed at health professionals that is impulsive in nature, with the intention to harm someone or something is referred to as hostile aggression. It often occurs as a reaction to a perceived threat (Dickens et al., 2013). Violence between health professionals covers a range of behaviours and many terms are used to refer to it, including lateral violence, horizontal violence, inter/ intra professional or nurse-to-nurse violence, bullying and incivility (Hegney et al., 2010). This sort of violence can be direct, which includes overt and observable actions such as hitting and yelling, or indirect which is
covert and less observable such as gossiping and ignoring a colleague (Thomas, 2010). Violence between health professionals is characterised by behaviour that is negative, that purposefully and systematically targets a victim, often happens over a prolonged period of time and has the intention of causing harm (Clark et al., 2011).

Proposed definition

While a definition that is applicable in all contexts and all situations is unrealistic, Farrell and Mann (2014) suggest that some consistency should be possible within certain jurisdictions and that the definition be broad enough to include bullying and harassment. Rippon (2000) adds that certain factors appear to be constant in definitions, including physical, psychological and/or emotional harm resulting from the behaviour. For the purposes of this study, a definition needed to be inclusive of the many areas in which nursing is practiced and sit within the NZ legislative framework and so WPVA was defined as:

Any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, wellbeing, or health. The violence episode can be instigated by a patient, another staff member or a member of the public. (Department of Labour (NZ), 2009, p. 11)

While the debate continues, some scholars feel that the emphasis on defining and quantifying WPVA has resulted in a significant body of research that provides evidence of the extent of the problem but less on understanding the causes and possible solutions (Anderson, FitzGerald, & Luck, 2010; Hutchinson, Jackson, Haigh & Hayter, 2013). As a way forward, Anderson et al. (2010) state: “The way ahead lies in investigating interventions rather than repeatedly redefining the problem and misdirecting resources into debating semantics or differentiating ‘degrees’ of violence and aggression” (Anderson et al., 2010, p.2528).

Prevalence of WPVA

Inconsistencies with defining WPVA, variations in reporting and suspected under reporting as well as cultural differences impact on establishing the prevalence of WPVA internationally and nationally. However, there is agreement that nurses are at high risk of exposure to WPVA with many exposed in their day to day work and few being untouched by it (Armstrong, 2006; Farrell, Bobrowski, C. & Bobrowski, P., 2006; Farrell & Cubit, 2005; Hegney et al., 2010; Spector et al., 2014). This section presents an overview of international and national trends of WPVA as well as the incidence of WPVA amongst new graduates.
International trends

Prevalence estimates of WPVA vary between studies depending on the type of violence measured, the context in which it occurred, the country in which the study was conducted, the discipline of those conducting the study and the definition of violence (Lancôt & Guay, 2014). However, a quantitative review of 136 articles from all over the world conducted by Spector et al. (2014) provides a contemporary, international perspective on the prevalence of WPVA involving nurses.

This study found that worldwide approximately a third of nurses’ experience physical violence, two-thirds experience non-physical violence and about a quarter experience sexual harassment. There is a variation in exposure depending on clinical setting and geographical region. Physical violence is most prevalent in psychiatric settings, emergency departments and older person facilities. Geographically, the Anglo region (Australia, Canada, United Kingdom, NZ and America) has the highest incidence of physical violence and the second highest incidence of non-physical violence and bullying (Spector et al., 2014). In comparison, Asia (China, Japan, Taiwan, Philippines and Thailand) had the lowest incidence of non-physical violence and the second lowest for physical and bullying. Also, the incidence of WPVA generated by family and friends is higher in Asian and Middle Eastern regions and low in Anglo and European settings where individual and client generated violence is higher (Spector et al., 2014).

National trends

Swain et al. (2014) conducted one of the more recent studies undertaken in NZ surveying 227 hospital staff employed by an unnamed DHB. The aim of this study was to collect data on levels of aggression experienced by DHB hospital staff to determine patterns of aggression according to health worker role and place of work (Swain et al., 2014). Most of this group were nurses, however, medical staff, allied health staff and support workers were included. Behaviour reported by respondents included threats and assaults that were physical, verbal or sexual in nature. The difference in physical assault by profession was significant with 43% of nurses reporting physical assaults in the past year compared with 14% of medical staff (Swain et al., 2014).

Several concerning patterns and trends were evident in this study. Firstly, the rates of aggression reported in the past year by hospital workers in NZ were higher (38%) compared to those in the United Kingdom (27%). Secondly the rates of assaults on health care workers in NZ in one year (38%) were higher than the lifetime incidence of interpersonal violence
experienced by the general population (17 – 19%). Thirdly, inexperience does not appear to be a contributing factor with average length of experience for health care workers being 18 years. Fourthly, nurses’ experience of WPVA was the highest among the professional groups: 43% of nurses reported physical assaults compared to 14% of doctors with a similar pattern reported in threatening behaviour. Finally, 63% of data for this survey was supplied by psychiatric areas compared to 37% from other hospital areas suggesting that the incidence of reported WPVA is significantly higher in this area (Swain et al., 2014).

Experiences of new graduates

The first year of practice for nurses can be a challenging time where knowledge is integrated into clinical practice and skills are further developed. In addition, exposure to WPVA from clients and other nurses is a significant issue for this group (McKenna et al., 2003; Thomas, 2010). Respondents to a NZ-based study that looked at violence generated by clients towards new graduate nurses reported exposure to a range of abuse including being verbally threatened (35%) and physically assaulted (33%), with Mental Health identified as the area of greatest risk (McKenna et al., 2003).

Ferns and Meerabeau (2008) researched 156 nursing students’ experiences of verbal abuse. Verbal abuse was reported by 45% of respondents and this included threats to kill and racial and sexual orientated abuse. A common theme was that the majority of these incidents were overt and occurred in the presence of others and that the effects of verbal abuse can produce the same degree of psychological distress as physical abuse (Ferns & Meerabeau, 2008).

Most new graduates are familiar with the phrase ‘nurses eat their young’ and many consider an experience of horizontal violence (that generated by another health professional) or bullying to be a ‘rite of passage’ (Thomas, 2010). This group have often not yet integrated well into the organisation, established professional relationships or sufficently developed their professional communication skills making them particularly vulnerable to experiencing horizontal violence (Clark et al., 2011; Thomas, 2010). In addition, bullying can be a learned behaviour that new graduates and nursing students experience and / or observe and later adopt in order to be accepted into the workplace (Clark et al., 2011).

Contributing Factors

The literature reviewed identified a range of factors that are thought to contribute to the occurrence of WPVA and included perspectives from nurses, clients and families. Drawing on
models of causation these can be broadly categorised as internal, external and situational / interactional factors (Duxbury & Wittington, 2005; Pulsford et al., 2013).

**Internal factors**

Internal factors are characteristics within the perpetrator or recipient that contribute to the occurrence of WPVA. These can include physical or mental illness, personality disorders, substance misuse and fear and anxiety (Chapman, Perry, Styles & Coombs, 2009; Duxbury & Wittington, 2005; Ventura-Madangeng & Wilson, 2009). All of these can impair judgement and contribute to inappropriate actions and behaviour, including aggression and violence (Ventura-Madangeng & Wilson, 2009). Research on violence in emergency departments found conditions such as temporary organic derangements (such as diabetic hypoglycaemia), intracranial trauma, pain, stress and frustration and substance abuse (alcohol and drugs) were often associated with violence and aggression (Chapman et al., 2009).

Bowers (2014) adds that in mental health settings certain client characteristics are thought to give rise to conflict with the potential to escalate to violence. These include psychiatric symptoms such as the experience of paranoia, delusions and hallucinations, which can be exacerbated by the use of alcohol and substances; personality traits such as antisocial or borderline personality and demographic features particularly being young and male (Bowers, 2014). Characteristics of staff, such as limited range of affective responses and lack of empathy have the potential to create a therapeutic gap, leading to a sense of otherness and the potential for conflict (Holmes et al., 2012). This is supported by Bowers (2014) who found that the health professionals’ inability to control and regulate their anxiety and frustration in response to disruptive behaviours demonstrated by clients had the ability to escalate and amplify client behaviour.

**External factors**

External factors are those that are present in the immediate or wider physical and social environment and range from the routines and layout of a unit to increased levels and tolerance of violence in communities (Duxbury & Wittington, 2005).

In a study of approximately 100 nursing students (Hinchberger, 2009) identified several predisposing social factors for violence in the health sector. These include prevalence of weapons among patients, families and their friends and presence of gang members, drug users, trauma patients and distraught family members in hospital environments. In a study of 322 nurses working across the health sector Chapman et al. (2009) adds that a significant predisposing social factor has been the shift to community based mental health care.
accompanied by a reduction of in-patient mental health beds. This has resulted in Emergency Departments becoming the single point of entry for all clients, including those with mental illness and a higher acuity of physical and mental illness in this population. While both these studies were conducted outside of NZ they reflect similar social policies and issues within our society and are supported by Rolls (2006) who researched a small number of nurses in a NZ, ED. Participants in this study identified increased use of weapons and an increase in mental health clients using ED as significant factors to levels of violence in their department.

Kingma (2001) adds a global perspective stating that for many nurses violence occurring in the external environment such as war or conflict zones also impacts on their work environment. In addition, nurses may be working in societies where there is a tolerance of violence and where there is a belief that to practice nursing is to accept the risk of personal violence (Kingma, 2001).

In a concept analysis study of literature on nurses’ experience of violence spanning the years 1990 – 2005, Ventura–Madangeng and Wilson (2009) identified several aspects of the clinical environment that nurses felt contribute to WPVA. Organisational policies that impose limitations and rules (such as visiting hours, number of visitors, no smoking, triage times) can lead to staff, clients and families feeling powerless resulting in frustration, stress and anxiety. For staff, the challenge of managing the implementation and monitoring of these policies along with clinical care can cause high levels of tension. Institutional health care systems and policies that directly impact on the workforce such as casualization of labour, heavy workloads, high acuity of clients, unclear admission policies, and waiting times were identified as contributing factors (Ventura–Madangeng & Wilson, 2009).

These factors can cause nurses to feel powerless and not in control over their work environment with the potential to be in conflict with codes of ethics and standards of practice (Chapman et al., 2010; Ventura-Madangeng & Wilson, 2009). Combined with clinical procedures that can be intrusive and / or painful the potential for WPVA in a health care setting is significant (Ventura-Madangeng & Wilson, 2009). Dickens et al. (2013) refers to an earlier study (Carmel & Hunter, 1993) which found that patients were more likely to exhibit aggressive behaviour at specific times within a ward routine including handover, meal times, medication and treatment times when staff were less available to meet client demands. Features such as locked doors, metal detectors, alarms sounding, intrusive surveillance and use of security can convey containment and restriction. Such features are often the flashpoints of conflict (Anderson et al., 2010; Bowers, 2014).
A further study that looked at the relationship between violence experienced by nurses, the work environment and the impact on client care in the medical surgical setting (Roche, Diers, Duffield, Catling-Paull, 2010) suggests that the incidence of violence in these areas is more related to ward circumstances than to the client population. The study found that as ward environments become less stable (such as increased workload, unanticipated changes in client needs, less nurse autonomy, fewer registered nurses) perceived violence increases (Roche et al., 2010). This study also noted that areas such as MH and ED units often provide training and policies to address WPVA; areas such as Medical – Surgical units do not and this is largely because it is not recognised that medically ill clients and their families could be abusive to nurses.

For many nurses their work environment is in community-based services. Public health nurses, district nurses and mental health nurses all face risks associated with the fact much of their work is conducted in people’s homes (New Zealand Government, 2009). There are specific risks associated with working in the community including working in isolation; where relatives, friends or dogs may be present, limited cell phone coverage and access to weapons (Burns, 2014; New Zealand Government, 2009).

There is a suggestion that workplace violence and aggression can occur in ‘environments of acquiescence’ where such behaviours may be witnessed or be known to have occurred by others who have been inactive or passive in their responses (Hutchinson et al., 2013). Inaction by bystanders can perpetuate the incidence of WPVA resulting in a cycle of enculturation where the behaviour becomes normalised and considered to be ‘part of the job’. A lack of intervention or a passive response can increase the likelihood of WPVA occurring and reduces the social support available for victims of the abuse (Hutchinson, 2009).

**Situational / interactional factors**

Situational and interactional factors are present in the immediate situation or interaction between those involved, and often have an interpersonal component such as communication, relationships (Duxbury & Wittington, 2005). Relationships of an interpersonal nature are a defining attribute in nursing. At any one time a nurse has relationships with clients, their families, other nurses and other disciplines including employers (Ventura-Madangeng & Wilson, 2009). Power is inherent within these relationships and it can be used or misused in an attempt to achieve goals, elicit a particular response or to maintain power and ultimately contributes to the occurrence of WPVA (Ventura-Madangeng & Wilson, 2009).
The nurse–client relationship is often cited as the cornerstone of mental health nursing and is significant in the management of aggressive clients in this setting. However, as Hewitt (2009) suggests the increase in MH policies which focus on the prevention of risk and evidence based nursing practice tends to prioritize technical rather than interpersonal skills causing significant threats to establishing and maintaining the nurse–client therapeutic relationship. Evidence based nursing supports interventions that are measureable and supported by scientific evidence. This tends to favour standardised interventions, often neglecting the unique experience of the client and the value of therapeutic engagement and the interpersonal skills required to develop this (Hewitt, 2009). The loss of the therapeutic relationship has been linked to creating a vicious cycle where client aggression is further generated when nurses emotionally withdraw and become disconnected from the client as a person (Camuccio, Chambers, Valimaki, Farro & Zanotti, 2012).

When seeking the staff and relatives’ perspective on aggressive behaviour of older people in a residential facility Duxbury, Pulsford, Hadi and Sykes (2013) found the interpersonal component to be significant. Aggressive behaviour was largely seen as being needs related; the need to relieve frustration or to remove a perceived threat. This was evident on providing personal cares, interactions with other residents or when clients were denied something from staff (Duxbury et al., 2013).

Traditionally, health professionals have been considered experts on treatment with the duty to protect their clients. The main argument in support of this approach has been that clients lack medical knowledge and insight into their conditions. Coercive and restrictive measures, such as compulsory assessment and treatment are considered necessary and in the best interest of clients and the general public and not considered acts of violence or aggression (Abderhalden, Hahn, Bonner, & Galeazzi, 2006; Hughes, 2013). However, this paternalistic approach is being increasingly challenged, particularly in the area of mental health and in relation to restrictive practices (Abderhalden et al., 2006). There is an increasing body of research that explores, voices and values the clients’ perspective (Abderhalden et al., 2006; Duxbury & Whittington, 2005). In these studies, clients report a variety of factors but central to episodes of aggression and violence is the use of restrictive practices employed by staff including being detained and given medication against their will. Being secluded or restrained can lead to feelings of anger and frustration and a cycle of coercion – client aggression with ever increasing use of restrictive practices can develop (Abderhalden et al., 2006; Duxbury & Whittington, 2005).
Ferns and Meerabeau (2008) add that effective communication is generally regarded as integral to nursing having a positive effect on client outcomes. Modern nurses are seen as facilitators, adopting a holistic approach to clients’ needs and working with the client to address physical and psychological needs. As a result, there has been a shift away from authoritarian approaches and patients are aware of their rights and described as consumers or service users (Ferns & Meerabeau, 2008). Nursing literature encourages nurses to value and respect patients’ rights to informed consent and to question treatment and care. There is an emphasis on demonstrating unconditional positive regard and accepting clients as individuals. However, this approach can contribute to clients having high and in some cases unrealistic expectations of health care and those providing it (Deber, Kraetschmer, Urowitz & Sharpe, 2005). Occupational Safety and Health (2004) add that an imbalance between the rights of clients and staff can be a contributing factor to WPVA and state:

Clearly a balance must be established between the quality of services to patients / clients and the health, safety and effective functioning of employees. It is inappropriate to allow any one group or person a veto on a matter of potentially serious personal health and safety when reasonably practicable steps are available to prevent it.

(Occupational Safety and Health, 2004 p. 8)

Theories of violence and aggression are intended to provide a broadly applicable explanation of the phenomenon as well as assisting in its prediction and management. Jackson, Luck and Usher (2006) present an overview of some of the more traditional explanations of violence that are sometimes used to explain its incidence in nursing (psychoanalytical, social learning, personality and biopsychosocial) but argue that with the escalation of WPVA there is clearly a need for a different understanding that considers contextual and professional factors, together with the values and beliefs of nursing. Drawing on the work of Foucault, they suggest that, “…violence in the health care setting and nurses’ perceptions of violence and aggression are socially constructed by the discourses used to define them” (Jackson, Luck & Usher, 2006, p. 256).

Nurses’ beliefs, attitudes and understanding about what causes aggressive behaviour may be inversely related to how they respond (Pulsford et al., 2013). Drawing on a range of explanations for aggressive behaviour is more likely to generate psychotherapeutic responses from staff and support their emotional regulation (Bowers, 2014). Holmes et al. (2012) state that research on WPVA should confront some of the previously held beliefs and attitudes:
“We begin to get a glimpse that violence and its solutions may not lie in simply thinking about the problem as having a single source or origin” (Holmes et al., 2012, p.3).

**Impact and Consequences of WPVA**

The impact and consequences of WPVA is pervasive with nurses, clients and their families as well as the organisation and the community in which the violence occurs being affected. This section presents selected studies that are relevant to the background of this study encompassing the physical and psychological impact of WPVA on health organisations, clients, nurses and new graduates. While research would indicate most of the impact is negative, positive effects have also been identified.

**Impact on health organisations**

The incidence of WPVA can have an impact on health organisations, particularly in terms of costs. These costs are often associated with staff turnover and recruitment, absenteeism and sick leave, reduced efficiency and performance and reduced experienced staff (Rew & Ferns, 2005). Other costs to organisations as a result of WPVA include sick leave and absenteeism, counselling, insurance and Accident Compensation Cooperation (ACC) levies, security and training (American Psychiatric Nurses Association, 2008; McNamara, 2012).

Nurses can become fearful, disillusioned and burnt out with many considering leaving the profession after frequent exposure to WPVA (Chapman et al., 2009). While the cost of rates of attrition are an issue for the employer there is also the potential loss of skilled nurses available to the general public and the community (Kingma, 2001). WPVA can lead to a reduced commitment from staff to the organisation and lack of confidence in the organisations ability to manage this issue and potentially other issues adequately (Lancôt & Guay, 2014).

Gates, Gillespie and Succop (2011) state there is little research examining the effect WPVA can have on nurses productivity including nurses ability to provide quality, safe and compassionate care following an event. Using a cross sectional design to survey 264 ED nurses, they examined the relationship between WPVA, symptoms of post-traumatic stress disorder (PTSD) and productivity. In total, 94% of this group experienced at least one symptom of PTSD with 17% meeting the criteria for diagnosis of PTSD. The findings also suggest that exposure to WPVA for these participants significantly affected their productivity in terms of meeting cognitive and support communication demands so affecting the overall quality of care (Gates et al., 2011). In addition to impaired quality of care, high rates of
WPVA can damage an organisation’s reputation and result in increased complaints, reviews and investigations (Rew & Ferns, 2005). Clearly, health organisations have not only a social and legal responsibility to address WPVA but have a financial responsibility and incentive to do so.

**Impact on nurses**

In a qualitative study of 33 registered general nurses who had experienced workplace aggression, Deans (2004) explored the effects this exposure had on the participants. The study identified that participants experienced feelings of ‘professional incompetency’, which commenced at the start of the incident and could continue for some days afterwards, particularly if there was no resolution or follow up on the incident. This lack in confidence of their ability to respond to violent incidents was noted to be a factor in non-reporting. Participants felt that there was an ‘expectation to cope’ and this was conveyed to them by lack of additional resourcing for working with identified challenging clients, lack of further action following an incident and by platitudes such as ‘get back on the horse’ and ‘we all have to put up with this’. The emotional effects of WPVA are described by Deans (2004) as ‘emotional confusion’. Participants described a wide range of emotions such as fear, guilt, anger, humiliation and embarrassment. Not surprisingly emotional confusion was worsened by non-supportive responses by senior staff and colleagues (Deans, 2004). Rodwell and Demir (2012) add that persistent and repeated exposure can worsen the affects and lead to emotional wellbeing and motivation being insidiously eroded.

A further study by Camuccio et al. (2012) explored the feelings and emotions of 33 Italian nurses working in a mental health setting. They found that that fear was the dominant emotion experienced by nurses caring for aggressive clients. This extended to fear of being harmed or doing harm and fear for the teams’ safety. The sense of fear was worsened in situations where the client was unknown to staff and where the client was not considered to have a psychiatric illness. Nurses’ reaction to fear can lead to withdrawal, a deterioration of the therapeutic relationship and a de-personalised approach to the client based on standardised rather than individualised interventions (Lakeman, 2006). This in turn can generate further client aggression, therefore creating a vicious cycle.

Fewer studies address the physical impact of WPVA. In a systematic review of 68 international studies on WPVA in the health sector Lancôt and Guay (2014) found that 5% of physical repercussions were life threatening, with 60% requiring medical attention. Injuries included injury to the head, back and arms, bruising, abrasions, scratches and lacerations.
Clothing and glasses were also damaged. Additional reports of head injuries resulting in concussions, scratches and bites resulting in infections, puncture wounds from weapons and fractures were reported in the health sector of which a significant number were nurses (Occupational Safety and Health, 2004). However, some of the physical effects are not directly related to injury. Physical disturbances such as nausea, headaches and insomnia were reported by those who had experienced verbal abuse (Lancôt & Guay, 2014). McNamara (2010) noted that recipients of WPVA can experience weight disturbances and increased substance use.

In a review of literature focusing on horizontal violence Hutchinson (2009) found that this type of violence affects targeted individuals as well as those who witnessed the violence. Nurses reported a reduction in their commitment and involvement at work and that they developed strategies to avoid certain staff or situations (Hutchinson, 2009). Others reported being unable to continue to work in certain areas leading to resignation or requests to transfer (Hutchinson, 2009). In a qualitative study conducted by Bonner (2012) participants reported that WPVA contributed to them resigning from direct care nursing or from nursing completely.

**Impact on Clients and families**

One of the consequences for clients who are violent towards nurses is the use of restrictive practices such as restraint and seclusion. The use of restraint is intended to confine and restrict a person’s movements. It can be physical (such as restrained by others), chemical (such as restrained by sedatives) or environmental (such as seclusion) in nature and is often used to control a violent client to prevent further injury and to administer treatment (Bigwood & Crowe, 2008). However, there are adverse effects of this practice for clients including physical harm (such as injuries, pain) and psychological harm (such as fear, anger, humiliation). In many cases where restraint is used, nurses are involved to initiate, administer or maintain the restraint. This can impact on the therapeutic nurse – client relationship leading to a breakdown in trust, respect and positive regard between the nurse and client and to a reduction in client autonomy (Bigwood & Crowe, 2008; Swain et al., 2014).

WPVA can lead to a disruption of nursing care. Nurses can become reluctant to care for a violent client and so avoid or limit the level of engagement with a particular client potentially increasing the burden of care for others (Bigwood & Crowe, 2008; Chapman et al., 2009). Nurses also report that dealing with a violent client, both at the time of the incident and
afterwards, can be time consuming and can reduce the amount of care provided to other clients (Bigwood & Crowe, 2009).

A correlation between violence (and threats of violence) has been linked to adverse client outcomes in the medical – surgical setting (Roche et al., 2010). Of note was an increase in falls, medication errors and delayed medication administration (Roche et al., 2010).

**Impact on New graduates**

The number of studies focusing specifically on WPVA and new graduates is limited. While many of the effects of WPVA are generic to nurses at all stages of their career, the new graduate year is acknowledged to be a time of vulnerability (Boamah & Laschinger, 2015). A study on new graduates’ experience of WPVA conducted by McKenna et al. (2003) included significant consequences on participants of this group who are at a formative stage of their career. While a small number (7%) discussed the physical impact (sore arm, stomach ache), approximately 30% identified psychological responses including fear, anxiety, over-caution, mistrust, resentfulness and loss of confidence with 7% requiring days off work. There were reports of increased absenteeism and consideration of alternative employment. The experience affected how participants felt about nursing with 13% considering leaving nursing as a consequence of an incident with 6% actively seeking employment out of nursing. However, 3% identified some positive effects. The experience enabled the refinement of assessment skills, increased awareness of safety and left them feeling confident in how more experienced staff dealt with the situation (McKenna et al., 2003).

A longitudinal study of 342 new graduate nurses found that in the first year of practice nurses experienced uncertainty and vulnerability and were impressionable (Boamah & Laschinger, 2015). Participants were predisposed to stress and anxiety and at risk of becoming disillusioned with nursing. A work environment that empowers this group is more likely to increase their engagement with nursing and decrease their desire to leave (Boamah & Laschinger, 2015). Violence that occurs early in a nurse’s career can lead to disillusionment with chosen career and retention / recruitment issues (McEwen & Dumpel, 2012).

Thomas (2010) adds that students and new graduates are particularly vulnerable to the effects of violence, which can result in the adoption and perpetuation of violent behaviours and abuse after registration. Finally, clinical experiences of new graduates in NZ have been found to influence choice of long term practice area, with preference linked to areas of positive experiences and may account for less interest in areas where WPVA is more likely to occur (Huntington, Wilkinson & Neville, 2014).
Positive consequences

Overwhelmingly, the effects of exposure to WPVA are reported to be negative however, studies by Bonner (2012) and Chapman et al. (2009) identified potential opportunities such as team strengthening, increased empathy for clients and increased resilience and adaption.

Research by Chapman et al. (2009) found that after such an experience, participants in their study felt they were better clinicians, they continued to be part of the workforce and continued to care for those who posed a risk to their safety. They did this by adapting to their experiences in three ways. Firstly, by finding meaning through describing the event in a logical, sequential fashion and explaining what had happened. Secondly, they used physical strategies (such as calling for assistance, personal safety techniques and restraining) and psychological strategies (such as debriefing and counselling) to achieve control or mastery over events. Finally, they boosted their self-esteem by making favourable comparisons between themselves and other colleagues, and evaluating themselves positively. This raises questions such as: what are the long-term effects of adapting to WPVA? Does adapting increase vulnerability and lead to unacceptable risk taking (Chapman et al., 2009)?

When considering the effects of WPVA Chapman et al. suggest that:

> Understanding the strategies nurses use to maintain and enhance their emotional well being may enable organisations and educators to develop policies and programmes to support nurses and reduce the impact of WPVA.

(Chapman et al., 2009, p.1260)

Prevention and management of WPVA

The global prevalence of WPVA has resulted in the development of diverse approaches that aim to prevent and manage situations where violence and aggression occur (Paterson, Leadbetter & Miller, 2005). This section discusses the most commonly used strategies, which are broadly categorised as active, passive, and administrative (Farrell & Mann, 2014).

Active strategies

Active strategies target front line staff and focus on training and skills development (Farrell & Mann, 2014). The active strategies discussed in this section are personal safety training and coping skills.

Personal safety training

Many organisations provide personal safety training to prepare staff to respond to WPVA safely and within the legal framework. The content typically includes some theoretical
background (such as medico legal aspects, underlying reasons for aggression) however, the focus is usually de-escalation skills, personal safety techniques (such as breakaway techniques) and restraint techniques (Farrell & Mann, 2014). In NZ there is a lack of standardised training offered to nurses to prepare them to respond to WPVA with content varying depending on the provider and their background (Farrell & Mann, 2014; Rolls, 2006).

Some options for training include Calming and Restraint (C&R) which is usually provided to mental health, security and orderly staff; Safe Practice and Effective Communication (SPEC) which is increasingly replacing C&R and Non Violent Crisis Intervention (Te Pou o Te Whakaaro Nui, 2015). Many of these courses are delivered via a ‘train the trainer’ method which is based on a pyramid training structure. Expert instructors teach the content along with learning strategies to key staff members who then provide the training to other staff (Nakaumr et al., 2014).

There are several issues regarding personal safety training in NZ; nurses typically attend these courses once they are registered, there are no national providers of these courses, there are a lack of formal systems monitoring quality or effectiveness, there is a lack of formal assessment of instructors and participants, who are only required to attend and participate (Farrell & Mann, 2014; Rolls, 2006; Te Pou o Te Whakaaro Nui, 2015). These courses have considerable resourcing requirements; they are time consuming (up to four days), usually involve two instructors and require spacious, flexible venues in which to be delivered (Farrell & Mann, 2014).

Personal safety training for WPVA has its limitations, it draws on the internal model of explanation for violent and aggressive behaviour (Björkdahl, Hansebo & Palmstierna, 2013). This assumes that the main cause of client generated violence are internal factors such as illness and personality characteristics and result in a reactive and controlling approach to this sort of behaviour, often supported by training in techniques focused on control and restraint of the individual involved (Björkdahl et al., 2013). Secondly, skills-based training is primarily directed at training individuals, less so on teamwork in managing aggression (Anderson et al., 2010). Thirdly, there can be a sense that they are provided by the organisation to meet compliance with legislative requirements rather than to address an identified need which can impact on learning and application which is enhanced when training is mandatory (Anderson et al., 2010). Fourthly, this sort of training tends to be generic and supports detection of early warning signs such as rapid speech, tone of voice, demanding behaviour. While these can be helpful, Chapman et al. (2010) suggest that these signs are not always present and that nurses should trust their instincts and remain alert. As this training is generic it is often held away
from the workplace and relies on trainees being able to integrate and implement into their particular area of practice (Anderson et al., 2010).

Finally, training can be seen as a panacea for WPVA and while it is an integral part of an approach, environmental and organisational aspects also need to be addressed (Anderson et al., 2010). More recently, research on WPVA has supported the view that violent behaviour is the result of an interaction between internal, external and situational/interactional factors and that a proactive approach that reflects this interaction is recommended (Björkdahl et al., 2013). Farrell and Mann (2014) add that supporting staff to develop skills in navigating potentially aversive situations will reduce potentially violent situations developing.

Coping skills

Organisations follow a predictable course when attempting to address WPVA with a focus on providing training and developing policies and procedures to guide practice (Patterson et al., 2005). This can lead to reactive, short term solutions that are often imposed on staff and are based on the assumption that WPVA is not being adequately dealt with because it occurs (Patterson et al., 2005). Another perspective is provided by Luck, Jackson and Usher (2009) who observed and interviewed ED nurses dealing with 16 episodes of client-generated violence and aggression.

The intention of this study was to identify the interpersonal skills already in use to effectively reduce, avert and prevent violence and it identified five broad categories of skills (Luck et al., 2009). Firstly ‘being safe’, which focused on the physical and psychological safety of self and others at all times. This included considering environmental factors such as restricting access to some clients and to some areas, clear exits, skilled use of body positioning and being mindful of weapons or potential weapons and removing these. ‘Being available’ was identified as a key attribute to avert and reduce violence and included interpersonal skills such as active listening, attending, communicating and providing information. ‘Being respectful’ was an essential part of violence prevention and was conveyed to clients (and their families and friends) through polite language, remaining calm, building rapport and effective non-verbal communication (such as a non-threatening and non-judgemental approach and stance). Participants reported that being respectful assisted in boundary setting. ‘Being supportive’ was demonstrated by behaviours and communication that conveyed a genuine understanding and caring for clients. Where resources permitted, this included the provision of comfort measures (such as drinks, food, use of telephone and toilet facilities). Participants recognised that clear, frequent and jargon free explanations of the triage system de-escalated many
situations. ‘Being responsive’ included recognising and responding to physical and emotional needs of clients. This was shown by allowing people space, decreasing stimuli and manipulating environmental factors to ensure comfort and safety for all (Luck et al., 2009). Participants also reported the use of these attributes towards each other, particularly supporting each other during and after a violent incident (Luck et al., 2009).

This study is relevant as it identifies and reinforces the use of skills that are already in use in everyday nursing routines, which could be transferred to other areas (Luck et al., 2009). It also supports the empowerment of nurses to exert some control over their work environment and suggests that in certain contexts nurses can, and do take responsibility for their safety and that of others if supported to do so (Luck et al., 2009).

**Passive strategies**

The passive strategies discussed in this section focus on the work area; the environment in which care is provided (Farrell & Mann, 2014). They draw less on internal factors and place greater emphasis on external and interactional/ situational explanations for aggression and violence.

On a fundamental level, passive strategies address security and include building design, particularly access and egress; surveillance; safe care parks; duress alarms; security services; safety plans; identification of high risk areas such as waiting rooms, treatment areas and ensuring visibility in these areas (Farrell & Mann, 2014). Other aspects consider workplace design, which can impact on behaviour and include flow, privacy for clients and family, noise levels, colours and temperature control (Farrell & Mann, 2014).

The Safewards Model (Bowers, 2014) draws on a broader perspective. It provides a framework for addressing WPVA citing internal, external and situational / interactional factors that contribute to create ‘flashpoints’ where conflict, and potentially violence and aggression can occur. The framework suggests in the first instance addressing or eradicating factors that can lead to flashpoints arising. This includes the general appearance of the environment, which can convey the standard of care and how clients are regarded. Clean, tidy and attractive décor with sufficient space conveys respect for clients and quality care. The environment should allow for therapeutic interventions such as adequate supervision, care routines and support a high level of engagement between staff and clients. Nurses have a role in maintaining the environment to the accepted standard by modifying where possible and reporting defects or damage (Bowers, 2014). Secondly, staff response to flashpoints should include least restrictive options with the judicious use of containment or restraint, which can
serve to escalate a situation (Bowers, 2014). Crucial to this approach is the use of alternative interventions based on an understanding of thought disorders such as, de-escalation, cognitive behaviour therapy, sensory modulation and trauma informed care (Bowers, 2014; Te Pou o Te Whakaaro Nui, 2015).

**Administrative strategies**

Administrative strategies focus on policies, procedures and practices that are employed by organisations to prevent and manage WPVA (Farrell & Mann, 2014). This section presents the NZ legislative requirements that underpin many administrative strategies and other organisational responses.

**Legislative requirements**

There are multiple acts, codes and national standards that form the legislative framework that DHBs are required to work within however, this discussion is limited to the most relevant to WPVA.

**Code of Health and Disability Services Consumer Rights, 1996 (CHDSCR, 1996)**

The CHDSCR (1996) outlines the rights of those using a health and disability service and the responsibilities of a provider of these services. The code lists ten rights, with Right 4 having particular influence on an organisations policies and procedures relating to WPVA (Health and Disability Commissioner, n.d.). Right 4 states that consumers have the right to services of an appropriate standard. To meet this, services need to be provided in the following manner: with care and skill; comply with legal, professional, ethical and other relevant standards; minimise the potential harm to and maximise the quality of life of that consumer. An organisation will comply with this right by ensuring staff receive adequate training on managing aggressive and violent clients and that policies and procedures give clear guidance and direction to staff when working with clients in this situation (Health and Disability Commissioner, n.d.).

**Health and Disability Service Standards, 2008 (H&DSS, 2008)**

The H&DSS (2008) were developed to assist providers to meet their obligations under the CHDSCR 1996 (Ministry of Health NZ, n.d.). The intent of these standards is to support the safe provision of services and an organisational culture of continuous quality improvement (Ministry of Health NZ, n.d.). There are three categories of standards with the most relevant to WPVA being NZS8134.1 Health and disability services (core) standards and NZS8134.2
Health and disability services (restraint minimisation and safe practice) standards (Ministry of Health NZ, n.d.). The first of these (core standards) includes standards of organisational management. There are clear expectations of organisations in terms of governance, service management, quality and risk management systems, adverse event reporting, consumer and family participation and human resource management (Ministry of Health NZ, n.d.). The second set of standards (restraint minimisation and safe practice) require that organisations: demonstrate that the use of restraint is actively minimised with staff trained in de-escalation as an alternative; maintain a process for restraint approval and its uses in keeping with least restrictive practices; that restraint is used safely and only by trained staff; that all use of restraint is monitored and reviewed (Ministry of Health NZ, n.d.).

**Health and Safety Employment Act, 1992 (H & SEA, 1992)**

In NZ, workplace health and safety is governed by the H&SEA (1992). This has recently undergone reform and will be known as Health and Safety at Work Act (2015), coming into effect in April 2016 (Worksafe NZ, 2014). Worksafe NZ is the appointed government agency to work with employers, employees and others to improve health and safety in the workplace and to enforce the act (Worksafe NZ, 2014). There are several basic principles of this legislation that are relevant to WPVA. Firstly, occupational health is considered the responsibility of both employers and employees with both parties legally obligated to operate in a manner that reflects safe work practices (Barr & Welch, 2012). Secondly, hazards are present in all work environments therefore some level of risk is always present. Finally, all hazards must be managed by recognition, evaluation of risk and minimising the impact of harm that the hazard can cause (Barr & Welch, 2012; Worksafe NZ, 2014). Worksafe NZ also recognises horizontal violence (which it refers to as bullying) as a work hazard and has developed guidelines for employers and employees to recognise and respond to this hazard. An organisation will meet compliance by having policies and procedures that contribute towards the identification and management of risk and engaging with it employees to do so. Worksafe NZ also requires notification of certain work related events. This includes death as a result of work, injury that requires the person to be admitted to hospital for immediate treatment or medical treatment within 48 hours, illness as a result of work and incidents where a person’s health and safety are seriously threatened as a result of a work situation (Worksafe NZ, 2014).
The intention of The Health Practitioners Competence Assurance Act (2003) is to protect public health and safety by ensuring the competence of all health practitioners, including nurses (Ministry of Health, n.d.). The Nursing Council of New Zealand (NCNZ) is the appointed regulatory body for registered nurses to monitor compliance with the act and has several roles including: the registration of nurses, the investigation and disciplining of professional misconduct by nurses and the setting and monitoring of educational and practice (competency) standards (NCNZ, 2012). There are four domains of competence (NCNZ, 2012):

- Domain One: Professional responsibility
- Domain Two: Management of nursing care
- Domain Three: Interpersonal relationships
- Domain Four: Inter professional health care and quality improvement

Registered nurses are required to demonstrate competency in all four domains to NCNZ. Each domain consists of number of competencies that are applicable to registered nurses in a variety of clinical contexts. Within each competency are generic examples of how competency might be demonstrated and these are called indicators. Of particular relevance to WPVA is competency 2.5 that states a nurse: “Acts appropriately to protect oneself and others when faced with unexpected client responses, confrontation, personal threats or other crisis situations” (NCNZ, 2012, p.18).

The indicators for this competency include that a nurse understands emergency procedures and associated plans and communication required to respond to a crisis situation, takes appropriate action in situations where a consumer’s safety and well-being may be compromised and that a nurse is able to manage threats to safety within the clinical environment (NCNZ, 2012).

Other organisational responses

Organisations implement and drive other approaches to prevent and manage WPVA and these include instrumental and informational support, zero tolerance and interventions for addressing horizontal violence.

Chapman et al. (2009) suggest that to reduce the impact of WPVA organisations need to provide instrumental and informational support which have been shown to moderate the
effects. Instrumental support includes support and assistance at the time of the incident such as counselling, defusing and debriefing (Chapman et al., 2009). Informational support includes policies that support, protect and prepare staff for responding to violent clients (Chapman et al., 2009). Bowers (2014) adds that organisational structure can enhance a health service and lead to less conflict. This includes policies and procedures that are clear and consistent with an underpinning philosophy and that these are collaboratively developed and effectively communicated (Bowers, 2014; Te Pou o Te Whakaaro Nui, 2015). Other related organisational activities should include robust and efficient reporting, complaint and investigating processes (Bowers, 2014). Finally, efficient and adequately resourced non-medical services, such as administration and cleaning are required to create a therapeutic environment (Bowers, 2014).

‘Zero tolerance’ has its roots in the criminal justice system of the United States of America and was developed in the 1980s in the war on drugs (Holmes, 2006). In recent years this approach has been adopted by health organisations in response to the increasing prevalence of violence and aggression towards health professionals (Farrell & Salmon, 2014). Zero tolerance provides a clear, ‘catchy’ and simple message that is easily implemented through the use of policies and procedures and has the overall aim of protecting employees (Farrell & Salmon, 2014). However, it has been suggested that:

...zero tolerance serves as a convenient smoke screen and, like self defence skills and the introduction of security staff, it is little more than a ‘band –aid’ applied to the gaping wound caused by the lack of commitment among the nation’s governments to public health services.

(Holmes, 2006, p.222)

Farrell and Salmon (2014) add that zero tolerance potentially supports the distancing of health professionals from the emotional and physical aspects of a patient’s illness by placing it out of a nurse’s remit. The implications of this are missed therapeutic opportunities between aggressive clients and nurses and the de-skilling and disempowering of nurses in dealing with violent and aggressive behaviour (Farrell & Salmon, 2014; Holmes, 2006).

Nurses working in community and rural settings have specific risks to safety related to working in isolation. A study that aimed to reduce the risk of violence towards remote area nurses in Australia (McCullough, Lenthall, Williams & Andrew, 2012) suggests a toolbox approach drawing on the work of Viitasara and Menckel (2002) (cited in McCullough et al., 2012). The approach recognises that WPVA is a complex issue that requires a range of tools
that can used by staff with mixed skills and experience and can be adapted to different situations (McCullough et al., 2012). The toolbox consists of primary, secondary and tertiary strategies. Primary prevention strategies are universal precautions that should happen in everyday practice such as community specific orientation, hazard identification, mentoring, training and education and policies and procedures to guide practice. Secondary strategies are used when a WPVA incident occurs and includes use of personal safety techniques, calling for assistance, restraint and use of medication. Tertiary strategies apply to what happens after an incident to prevent recurrence and minimise the impact of the event and include support, incident reporting, reviews and consequences for violent individual (McCullough et al., 2012).

Following a review of literature on approaches to horizontal violence (HV) Hutchinson (2009) developed a typology where responses to HV ranged from being remedial, corrective, regulatory or restorative in nature (Hutchinson, 2009). Remedial and corrective strategies regard HV as interpersonal conflict between perpetrator and recipient and support the use of facilitated mediation and education programmes. One of the limitations of this approach is that the group and organisational factors that contribute to and perpetuate HV are not addressed (Hutchinson, 2009). Strategies that are regulatory in nature, such as zero tolerance can create an environment where HV is not reported as recipients fear retribution or further abuse (Hutchinson, 2009). In comparison, restorative strategies are less punitive and reduce the emphasis on blame and punishment. There is a move towards rebuilding relationships, with all parties being actively involved and sharing responsibility for addressing the wrong doing that has occurred and to make amends for the future (Hutchinson, 2009).

**The New Graduate Nurse**

A new graduate nurse is a newly registered nurse who has undertaken considerable theoretical and practical preparation. This section outlines the journey undertaken to become a new graduate including undergraduate education, new entry to practice programmes and preparation for responding to WPVA.

**Undergraduate education**

In NZ, programmes for nursing are offered by tertiary educational providers (either polytechnic institutes or universities). To become a Registered Nurse (RN) a student is required to successfully complete an undergraduate or graduate entry programme, so being awarded a Bachelor of Nursing (BN) degree (NCNZ, 2015). Students are required to complete a minimum of 1100 clinical practice with DHBs or other health services under the
preceptorship of another RN (NCNZ, 2015). This clinical experience is broad and includes eldercare, primary health, medical-surgical experience and mental health. On successful completion of BN, a student is then eligible to sit The State Final Examination (NCNZ, n.d.). Although there is no standardised curriculum, NCNZ accredits and monitors educational providers to ensure they offer a structured programme that enables students to meet the Council’s competencies for a registered nurse and they set The State Final Exam (NCNZ, n.d.).

**New Entry to Practice Programmes**

The transition period from student to Registered Nurse which occurs in a nurses’ first year of clinical practice is referred to as the new graduate year. It is recognised as an opportunity for the nurse to increase confidence and competence, consolidate skills and knowledge and to establish relationships that will support them in their career development (Clendon, 2011; Haggerty, Holloway & Wilson, 2013). Programmes for nurses in their first year of practice were historically informal and provided and determined by individual DHBs. However, since 2006, programmes have become formalised and structured with the intention of providing support for new graduates, preceptorship, supernumerary orientation periods and dedicated study days (Haggerty et al., 2013). There are two programmes available in New Zealand: New Entry to Practice (NETP) which prepares new graduates to work in general clinical settings and New Entry to Specialist Practice (NESP) which prepares graduates to work in MH services (Haggerty et al., 2013). While enrolled in NETP or NESP programmes new graduates are employees and therefore have access to employer provided training and professional development opportunities, including personal safety programmes.

**Conclusion**

The purpose of this chapter was to present the background to this study including themes identified by reviewing the literature on WPVA and the rationale for this study. Information on the population studied, new graduate nurses, was included to better understand the experiences and challenges faced by those who participated in the study. Undertaking a review of literature also provided exposure to previous research studies and informed the choice of theoretical framework and methodology drawn on for this study. This is presented in the next chapter.
CHAPTER THREE: Methodology

Introduction:

This chapter presents an overview of the descriptive, qualitative approach that was drawn on to conduct this study and is presented in several sections. The first section provides a background to the choice of methodology and includes a broad discussion on qualitative and quantitative research approaches and the rationale for choosing a descriptive, qualitative approach. The second section provides background to the researcher and includes a discussion on the theoretical positioning of the researcher and the application of reflexivity. The final section addresses ethical considerations including ethical principles that guided the study and methodological rigour.

Quantitative and qualitative methodologies

Nursing research utilizes two major methodologies; quantitative and qualitative, each of which are based on different paradigms (Davidson & Tolich, 2003; Robson, 2011). Robson (2011) cautions against comparing the two approaches as it can lead to viewing each in opposition and an over simplification of characteristics. Also, there is a tendency to evaluate qualitative data by using criteria that is more suitable for quantitative studies (Ryan-Nicholls & Will, 2009). However, a comparison of quantitative and qualitative methodologies was useful to gain a greater understanding of the strengths and limitations and the value of each approach so contributing to an informed choice as to which method is the most suitable for the intended line of enquiry. Given that many aspects of each approach are contestable, the following discussion is simplified and limited to areas of difference considered relevant to this study including the philosophical underpinnings, relationship to researcher and data and concludes with a rationale for choosing the descriptive, qualitative approach.

Philosophical underpinnings

The most fundamental difference between these approaches lies in the paradigm alignment and philosophical underpinnings of each. Quantitative research is aligned with the positivist paradigm which incorporates deductive logic, reductionism, objectivity and numerical evidence to prove or disprove a theory or hypothesis (Cresswell, 2009; Davidson & Tolich, 2003). The underpinning philosophy is rationalism: that knowledge is gained through rational thought and reasoning (Kumar, 2011). The result is a methodology that is structured, rigid and
predetermined in nature (Kumar, 2011). Qualitative research is aligned with interpretivism which incorporates an inductive approach, holism, subjectivity and multiple meanings to make sense of (or interpret) a pattern of meaning (Cresswell, 2009; Davidson & Tolich, 2003). It is underpinned by the philosophy of empiricism: that knowledge is acquired from sensory experiences (Kumar, 2011). This results in a less structured, flexible and open methodology (Kumar, 2011).

The flexibility of this approach allows for a shift in focus and direction as the study evolves (Patterson & Morin, 2012). Through the use of open ended questions data is allowed to emerge in a less restrictive manner and the data generated is rich, descriptive and illustrative and unforeseen information can come to light (Farrelly, 2013). Associated with flexibility however, is the challenge to maintain rigour and conduct research that is plausible, credible and has integrity (Ryan, Coughlan & Cronin, 2013).

**Relationship with researcher**

A significant difference between the two approaches is the relationship between researcher and those partaking in the research. In quantitative research detachment and objectivity are considered important qualities of the relationship with some methods requiring little or no direct contact between the researcher and the ‘subject’. The relationship between researcher and the ‘participant’ in qualitative research is considered crucial to obtaining quality, trustworthy data and provides an opportunity for the empowerment of participants through sharing their experiences (Carr, 1994).

The researcher and participants work closely together at the data collection stage so the relationship established impacts on the whole project. Through the use of various data collection methods, such as interviews or observations, qualitative researchers are able to ‘hear the voice’ of those involved with a phenomenon or issue (Smythe & Giddings, 2007). It provides an opportunity to gain the perspective of the chosen population. It is especially effective for obtaining information that is culturally specific; in this case the values, opinions, behaviours for new graduate nurses and the context in which these occur (Farrelly, 2013). Researchers also have opportunity to ‘be with’ participants allowing for greater understanding of participants responses during all stages of the study (Kavanaugh, Moro, Savage, & Mehendale, 2006). This allows for the researcher to respond to the participant and to clarify responses from participants (Farrelly, 2013). Furthermore, because the uniqueness of each participant is explicitly stated and upheld, there is less danger of assuming that people involved in one study will behave as others in a different context (Smythe & Giddings, 2007).
However, the nature of this relationship does pose challenges and limitations for the researcher. A considerable amount of skill is required on the researcher’s part to collect data, particularly with the use of semi-structured interviews (Carr, 1994). An awareness of researcher bias including the effect that the researcher can have on the research process and on participants, as well as the effect of participants on the researcher is required (McCabe & Holmes, 2009). There is potential conflict for nurse researchers between the need to minimise risk to participants and gain results for the study (Ashton, 2014). There is a need for nurse researchers to establish rapport and demonstrate empathy however, this needs to be balanced with neutrality and a non-judgemental approach to ensure results are credible (Ashton, 2014). In addition, the researcher needs to be open to having personal beliefs and assumptions challenged (Smythe & Giddings, 2007).

**Data**

The data generated by each approach differs in collection, nature and use. Quantitative research relies on random selection of the sample from the study population and tends to involve larger numbers (Carr, 1994). The methods used to collect and analyse the data, which is often numerical and statistical in nature, ensures the reliability of the study and the validity of the data are maintained (Davidson & Tolich 2003; Offredy & Vickers, 2010). Data collected from quantitative studies is referred to as ‘hard data’ and has external value (Carr, 1994). Because of this, the findings of these studies are often generalizable and can be applied to larger populations and in different contexts (Davidson & Tolich 2003).

Qualitative research relies on purposeful sampling whereby the researcher targets or selects a particular sample, usually those who have or have not had a particular experience. The sample size tends to be much smaller and the data is normally written words (Carr, 1994; Offredy & Vickers, 2010). The methods used to collect and analyse the data ensure the findings are authentic, reflecting the opinions and actions of the participants involved and that the rigour of the study is maintained (Davidson & Tolich 2003). Data collected from these studies is known as ‘soft data’ and while it raises awareness it does not always lead to action or change (Carr, 1994). While findings from qualitative studies are not considered generalizable, findings from one situation can inform and contribute to the understanding of another situation (Davidson & Tolich 2003; Smythe & Giddings, 2007).

The qualitative approach offers many strengths and advantages. However, these also give rise to limitations which can impact on all aspects of a research project. The management of the
limitations is therefore essential to maintain rigour and a more detailed discussion on how this was done is provided in the methods chapter.

**Methodology for this study: Qualitative description**

An understanding of qualitative and quantitative approaches was useful for making an informed choice as to which approach would best fit the aims of this study. Many studies on this topic were found to be quantitative in nature and these provide valuable, objective information, particularly on the nature and prevalence of WPVA. However, it was the researcher’s intention to contribute to the understanding of WPVA by exploring the actual experience of WPVA; how those exposed had been affected and how ready they felt to respond. The qualitative approach supported the researcher’s commitment to present the participants’ perspectives and the belief that individuals will have a different experience of WPVA (Vaismoradi, Turunen & Bondas, 2013). Qualitative research methods are often used in the mental health context and are useful for gaining insight and knowledge on poorly understood or complex issues where the subjective experience is sought and valued (Crowe, Inder & Porter, 2015). While this study is not limited to the mental health context, it does draw on literature from this sector. It was anticipated that new graduates working in this sector would participate and the researcher is a mental health nurse.

There are numerous methodologies within qualitative research. These include phenomenology, grounded theory and ethnography, which have a strong theoretical basis and qualitative description which is considered less theoretical but still a necessary and valuable methodology (Sandelowski, 2000; Vaismoradi et al., 2013). Approaches can be considered on a continuum indicating the degree of transformation and analysis that the findings undergo, which ranges from descriptive to interpretative (Vaismoradi et al., 2013). Descriptive approaches (such as content analysis and thematic analysis) are therefore suitable for researchers who wish to employ a relatively lower level of interpretation in contrast to those approaches that employ a relatively higher level such as grounded theory (Vaismoradi et al., 2013).

Content analysis and thematic analysis are two methods often associated with descriptive approaches and they are similar in many respects (Crowe et al., 2015). They use similar techniques for data collection: purposeful selection of participants, interviews (one to one or focus groups). They enable the researcher to capture the meaning within the data through the development of codes and categories, however, thematic analysis has the additional step of examining the relationships and meanings between the categories to identify themes (Crowe
et al., 2015). Each of these methods generates different information and use different methods: content analysis is closely linked with answering the research question, while thematic analysis is more inductive, interpretive and seeks a broader meaning (Crowe et al., 2015). Braun and Clarke (2006) add that thematic analysis is a foundational method of analysis of qualitative data that offers flexibility to researchers.

The current study was designed using a qualitative descriptive approach and utilised the following methods: purposeful sampling, one to one semi structured interviews and thematic analysis. The less theoretical structure was considered an advantage as it allowed for findings to emerge from raw data with less restriction (Braun & Clarke, 2006). By staying close to the raw data, it was possible to capture participants’ descriptions of their experiences authentically and in the everyday language used by participants with a relatively low level of interpretation (Sandelowski, 2000; D.Thomas, 2006; Vaismoradi et al., 2013). In addition, participants’ descriptions of their experiences at the start of the interview served as a platform for participants to explore in greater depth what had happened to them and why (Sandelowski, 2000). Finally, the descriptive approach is ideally suited not only to those from a MH background but also to developing researchers (Braun & Clarke, 2006; Crowe et al., 2015). Braun and Clarke (2006) add that thematic analysis can be undertaken by those wishing to develop qualitative research skills as it provides core skills that can be used with other types of research.

The current study draws on the work of other researchers who have used a similar methodology for their study design: Bigwood and Crowe (2008) examined MH nurses’ experience of restraint and Manuel and Crowe (2014) explored MH nurses’ understanding of clinical responsibility. Although these studies have different topics from this study, they are aligned with the qualitative descriptive approach and utilise thematic analysis. There are relevant contextual similarities with both studies being NZ based, set in MH contexts (several of the participants experiences occurred in this context) and conducted by MH nurses.

**Theoretical positioning of researcher**

The qualitative descriptive approach is regarded as less structured and less complex then other forms of qualitative research, however, the researcher still needs to consider philosophical congruity between the aims of the study and the study design or methods used to achieve these aims (Houghton, Hunter & Meskell, 2012). To do this, Houghton et al. (2012) suggest that researchers draw on paradigms to assist in integrating these key aspects of a research study. This section presents the paradigms of interpretivism, pragmatism and naturalistic
inquiry that were drawn on and influenced aspects of the research process (Houghton et al., 2012). Central to the qualitative descriptive approach is an awareness of the researchers’ influence and a discussion on the application of reflexivity is provided to acknowledge this influence.

**Interpretivism**

As this study draws on the qualitative descriptive approach the degree of interpretation is relatively low. However, a degree of interpretivism underpins all qualitative research (Davidson & Tollich, 2003; Sandelowski, 2000). It refers to the belief that humans constantly interpret and make sense of their surroundings and that the reality of others is socially constructed and is therefore influenced by factors such as time, context and culture (Schwandt, 2007). Interpretivism considers more than one truth exists, and that there can be multiple realities (Houghton et al., 2012) therefore the methods used in research drawing on this approach aim to capture participants’ subjective experiences. For this study, the researcher sought new nurses’ subjective experiences of violence and aggression and the context in which these had occurred (such as mental health or older persons’ care). Participants provided a description of what happened to them, the circumstances surrounding the event and possible explanations of why it happened. The use of semi-structured interviews and thematic analysis facilitated the capture the subjective view of each participant.

**Pragmatism**

Although there are many views of pragmatism or the pragmatic outlook, generally this paradigm focuses on the integration of theory and practice (Schwandt, 2007). It is suited for research that asks how do people cope with, deal with or describe their situations (Wellford, Murphy & Casey, 2012). Houghton et al. (2012) add that pragmatism requires the researcher to use methods that generate data that addresses the research question and produces meaningful results for participants. For this study, the researcher sought to explore new graduate nurses’ experiences of WPVA and their sense of readiness for responding, including the adequacy of the theoretical and practical preparation they had undertaken. It also explored how participants coped with their experiences, generating practical and useful coping strategies.
Naturalistic inquiry

Naturalistic inquiry emphasises that understanding of social action (i.e. the meaning, character and nature of an event that occurs in a social context) can only come from first hand eyewitness accounts of ‘being there’ (Schwandt, 2007). It aims to study human actions in a way that is not contrived, manipulated or artificially shaped by the researcher (Schwandt, 2007). For this study, the researcher considered it important to gain data from those who had firsthand experience of WPVA either by being directly involved or by witnessing the situation first hand. The use of a semi-structured interview provided opportunity for participants to describe their experiences in their own words, with minimal intervention from the researcher. While this interview took place away from the clinical setting where WPVA occurs this was for practical and ethical reasons and interviews were held in an area that participants had some familiarity with and in a manner that put participants at ease.

Application of Reflexivity

The relationship between the researcher and participants in qualitative research is significant with the researcher influencing, and being influenced by the process of engaging in the study (Northway, 2000). Reflexivity recognises the reciprocal nature of this relationship and seeks to make it explicit (Northway, 2000). It requires that the orientation, values and beliefs of the researcher and the inherent bias and prejudices that these bring to the research be examined in an open and transparent manner (Northway, 2000). The researchers professional background and position influences each stage of a research study including what they choose to investigate, how it is investigated (methodology and methods), findings that are captured and the resulting discussion and conclusions (Malterud, 2001).

The researcher for the current study was a Registered Psychiatric Nurse who was hospital trained in the mid 1980s at Kingseat Hospital, South Auckland. The three-year training programme followed an apprenticeship model where students worked alongside experienced nurses with short periods of study to provide theoretical knowledge. This initial training, along together with subsequent further education led to broad experience in state MH services including in patient and community services, and has involved roles in management; nursing education in polytechnic institutions and the researcher’s current position as Associate Director of Nursing – MH and Addictions. Throughout this career path, the researcher has been interested in nurses caring for aggressive and violent clients, including the effects of this exposure and the preparation they receive to respond to these situations. This led to being an instructor in Non Violent Crisis Intervention for several years. The ongoing interest has
provided the motivation for this study and the decision to work with new graduate nurses was based on the belief that nurses at this level are particularly vulnerable and would offer a fresh, contemporary perspective on WPVA and their sense of readiness.

It is the researcher’s belief that at some stage of in their career it is very likely that nurses will find themselves dealing with potentially violent and aggressive people and that they have a professional responsibility to be able to respond in a competent and safe manner. Her experience indicates that nurses rely heavily on ‘trial and error’, gaining experience and learning by role modelling to deal with these situations. The disadvantages of learning in this manner include; new graduates and less experienced nurses are vulnerable, clients care can be compromised, and opportunities for critical reflection on WPVA and alternative ways to respond, such as preventative approaches are limited. It is the researcher’s belief that nursing education programmes and employers of nurses have an obligation to prepare and support nurses to deal with WPVA competently at the start of their career and as part of continued professional development.

**Ethical considerations**

Health professionals who undertake research need to be mindful of professional and research ethics that are present at all stages of the research process, with ethical principles forming the foundation of decisions made to protect participants and uphold the methodological rigour of the research study (Iphofen, 2005). This section presents a broad overview of the ethical principles that underpinned this study: beneficence, non-maleficence, veracity, confidentiality and respect for autonomy. A more detailed discussion of how these ethical principles were applied to each stage of the research process such as recruitment, data collection and data analysis is included in the methods chapter. Although these principles are considered individually, in application many of them are closely linked. A discussion of methodological rigour is also provided.

**Beneficence**

In research, the principle of beneficence requires the benefits of participating in the research to outweigh the potential risks to firstly participants and secondly, society in general (Gelling, 1999; Liamputtong, 2013). It is therefore unethical to involve participants in research where there is no benefit expected to participant or society in general (Gelling, 1999; Liamputtong, 2013). The intention of this study is to contribute to the understanding of nurses and WPVA. It is anticipated that improved understanding of WPVA will benefit nurses and those that they care for who have the potential to become violent and aggressive. It is also anticipated that
participants will find benefit in reflecting and sharing their experiences and by being involved in research at an entry level. In particular, there was an emphasis on exploring participant’s experiences in a professional, non-judgemental manner that avoided apportioning blame, supported professional development and a sense of empowerment (Panko, 2014).

Non-Maleficence

In research, non-maleficence requires that no harm come to the participant as a result of taking part in the study and this includes physical, psychological, social or economic harm (Gelling, 1999; Liamputtong, 2013). For this study, physical harm was unlikely therefore not specifically addressed; however, the potentially sensitive nature of the topic increased the risk of psychological or emotional harm to participants. Research can be considered ‘sensitive’ if the topic is socially sensitive, could be regarded as personal, threatening or revealing by participants or involves groups considered vulnerable (Kavanaugh et al., 2006; McGarry, 2010). The topic for this study is considered sensitive as participants discussed their personal experience of workplace violence and aggression including how they had responded and how it had impacted on them. Kavanaugh et al. (2006) recommend researchers anticipate and develop strategies in advance to ensure successful recruitment and involvement of participants.

They draw on Swanson’s ‘theory of caring’ (Swanson, 1991) as a framework as it stresses the wellbeing and needs of participants, and is transferable to nursing research (Kavanaugh et al., 2006). The framework consists of five dimensions; knowing, being with, doing for, enabling and maintaining belief (Swanson, 1991) and aspects of this underpinned the manner in which this research study was conducted. These included ‘knowing’ where an attempt was made to understand the experience from the person who lived it by avoiding assumptions and responding to cues; ‘being with’ where the researcher was authentically present for the participant while conducting the interview; ‘doing for’ by providing physical and psychological comfort (such as participants were provided with a quiet, private room with refreshments, tissues and toilet facilities, and given reminders about the process of recording and confidentially); ‘enabling’ by giving participants some control over the process (such as choosing times, places to meet and allowing for re-scheduling which happened for two participants) and reviewing the transcripts; ‘maintaining belief’ by believing in participants capacity to work through and find personal meaning in their experiences despite the challenges and conditions faced (Kavanagh et al., 2006).
In addition, Wilson and Neville (2009) recommend culturally safe research practices when working with vulnerable groups. While the concept of vulnerability is contestable, the fact that participants were novice nurses, who may potentially identify with cultural groups generally considered vulnerable (such as Maori, Lesbian – Gay – Bisexual, Transgender people [LGBT], those with disabilities) and that participants have been exposed to WPVA, needs to be taken into consideration. The framework recommended by Wilson and Neville (2009) is based on the four principles of Te Tiriti o Waitangi: partnership, participation, protection and power. These principles were embedded in all stages of this project so that all participants would feel included, valued, respected, able to trust the researcher and secure in what would happen to the information shared. This was evident in the information that was provided to participants as part of the informed consent process and by the use of a semi structured interview process, which included asking participants if they had any questions or if there was anything else they would like to add.

Participants need to be protected from exploitation. In qualitative research participants enter into a special relationship with the researcher and this makes them vulnerable to exploitation, be it overt (such as asking more of the participant than was originally agreed to) or more covert (such as leading the participant to reveal more information than is required). Exploitation can become more of an issue as the study progresses and the relationship develops (Polit & Beck, 2010). This was minimized by the use of prepared questions and prompts, which were provided before the interview.

It was also acknowledged that in some cases, further support may be indicated in which case participants were encouraged to access counselling through the DHB Employee Assistance Programme (EAP) which is free of charge to employees and NETP or NESP students. Participants were advised of possible distress when sharing their experiences at the interview and on reading the transcription. Therefore, it was felt important EAP be available for this period.

Veracity

The principle of veracity highlights the obligation of the researcher and participant to be truthful. For the researcher there is the responsibility to be truthful about the research even if this deters people from participating. It would be unethical to withhold any information or to misrepresent the potential benefits or risks of associated with the study (Gelling, 1999; Liamputtong, 2013). For participants there is an expectation and assumption made that their stories would be shared truthfully. For this study, information was provided to participants at
a presentation and in writing. This included information on the aims of the study, who could participate, what would be asked of participants and what would happen to information provided. See appendix three: information sheet for participants.

With the phenomenal increase in nursing research, often supported by the use of information and digital technology, Booth, Colomb and Williams (2008, cited in Panko 2014) suggest researchers implement strategies that reflect some of the contemporary challenges to veracity. These include avoiding plagiarising or claiming credit for the work of others, accurate representation of sources, data and results, discussion on opposing or conflicting views and providing a clear and true record of sources and data for others to follow. For this study The American Psychological Association (APA) style was consulted to ensure the above guidelines were adhered to (Schwartz, Landrum & Gurung, 2014). In addition, this thesis was submitted to SafeAssign, the University of Otago’s preferred plagiarism checking software. It was found to have a match of 6% which was attributed to quotations and a small number of standard phrases. Scores of less then 15% indicate that there is no evidence of plagiarism (https://en-us.help.blackboard.com). Please see Appendix Fourteen: Evidence of Safe-Assign Plagiarism Check.

Confidentiality

In research, confidentiality is an essential component of the researcher – participant relationship. The researcher is obligated to take rigorous precautions to uphold confidentiality and to convey these to the participant to create a climate of trust (Gelling, 1999; Liamputtong, 2013). For this study, these precautions included secure storage of electronic and hard copy information, maintaining anonymity through the use of pseudonyms and the exclusion of any data that could identify participants, others involved or the clinical practice area where an event has occurred. Should any information have come to light that was of a more serious nature and further action was deemed necessary, then this would have been discussed with the participant and supervisor (Polit & Beck, 2010). Similarly, there was an awareness of the need to maintain the anonymity of any organisations, such as DHBs and tertiary institutes, which may be identified by participants or contribute to the identification of participants.

Respect for Autonomy

The researcher respected participant’s autonomy by ensuring participants understood that they were free to participate or not without any prejudicial consequences, that they had the right to ask questions or refuse to give information, including the right to withdraw from the study at any stage (Polit & Beck, 2010). Central to this was the use of informed consent. Participants
were provided with an information sheet outlining the aims of the study, the questions that were to be asked, expectations regarding their participation, responsibilities of the researcher, risks and benefits of participation and the voluntary nature of the study (Polit & Beck, 2010). Underlying this awareness is the researcher’s belief that people’s stories are primarily owned by them and should be regarded as a precious gift. The sharing of personal stories first hand is a privileged and fortunate position for the researcher to be in. The onus is on the researcher to share this gift with others in a manner that upholds the rigor of the research methodology as well as the authenticity of the participant’s experience (Iphofen, 2005). Participants were also given the opportunity to review the written transcript of their interview prior to its analysis. A copy of the transcript was sent to each participant and they could amend this as they say fit.

The research proposal for this study received the following approvals prior to the study commencing:

- University of Otago: Board of Studies (see appendix one)
- University of Otago: Human Ethics Application – category A (see appendix two)
- University of Otago: Research Manager – Maori (see appendix three)
- XXDHB: Research Approval Committee (see appendix four)
- XXDHB: Iwi Health Board (see appendix five)

**Methodological Rigour**

In qualitative research rigour refers to the trustworthiness of the research ensuring that the findings are authentic. It includes credibility, transferability, dependability and confirmability (Liamputtong, 2013). For this study various strategies were employed to ensure methodological rigour was maintained.

Credibility requires that what the participants say is accurately presented by researchers in the findings and this was maintained by; all interviews were recorded then transcribed by the same person, transcriptions were checked by the participants, samples of transcriptions and coding were sighted and discussed with supervisors (Liamputtong, 2013). Transferability relates to the degree that findings can be generalised or applied to other individuals, groups or contexts and for this study transferability is limited due to the small sample size and under representation of gender and various ethnic groups (Liamputtong, 2013). Dependability relates to the congruency and consistency of processes used in the study and this was maintained by systematically using approved and researched based approaches to recruitment, data collection and data analysis (Liamputtong, 2013). Each of these stages were undertaken by the researcher in consultation with supervisors. Confirmability, ensures that the findings
are clearly linked to the data and this was maintained by using direct quotes from transcripts as evidence to substantiate all findings (Liamputtong, 2013).

**Conclusion**

The descriptive, qualitative approach that informed this study’s design is well suited to research that seeks to explore the lived experience of a phenomenon such as WPVA and authentically capture the participants’ experience. The purpose of this chapter is to provide a broad overview of this approach and to provide transparency to decisions made at key stages of the study. It includes the ethical considerations that guided the research process and acknowledges the influence of the researcher. The following methods chapter outlines more specifically how this approach was implemented.
CHAPTER FOUR: Methods

Introduction

Chapter four presents the study design applied in undertaking this research. In considering the study design (methods), it was important to ensure that these were consistent with the descriptive, qualitative approach that the research draws on. The following components of the study design are addressed: sampling strategy, recruitment of participants, data collection and data analysis.

Sampling Strategy

In qualitative research a robust sampling strategy serves several purposes. It contributes to the usefulness and credibility of the study, minimises selection bias, assists with pragmatic aspects of conducting the study and ensures that the research question will be addressed (Houser, 2008). To be effective, a sampling strategy needs to be well considered and established at the developmental stage of the research planning (Houser, 2008). For this study, a purposeful sampling strategy, where the researcher intentionally targeted individuals who had experience of WPVA and were new graduate nurses, was employed.

Offredy and Vickers (2010) recommend that researchers initially identify a population of interest, then identify the group that best represents this population. For this study the population of interest was new graduate registered nurses who lived and worked regionally and the sample chosen was those who were enrolled in either NETP or NESP new graduate programmes. Enrolment on either of these programmes was considered important as it was assumed the new graduate would have a range of practice areas to draw on and would also be receiving support through preceptorship and through membership of this group. It was also assumed that the DHB environment was likely to have robust policies and systems in place relating to WPVA, which the new graduate participants could be expected to have some knowledge or experience of. Finally, a significant number of new graduates are part of the NETP or NESP schemes so it was assumed that it would be easier to recruit from this group as they met regularly.

Inclusion and exclusion criteria

In developing inclusion and exclusion criteria the process was guided by Offredy and Vickers (2010) who recommended a transparent, meaningful and justifiable rationale. Established
criteria enables objective selection of participants, thus reducing the potential of selection bias and ensuring that participants have the characteristics or experiences needed to answer the research questions (Houser, 2008). Practical considerations such as ability to participate and availability for interviews also need to be addressed (Offredy & Vickers, 2010). For this study the following inclusion and exclusion criteria were developed to ensure that participants were able to provide information that would address the research question, were working in a range of clinical areas, had experienced WPVA in their new graduate year and were to participate in the study. As the intention of the study was to provide a NZ perspective it was considered important that participants had undertaken their nursing education in NZ.

Inclusion criteria:
- Have undergone undergraduate nursing education in NZ
- Be a new graduate nurse with NZ registration
- Be enrolled in either a NETP or NESP programme
- Have experienced (including witnessed) workplace violence and or aggression in their new graduate year
- Be able and available to share their experiences within the six months following recruitment and be resident within the DHB catchment area
- Fluent in the English language

Exclusion criteria:
- Had not undergone undergraduate nursing education in New Zealand
- Were not a new graduate nurse with New Zealand registration
- Were not currently enrolled in either a NETP or NESP programme
- Had not experienced (including witnessed) workplace violence and or aggression as defined within the last five years
- Were not able and available to share their experiences within the next six months or lived outside the DHB catchment area

Sample size
In qualitative research there is some flexibility as to sample size and factors such as quality of data, resource availability and the feasibility of obtaining and retaining participants can impact on the number chosen (Gerrish & Lacey, 2006; Houser, 2008; Offredy & Vickers, 2010). As a result, predicting the sample size can be difficult, and this is often not predetermined although the researcher may have a general number in mind (Houser, 2008). Prior to the commencement of this research, a sample of twelve participants was anticipated.
This number was calculated on the total number of new graduates enrolled at any given time in NETP or NESP programmes and guidance from supervisors. However, once recruitment and data collection were underway the following factors influenced the sample size for this study.

Firstly, recruitment for this study occurred over a twelve-month period and covered the catchment area of the local DHB, which yielded a potential population of sixty participants. Initially six people indicated a willingness and ability to participate; however, one of this group did not meet the research criteria, as she was not a new graduate. A second round of recruitment resulted in a further four participants. However, one withdrew prior to the interview for personal reasons. The study was conducted in a small provincial region and the researcher believed that all new graduates who currently worked or resided in the region had been contacted either through attending a presentation, word of mouth or through having read the flyer (see appendix seven) that was placed on noticeboards. Due to the scheduling of NETP and NESP courses, any further recruitment outside this group could not happen until the following year, so delaying the progress of the study by up to a year.

Secondly, it became clear at the early stages of data collection that participants were able to provide a large amount of data. They seemed well prepared and had clearly reflected on their experiences prior to the interview and came ready to talk about a particular incident. As a result they spoke clearly and articulately about their experiences and provided data that was rich and covered a range of experiences.

Lastly, seeking participants out of the area was considered. However, the pragmatic challenges in doing this including expense, additional approvals and time required would have been considerable. Once all available participants had been interviewed, a decision was made to limit the study to these eight (including the pilot participant), following consultation with the author's academic supervisors.

**Recruitment of Participants**

The recruitment stage of a research study is significant. It is often the first contact between the researcher and potential participants and so marks the beginning of a relationship that will continue for the duration of the research study and sets the scene in which the research will be conducted (Kavanaugh et al., 2006). Recruitment strategies for this study included presentations and snowballing.
Presentations

As potential participants were enrolled in NETP and NESP programmes they were already part of established groups that met regularly so recruitment was undertaken by way of a presentations within this setting. Preparation for the presentation included consulting with others who had an understanding of new graduates, including the NETP and NESP coordinators (Kavanaugh et al., 2006). Consent was granted by representatives of the DHB to include the presentation as part of a planned study day as the topic was thought to be relevant to new graduates on many levels including the topic of the research and the nature of the research. The researcher presented an outline of the study discussing the aims and objectives, the approval process that had been successfully undertaken, what would be expected of participants and what would happen to information provided. A description of the interview process including the types of questions that could be expected, the recording and transcription of interviews, and the environment in which interviews would be conducted was provided.

It was made clear that the study was part of a Master of Health Science’s thesis and that it was endorsed by the University of Otago, NZ. This was followed by a question and answer session. Attendees were provided with a form to complete providing contact details if they wished to know more about the study and were interested in participating which was collected at the end of the session (see appendix six). If an attendee agreed to further contact, they were emailed an information sheet (see appendix eight) that provided more detailed information and a consent form (see appendix nine). A hard copy of the information sheet and consent form was reviewed and discussed at the time of interview.

The four presentations were kept informal, welcoming but professional. An attempt was made by the researcher to come from a strengths based perspective so maintaining belief and optimism in the value of participants’ experiences, their ability to share these experiences and to find personal growth and meaning in doing so (Kavanaugh et al., 2006; Swanson, 1991; Warne & McAndrew, 2010). This was conveyed by ensuring language used was respectful and professional but free of overly technical terms. The pace of the presentation allowed for discussion and some initial sharing of experiences. Similarly, care was taken to ensure documents were written in a way that was understandable, respectful and captured the sensitive nature of this topic. Where possible, first person was used and forms were specific to this group and study rather than generalised. Contact details of both the researcher and their academic supervisors were clearly presented. The documentation used had received approval from the University of Otago Ethics Committee.
‘Snow balling’

As well as presentations, word of mouth, sometimes referred to as ‘snow balling’ was used to promote the research study and reach more potential participants. This form of recruiting uses existing networks to contact others who are part of a group. It can be useful for groups that are hard to reach or where the research is of a sensitive nature (Gerrish & Lacey, 2006). The NETP and NESP networks that new graduates were part of provided an opportunity to use ‘snowballing’ in different ways. Attendees at the presentation were invited to share the researchers contact details with anyone they thought might be interested in participating. At the time of an interview one participant asked if she could provide the researcher’s contact details to an associate who she felt could contribute to the research. Another participant stated that she had talked to others in the new graduate network about her experience and they had supported her to participate.

**Strategies to manage recruitment risks**

The researcher was mindful of the risks associated with the recruitment of participants. There was the risk of coercion or pressure for new graduates to participate, particularly as DHB management had indicated their support for the study (Gerrish & Lacey, 2006). Given that attendees were employees and the background of the researcher (i.e. former DHB manager and currently senior academic staff member at local polytechnic where some attendees had been students) the potential for abuse of power existed (Comer, 2009). Several strategies were used to minimise the risk of coercion. At the start of the presentation it was made clear that the intention was to share the researcher’s experiences as a novice researcher as well as to recruit participants (Tolich & Davidson, 2011). Attendees were advised that confidentiality applied at all stages of the study and that the identity or any other information that could lead to identification of those who chose to or chose not to participate would remain confidential (Gerrish & Lacey, 2006). Further reassurance was provided that those who chose not to participate, would not experience any consequences as a result of their decision (Comer, 2009). Only those who agreed to be contacted were sent further information on the study.

Similarly, the caring and supportive approach that underpinned the study had the potential to lead to role confusion. Establishing clear role boundaries at the recruitment and consent stage of a study can assist in clarifying the researcher – participant role (Kavanaugh et al., 2006; Swanson, 1991). In this study the researcher did not have a therapeutic role and if participants required further support either as a result of their experience, retelling their experience or revisiting this through reading the transcript then the DHB Employee Assistance Programme
(EAP) was available to them. Also, potential participants were made aware that should any information come to light that might be ethically or legally of concern then this would be discussed with participant and supervisors of the study. Should further action be deemed necessary, the participant would be notified and involved. This information was also provided in print format in the information sheet (see appendix eight).

**Data collection:**
In qualitative research there are several methods used for data collection including individual interviews, focus groups, observation, diaries and questionnaires or surveys and for this study individual interviews were used. While there was an underlying assumption that face to face interviews would result in accurate information about participants’ experiences there were several aspects considered to ensure the interview was conducted successfully and that data gathered was rich, accurately recorded and transcribed and relevant to the phenomena being studied (Al-Yateem, 2012). These included rationale, management of resources, interview skills, interview sequence, transcription of data and the use of a pilot study.

**Rationale for interviewing**
For this study individual interviews were used because of the skills of the researcher and to capture participants’ thoughts, feelings and opinions first hand to answer the research question (Meadows, 2003; Offredy & Vickers, 2010). Categories of interviews range from structured with set questions only used, semi-structured with set questions as well as prompts for further investigation through to unstructured which are more conversational in nature. For this study a semi-structured approach was chosen. This enabled the researcher to ‘be with’ the participant in a way that was authentic and allowed for the researcher to assess and understand participants’ responses with greater depth while still maintaining focus and consistency across interviews (Kavanaugh et al., 2006; Swanson, 1991). Within the interview there was provision for participant and researcher to work in partnership with the participant willing to share their story from their own perspective and the researcher facilitating the expression of this by the use of prompts, so maintaining some control of the process (Offredy & Vickers, 2010; Wilson & Neville, 2009).

**Management of resources**
Resources required for conducting and recording the interviews successfully needed to be organised well ahead of time and included recording equipment and venues (Gerrish & Lacey, 2006).
Interviews were recorded using an Olympus DS-30 Digital Voice Recorder which included a transcription kit. It was relatively easy to use, compatible with computer and came recommended by a colleague who had used it extensively. Care was taken to position the recorder to ensure good sound quality and be clearly visible to participants without being obtrusive (Serry & Liamputtong, 2013). Seven out of the eight interviews were recorded without issue and the sound quality was excellent. However, the last interview had poorer sound quality, which did not become evident until transcription, but it was still usable. The recordings were transferred to password-protected storage and removed from the recorder’s files.

Venues for conducting the interviews were chosen with an emphasis on privacy, convenience and appropriateness (Kavanaugh et al., 2006; Serry & Liamputtong, 2013; Swanson, 1991). They were held at two locations to reduce travel costs and time for participants. The sites chosen were independent of new graduates’ employers, familiar to participants and had adequate parking facilities (Serry & Liamputtong, 2013). The rooms where the interviews took place were specifically designed for this purpose: private, quiet, with comfortable furniture and professionally laid out. Water was provided and toilets were nearby. Dates and times were negotiated with participants via email with several options provided to accommodate shift work (Kavanaugh et al., 2006). Mostly it was possible to undertake interviews in ‘blocks’; two interviews per day spread over two to three weeks. This enabled the researcher to keep some consistency and to become fully immersed in the process of data collecting. Interviews took approximately one hour and generated a large volume of data.

**Interview skills**

The quality of data collected through semi-structured interviews is highly dependent on the skill of the interviewer (Offredy & Vickers, 2010). Nurses are experienced at interviewing in clinical settings, which can be useful preparation for research interviews, however, the purpose of a research interview is different and different skills are required. In a clinical setting the information sought is more likely to be specific to a clinical condition and the nurse is coming from a position of ‘knowing’ and therefore has more influence on the outcome (Gerrish & Lacey, 2006; Kavanaugh et al., 2006). For this study, the focus was broader and the nurse – researcher attempted to come from a position of ‘not knowing’ so empowering participants to influence the outcome (Gerrish & Lacey, 2006; Kavanaugh et al., 2006). Communication skills to support this included open-ended questions, paraphrasing, and silence, active listening, developing trust and empathic neutrality, which were effective in exploring experiences at greater depth (Holloway & Wheeler, 2002; Serry & Liamputtong,
To promote authenticity and reduce researcher bias, the researcher avoided ‘testing’ participants, asking leading questions, and creating dichotomies (Serry & Liamputtong, 2013).

**Interview sequence**

An interview sequence was developed prior to conducting interviews. It contributed to a systematic and consistent approach for all interviews, guided the interview process ensuring all requirements were met and enabled the researcher to focus on relating to participants (Serry & Liamputtong, 2013; Gerrish & Lacey, 2006). The sequence used for this study covered the arrival and introduction, the beginning, middle and the end of the interview as well as what happens post interview.

On arrival, participants were greeted and there was a brief exchange of small talk to enable the participant and researcher to become comfortable prior to discussing research requirements. Participants had been provided with electronic copies of the information sheet, consent form and interview guide to review prior to the interview. Hard copies of these were provided at the time of the interview and these were discussed with any questions addressed (see appendixes eight & nine). Participants were also asked to complete a form to provide demographic information (see appendix eleven). Once this had been completed an outline of the interview process (including recording, transcription and review with possible amendments of transcribed interview) was discussed. Participants were also informed that the researcher would be taking some brief notes to assist in keeping to task. They were reassured that they could stop the interview at any time and were free to ask questions.

At the beginning of the interview the recorder was switched on to allow the participant and researcher to adjust to its presence. An interview guide (see appendix ten) provided some structure to the interview while still enabling the participant to share their perspective without constraint. It consisted of a series of questions that were used as prompts rather than asked verbatim that reflected the aims of the research study. When questions were used, these were mainly open ended to facilitate discussion (such as how did this experience affect you?) but closed questions were useful for clarification and more specific data (such as has this experience affected how you feel about nursing?) (Serry & Liamputtong, 2013). Interviews began within approximately ten minutes of the person arriving and commenced with the broad, open-ended question “tell me about your experience of violence and aggression while nursing” (Serry & Liamputtong, 2013).
The middle of the interview focused on the researcher’s use of self to ‘be with’ the participant (Kavanaugh et al., 2006; Swanson, 1991). This allows for greater understanding of participants response and facilitates authenticity. ‘Being with’ was particularly important while interviewing and was conveyed by open body language, gentle tone of voice, allowing adequate time for response and enabling participants to share their story.

As with the beginning, consideration was given as to ending the interview. Given the nature of the topic, it was important to end on a positive note. In partnership with participants the key aspects of their experiences were summarised and the positive aspects were acknowledged, including their willingness to share their story to help others. When it was felt that participants had discussed their story and questions on the interview guide had been addressed, participants were advised that the researcher had no further questions and they were asked if they had anything more they would like to say. Several took the opportunity to comment on how worthwhile the process of being involved with the research had been, others added to what they had said with the intention of clarifying material already covered. This ending gave a sense of closure for participants and researcher and in some cases further valuable data was obtained (Serry & Liamputtong, 2013).

Post interview, the recorder was switched off. The researcher was mindful not to underestimate the potential effects of sharing personal experiences following interviews of this kind. Two participants who had experienced horizontal violence were of concern because although there had been some action following the incidents, they were far from being resolved. Both indicated a desire to have ongoing clinical supervision as a way of dealing with the incidents they shared for this study but also to enhance future practice. Other participants used this time to discuss their career and how nursing in general was for them.

All participants were thanked and reassured about the value of their contribution to the study (Gerrish & Lacey, 2006). They were briefly reminded about the process regarding the generation of the interview transcript, which would be forwarded to them in the following weeks. This included possible distress as a result of reading the transcript and to consider further support from EAP if this was the case.

**Transcription of data**

To be useful, data collected by interview needs be transcribed into written format so it can be analysed. The process of transcribing is in itself the beginning of data analysis and allows for full immersion with the data, so it is recommended that the interviewer does the transcribing (Gerrish & Lacey, 2006; Holloway & Wheeler, 2002; Serry & Liamputtong, 2013).
Transcribing data does, however, present challenges. It is time consuming with an experienced transcriber estimated to spend approximately six hours to transcribe an hour-long interview. It requires a range of skills: careful listening, attention to detail and systematic record keeping (Holloway & Wheeler, 2002).

Despite the challenges associated with transcribing, for this study the researcher conducted the interviews and transcribed the interviews. The task was made more manageable by the using of the Olympus AS-2300 transcription kit that was compatible with the digital recorder. Also the transcription took place as close to the interviews as possible and these were spread out over a six-month period. There were several unanticipated benefits. Transcribing was a useful way of staying connected with the study when it was not possible to work on the more academic components. Another dimension of understanding was added through the process of re-hearing people’s stories in a context that was free from distractions. Hearing people’s voices supported an ongoing connection with participants even though there would be no further contact until dissemination of findings. Combined, these benefits were a source of motivation to the researcher (Serry & Liamputtong, 2013).

The data was transcribed verbatim including all emotional expressions such as laughter, uncertainty and hesitancy so capturing the depth and complexity of the interview (Holloway & Wheeler, 2002; Serry & Liamputtong, 2013). Both questions and answers were recorded to provide contextual clarity (Serry & Liamputtong, 2013). The data was transcribed in a table format so it was possible to clearly distinguish between interviewer and participant and allow room for additional comments for data analysis. Key information such as date and location were noted on each transcription to assist with retrieval and analysis at a later date. As transcribing was completed an electronic copy was forwarded to each participant for amendment. Serry and Liamputtong (2013) suggest that this reinforces with participants that it is their data and that they continue to have ownership of the story they have shared. Only one participant amended material. She stated that she couldn’t recall a particular comment she had made and asked for it to be discarded and this was actioned.

Storage of voice recordings and transcribed data needed to be secure and organised. An electronic folder was created for each participant and these were labelled numerically in the order that interviews had occurred (such as participant1, participant2). The voice recording and transcription were kept in respective folders. Due to the size of the media files, some of which were up to 25,000 kilobytes, and the need for secure storage, the folders were stored in a password protected hard drive.
Pilot study

Gerrish and Lacey (2006) recommend a pilot process be conducted to allow for any changes or amendments prior to embarking on the whole research project. For this study, one participant was chosen to partake in a pilot interview, which provided an opportunity to trial the venue, the interview guide, the researcher’s approach and the technical equipment involved in recording and transcribing the interview. A recording of this interview along with the interview guide and a sample of the transcription was provided to supervisors for feedback.

As a result of the pilot process, changes were made to the interview guide. These were the inclusion of the following prompts:

- Can you describe the most significant incident you have experienced?
- What enabled or hindered you from talking about these incidents (To whom? At the time? Later? )
- Has this experience influenced how you feel about nursing?
- Is there anything else you would like to add?
- Do you have any questions?

It also became evident that interviews could take longer (at least 45mins) than the 30mins that was first anticipated, as would the transcription of the data. The pilot confirmed the suitability of the venue and the pre interview process outlined above. It allowed for the researcher to become more competent in using the digital recorder and transcriber. Although the researcher has had experience in interviewing, this was the first experience as a researcher. While listening to the pilot recording and transcribing the data collected it became evident that different skills were required. In particular it was surprising how freely the participant spoke; many of the prompts on the interview guide were addressed without being stated. This meant a large volume of data was provided and it would be helpful to take notes to follow up on points made and any gaps in data. It also became apparent that the researcher spoke too much. At times this was to provide reassurance and validation for the participant but at other times this was unnecessary and seemed to lead the participant excessively. There were also times when more than one question at a time was asked, potentially confusing the participant. To address this the researcher took brief notes and disclosed this prior to interview starting, made a conscious effort to speak less, used non verbal encourages (such as um, head nodding) and asked one question at a time. The data collected in the pilot study was not included in the study and the pilot participant was aware of this prior to the interview.
Data analysis:

After reading similar research which aimed to capture the perspective of participants with minimal interpretation and in discussion with supervisors, thematic analysis was undertaken for this study. The intention was to reduce the data gathered into meaningful units and in a format that is clear, understandable and trustworthy (Houser, 2008; Liamputtong & Serry, 2013). To do this, a step-by-step process to identify codes, categories and themes was adopted (Braun & Clarke, 2006). The challenges this form of analysis presented are outlined.

Step by step process

A five-step process was utilised to effectively manage the large volume of data generated. This facilitated a methodical, systematic approach that also allowed for some flexibility. As suggested by Braun and Clarke (2006) the process was recursive rather than linear, requiring the researcher to move back and forth across the steps as needed. Drawing on the work of the work of Braun and Clarke (2006), Saldaña (2013), and Liamputtong and Serry (2013) this study used the following steps as a framework:

- **Became familiar with data:** this began with the researcher transcribing the data. In the process of doing this initial impressions and ideas were noted. The process of re-listening to participants and transcribing this into written text provided a deeper immersion with the data. The transcription kit allowed for the recording to be slowed down and replayed allowing for more time to reflect on what people were saying. The text was entered into a table, which had a column for the researcher’s comments or queries (see appendix twelve). The researcher’s first impressions included: the level of vulnerability experienced and how this was managed by individuals; the profound affect that WPVA, particularly horizontal violence had on participants; the lack of preparation for dealing with WPVA and finally the positive effects that result from the experience.

- **Developed initial codes and categories:** Following the recommendation of Auerbach and Silverston (2003, cited in Saldaña, 2013) a written copy of the research aims and objectives and a list of general questions (see appendix thirteen) was referred to while coding. Coding happened in several phases. In the first phase, large chunks of text that contained key words, phrases, ideas that linked to aims of the research or were of interest were highlighted in individual transcripts, with comments and possible code names made alongside. A significant amount of text was highlighted to provide context (Braun & Clarke, 2006). In the second phase, individual transcripts were
reviewed resulting in smaller amounts of text being highlighted, some codes eliminated or renamed and others combined to form categories. In the third and final phase, transcripts were reviewed as a group resulting in further amendments to codes and the formation of categories. Data was transferred to a spreadsheet which helped categorise data and move between categories. All stages of coding were done in consultation with supervisors. A total of sixteen categories were identified. See Tables one, two and three for the development of codes, categories, sub themes and each theme for tabular representation of this process.

• *Searched and identified sub themes*: Once categories had been formed, common factors and links were searched for across all transcripts to identify sub themes. This was done using mind mapping on a white board with post its and whiteboard pens to identify patterns, common ideas or terms and how these could be combined to meet the aims of the research study. Sub themes were kept broad to ensure that they were relevant to all participants but allowed for the individual experience to surface. An example of how categories became sub themes: when participants described their experiences, which formed the category ‘nature of WPVA’ they considered contextual factors (such as it was their first experience, they hadn’t predicted it would happen, low staffing numbers) which formed the category ‘impact of contextual factors’. These were combined to form the subtheme of ‘what happened’. A ‘parking lot’ was created for material that didn’t seem to initially fit but that was deemed of value and this included: data relating to how participants felt about nursing, the challenges of working in small teams, small services and in small towns and the impact of WPVA on their personal lives. A total of six subthemes were identified.

• *Checked and reviewed sub themes*: The sub themes were checked to ensure they were sufficiently broad to encompass all of the participants’ experiences that they were relevant to the aims and objectives of the research study and the naming reflected the categories they were made up from. As a result there was some renaming of subthemes: ‘why is it happening’ was renamed ‘making sense of it’, ‘maintaining integrity’ was renamed ‘ways of coping’. Three draft themes were formulated and the writing up of findings began in consultation with supervisors.

• *Identified and named themes*: Themes were continuously reviewed while findings were written up to ensure consistency with aims and objectives and the data provided by all participants. The researcher felt it was important that themes reflected the strengths based approach that under pinned the research and were reworded
accordingly. This resulted in further name changes, such as ‘surviving the journey’ was ‘renamed maintaining integrity’ which are illustrated in table one: Development of categories, subthemes and themes. Material placed in ‘parking lot’ was revisited and integrated into categories as writing up of findings occurred.

(Braun and Clarke, 2006; Saldaña, 2013; Liamputtong & Serry, 2013)

There is much written about the challenges to this stage of a research project, particularly for novice researchers. Firstly, there are multiple approaches used for analysing data within the qualitative paradigm making it difficult to identify a clear process. Drawing on several researchers’ work was useful in informing the process. Secondly, qualitative research generates a large volume of data that needs to be reviewed, reflected on and summarised (Liamputtong & Serry, 2013). A systematic approach using various tools (such as whiteboard, computer, hard copies and highlighters, spreadsheets) was time consuming but proved essential in providing perspective on individual participant’s data and on the group as a whole. Thirdly, for the richness of the data to be maintained words and phrases from participants needed to be recorded and constantly reviewed. Writing up the findings once subthemes had been identified kept the researcher engaged with the raw data and assisted in finalising themes (Houser, 2008). Finally, the researcher found undertaking data analysis needs patience, perseverance and self-discipline to complete what at times seems an insurmountable task (Houser, 2008).

Despite the challenges, there were opportunities to develop skills. Liamputtong and Serry (2013) suggest that analysis of qualitative data combines systematic and rigorous thinking alongside creative and reflective thinking that leads to a rich experience for the researcher. In many respects this stage of a research study represents an accumulation of the work that has happened prior and leads the way to establishing findings and a conclusion to the project.

Analysis takes you step by step from the raw data…..to clear and convincing answers to your research question. Your analysis is strengthened by what you have already built into your design – the richness, the thoroughness, the balance, the nuance, the detail – that allows you to prepare a report that is vivid and convincing based on what your participants have said.


Conclusion:

The purpose of this chapter was to outline the study design used to conduct this research, providing evidence of choices made and processes followed that ensured rigour was
maintained. It included a detailed outline of the purposeful sampling strategy to ensure participants who could answer the research question were involved, the semi structured interviews used to collect data and the use of thematic analysis to analyse data collected. This study design was crucial to generating the findings presented in the next chapter.
CHAPTER FIVE: Findings

This chapter presents the findings of the study in several sections. Firstly, the introduction provides the relevant demographic and contextual data of the sample and an outline of the three key themes, which were generated by analysing the raw data. Following this the findings are presented in three sections with each section focussing on a particular theme with a detailed presentation of the subthemes and categories that make up each theme. Direct quotes from the transcriptions have been used to illustrate and provide evidence supporting each theme and to give voice to the new graduates who participated.

Introduction

Demographic data

Seven new graduates participated in this study and for the purposes of anonymity these will be referred to as P2-8; note that P1 was a pilot participant so data provided by this participant was not included. Table One sets out the demographic data collected relating to age, ethnicity, gender, area of work and the type of WPVA experienced, including who was involved so providing relevant context to the findings.

All of the participants were women, NZ European and ranged in age from 18 – 39. As to be expected the new graduates who came forward to be involved in this study were working in areas well known to have high rates of WPVA; Mental Health, Older persons and less so Medical / Surgical services. The majority of participants (n=6) were employed by a district health board (DHB). P6 was the only participant working outside of a DHB and was employed by a Non Government Organisation (NGO). Two participants reported experiences of horizontal violence, P2 and P8. Four participants reported experiences of both physical and verbal abuse (P3, P4, and P5) and one (P6) had experiences of verbal abuse only. All participants (n=7) were the only new graduates assigned to a particular area at the time of the incident occurring.

Participants were not asked to provide specific detail regarding others who were involved in their experiences, for example clients. However, in describing experiences, some common characteristics were evident and relevant. Five of the participants described experiences involving clients. These clients were receiving medium (1-2 weeks) to long-term care (more than two weeks). No gender patterns were detected, with both male and female clients equally represented in descriptions. Clients involved in verbal and / or physical abusive incidents
were older (60+) or in aged care facilities with one exception, the client who assaulted P4. The incidents involving clients (n=5) arose when delivering nursing care such as toileting, washing, setting limits and administering medication. Clients were described as confused and irrational in their behaviour at these times. Only two participants (P3 & P6) described WPVA involving the families of clients who were receiving care. In both these incidents relatives were not directly involved or responsible for the day-to-day care of the client and did not live with the client. Health professionals involved in incidents of horizontal violence were more experienced and in positions of seniority to the new graduates involved (P2 & P8).

Table One: Demographic and contextual data

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Gender</th>
<th>Area of work</th>
<th>Nature of WPVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>P 1 (pilot)</td>
<td>40-44</td>
<td>NZ European</td>
<td>Female</td>
<td>Older Persons Community MH DHB</td>
<td>Verbal abuse from families</td>
</tr>
<tr>
<td>P2</td>
<td>30-34</td>
<td>NZ European</td>
<td>Female</td>
<td>Adult Community MH DHB</td>
<td>Horizontal violence involving senior nurse</td>
</tr>
<tr>
<td>P3</td>
<td>26-29</td>
<td>NZ European</td>
<td>Female</td>
<td>Medical/ surgical DHB</td>
<td>Physical and verbal abuse involving clients and families</td>
</tr>
<tr>
<td>P4</td>
<td>18-25</td>
<td>NZ European</td>
<td>Female</td>
<td>Adult In patient MH DHB</td>
<td>Physical and verbal abuse involving client</td>
</tr>
<tr>
<td>P5</td>
<td>35-39</td>
<td>NZ European</td>
<td>Female</td>
<td>Older Persons In patient MH DHB</td>
<td>Physical and verbal abuse involving clients</td>
</tr>
<tr>
<td>P6</td>
<td>30-34</td>
<td>NZ European</td>
<td>Female</td>
<td>Adult Community NGO</td>
<td>Verbal abuse involving clients and families</td>
</tr>
<tr>
<td>P7</td>
<td>35-39</td>
<td>NZ European</td>
<td>Female</td>
<td>Older Persons In patient MH DHB</td>
<td>Physical and verbal abuse involving clients</td>
</tr>
<tr>
<td>P8</td>
<td>18-25</td>
<td>NZ European</td>
<td>Female</td>
<td>Med / surgical DHB</td>
<td>Horizontal violence involving medical staff</td>
</tr>
</tbody>
</table>

Overview of themes

As the demographic data indicates, this study was based on information provided by a small group of participants working in a range of different clinical areas. This variance is reflected in the experiences shared by participants. For this reason, the themes and subthemes are broad
and attempt to capture the common essence of participants’ experiences and views. The categories are more specific and represent the uniqueness of each participant’s experience.

Table Two provides a tabular summary of categories, subthemes and themes. Section one presents theme one, which is titled ‘Part of the Journey’ and focuses on the participants’ description of their experiences and how they made sense of them. Section two presents theme two, which is titled ‘Towards Self Efficacy’ and focuses on the effects WPVA had on participants and how ready they felt for responding to these events. Section three presents the third and final theme, ‘Maintaining Integrity’ which looks at participants’ vulnerability in relation to WPVA and coping strategies they used to maintain integrity.

**Table Two: Summary of categories, subthemes and themes**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Subthemes</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature of WPVA</td>
<td>Sub theme one: What happened</td>
<td>Theme One: Part of the Journey</td>
</tr>
<tr>
<td>Impact of contextual factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client’s medical condition and diagnosis</td>
<td>Sub theme two: Making sense of it</td>
<td></td>
</tr>
<tr>
<td>Socio – political influences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other contributing factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The negative impact</td>
<td>Sub theme one: A mixed bag</td>
<td>Theme Two: Towards-Self Efficacy</td>
</tr>
<tr>
<td>The positive effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undergraduate education</td>
<td>Sub theme two: Sense of readiness</td>
<td></td>
</tr>
<tr>
<td>Post graduate training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suggested improvements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trying to fit in</td>
<td>Sub theme one: Vulnerability</td>
<td>Theme Three: Maintaining Integrity</td>
</tr>
<tr>
<td>Working in a ‘small world’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘Do I get a black X next to my name’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reconciliation</td>
<td>Sub theme two: Ways of Coping</td>
<td></td>
</tr>
<tr>
<td>Reflective practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support from others</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Theme One: Part of the Journey

This section presents the first theme titled ‘Part of the Journey’ which depicts the WPVA that this cohort of new graduates experienced as part of the journey to becoming a registered nurse. It consists of two subthemes. The first subtheme, ‘What happened’ captures participants’ experiences of WPVA in two categories: a description of the nature of the experience and the impact of contextual factors surrounding the incident. The second subtheme: ‘Making sense of it’ presents factors considered by participants as they attempted to make sense of their experiences and fall into three categories: clients’ medical condition and diagnosis, socio political influences and other factors.

Subtheme One: What happened

In this subtheme, participants describe what happened to them in relation to WPVA and these are presented in two categories. In the first category, ‘Nature of WPVA’ participants describe in their own words their experiences including those they witnessed involving other colleagues. The descriptions include physical assaults (such as being hit) and verbal assaults (such as being yelled at), and horizontal violence (such as feeling bullied by a colleague). In the second category, ‘Impact of contextual factors’ participants describe factors surrounding the event that they felt impacted on their experience including the event being their first experience of WPVA, the timing of the event and the degree of exposure when caring for a client who is repeatedly aggressive when receiving nursing interventions.

Nature of WPVA

Participants described a variety of WPVA experiences including verbal and physical assaults (n=5) and horizontal violence (n=2). The descriptions presented include series of aggressive incidents relating to a particular client and aggressive incidents involving different clients.

P3 describes the range of physical assaults such as being pinched, slapped and punched she and other colleagues experienced from a particular client, and also refers to incidents involving other clients:

We all got a good slapping from getting too close to him ... him trying to push us away. He wasn’t aiming to hit at us. It wasn’t ‘I’m going to give you the bash’ aggression it was a panic, flaying arms everywhere and if you didn’t duck then you got hit in the face or the back or wherever. You are told keep a safe distance at certain times because they can be physically (pause) pinchy pinchy slappy slappy. (P3)

It would be weekly that we get a client that we have to be extra cautious with for their safety, our safety and other patients. In terms of someone, a staff member,
being punched, hit or pinched it would probably be monthly. We have had a bad month this month! (P3)

This same participant described incidents of inappropriate touching, involving several different clients. While the rationale for choice of language is not known, the use of humour suggests that this sort of experience was regarded as different from other forms of assault:

There’s a lot of old chaps that will give you a pinch on the bum. Which (pause) I’ve seen it happen and some people, you just laugh (pause, laugh) You cheeky bugger, get your hand off (pause, laugh) and for other nurses they really get offended by that. I guess you were never prepared for that as an undergraduate. Some times what you deem as inappropriate and aggressive behaviour, that clientis actually being funny. They may be (pause) it’s always someone that is dying. That little old man on his last breath and you are rolling them and they will touch you somewhere. (P3)

The assault P4 experienced was physical in nature and was an isolated incident involving one client. She describes being pushed into a wall by a client:

I was trying to remove her away from somebody who was making her feel unsafe. A lot of her delusion and psychosis was about this person. Another health care worker who doesn’t normally work in that area but he’d come in for whatever reason for another client. She became quite escalated. I ended up walking her back down to another part of the ward. It was in an area of the ward which is quieter and not a lot of people or hustle bustle going on. Which is good because I was trying to get her away from the situation. But also it was bad because when I got assaulted no body was around. I basically just got (pause) I was trying to unlock her door. There was lots of loud music playing, another client had the music on. I was asking her nicely to turn the music off. I was in the middle of the door, unlocking her door when she pushed me into the wall. It didn’t hurt but it was (pause) it gave me a fright. (P4)

For P5, the experience of WPVA involved a series of assaults that related to one client. These were a combination of physical and verbal abuse, including throwing equipment:

With a particular patient that came in from the acute unit. She was very physical. She actually threw an IV pole at staff the other day. (P5)

At night she was throwing her bedpans around the room, she didn’t care who you were. (P5)

She was everything you could ask for. You got it all (pause) spitting, kicked and punched and all a lot of verbal. All that went with it. She’d tell you she would cut your knees off. She gave you everything. (P5)
P6 described being verbally abused while talking to a particular client over the phone. This was an isolated event and the abuse included a threat of a complaint and was witnessed by a student nurse:

> Probably more for me of verbal aggression. A classic example I’ve got is a client who has just come on board. She just flew off the handle. It was down the phone but she really went to town (pause) ‘This is what I can get, I can get anything I like out of ACC blah blah blah.’ She was very anti, quite aggressive, quite threatening. She was going to write to the paper about the nursing service and all the rest of it. So I (pause) in the end I couldn’t speak, she wouldn’t let me get a word in and I said I don’t think we are going to come to a resolution to this and I feel the best course of action is for another service provider to step in and assist you. I then called the case manager and left it with her. This took a good 40 minutes (pause) and I had a student with me at the time and she was sitting there going what?????? Is that what we deal with! (P6)

Experiences of WPVA, both physical and verbal were described by P7. They included incidents relating to a particular client and different clients that she and other nurses were involved with:

> I work in the mental health sector, psychogeriatric unit. So I encounter violent or some patients that can be prone to be violent there. There is one particularly challenging client that we have that is often verbally abusive and threatening. Sometimes he waves his fists and lashes out but hasn’t caused that much because he is a reasonably frail man. He is not going to physically hurt me much but he would if he could. (P7)

> He has made contact with other nurses and other patients there as well but he is particularly very verbally abusive. Even if you are not engaging with him and you are with someone else he will walk by and just start screaming and shouting at you using every swear word under the sun. (P7)

> Another male. He is slightly younger, slightly stronger who is quite resistive to cares as well. He can push and he has learnt to kick and stuff recently. Not in an aggressive violent way but as a defensive way for him to not have the cares done. (P7)

Two participants, described incidents of horizontal violence that were verbal in nature. For P2, the incident involved being spoken to in what she perceived as being a hostile manner and not being able to present her position. The staff member involved was a senior nurse:

> When I read through the overview of your research one particular incident that was in my first week of practice came up where a staff member had an issue with something that I had done. And instead of just discussing that issue with me waited until a bunch of people had left the room and then just (pause) kind of had me up about it in a (pause) hostile manner. Basically not giving me any chance to talk or asking me my rationale for why I’d done what I did and basically criticised
my position in that I shouldn’t have got in the position and didn’t belong there and all sorts of things. (P2)

For P8, her experience of horizontal violence involved being spoken to by a surgeon in what she perceived as an aggressive and confrontational manner after she misplaced clinical notes:

The surgeon looks up and she’s like ‘What’s going on here?’ Pretty much yelling at me ‘There are three pages of someone else’s notes in with this patient’s notes and who do I know is going for this procedure?’ and ‘how do I know that the right patient is on the table?’ So I am standing there going ‘um to the best of my knowledge I got the notes and thought everything was correct’. Then she shoved this patient’s notes in front of me and I noticed on the name that this client had been discharged days before. (P8)

Impact of contextual factors

All participants (n=7) identified contextual factors surrounding events that they felt impacted on their experience of WPVA and made it significant. For P3, the fact that it was her first experience of WPVA where she was directly involved was significant even though she had previously heard about aggressive clients in the unit:

Probably the first couple of experiences of working with a patient that’s quite violent is probably what sticks in your mind the most because it actually becomes quite a regular thing expected in this environment. You hear about it quite often at handover. You get a handover that this patient has had a terrible night (pause) we get a lot of people who come evening get the sundowners, the dementia just goes of the Richter. So you hear it almost daily in handover (pause) such and such is being aggressive or verbally aggressive but that was the first time I had actually not only witnessed it but it was my team that was actually involved. It was our shift. (P3)

P4 describes her assault as being impacted by her perceived failure to predict this event. Even though this client often presents as agitated and aggressive, P4 felt she had developed skills to intervene earlier and so prevent assaults occurring:

It was out of the blue for me. I guess because the client themselves sort of presents that way all the time (pause) angry or agitated state. (P4)

That is why it took me by surprise because most of this year I have been able to pick up on things. If it was anybody else that was wound up like that who I would be able to tell. Oh, no. Need to get something here happening for this person other than just putting them into their room. There are limited resources for what you can do with people (pause) like with her in particular. It was just kind of
For P5 and P7, their experiences were affected by the staffing numbers and rostering associated with the size of their respective teams which increased the likelihood of working with a particular client either by being directly responsible for their care or by being part of the team rostered on that day:

Yes, because you can’t get a break away from her. We don’t have the numbers. The staff. You only have her for a day under your load but then the next team have her and you have to assist. So you still cop it. (P5)

Yes. I have him (pause) I am on a ‘four on, two off’ schedule. So once in those 4 days he would be allocated to me. We would very rarely allocate someone every day in a row because it would be quite demanding. But we regularly do encounter him because we are a small unit. Particularly when he is very aggressive it will require 2 people to help him with ADLs or sometimes he will refuse point blank his medication and a second nurse will need to go in and help to attempt to administer it. (P7)

In addition, P5’s experience was affected by the uniqueness of a particular client, whose behaviour was unpredictable and she and other more experienced staff had not come across this before:

You can’t see when she’s about to hit you. She does give any (pause) you don’t see the body tense up or anything like that. She’s had 2 ½ years spitting, aiming at people so she is really pretty good at it. (P5)

None of the patients we’ve had over the whole year up until this point I’ve ever seen with behaviour like this lady. So it has always taken two to four people to protect staff. Even more experienced staff say they have never come across any one like her. (P5)

For P6, many of the clients receiving the service are appreciative so she was ‘taken back’ when a client was not. She found it difficult to deal with their reaction particularly when it escalated and became irrational and she felt she had exhausted her options:

Ninety nine percent of people are overly grateful of having someone being able to support them. I also (pause) I was a bit (pause) I was really taken back because I hadn’t encountered that personality that I struck on the phone. The ability of not being allowed or able to have any sort of rational conversation with her? It was like, where do I go from here. (P6)
Interestingly, for the two participants who reported horizontal violence (P2 & P8), their experiences both occurred within the first few weeks of their placement. Because of this, P2 expected that there would be some understanding within the team:

*I think partially it was because I wasn’t expecting it. The fact that I was new to the area would give me a certain amount of grace that I would be able to fumble the first week or two (pause) And be able to settle into the routine and be able to understand what it was because I hadn’t worked in that setting before. I assumed that would happen and it didn’t (pause) I was still even during / going through my orientation days. I was actually still within those first four orientation days. It should have been given that I was supernumerary anyway. (P2)*

P8 had a similar experience of horizontal violence which she described as her ‘standout’ experience because it occurred in the first three weeks of her placement and it was related to a task she was completing for the first time. She recalls her reflection on this event when she was called to theatre to explain an error:

*I had only been in the unit for about 3-4 weeks I think. I was getting used to the ropes – all the paperwork and this and that (pause) so I thought oh my gosh, gulp, this is the first time I’d sent someone down for a procedure. (P8)*

The fact that the senior staff member involved in the incident of horizontal violence described by P2 had behaved in this manner before, and that others knew about this further impacted on her experience:

*I did also on the Monday go and talk to my clinical coordinator and the manager of the facility who wasn’t that (pause) he wasn’t that surprised that it happened. Later I found out that the reason that is because the person who had a go at me was quite volatile anyway and would blow up about everything. It was how she dealt with things. (P2)*

*The manager was like (pause) it was bound to happen, better sooner than later. I thought that was quite unacceptable. I talked to X who was wonderful about it. She sat down with me and just explained a few things that were going for the person who had had a go at me. In a sense I was “so you guys knew this was going to happen and you were putting me out there to have this happen to me which I think is unsupportive and a little bit like feeding the lambs to the wolves? (P2)*
Subtheme Two: Making Sense of It

The second subtheme, ‘Making Sense of It’ presents participants thinking as they attempted to make sense of their experience by considering clients’ medical condition and diagnosis, socio-political influences and other contributing factors that may impact on people’s behaviour.

Client’s Medical condition and diagnosis

For the new graduates who reported WPVA involving clients (n=5) the aggression demonstrated was believed to be as a result of that client’s medical condition or diagnosis, such as post operative confusion, psychosis and undiagnosed mental illness.

P3 had experienced frequent physical assaults from confused elderly clients in a medical / surgical facility. She explained this by recognising the frustration these clients can experience:

It’s not that person (pause) they are not trying to hit you but you are in their space when they are expressing whatever they are expressing. It is not their fault; it is your fault partially. Sometimes you have to get in their space for their safety but a lot of times, you have take a step back. (P3)

Following being pushed into a wall, P4 was mindful of the client’s mental state and ineffective medication. Their behaviour was attributed to psychotic delusions and ineffective treatment of their psychosis suggesting the client couldn’t be considered responsible for their actions:

So she was very under medicated. At times very volatile and frightened and vulnerable I think. It was one particular incident that (pause) I was trying to remove her away from somebody who was making her feel unsafe. A lot of her delusions and psychosis was about this person. Another health care worker who doesn’t normally work in that area but he’d come in for whatever reason for another client. (P4).

In addition, P4 considered the client’s history of trauma prior to admission as playing a significant role in the way she related to nurses and other health professionals:

I think it is related to a lot of trauma that has happened to her in her life so she relates a lot of it to that and reverts back to it and then projects that on to clients and patients, family or nurses, doctors, anyone really. (P4)
However, for P7 the fact that a person was actively psychotic meant that threats were not always taken seriously:

_He will say ‘I fucking hate you, you blah blah and I’m going to fucking kill you with my AK47’. Now we know that he has schizophrenia, and a lot of grandeur and delusions so (pause) we take it with a grain of salt when he says he is going to kill us with his AK47. But sometimes there is a lot of anger behind those words._ (P7)

For P6, who was working outside of mental health, there was a belief that some of the clients aggressive behaviours could be attributed to an underlying undiagnosed and untreated mental illness:

_Personally, and I’m no doctor, but I think there were some mental health issues there. I don’t know whether it’s never been a diagnosis or whether she’s hidden the diagnosis. When I spoke to xxxx they weren’t aware of anything._ (P6)

**Socio political influences**

All participants (n=7) identified socio political influences that underpinned WPVA including clients and families frustrations with the health system, poorly designed environments for delivery of nursing care, expectation that WPVA is part of nursing particularly in mental health and being put in positions of responsibility but lacking the experience to cope with this.

For P6, contact with families and clients is often over the phone and involves negotiating home based support. She was often the face of the health system and bore the brunt of its limitations:

_We are dealing with people who don’t have knowledge of the health system so they are frustrated because they don’t know where is their next step or where they should be looking for support from._ (P6)

_Maybe I can just think that people are going to get angry and upset, you are dealing with people who are sick or vulnerable (pause) I understand why they are. Or dealing with service (pause) trying to get services in place, its like banging your head against a brick wall._ (P6)

Poor environmental design, related to restricted funding was identified by P3 as being a contributing factor. In the medical surgical area where she worked, potentially violent clients were admitted. Although the unit had been extensively refurbished three years ago, the environment failed to meet the needs of this client group:
The argument was that when the hospital was rebuilt, there were certain aspects of the building that were asked to be put in that weren’t put in. One of which was a secure area for any kind of patient that needs either for their safety or for ours a safe/secure area to be in. We get a few with the Mental Health acute unit being some distance. (P3)

There was some ambiguity over whether WPVA is ‘part of the job’ for P7 and P3 who felt although it shouldn’t be part of the job; nurses are expected to deal with it.

I think I probably (pause) I’m too accepting of it. I just accept that there is going to be an element of it? You don’t want to see it every day but things will happen. From our side of things we may not get it right for the family or client and then you have to be able to deal with it. Work through it. (P7)

I think it needs to be made more aware but it also doesn’t need to be confused in that nurses, get hit and that’s just part of the job because it’s not OK and it’s not part of the job. It happens, but it is not OK and it never will be. No one is ever going to be oh well never mind you got hit that happens to all of us. That’s not OK and that’s not an attitude that I’ve found but I worry that undergraduates that haven’t had the experience of being through it start to think well I’m a nurse I’m going to get hit – its part of the job. (P3)

There was a suggestion from two participants that WPVA was to be expected when working in MH, but recognition that in fact it can occur in any area:

I guess as an undergraduate the only way it was ever explained was in a mental health setting where there might be someone displaying threatening behaviour (pause) that is the obvious example. It happens much more (pause) Cause I’m not in the MH setting and I’ve still seen tons of incidents in med/surg inpatients. (P3)

Many people probably go through the nursing career and not encounter people quite so aggressive. But then sometimes they do. Because we are a reasonably small unit we don’t have that many people of this level of violence. But I guess you get it in all health settings. (P7)

Other contributing factors

When attempting to make sense of their experience, four of the participants took a broader view and considered other contributing factors such as the effect of change, a colleague’s personal circumstances and the role of power and powerlessness when trying to make sense of their experiences.

P2, who reported horizontal violence, drew on her understanding of the effects of change to make sense of her colleague’s circumstances and behaviour:
“When I went home I was thinking about the managing change papers that we did in the 3rd year. I was able to pin quite a lot of what I was thinking about (pause) how it was for them. This was two senior clinicians with the first new grad in 6 years. Neither of them had worked with a new grad before. I was using that as a way of (pause) seeing it, rather then just seeing them as awful bad people. This was just people going through and very resistant to change. These were both trained psych nurses in institutions and I’ve got no experience of that what so ever” (P2).

This new graduate later became aware of her colleague’s personal circumstances that may have impacted on her behaviour. However, there was frustration expressed that other staff knew and didn’t address the issues so allowing the horizontal violence to continue:

In some ways it helped to find out about personal issues that were affecting this person’s behaviour but knowing that the staff knew what might happen was a little bit like feeding the lambs to the wolves? (P2)

P8, who also reported horizontal violence, recognized that the perpetrators circumstances might be a contributing factor, but still regarded the behaviour as unacceptable:

She was looking quite pissed off and at the end of her tether. You never know what has been going on for that person but I just decided there is never an excuse to be yelling like that. I just thought she is being irrational because we are professionals. This is not OK, we can be quite firm and tick off but when is it ever OK to yell? (P8)

Other participants (n=2) were aware of the role power and loss of power can play in aggressive behaviour. P3 describes her experiences with family members who live out of town and have an elderly relative who has been living alone in the community and not coping:

It is usually the person who comes from the community that has been assessed to go to a rest home. Then the family arrive. They are angry. ‘How has Mum been left like this for so long?’ Or they are not happy about choice of rest home. Or all of that. It’s just anything. Even things that you wouldn’t think people would be unhappy about, people get unhappy about. They see us as having all the power. It’s that power thing as well. I guess people feel they can take power back by being aggressive and loud and be the bigger person. When in actually fact they aren’t. (P3)

The loss of power that clients feel when detained in a locked facility was identified as a reason for an increase in assaults on nurses by clients:

It seems to be once people feel like they are contained that there’s definitely more violence and assault risk I think. Even though the unit I work in isn’t actually
considered secure it’s still fairly well fenced and lots of locked doors. I guess people feel like it is locked. The front door is always locked so they can’t get out unless they feel like jumping the fence there isn’t any way of leaving. (P4)

Summary of theme one:

Theme one is titled ‘Part of the Journey’ and it consists of findings that provide some insight into what happened to this group of new graduates on their journey to becoming a Registered Nurse. The new graduates worked in a range of areas and this is reflected in the diversity of their experiences, which included being physically and verbally abused, predominantly by clients. As part of their journey, participants attempted to make sense of what had happened to them drawing on their knowledge of medical conditions, socio political influences and other contributing factors they felt had impacted on people’s behaviour. Tabular representation of the codes, categories and subthemes that make up theme one is provided in Table Three.

Table Three: Development of codes, categories and subthemes for theme one

<table>
<thead>
<tr>
<th>Sample codes</th>
<th>Categories</th>
<th>Subthemes</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical assault</td>
<td>Nature of WPVA</td>
<td>Subtheme one: What happened</td>
<td>Theme one: Part of the journey</td>
</tr>
<tr>
<td>Verbal assault</td>
<td></td>
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<tr>
<td>With client</td>
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<tr>
<td>With family</td>
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<tr>
<td>With other health professional</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>First experience</td>
<td>Context</td>
<td>Subtheme two: Making sense of it</td>
<td></td>
</tr>
<tr>
<td>Failed to predict</td>
<td>Impact of contextual factors</td>
<td></td>
<td></td>
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<tr>
<td>Staffing/ roster issues</td>
<td></td>
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<tr>
<td>Challenging client</td>
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<td></td>
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<tr>
<td>Still in orientation</td>
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<td></td>
<td></td>
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<tr>
<td>Client frustrated and confused</td>
<td>Client medical condition and diagnosis</td>
<td></td>
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<tr>
<td>Psychosis and ineffective treatment</td>
<td></td>
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<td></td>
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<tr>
<td>History of trauma</td>
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<tr>
<td>Undiagnosed mental illness</td>
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<tr>
<td>Limitations of health system</td>
<td>Contextual factors</td>
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<tr>
<td>Poor environmental design</td>
<td>Social political influences</td>
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<tr>
<td>Is it part of the job</td>
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Theme Two: Towards Self-efficacy

This section presents the second theme titled ‘Towards Self-Efficacy’ which depicts the impact WPVA had on this cohort of new graduates and the preparation they received for responding to it. It consists of two subthemes. The first subtheme, ‘A mixed bag’ captures the negative and positive effects of WPVA as determined and described by participants. The second subtheme, ‘Sense of readiness’ presents the preparation participants recalled and drew on to respond to incidents and their suggestions for possible improvements.

Subtheme One: A mixed bag

In this subtheme, participants’ descriptions of the impact of WPVA are presented in two categories. In the first category ‘The negative impact’, participants describe what they considered to be the negative aspects effects of WPVA. In the second category, ‘The positive impact’ participants reflect on perceived positive effects of WPVA, which became more apparent some time after the event.

The negative impact

All participants (n=7) disclosed experiencing a range of negative effects that were a combination of psychological and physiological effects. The negative effects were reported as being felt either at the time of the event or shortly afterwards (up to 2-3 days).

Following a physical assault, P4 reported initially feeling shaken and exhausted and these feelings continued for some hours after the event:

      Maybe to the end of that shift. Probably to the end of that shift, till about 4pm I was quite shaken. I got home and felt so exhausted I just wanted to go to sleep.
      (P4)

P5, who had experienced a series of assaults while nursing one particular client, described feeling angry and dirty, commented that the effects continued once she got home:
Sometimes you come away just really, really angry. Especially if you’ve had hold of her and her arms have managed to come away and connect with someone. And sometimes you go home feeling very dirty. You’ve been spat on and she doesn’t wear clothes. She’ll try not to put her clothes on. It’s just disgusting the things she actually says. And you actually feel very dirty at the end of it. (P5)

Both these participants (P4 and P5) felt that WPVA negatively affected their self esteem and confidence:

_Some days you find that when you go home your self esteem is just absolutely shot._ (P5)

_I started to second guess my skill level. Because it took me by surprise and I think I was pretty good at doing a risk assessments but you look and you learn._ (P4)

The psychological effects of being verbally abused for P6 were not limited to herself but extended to other staff she had a delegated responsibility for, the support workers:

_I was very angry that our support staff had been put in that position where they felt so uncomfortable. They both had to go out of their way, she lived out of town. It made me quite angry that we put our support staff in a situation where they felt unsafe. And I guess I was also angry at someone abusing the service as well._ (P6)

P3 reported her emotional responses were affected by perceived intent of clients’ actions:

_I find with the patients where it is not their fault and you get in the way. That emotionally doesn’t worry me particularly because I got in their way and I can accept that it is on me. Whereas I find it a lot harder to deal with people who will look you straight in the eye and then swing for you._ (P3)

P7 was initially fearful and described feelings of worry and apprehension in anticipation of having to deal with a particular client, especially once she was working independently.

When asked if the incident impacted on her ability to relate to a client who had physically assaulted her, P4 noted that she engaged with the client less then previously:

_It did for a few days. With that client in particular, not all clients. Just her. I was a little bit more dismissive towards her I guess. She wasn’t allocated to me in anyway. But I just kind of ignored her and it wasn’t like she asked me any questions or wanted to talk to me. It was that I didn’t really want to be engaging with her that much._ (P4)
For the participants who experienced horizontal violence (P2 & P8) the effects were immediate and profound. At the time of event P2 describes feeling silenced and criticised by a senior staff member:

..where a staff member had an issue with something that I had done (pause) And instead of just discussing that issue with me waited until a bunch of people had left the room and then just (pause) kind of had me up about it in a (pause) hostile manner. Basically not giving me any chance to talk or asking me my rationale for why I’d done what I did and basically criticised my position in that I shouldn’t have got in the position and didn’t belong there and all sorts of things. (P2)

Immediately after the event, P2 stayed on duty but the effect of being spoken to in such a manner was devastating:

I stayed. It wasn’t too long before I could go home and my day had finished and luckily it was a Friday. I slipped away a bit early but they did have another colleague in OT who worked in this facility who’d heard through the grapevine that this had happened who came and asked me if I was OK. I burst into tears and couldn’t talk. I couldn’t even articulate what was happening for me at the time. It was just so devastating and awful. (P2)

P8 describes initial feelings of shock when she was summoned to theatre but feeling calm at the time of the event. She confronted the surgeon involved at the time, possibly due to pressure to resolve the situation immediately:

I think it was shock, I was shocked. Initially I was thinking while I was walking down there – what have I done? Did I put the wrong notes down there? So when I got down there I was expecting the worse. So then I realised it was not actually directly what I would call my fault. (P8)

It was pretty much a yelling spiel at me and I (pause) its quite interesting because after this I wasn’t very emotional but I felt quite put on. At the time, I just remained calm and said OK, it is not good that this has happened “bloody hell it is not good! An incident report needs to be filed blah blah blah” So I said, I agree with you and I didn’t say that it wasn’t my fault. I didn’t. (P8)

Following the incident P8 noted physical affects:

My heart rate was up, pulse up, shakey. I remember getting back to the nurses’ station and someone asked are you all right? (P8)
P5 and P7, who both had repeated exposure to particular clients who were aggressive, reported a level of anxiety and dread associated with the thought of continuing to work with these clients:

*You so didn’t want her on your workload because you knew that you would have to get in close contact with her. Even when it came just to changing her sheet (pause) even if she was just on my workload I still had to have another three people to help. So really everyone just copped it.* (P5)

*Especially if you know that you are on a shift that requires you to do insulin administration which is getting very close and personal with him, and a sharp object as well. You feel a little apprehensive before going in. I hope he is in a good mood today and compliant with allowing me to do these interventions. If he is really angry you can get a little bit, stressed isn’t the proper word, it is in the back of your mind the whole shift until that insulin is given. It is like, I’m going to have to face this at some stage.* (P7)

*It is constant stress in the back of your mind. And once you do it and you leave the room it is a big sigh of relief. That’s done; I can relax now and get on with the rest of my duties. It is just an ongoing form of stress really.* (P7)

For two participants, their experiences of WPVA led to the questioning of their preconceptions of nursing:

*I went away over the weekend and I just wanted to give it in. I’ve moved my whole family over from another town and my daughter had changed schools. My partner had left his job and didn’t have a job yet and all for me to have this job that I wasn’t fitting in to. I spent the whole weekend just stressing about it.* (P2)

*When I first saw him I was (pause) when I first started the job it was ‘what have I got myself into’.* (P7)

**The positive effects**

All participants (n=7) identified what they felt were positive effects resulting from their experience of WPVA. However, these effects were more apparent to participants some time after the event and were at times in contrast to the immediate or short-term effects earlier reported. The effects reported included greater awareness of risk, becoming more client focused, greater awareness of duty of care and increased self esteem. In addition, participants explored the impact WPVA had on how they felt about nursing in general or in a specific context (such as mental health) and the findings for this were positive.
Participants (n=5) spoke of an increased awareness of risk and safety after experiencing WPVA, which led to being increasingly vigilant and tending to intervene and engage with clients earlier. This extended to assuming more responsibility for personal safety:

*When I came back to work I was thinking to myself risk, risk, risk. Always think of risk.* (P4)

*Even today I saw somebody in the same sort of situation and I took myself over to them quite quickly and tried to talk to them. I ended up giving them some medication and they wanted to leave. I was able to break down the situation and make it not risky pretty quickly. I notice that I’ve been doing that a lot. It was more of a learning curve. I look at it more as a learning curve now.* (P4)

*It has made me a bit (pause) you learn a lot from it. You learn pretty quickly that you are the one that needs to do the ducking and diving and getting out of the way or swinging arms or you are going to get hit.* (P3)

For P3, exposure to WPVA resulted in a greater awareness of the need to provide nursing care that was client focussed.

*So you learn pretty quickly. When you are a new nurse you are really task orientated – my patient must have their 8 o’clock meds, then their obs done, then their shower, then visitors can come, then it’s doctors rounds and in the reality of nursing that’s not actually that important. You go much more patient driven…what does that patient need right now rather than I’ve got this list of jobs to do to make me a good nurse.* (P3)

After nursing a client who had repeatedly verbally and physically abused nursing staff and had been cared for unsuccessfully in a range of health settings previously, P5 was alerted to the concept of ‘duty of care’ that nurses have towards their clients at all times:

*I think we actually learnt about your duty of care. How your duty of care depends on who your staff is. The nurses’ duty of care was different to the way the people or some of people at the acute unit saw the duty of care. Which is different again to how a med / surg area saw their duty of care. Like you would a toddler. Treat her like a two year old. They were leaving her in her faeces for hours and hours and hours. It’s like well hang on, you wouldn’t leave anyone to just lay in it regardless of who it was and what the behaviour was. Because she did it deliberately?* (P5)

In contrast to the negative impact on self-esteem reported at the time of the event, P5 and P7 felt that in the long term there was an increase in confidence and skill development:
I think I’ve got more confidence in myself now. Whereas before hand I’ve probably stood back a lot. Whereas now I feel more confident that I can handle it as well.” (P5)

I’d say I have probably developed better skills and feeling a far more confident nurse because of it. I’m now coping with this particular person. You feel, well if I can handle this particular patient I can handle anyone. (P7)

For P2, the positive effects of horizontal violence were linked to confronting the staff member involved. Her confidence and self-efficacy were improved when she confronted the staff member at the next available opportunity (2 days later).

It gave me a lot of confidence that actually, if you address it and tackle it head on and you say ‘don’t talk to me like that please, I don’t like it” people tend to settle down on you and they go ...oh, I can’t push that person around. That was really good for me because I think prior to that I would have been pushed around quite a lot. (P2)

Two participants reported that their experiences of WPVA had not affected how they felt about nursing, or the particular area they were working in at the time of the incident in the long term.

For P8, dealing with the incident had provided her with valuable experience as a nurse and in her personal life and did not have a negative impact on her decision to be a nurse.

No way. In fact, it just gives you more experience, more fallback information on what to do. Because you might experience something like that in your life – outside of your professional career that you learnt at work when you deal with things like this. I am going to bring this into my personal life so I think, no way. It wouldn’t put me off nursing. It’s too awesome. (P8)

For P5, who had applied to work in another area however, the experiences of WPVA that she had encountered in an older persons mental health in patient facility had resulted in her being unsure if she wanted to transfer:

I’m loving it. I got a surprise phone call from xxxxx saying did I want to come in for an interview and I’m thinking (pause) I applied for that way back in September and then I thought I better tell xxxx and she said no we are going to tell them that you are ours and they can’t have you. Do you want the job? And I said I don’t know now (pause) I said I always thought I did but I really like it here. (P5)

How many people can actually say that they’ve all this stuff thrown at them in a day and you still want to go back the next day? (P5)
Subtheme two: Sense of readiness

Undergraduate education

Participants were asked how well they felt their undergraduate education had prepared them to respond to their experiences of WPVA. Undergraduate education included nursing knowledge, skills developed in the classroom and clinical practice setting. While all of these new graduates were all able to recall and link some of the knowledge and theory they had studied as undergraduates to their experiences of WPVA, there were inconsistencies in how well they applied this knowledge in dealing with their experience either at the time or after the event.

P3 had received some preparation for horizontal violence, which had been useful for her to recognize and reflect on what had happened to her after the event:

_We did do a little bit about horizontal violence. It basically was identifying what it was and just thinking back I think it was one of xxx’s classes and (pause) there was a little bit about processes about it wasn’t tolerated and that there are certain actions that may not seem like horizontal violence but actually are, identifying some of what they were._ (P2)

P7 was able to recall a simple framework (AVIS: Acknowledge, Validate, Inform, Support) but struggled to apply it to this situation:

_I think it did. I knew the theory behind it (pause) in my head I was thinking I need to use AVIS for this lady. So in my head I knew it but once the situation was happening I just I had no way of putting it in place. Whether that was just one of those situations that no body would have been able to manage it or not I’m not sure._ (P7)

While a student in clinical practice, P3 felt that students were protected from WPVA that involved clients:

_You don’t get much insight into violence and aggression hugely as a student because you are sheltered from it. You are never given the patient that is violent or aggressive when you are on practicum and stuff like that._ (P3)

Three participants believed that undergraduate education was focused on WPVA happening in Mental Health Services and it was difficult to see how these skills could be transferred to
other settings. This was reinforced by most of the training or discussions on personal safety were provided in undergraduate education as part of the mental health curriculum. Students planning on working in other areas did not expect to be exposed to WPVA or could not relate their training to different contexts:

I would say that course was more geared up for patients that were really trying to be violent. For this particular man waves his fist he doesn’t really have any control or purpose of the waving of his fist (pause). He is not trying to really hit us, he is just waving it out. It is not like he is truly trying to attack us which the course I had done at the polytec might be better for. (P7)

I guess as an undergraduate the only way it was ever explained was in a mental health setting where there might be someone displaying threatening behaviour. (P3)

Participants were not asked how their preparation for dealing with WPVA compared to other aspects of the curriculum, however, P4 stated that this was the only area she felt unprepared for:

Unless you knew you were going to go into mental health straight away. There is nothing else that I have felt totally unprepared for, most of it you do learn as you go and then you use your foundation of knowledge that you’ve be taught. (P4)

Post-graduate training

The focus of this study is on undergraduate preparation and this is what participants were asked about. However, two participants referred to training they had received since graduating. They were working in Mental Health and therefore were enrolled in the NESP programme. Within a few months of commencing the programme, they participate in area specific training, which could be Calming and Restraint (C&R) for adult in-patient services or Safe Holding for older persons’ in-patient services. These courses prepare staff to deal with violent and aggressive clients by developing skills to de-escalate a situation and restraining safely if restraint is required. They are provided for new graduates in the absence of such training being part of their undergraduate education.

P4 felt that C &R was not suitable for the situation she found herself in:

To me at the time it was I’m here by myself I can’t do anything by myself unless she grabs me from behind I could do the breakaway moves. I wasn’t going to restrain her on my own, so none of that even came into my head. Which is interesting. (P4)
For P7, the Safe Holding training provided in her area was not available at the start of her placement leaving her feeling unable to assist in restraining aggressive clients:

I know my workplace offers a restraint and holding programme which I have not been on yet. I haven’t always been that useful in help because sometimes we do have to restrain this person temporarily and I don’t have the skills for that. It is something that I haven’t learnt at polytec but they do send people on a two day course which they haven’t sent me on yet. I’m still unprepared for that because it is expensive and a specialist course. It wouldn’t necessarily be applicable to send all students on it unless you are working on that field. (P7)

P4 found that once having completed C &R here were issues with getting the experience and support required for those new to the techniques:

When we do our C &R course, we do it but then there is no opportunity for us to be involved in a restraint. It just happens spontaneously (pause) come and restrain this person (pause) I’m not quite ready. Some times, I think the people that they are asking you to restrain, even though you’ve got like a team of five or four and it seems like it’s going to be quite easy it is always the guys that end up going on the arms or whatever and I think if people came in, like it was a small little old lady I would be able to do the arm. So if was given that opportunity for that time. Newbies never really get allocated people in seclusion. Maybe XXX did, because he’s a male but I definitely don’t. So that makes me feel a bit unprepared. So when I do do a restraint how am I going to cope? (P4)

Suggested improvements

All participants (n=7) were able to make suggestions on how they felt they could have been better prepared both in their undergraduate and new graduate education to respond to WPVA. The suggestions are presented in two parts. In the first section, ‘A head’s up’ participants identify the need for greater preparation about the occurrence of WPVA in nursing. In the second part, ‘Skills development’, participants identify areas of skill development they believe a greater emphasis should be on.

A ‘heads up’

Participants (n=3) expressed a need for more preparation about the occurrence of all types of WPVA in a range of health settings including in-patient and community settings, Mental Health and clinical services:
I think much of the education, and I’ve found it in my new grad year going on courses and study days and things, a lot of it is focused on an in-patient setting. While probably the majority of people do go into an in-patient setting, there is a group of us that don’t and it is a totally different situation being out in the community. Heaven forbid that you find yourself in a situation that is really unsafe; you are on your own. (P6)

WPVA shouldn’t just be associated with mental health. (P3)

Just giving people a heads up that there is a possibility. (P7)

P3 suggested new graduates are prepared to expect horizontal violence:

I think there needs to be a bit of preparation for the third years going into practicium for when you are a new grad. Not everyone is going to like you. That might be personal thing; it might be a threatening professional thing. I’ve found a lot of old school trained nurses – hospital trained nurses have a bit of an issue with polytec trained nurses. Here you come. ”(P3)

Similarly, P8, suggested preparations for horizontal violence happen in the third year of undergraduate education.

So maybe in the third year. Look I am going into a workplace at that end of the year, what is it going to be like and what are some situations I might be faced with and how am I going to deal with that. (P8)

P3 considered ‘how’ undergraduate students are prepared for WPVA to be significant:

I think if someone had said to me as an undergraduate – you are going to get smacked when you start working – it would have scared the living daylights out of you because you are not experienced and you’ve probably never been in that situation before. It is not necessarily appropriate to be saying to an undergraduate chances you are going to experience violence in some way or another. It needs to be done tactfully. (P3)

P3 added, the preparation of nurses for responding to WPVA needs to empower nurses, rather than increase their fear:

...needs to be approached in a way that reduces fear factor. (P3)

But that it’s OK and it doesn’t have to be scary. It is not like you are going to be mugged behind the office or something. It is more like you are going to get shouted at by a patient because they are pissed off. (P3)
Skills development

Participants (n=5) suggested preparation with an emphasis on personal development would have been helpful for dealing with WPVA. P2 suggested learning how to depersonalise a situation:

\[
\text{Maybe scenarios given on this person says this to you, how do you respond? Some thing like that could be quite useful. To be given a framework so you do depersonalise like you said. That's really a hard thing to do. (P2)}
\]

P8 added that skills relating to self-awareness are encouraged in preparation for coping with experiences:

\[
\text{It may be just about finding in your personal nature what (pause) you might be really shy, you might be inwardly confident. Bringing out the positive things in each person. Everyone has their coping mechanisms and different ways of approaching people. So in that situation I'm going to draw on that strength of mine. Some people don't know what their strengths are. A workshop could actually be quite beneficial in helping them identify their fall-back. (P8)}
\]

Preparation should include skills for dealing with situations, including what to do afterwards in terms of debriefing and reporting

\[
\text{And maybe be prepared for what to do if you feel like you are being personally attacked by a staff member. (P3)}
\]

\[
\text{Scenarios about what kind of real life events could occur, that you do have the option to maybe put in a report about this person. It wasn't even on my radar at the time (pause) and that it isn't just a rite of passage that you have to put up with because you are lower down on the ranks. That is not a good enough reason for putting up with things or saying things to you that make you feel so bad. (P2)}
\]

\[
\text{It would be pretty incredible to have some sort of workshop where (pause) like (pause) I know there are groups that do like restorative justice kind of things. It would be really cool to have some specific skills in place. Thinking back through the years you pick up stuff but I can't think of a set thing that we did that addressed this (pause) might be a good thing to have an outside organisation come in and do an intensive workshop. (P8)}
\]

Recognising that for RNs, responding competently to WPVA includes supporting staff they may have responsibility for, there was a suggestion from P6 that new graduates could be better prepared for the role of delegation:

\[
\text{Throughout undergrad study you go along and (pause) once again, probably not many people will be managing staff in their first year out, but I think of the}
\]
similarly, some preparation of dealing with families at risk of behaving aggressively
including maintaining professional boundaries for self and other unregulated staff:

"that has probably been the toughest thing. When Mr Brown comes in because he
is unhappy about the support his parents are getting and in actual fact we didn’t
realise there was an issue. Or, actually professional boundaries. When support
workers have well and truly overstepped their professional boundaries, we have
no clue about this. But the family comes in and threatens legal action and it is like
(pause) OK, hang on a moment. (P6)

Summary of Theme Two:
Theme two titled ‘Towards Self-Efficacy’ consists of findings that reflect the overall impact
that exposure to WPVA had on this group of participants in terms of their development as
Registered Nurses and includes suggestions about how they could be better prepared to
respond. Despite the negative effects which were psychological in nature, and in some cases
were profound and far-reaching, participants were able to identify the learning and
development that occurred which contributed to an increased sense of self-efficacy. Tabular
representation of the codes, categories and subthemes that make up theme two is provided
below in Table Four.

Table Four: Development of codes, categories and subthemes for theme two

<table>
<thead>
<tr>
<th>Sample codes</th>
<th>Categories</th>
<th>Subthemes</th>
<th>Themes</th>
</tr>
</thead>
</table>
| Immediate effects          | The negative impact         | Subtheme one: A mixed bag      | Theme two: Towards self-
| Short term effects         |                             |                                | efficacy                   |
| Long term effects          |                             |                                |                             |
| Positive effects           | The positive effects        |                                |                             |
| Contradictions             |                             |                                |                             |
| Help with identifying HV   | Under graduate education    | Subtheme two: Sense of readiness|                             |
| AVIS framework             |                             |                                |                             |
| Protected when a student   |                             |                                |                             |
| Part of prep for MH services|                            |                                |                             |
| Unprepared                 |                             |                                |                             |
Theme three: Maintaining Integrity

This section presents the third and final theme titled ‘Maintaining Integrity’ which depicts how this cohort of new graduates were challenged to maintain professional values, attitudes and beliefs when exposed to WPVA. It consists of two subthemes. The first subtheme, ‘Vulnerability’ captures the vulnerability they felt as new graduates being involved in violent and aggressive situations. The second subtheme, ‘Ways of Coping’ captures strategies used by this cohort to cope with WPVA.

Subtheme One: Vulnerability

All participants (n=7) expressed a degree of vulnerability associated with being a new graduate, which influenced their response and approach to WPVA. In the first category, ‘Trying to Fit In,’ participants describe their motivation to be part of the teams they work in and the challenges they face in doing this. The second category ‘Working in a small world’ captures some of the issues faced by participants when working in teams within provincial regions. The third and final theme ‘Will I get a black X next to my name?’ presents participants concerns about their reputation and their future career options.

Trying to fit in

Three participants expressed a desire to ‘fit in’ with their respective teams when involved in WPVA and described challenges they faced including their perceived level of competency, their youth and gender and the fear of consequences when not fitting in.

For P3, fitting in meant not complaining about dealing with violent clients and being able to deal with them competently:

Because I think as a new grad you are still trying to impress your workplace and you shouldn’t be complaining. It’s a huge issue trying to fit in. Everybody wants to fit in. Doesn’t matter who they are, how confident they are, they still want to fit in. The people with all the confidence are OK because they have the confidence to say actually that ’s not cool don’t do that to me again. It’s our shyer, quieter, desperately want to fit in nurses. But if someone does something to them they are
P4 expressed having high expectations of herself to deal with violent clients in the same manner as more proficient nurses. The fact that she was assaulted by a client left her feeling like a failure.

\[\text{I’m pretty hard on myself. It was ‘I should have seen this coming’ in my head. I should have done my risk assessment better. I think that is part of being a new grad. You take it on board. It felt like I’d failed a bit. (P4)}\]

For P4 the challenges of fitting into the team also related to her age, gender and appearance.

\[\text{The only other thing I was going to talk about was probably being young and female and small, sometimes I find that some of the male new nurses maybe find me a bit intimidating. Maybe it is my personality. If I try and do some work with their clients and intervene with something that is going on' and 'Its just everyone’s personality is different but some people just can’t get over themselves where other nurses have a better rapport with some patients and are able to give medication. Whereas the client might not take it from them. I’ve had a few moments where I’ve thought … yeah they didn’t like that but I don’t care because it is the best thing for that client at the time. They need to deal with that themselves if a young nurse can get 2 lorazepam into a young guy who is psychotic and winding up and is going to hit somebody. At the end of the day don’t take it too hard. (P4)}\]

Working in a ‘Small World’

For two of the participants, vulnerability was associated with the size and rostering of the team, entering an established team and working in provincial towns.

P6 was part of a two-person team and she often felt alone; physically and emotionally.

\[\text{Probably the thing I find the hardest is, because X only works part time, if I am in the office on my own and a situation crops up and I don’t have anyone to talk to about it. That I find really hard. It can be quite overwhelming. Working independently, as much as I enjoy it and I like being able to have that ability for decision-making, it’s hard. (P6)}\]

For P2, working in a unit with staff rostered Monday to Friday and within a provincial town made it important to have good relationships with colleagues:

\[\text{Being that we work daily together it is not like a roster system. The unit is like a little house. You do all of that stuff together. (P2)}\]
P2 was mindful of being not only a new graduate but also a new team member, which meant developing an awareness of existing team dynamics and finding a way of working within these.

*I think I kind of got maybe in between a bit of ‘us and them’ issue with a couple of clinicians not liking the two clinicians who had offered to take me. They were basically having a kind of personal issue.* (P2)

‘Do I get a black x next to my name?’

New graduates who participated in this study described feeling most vulnerable when reporting their experiences of WPVA. While all participants (n=7) shared their experiences informally with others there were inconsistencies with formal reporting. Participants presented several reasons for this.

Firstly, reporting processes were not part of the culture of a particular area.

*The main reason I didn’t do anything was because no one really suggested it as being that kind of issue. No one mentioned anything about that process to me so I didn’t think of it in the moment.* (P2)

Secondly, the process of reporting was impersonal and didn’t always fit the particular situation staff experienced making it difficult to accurately describe the event.

*We’ve learnt to hide some of it from the ‘reportable incident person’, who ever they get. They are considering some of the stuff restraint. Where as we are doing safe holding that we know. The acute unit do their restraint and we don’t know how. So we’ve been told to file things under restraint not safety and conduct. But as far as we’re concerned it’s safety and conduct because staff are getting hit. I think it’s just a lot of jumbling up the words. I think it is all coming down to the same sort of thing. It’s just got a different name.* (P5)

*We were told that we should be reporting the spitting and we should report the throwing of the glasses of water but then figured all we’d be doing is filling report after report.* (P5)

*We don’t go into much detail because it is accepted within the unit that this man so frequently acts out. We will just say ‘had a settled duty’ which means not much shouting or else ‘disruptive duty’ and there has been 2 – 3 verbal outbursts. Some times with the verbal outbursts we walk him down to the seclusion type area just to chill out for a little bit. In which case we would report that ‘he spent x amount of time in a seclusion room’. We don’t go into detail because it is an accepted part of that (pause) he is going to be like that. We don’t need to describe it in...*
Thirdly, the senior staff member they reported it to did not suggest or support them to report the event.

*I would have expected that the management or clinical coordinators or preceptors would have said something. It just didn’t even occur to me at the time because if someone had said there is this option for you, I don’t whether I would have taken that anyway. There was never anything mentioned.* (P2)

Fourthly, there was a lack of trust in the process and a fear of being blamed for the event.

*When I first started it was almost, not frowned upon, but if you put in a reportable event you knew that you were going to get a talking to from the boss or what happened that this happened.* (P3)

*So I talked to the charge nurse about this and filling out the SIR. ‘Does this mean I get a black X next to my name or what?’ Pretty much she said, there is no way she can use this against you. No one intentionally did this.* (P8)

Related to this was the shame of being involved in an aggressive incident, particularly when there was a visible sign of injury.

*I didn’t really want to say that I had a sore eye. Maybe, its just part of my personality. I was (pause). Once you say to someone you’re fine. I did say I’m fine. It didn’t (pause) it was sore and I thought it was getting a bit fat and it went purple and I did cover it a bit with makeup. It wasn’t to me a big deal. It wasn’t about the physical injury. It was more about (pause) I’m pretty hard on myself. It was (pause) I should have seen this coming in my head. I should have done my risk assessment better. I think that is part of being a new grad.* (P4)

Finally, there was an uncertainty about the consequences of lodging a formal written report. They were concerned their reputation would come under scrutiny and that they might be blamed for the incident.

*If she had become aware of me reporting it I think it would have made it more difficult for us to have a good working relationship. I think there would have been a grudge held.* (P2)

There was some motivation to report however. For P6, written and verbal reports provided a way of sharing accountability and providing some cover over her actions.
I would tell J ‘I’ve just had this conversation, she was upset and I have withdrawn service and I’ve let the case manager know (pause) and this is what she has threatened to do, just to let you know’. Fortunately J has had dealings with her in - - and her children. So, long history. The reality was it was empty threats but that was what I needed to make her aware of. (P6)

Within her new graduate year, P3 saw a shift in culture within her work area, where staff are now supported and encouraged to report events.

Now it is the exact opposite. There has been a shift in thinking (pause) there has definitely. You don’t feel judged or put upon. If anything it is encouraged. (P3)

Subtheme Two: Ways of coping

All participants (n=7) identified strategies they used to cope with their experiences and theses are captured in three categories. The first category ‘Reconciliation’ presents examples of how participants attempted to re-engage with others involved in incident. In the second category, ‘Reflective practices’ participants’ use of self-reflection and supervision is outlined. In the third category participants describe the support from others that helped them cope.

Reconciliation

Participants were clearly affected by their experiences, which may have contributed to mixed and sometimes contradictory responses, particularly as they attempted reconciliation and to re-engage with others involved.

As presented in Theme Two, when P4 was asked if the incident impacted on her ability to relate to a client who had physically assaulted her, she acknowledged that she engaged with the client less the previously. However, P4 also attempted to re-engage with the client by meeting with her while she was in seclusion and apologising for her part in the incident:

After she had gone into seclusion, after about half an hour, I went out and apologised to her and said ‘I’m sorry for winding you up. I didn’t realise you were becoming so angry other wise I would have left you alone’ and she said ‘I’m sorry too, I just lost it’. I tried my best to try and defuse the situation because I wanted to keep my therapeutic relationship with the client. No matter what. I wanted her to know that I had tried my best at the time and that I’m sorry that I couldn’t see what was coming for her because she is unwell. (P4)

Approaching the client in this way provided an opportunity for the client to apologise, which the new graduate found helpful.
Especially as her response was quite positive as well, apologising. And it’s not nice for anyone to be restrained and put in seclusion. So I always do that. But it was more 1:1 on a more personal level now so I had to break that down. (P4)

P5 also presented with mixed feelings in relating to an aggressive client. As presented in Theme Two, she reported not wanting to work with client. However, she also described an attempt to engage with this client when the opportunity arose:

Since the day after she was admitted that I’ve been able to talk with her. She was from xxxxxx and from a very high status family. She had such a horrible life in that she was (pause) I told her that some of the stuff she was saying (pause) didn’t really make sense, I can’t understand you. But she just kept talking on anyway. If she was nice and quite and happy, then she could talk to me as long as she wanted. Staff were really quite worried because I was gone for an hour and didn’t even realise. So they were quite surprised.”(P5)

For participants who reported experiencing horizontal violence (n=2), part of maintaining relationships with the colleague involved included regaining their personal power. This was done by confronting the respective staff members involved. For P8 this happened at the time of the event:

It’s a bit silly but there was one moment that was like ‘bravo’ because when I turned to her and said ‘I’m not talking to you anymore’ I felt like I had a bit of power. I wasn’t just the one being yelled at, I was saying hang on a minute here, you just (pause) wow (pause) You’re untalkable to. (Laugh). I ’m the one being rational here. I was quite pleased. (P8)

For P2, the sense of power was associated with the choice to confront and or to remove herself from the situation:

I was aware that if I wasn’t standing and feeling strong and able to exit the room if I needed to quickly, that I would feel quite powerless and stuck. Just that awareness of oneself and being able to put myself in a position where I was able to feel strong and know that I was not stuck in that situation if it all went to custard. (P2)

Reflective practices

The use of reflective practices such as personal reflection, peer supervision or 1:1 supervision by all participants was evident and cited as being one of the tools that was the helpful for
maintaining integrity. For P2 this was a process of looking back on the situation and identifying how she could have dealt with circumstances prior to the event differently.

> Also just looking at the situation and what was it that I did and what do I need to take responsibility for and there were a couple of things like I left a note and I could have found the cell phone but I was feeling rushed. All of those things... I could have found the cell phone number for the other clinician and I could have rung to double check and I could have asked for five minutes from the other. (P2)

For P4, reflecting with others provides another perspective that might not be apparent at the time:

> Reflection and supervision always helps me. I reflect on everything. So it always helps. Everything was discussed, seeing all those different aspects, just literally pulling it apart. It could have happened like this or could have done that. (P4)

Participants found reflection useful for exploring their own values, attitudes and beliefs and how these had influenced their experiences. For P2, her experience of horizontal violence was linked to her values on how people should communicate with each other.

> I can’t wrap my head around that one and ask myself quite frequently about a lot of things nurses do, even just in the wider team. The critical nature (pause) looking over each other’s work as though it has got to be infallible and I don’t understand that at all. I can’t understand why people do it to each other and why they put up with it is probably it is just that much easier to modify or just go that is just that person and in 10mins they will be off on their other little tangent. (P2)

P6 found 1:1 supervision with her upline manager on a regular basis useful.

> XXXX and I do a lot of reflection and supervision between ourselves about when things haven’t gone so well. What we can do better. A couple of occasions I’ve gone ‘that’s a bit of a learning curve. (P6)

At the time of the research study, P8 was well into her new graduate year and had identified a need for more formal supervision:

> I’ve been considering having it. I don’t feel like a person in need of counselling per se, but I think it would benefit me to have someone like a counsellor and go and piece the whole jig saw together. (P8)
Support from others

All participants (n=7) cited support from others as a significant factor in coping with their experiences they received from others. Support came from colleagues, fellow new graduates, managers, friends and partners as helpful and essential to coping.

For P5, the fact that she could openly disclose to her manager as well as receive support from others in the team was significant. When asked who she received support from for dealing with aggressive clients she responded:

*Everyone that's actually there. And that is what amazes me so much at that place.*

*Including your manager?*

*Yes, you can tell her anything. I can tell anyone anything out there. I think I’m so lucky. I’ve heard from other new grads who haven’t got on with their preceptors and I think just got (pause). I don’t think I could have got anything better. (P5)*

P3 identified several aspects of the area she worked in to be supportive including preceptorship provided in the first year, established systems that facilitated de briefing as well as support from the charge nurse and other team members:

*We’ve got a really cool team at work. We get preceptors for the year and they have become like our nursing mothers for all the new grads. We’ve got a really strong system and our charge nurse is really awesome as well. If anything happens there is always de briefs. If is not been acknowledged by the team as being a big thing but it is a big thing for you then you talk to your boss and it becomes a big thing. She accepts that it is big for you and you get the proper follow up. Which is good. I’ve heard stories in other wards with other new grads when stuff like this happens and there is nothing for them. (P3)*

Colleagues were helpful in providing in practical support as well as emotional. P7 actively sought out the support of others:

*I do ask the other nurses for tips and techniques particularly my first few months have been at this unit. What do you do when he is acting out this bad or advise as to when to give prn or should I leave him alone to settle down a bit? Learning from them and they have all been very supportive. (P7)*

De–briefing with another colleague of the same age group and who was also a friend helped P4:

*I had a bit of a debrief with one of the other younger nurses who is really one of my proper close friends at work now. She was also having a really horrible shift*
and we just both had a breather together in the bathroom. Had a vent and a whinge about the management of the incident ... what had happened beforehand. To try and rationalise in my head why it had happened and vice versa with whatever she was going through that day. I felt a little bit better. (P 4)

Support from others was not limited to colleagues but extended to a circle of new graduates and partners.

I think that is where I relied quite strongly on my partner – I vent with him and he is very good at listening. He always says that if this was something that was happening in your home life you wouldn’t tolerate that crap at all, why are you tolerating it at work? (P2)

The lack of support from others was cited as being particularly challenging when dealing with aggressive clients for P6:

Probably the thing I find the hardest is, because XXXX only works part time, if I am in the office on my own and a situation crops up and I don’t have anyone to talk to about it (pause) that I find really hard. It can be quite overwhelming. Working independently, as much as I enjoy it and I like being able to have that ability of decision making. (P6).

Summary of theme three:

Theme three titled ‘Maintaining Integrity’ consisted of findings that provided some understanding into the vulnerability that this group of new graduates experienced when exposed to WPVA. It includes strategies used to cope with incidents and to maintain professional values, attitudes and beliefs. Tabular representation of the codes, categories and sub themes that make up theme three is provided below in Table Five.
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CHAPTER SIX: Discussion

The purpose of this chapter is to discuss the findings of the study. It begins with a summary of the major findings that make up each of the three themes and an overview of the aim and objectives of the current study is provided. Each theme is then discussed in relation to existing research and literature, and the stated aim and objectives. Finally, the strengths and limitations of this study are addressed. Possible implications and recommendations for future research are suggested.

Summary of findings

The findings from this study reflected the diversity of experiences and challenges that this group of new graduate nurses faced when exposed to WPVA. These are captured within three major themes:

- Theme One: Part of the Journey
- Theme Two: Towards Self-Efficacy
- Theme Three: Maintaining Integrity

The first theme, ‘Part of the Journey’ captured what happened to this cohort in terms of the WPVA they were exposed to in their first year of being a registered nurse. They described the nature of violence, who was involved and factors that influenced their experience. This theme also incorporates participants thinking as they attempted to make sense of their experiences. They did this by considering the clients’ medical condition and diagnosis, socio political influences and other contributing factors such as the effect of change.

The second theme, ‘Towards Self-Efficacy’ captures the effects of exposure to WPVA for this cohort and how these influenced their sense of self-efficacy. Participants described mostly negative effects, with fewer, but never the less significant positive effects identified. This theme also incorporates participants’ sense of readiness for responding to WPVA with a focus on adequacy of undergraduate education, post graduate training and suggested improvements.

The third theme, ‘Maintaining Integrity’ captures how this cohort were challenged to stay true to their professional values, attitudes and beliefs when involved in violent and aggressive situations. Participants described their sense of vulnerability, which was associated with trying to fit in, working in a ‘small world’ and with the consequences of reporting incidents.
This theme also incorporates strategies used by participants to cope including reconciliation, reflective practices and the value of support from others.

Combined, these themes present a perspective on WPVA from nurses who are at a vulnerable stage of their career: transitioning from student to registered nurse. As analysis of the data progressed it became evident that the subthemes and themes emerged in a sequential pattern reflective of the participants’ professional development following an experience of WPVA (Hodges, Keeley & Troyan, 2008). The expectations on nurses at this level are often high from the new graduates themselves, the clients and families they care for, their colleagues, those that employ them and those that have educated them (Parker, Giles, Langtry & McMillan, 2014). An insight into the challenges facing new graduates is essential to ensure they are adequately prepared and supported to deal with WPVA safely, competently and professionally throughout their career (Deans, 2004).

**Aim and Objectives of study**

As stated in the introduction, the aim of this study was to explore the experience and sense of readiness of seven new graduate nurses who had been exposed to WPVA. It was envisaged that by conducting this research an understanding that is contemporary and relevant to the New Zealand context would emerge. The specific objectives to achieve this were to establish:

1. The nature of WPVA that new graduates experience in clinical practice (such as physical, verbal, horizontal, sexual)
2. Those involved in WPVA directed at nurses (such as nurses, clients, visitors)
3. The effect of WPVA on the new graduate (such as immediate: within 24hrs; short term: within a month; long term; after a month)
4. What happened after the incident in terms of follow up and support? (such as the response from the new graduate, other nurses, management)
5. What was the new graduate’s sense of readiness for dealing with WPVA?
6. Possible improvements in preparation and support of new graduates for responding to WPVA

**Theme One: Part of the Journey**

To understand participants’ experience of WPVA it was helpful to hear their stories which for some participants focused on a particular incident, while others talked about several incidents. Their description included the nature of the WPVA, captured in subtheme one ‘What happened’ and their explanation of what happened to them, captured in subtheme two
‘Making sense of it’. Combined, these subthemes represent part of a journey on two levels. Firstly, coming to terms with what has happened to them and secondly the realisation that part of the journey to becoming a nurse includes the inevitable exposure to WPVA of some sort and at some time in a nurses’ career (Roche et al., 2010).

Sub theme one: What happened

This study demonstrated that a cohort of new graduate nurses in NZ experienced a range of violent and aggressive behaviours. They reported verbal abuse including being shouted at, sworn at and being insulted. Instances of physical abuse included being pushed, kicked, having equipment thrown at them and being spat at. One participant reported incidents of inappropriate touching (sexual harassment). These findings were consistent with the reported nature of violence experienced by nurses in other studies. Farrell et al. (2006) found 64% of nurses reported some form of violence or abuse. The verbal abuse included rudeness, shouting, sarcasm and swearing and physical abuse included being struck with a hand, fist, elbow, being pushed scratched and spat at (Farrell et al., 2006). Spector et al. (2014) found that approximately a quarter of nurses experience sexual harassment within a year increasing to 40 % experiencing sexual harassment during their career. However, in a study of approximately 500 new graduates in NZ exposure to WPVA, McKenna et al.’s (2004) participants described more extreme levels of violent behaviour including arson, attempted strangulation, threatened with an Aids-contaminated syringe, threats of rape and being stalked outside work environment. This difference could be explained by the larger number of participants and the contexts in which those studies occurred.

Participants in this current study reported violence mostly involving clients, with fewer incidents involving families and other health professionals (horizontal violence). In other studies, clients were also identified as the most common perpetrators of physical and verbal abuse, followed by visitors and family and health professionals (Farrell et al., 2006). Spector et al. (2014) add that physical violence towards nurses is more likely to come from patients (64%), while non physical violence is more likely from family / friends (47%), closely followed by medical staff (28%), and nurses (21%).

Those who agreed to participate in this study worked in areas where the incidence of WPVA is well known, in particular MH services for adults and older persons. There were no participants from the ED, as new graduates do not work in this area as a rule. Of note, was the repeated exposure associated with these areas either through providing care for extended periods for a particular client who was frequently violent and aggressive (such as older
persons in a long term care facility) or because they worked in an area where significant numbers of clients were likely to become violent and aggressive (such as a MH admissions unit). The study by Spector et al. (2014) had similar findings where internationally nurses were most frequently exposed to physical violence in psychiatric, geriatric and emergency departments. Burns (2014) adds that in NZ, the incidence of violence in the community MH in sector is on the rise: statistics obtained under the Official Information Act showed that for MH nurses, reports of WPVA had more than doubled in the 2010 – 2012 period (Burns, 2014). McKenna et al. (2004) found that new graduates in MH services were more likely than new graduates in all other services combined to report experiences of WPVA. However, two of the participants in this study described events that occurred in medical – surgical areas. A larger study of nurses working in medical - surgical areas, which asked participants if they had experienced WPVA in the previous five shifts (Roche et al., 2009) found that up to 50% of nurses experienced physical violence, 66% had threats of violence and up to 65% had experienced emotional abuse (Roche et al., 2009). This suggests that the incidence of WPVA is significant in these areas but perhaps not as well studied or consistently reported (Roche et al., 2009).

Two of the participants in this study experienced WPVA while working in a community setting. Their experiences were made all the more challenging because of the isolation and lack of support available and the expectation of working at an autonomous level. Edwards, Burnard, Coyle, Fothergill and Hannigan (2000) support this finding in a literature review on stress and burnout in community mental health nursing. They concluded that stresses inherent in the job itself included uncertainty and changes in levels of responsibility, safety issues revolving around potentially violent clients and the lack of support and supervision. Nurses working in the community were found to be particularly vulnerable to WPVA due to isolation, lack of control over working environment and the difficulty in attending relevant training and professional development (Burns, 2014; Department of Labour, 2009).

Any discussion on WPVA needs to be cognisant of the ambiguity regarding what constitutes a violent or aggressive event and how to define it (Ventura–Madanfeng & Wilson, 2009). This has been a barrier to recognizing and reporting incidents and impacts on research surrounding this topic (Ventura–Madanfeng & Wilson, 2009). In addition, when organisations use different definitions it is difficult to gain an accurate understanding of the nature and extent of the problem (Farrell & Mann, 2014) and to compare studies so adding to the challenge of addressing the issue (Jackson et al., 2006). Ambiguity can create confusion for clients and staff when certain behaviours are tolerated in one area and penalised in another.
(Farrell & Mann, 2014). Finally, interventions to prevent and manage aggression can be compromised, often resulting in more restrictive options being used (Farrell & Mann, 2014).

**Sub theme two: Making Sense of it**

For participants in this study, making sense of what happened to them was a significant part of their journey. They identified several internal factors including client’s medical condition and diagnosis (such as post operative confusion, delirium, and psychosis) and possibly undiagnosed, and therefore untreated mental illness. This is consistent with other studies that found disorders such as medical conditions and mental illnesses that impair a person’s judgement can contribute to WPVA (Chapman et al., 2010; Ventura–Madangeng & Wilson, 2009). However, substance abuse (such as alcohol and other drugs), pain and stress have also been identified as contributing to WPVA (Chapman et al., 2010; Ventura–Madangeng & Wilson, 2009) with Mullan and Badger (2007) identifying mental confusion and pain in the elderly as significant factors. Of note, was the lack of emphasis on internal factors relating to themselves which Bowers (2014) considered as potential areas of conflict with clients. A staff member’s inability to control and regulate their anxiety and frustration can cause behaviour in clients to escalate (Bowers, 2014).

The difference in the range of internal factors identified by this cohort in comparison to other studies could be attributed to the small number of participants, the locality in which studies occur, the level of experience and developing ability to reflect on own practice. However, it also suggests a possible deficit in knowledge and understanding of factors that can affect a person’s behaviour, possibly linked to inadequate theoretical preparation.

Björkdahl et al. (2013) caution that attributing violence to internal factors either within the perpetrator or victim can lead to the exclusion of other factors that if not recognised will not be addressed. Similarly, internal causes, such as a skills deficit can be solely or largely seen as a contributing factor by organisations and remedied by training so shifting the focus of responsibility from the organisation to the individual (Paterson et al., 2005). Emphasis on psychopathology can reinforce the stereotyping, stigma and discrimination associated with mental illness (Farrell & Mann, 2014). There is increasing support to shift the focus from a violent ‘individual’ to a violent ‘incident’ so recognising that violence seldom occurs in a vacuum and that internal and external factors contribute to this behaviour (Farrell & Mann, 2014; Whittington & Richter, 2006).

External factors were also identified in this study including the frustration of clients who struggled with the limitations of the health service and poor environmental design. Broader
socio-political influences such as the discourse surrounding WPVA (i.e. its part of the job),
effects of change, colleagues’ personal circumstances and inherent power struggles between
clients and staff were also identified. Research by Ventura-Madangeng and Wilson (2009)
expands on this and found that several aspects of the clinical environment impact on WPVA.
Their study identified policies that impose limitations or rules (such as visiting hours, no
smoking, triage times, ward routines) are potential sources of conflict between staff, clients
and their families. Policies that impact on the ward environment such as staff numbers, skill
mix and increased administrative duties have also been identified as contributing factors
(Roche et al., 2010, Ventura–Madangeng & Wilson, 2009). In addition, participants in this
study were largely accepting of external factors and it was implied that these factors were
beyond their control. This could be explained by their perceived status as a ‘new’ staff
member with limited experience but also by the role modelling of more experienced staff who
see themselves as powerless in regards to these factors (Luck et al., 2009).

Theme one addressed two of the objectives of this study (objectives 1 & 2). By capturing
what happened and how participants made sense of their experience the nature of WPVA was
established. It also identified those involved in WPVA directed at nurses including clients
and family members who may be receiving care in range of health contexts including mental
health, community services and medical – surgical units. Senior staff were also perceived to
be party to WPVA.

**Theme Two: Towards Self-Efficacy**

Participants described how they had been affected by exposure to WPVA and while each
experience was unique there were commonalities. The positive and negative effects described
by participants were captured in subtheme one ‘A mixed bag’. Similarly, the degree of
preparedness to respond to WPVA in a professional, competent and safe manner varied but
common themes related to undergraduate and postgraduate training and suggested
improvements were captured in subtheme two ‘Sense of readiness”. Combined the two
subthemes provide insight into influences on new graduates developing self-efficacy or
general sense of effectiveness (Franklin & Lee, 2014) for dealing with WPVA.

**Sub theme one: A mixed bag**

This study found that the effects of exposure to WPVA for new graduate nurses were
perceived to be mostly negative in nature. The physical effects of assaults included facial
bruising, feeling shaken and exhausted. There were no significant injuries sustained (medical
attention was not required either at the time or shortly afterwards) and the events could be
regarded as minor and non-notifiable events (Worksafe NZ, 2014). However, the psychological effects were significant and for some lasted several days and event months after the event. This was evident in the vividness of recall that participants demonstrated. Participants reported feeling angry and dirty, having lower self esteem and confidence, feeling worried and fearful of particular clients who were violent and reduced levels of engagement with clients. Participants who experienced horizontal violence described effects of feeling silenced, criticised, devastated and shocked. The considerable impact of these experiences led to questioning the values, attitudes and beliefs participants had about nursing. However, participants reported that their experiences had not had a lasting effect on the decision to become a nurse or to work in a particular area. Two commented that nursing was ‘awesome’ and that they are ‘loving it’ respectively.

Other studies on the impact of WPVA on registered nurses identified similar findings and placed an emphasis on the psychological impact. Deans (2004) found that nurses experienced ‘professional incompetency’ and ‘emotional confusion’ which lasted for some days after the event. This was worsened by lack of resolution and non-supportive responses from senior staff and colleagues (Deans, 2004). Rodwell and Demir (2012) add that repeated exposure can worsen effects. Fewer studies focused on new graduates however, McKenna et al., (2003) found experiences of WPVA affected how new graduates felt about nursing with 13% considering leaving as a result of WPVA and 6% actively seeking employment out of nursing. This difference could be explained by regional variations with fewer opportunities for employment in provincial areas and also increased competition for nursing positions. However, that fact that this cohort of new graduates remained positive about their nursing careers despite their experiences of WPVA main also be linked to moderating factors such as resilience and effective coping strategies (discussed in theme three).

This study found that participants were able effects they considered positive following exposure to WPVA. These were linked to the learning that occurred and became evident upon reflection several weeks later leading to some contradiction / ambiguity with the initial effects reported. Positive effects included an increased awareness of risk and safety resulting in earlier intervention and engagement, increased vigilance and heightened awareness of their own safety. One participant identified that she had learnt the importance of providing ‘client centered’ care. She found moving away from a task-orientated approach to taking time with personal cares and being more client focused resulted in less resistance and aggression. Similarly, another participant noted dealing with a very aggressive client who had been cared for unsuccessfully in several settings was a reminder about nurses’ duty of care, even under
adverse circumstances. Others felt there had been an increase in confidence and skill development as a result of dealing with a WPVA situation successfully particularly when there had been a successful resolution to a situation. Finally, participants noted that on reflection, their experiences had reinforced their decision to become a nurse.

Although overwhelmingly research and literature stress the negative aspects of WPVA, studies by Chapman et al. (2009) found that nurses became better clinicians, continued to be part of the workforce and continued to provide care for clients following an incident. They were able to do this by adapting their experience by making sense of what had happened to them, using physical (such as personal safety training) and psychological strategies (such as debriefing) to achieve control and by evaluating themselves and colleagues positively. The ability to adapt, cope and maintain self-efficacy under adverse circumstances has been linked to resilience (Hart, Brannan & De Chesnay, 2014). Bonner (2012) identified opportunities for team building and increased empathy for clients and families as positive outcomes experienced by nurses who had been assaulted.

An awareness and acknowledgement of the negative effects of WPVA is essential to understanding the phenomena that front line nurses face. However, insight into the potentially positive effects following an incident and actions that can moderate the negative effects provide a way forward in the preparation of nurses.

**Sub theme two: Sense of readiness**

Participants were asked about the preparation they had received and how this impacted on their sense of readiness to respond to WPVA. While all participants were able to recall some aspects of theory relating to WPVA there were inconsistencies with how this was integrated into practice. Several stated there had been a focus on WPVA happening in the context of MH, where people were ‘really violent’ and they found it difficult to transfer these skills to other areas. This was reinforced by any personal safety training and risk management being delivered as part of the mental health curriculum. This resulted in new graduates working outside of MH not anticipating WPVA and not expecting to have to deal with it. Participants noted that as students, and even as new graduates having completed personal safety training, they were protected from dealing with violent incidents with some areas (such as MH) excluding them from being involved with clients when there is a risk of violence. One participant noted that this was the only area of nursing practice that she felt unprepared for.

Participants made several suggestions for improvement. These suggestions included an awareness of the incidence of WPVA in all contexts (such as in-patient and community) and
in all areas (such as mental health, older people). One participant noted that ‘how’ students were prepared was important with an emphasis on empowering student nurses rather than increasing their fear. Those that experienced HV recommended that students receive preparation for this in their third and final year of education including how to identify HV and effective ways of dealing with it. Participants also made suggestions around skills development including de personalising incidents, self awareness and what to do when you have experienced WPVA such as debriefing, reporting and reconciliation. There was a call for practice in dealing with real life scenarios. This should extend to supporting others who have experienced WPVA and to dealing with hostile families effectively.

Undergraduate nursing education has been criticised for failing to produce ‘practice ready’ graduates who can move seamlessly from the educational sector to clinical practice (Wolff, Regan, Pesut & Black, 2010). It has been suggested that formal processes between education providers and health care providers could be improved to ensure that new graduates are practice ready and meet the current and future local need (Clendon, 2011). While the concept of readiness is contentious, a study by Wolff et al. (2010) to explore the perspective of nurses in the education, practice and regulatory sectors about the meaning of ‘practice ready’ found that there were four common themes: having a generalist foundation and some job specific capabilities, providing safe client care, keeping up with the current realities and future possibilities and possessing a balance of doing, knowing and thinking (Wolff et al., 2010). In addition, new graduates can find the difference between their academic preparation and the realities of the workplace challenging (Hart et al., 2014). The practice gaps between the academic setting and actual nursing practice in a healthcare organisation can become evident in the first year of practice, the new graduate year (Hart et al., 2014). Students find learning by simulation using real life scenarios has been effective in bridging the gap between classroom and practice (Ashley & Lee, 2014).

Readiness for WPVA in particular has come under question with Deans (2004) concluding that there is an overwhelming expectation of nurses to ‘cope’ with WPVA within a context that fails to provide educational preparation on coping strategies:

Nurses are unprepared, both professionally and emotionally for aggression emanating from their patients, colleagues or doctors. While they generally recognise that aggression may occur, nurses believe that it will not happen to them.”

(Deans, 2004, p36)

Deans (2004) suggests that tertiary education programmes systematically include content that prepares nurses to respond to aggressive behaviour but also to manage their own, often
negative responses or aggressive behaviour. Hewitt (2009) adds that nursing curriculums for the future include “values and attitudes, moral identity, interpersonal skills and the building of relationships, critical thinking and self-awareness through reflective practices” (Hewitt, 2009, p369) as an effective philosophical basis for the prevention and management of WPVA.

At undergraduate level, the introduction of restorative approaches could have a positive effect on the socialisation of nurses, so breaking the cycle of enculturation of nursing students into HV and equipping them with the skills and understanding required to respond to HV in a more effective manner (Hutchinson, 2009). The findings of research by Clark et al. (2011) support a similar approach. They propose that a shared vision for civility be integrated into the curriculum and that this should foster leadership and positive role modelling at an early stage of nurses’ development.

Finally, Roche et al. (2009) add that improved preparation of nurses can moderate the effects of WPVA so that it doesn’t have to be seen ‘as part of the job’ but as something that can be managed. Improved preparation will assist in developing self-efficacy and for nurses this includes the ability to think optimistically, persevere through difficulties and ultimately complete a clinical task (Franklin & Lee, 2014). A nurses’ sense of self-efficacy is critical to progression and development (Tanner, 2006). Nurses with high self-efficacy demonstrate a greater commitment to use and develop clinical skill, to achieve clinical goals and to overcome adverse and stressful situations more easily (Tanner, 2006)

Theme two addressed three of the objectives of this study (3, 5 & 6). It established the positive and negative effects experienced by this cohort following exposure to WPVA that influenced their developing self-efficacy. It also provided some understanding into new graduates’ sense of readiness for dealing with WPVA with many feeling unprepared and not expecting WPVA. Some possible improvements were suggested including increased awareness, skills development and knowledge of what should happen after an event.

**Theme Three: Maintaining Integrity**

Participants described challenges in dealing with WPVA, which were related to vulnerability. These included trying to fit in, working in a small provincial area and their reputation and were captured in sub theme one ‘Vulnerability’. They also described coping strategies including reconciliation, reflective practices and support from others presented in subtheme two, ‘Ways of coping’. Combined the two subthemes provide an insight into some of challenges facing new graduates when exposed to WPVA and how they developed they maintained their integrity.
Sub theme one: Vulnerability

This study found that participants felt vulnerable with several aspects of dealing with WPVA. They reported ‘trying to fit in’ with colleagues which meant not complaining about WPVA and expectations of dealing with WPVA as competently as more experienced nurses. One participant described feeling she wasn’t accepted by some staff due her gender and age which was apparent when dealing with violent incidents; she was one of only a small group of young women working in a particular area which was dominated by older male staff. Specific to this study was the vulnerability associated with working in a small provincial region. Participants reported that being in small teams contributed to feelings of isolation: physical and emotional isolation. Others reported that this pressure on having good relationships with other staff because of working and living in close proximity. It was noted that not only are new graduates new to nursing but they are also new team members and not always welcomed.

Although not specific to WPVA, Hodges et al. (2014) reported similar findings when researching new nursing graduates’ steps in developing resilience. Three themes were identified with each representing another step towards developing resilience. The first theme, ‘Learning the Milieu’ involved new graduates becoming familiar with the ward culture including formal and informal rules. It was also a time to develop RN skill set including techniques, time management and pace. The second theme, ‘Discerning Fit’ represented new graduates struggle to fit in as they sensed discrepancies between their expectations and the reality of practice. It included developing a sense of professional identity through critical reflection and reconciliation. As a result, new graduates had greater confidence and were more self-directed (Hodges et al., 2014).

In terms of vulnerability Sellman (2009) adds that the activity of nursing increases exposure to occupational hazards including but not limited to physical assault, threatening behaviour, verbal abuse and workplace violence. Sellman (2009) argues that in areas of high risk (such as MH and ED) nurses’ vulnerability is moderated by protection strategies, however, nurses working in areas where there is a perception of reduced risk may have reduced uptake of these practices. Finally, Sellman (2009) notes that vulnerability amongst nurses does not limit opportunities for development but it can compromise development if not moderated by protective practices.

This study found that aspects of reporting incidents contributed to participants’ sense of vulnerability. They noted that reporting events related to WPVA was not an accepted part of ward culture, they weren’t sure what events to report and had received minimal instruction on how to use system. When events were reported there was dissatisfaction with the process and
staff didn’t feel they were accurately able report what had happened. This was evident with more minor incidents (such as verbal abuse or threats) and in areas where WPVA was associated with providing nursing care (such as older persons’ facilities) and was a frequent occurrence. They felt discouraged to report incidences of similar events as nothing changed and they would just be filling in reports repeatedly. Participants noted that the reporting system was a barrier to accurate reporting, as it didn’t allow for all information to be provided but was reliant on pre-set response and drop boxes. When incidences of HV were reported informally to senior staff, participants were not encouraged to formally report or take matter further. There was a fear of being blamed shamed and of tarnishing your reputation if involved in WPVA which was exacerbated if reported. One participant acknowledged that reporting shared the responsibility and accountability that she struggled with as a new grad working in an autonomous role. Another acknowledged that there was a slow and gradual shift within teams to reporting incidents.

The non-reporting of incidents of WPVA among nurses is well known and there are several possible explanations for this, similar to those participants from this study provided (Ferns & Chojnacka, 2005, McKenna et al., 2004). Key themes include the frequency and number of incidence is so great that it is regarded as routine and it is just ‘part of the job’, reporting has led to little change, is time consuming and adds to already excessive workloads. There is fear of being accused of being negligent, providing inadequate care or of provoking WPVA; some violence is unintentional; a culture of tolerance and acceptance of WPVA exists as does a covert culture of non reporting, particularly with HV (Ferns & Chojnacka, 2005). Espin and Meikle (2014) found that barriers to reporting of incidents amongst new graduates included lack of knowledge regarding what constitutes an incident and lack of knowledge on how to report or when to report. Espin and Meikle (2014) also identified that new graduates used informal reporting such as speaking to a senior colleague with the understanding that this person would take the matter further if required. Further work by Ferns (2006) suggested that broader social factors contribute to non-reporting of incidents relating to WPVA. These include gender, with women preferring to deal with incidents informally and personal experience of violence influencing recognizing, dealing and reporting of violence (Ferns, 2006). Other factors included the position of nursing within the health care organisation and the associated lack of professional autonomy and power contributing to non-reporting (Ferns, 2006).
Sub theme two: Ways of coping

This study found that participants utilised a number of strategies to cope with their experiences. These were grouped into three categories: reconciliation, reflective practices and support from others.

Following assaults from particular clients, participants reported mixed feelings toward clients involved leading to some avoidance but also attempts to reconcile relationships by spending time with the client and attempting to engage. Participants reported reflective practices such as critical reflection, peer clinical supervision and one-to-one supervision as helpful for coping with situations and maintaining integrity. Seeking and receiving support from others, including colleagues, managers and personal friends was identified as a significant coping strategy. One participant noted that the lack of collegial support due to isolation made dealing with aggressive clients challenging.

Participants identified ways of coping that are supported by current research and literature. Reconciliation is a part of conflict management and for it to be successful the emotional needs of both parties need to be addressed and unsatisfied emotional needs can be a barrier to reconciliation (Shnabel & Nalder, 2008). The apology – forgiveness cycle is one way of reducing emotional barriers and involves the perpetrator apologizing to the victim and the victim reciprocating by granting forgiveness (Shnabel & Nalder, 2008). Reconciliation following events of WPVA can assist nurses in finding meaning in the event that is congruent to their values, attitudes and beliefs (Hodges et al., 2008). Reflective practices have been a part of nursing for many years with nursing scholars arguing that reflection is an essential component of professional practice which leads to insight and changes in practice (Asselin, Schwartz-Barcott & Osterman, 2013). For new graduates in particular, critical reflection can assist in bridging the gap between nursing education and clinical practice, problem solving in adapting to the realities of clinical practice (Hodges et al., 2008). However, Asselin et al. (2013) found that multiple terminology and models of reflection, lack of structured and facilitated reflection can impact on its effectiveness and suggests increased education for nurses at undergraduate and postgraduate levels could assist in more effective reflection practices. Supervision (sometimes referred to as clinical or professional supervision) has been identified as being central in improved client outcomes and to the development and retention of nurses working in the MH and addictions sector (Te Pou o Te Whakaaro Nui, 2009). For supervision to be effective it needs to be supported by management, delivered by trained and competent supervisors, regular and sustained, have a clear focus and be accountable to key stake holders (Te Pou o Te Whakaaro Nui, 2009).
The ways of coping participants identified are linked to literature on resilience. The concept of resilience includes the ability to not only overcome adversity but to grow stronger and learn from the experience (Thomas & Revell, 2016). It includes optimism, sense of humour, flexibility and a self-efficacy (Thomas & Revell, 2016). In addition, resilience enables a nurse to:

...reframe, adapt, balance, persist, and grow in the face of adversity and hardship but requires both suffering and perseverance in the struggle to work through emerging difficulties and to integrate experiences of crisis into a sense of well being.

(Hodges et al., 2008, p. 80)

Strategies for nurses to develop resilience include building positive professional relationships, maintaining positivity, and developing emotional insight, maintaining life and work balance and use of reflection (Jackson et al., 2006). Thomas and Revell (2016) found that resilience can be enhanced by support of family and friends and colleagues. McAllister and McKinnon (2009) argue that resilience is not limited to individuals but can apply to teams and communities and is essential in the health sector. They add that resilience should be included in all health professional undergraduate training and within workplace learning and practice contexts.

Theme three addressed two of the objectives of this study (4 & 6). It captured what happened after exposure to WPVA including the vulnerability participants experienced in dealing with these events particularly with reporting. It also presented the ways of coping participants used and added further suggestions for improvement of new graduates including enhancing reflective practices and developing resilience.

**Strengths and Limitations of Current Study**

The ability to draw inference and conclusions from qualitative studies is considered limited particularly when the sample size is small (Liamputtong, 2013). However, the benefit of the smaller sample size was that it made it possible for the researcher to conduct the face-to-face interviews personally and to transcribe the interviews herself. This resulted in the researcher being fully engaged with all aspects of data collection and ensured the quality of the data. It also provided reassurance to participants that the sensitive information shared was valued and would be treated respectfully (Liamputtong, 2013).

There is inherent bias associated with self-selection (Offredy & Vickers, 2010). These findings represented the experiences of those who agreed to participate in the study and were willing, comfortable and able to share their views. They also demonstrated an ability to
recognise and identify WPVA and in many cases aspects of their experience remained unresolved. The findings do not represent those who: were not in a similar position i.e. those new graduates who did not recognise, identify or experience WPVA, felt their experiences were resolved, were not comfortable discussing or not willing or able to participate (Offredy & Vickers, 2010). The strengths of self-selection for this study however, were considerable. Participants were prepared and highly motivated to share their experiences. This meant that interviews were focused and contributed to the quality of the data. In addition, participation in the study provided a safe and productive outlet for their concerns and contributed in part to resolution and closure (Ashton, 2014).

A further limitation of this study was that participants were asked how well they felt their undergraduate education had prepared them to respond to WPVA and this required a degree of recall and subjective interpretation. It is well recognised amongst educators that student recall is influenced by a number of factors (such as attendance, concentration, interest, perceived relevance, learning and teaching styles) and therefore recall is not a reliable indicator of curriculum (Nakamura et.al, 2014). The focus of this study however, was not to assess the curriculum but to explore graduates’ perceptions of their preparation and sense of readiness for dealing with WPVA and it is acknowledged that many factors impact on this. There were benefits in asking participants to describe their preparation and sense of readiness. It provided an opportunity for participants to reflect on their sense of readiness, identify factors that had influenced this and identify suggested improvements. In addition these findings were expressed in their own words and so contributed to the authenticity of the data.

At the time of conducting the research, the researcher was an employee of a local tertiary institute provider and worked on the Bachelor of Nursing programme. In this capacity, she had some professional standing in the local community and inadvertently the respondents were known to the researcher. Respondents were aware of this when deciding to participate. While this introduced a degree of bias, the researcher also believes there was a degree of trust already established that facilitated the sharing of sensitive information. This relationship was also discussed with supervisors and strategies to manage this were developed and outlined in methods and methodology section.

Finally, there were inconsistencies in findings from data provided by individual applicants. At times, participants struggled to articulate clearly their thoughts. For example, the positive effects, which were more apparent on reflection and some time after the event, were in contradiction to the initial negative effects, which were noted either at the time or shortly after the event. Clearly exposure to WPVA is a distressing experience and this is likely to cause
mixed feelings and some inconsistencies. Also, Crowe et al. (2015) suggest that participants’ perceptions of experiences are dynamic in nature. The same questions may elicit different responses at different points of time. Although this was minimised by the use of semi structured interview questions, the same person interviewing participants and the interviewer also transcribing the recorded interviews (Serry & Liamputtong, 2013), it is noted that participants were at different stages of their first new graduate year (Crowe et al., 2015). Data wasn’t collected as to the timing of the incident in relation to the interview but the researcher was aware that in some cases events were recent and for others they were up to a year prior to interview.

**Implications**

The findings of this study indicate that new graduate nurses are often exposed to a range of violent and aggressive behaviours which can have a considerable psychological effect at a formative stage of their nursing career. Improved preparation could contribute to a higher degree of self-efficacy amongst new graduates and the registered nurses of the future, leading to a positive impact on health outcomes for clients and their families. While several suggestions have been made on how their sense of readiness could be improved, it should be noted that the coping skills utilised by this cohort to maintain integrity indicate that aspects of their undergraduate education, such as the use of reflection and supervision, provide a sound foundational basis for new graduates to draw on. Also, research and literature accessed for the background to the current study suggests that the responsibility for the preparation of nurses of the future is a shared one and needs to be ongoing in a nurses’ career. Effective preparation involves nurses themselves, providers of undergraduate and postgraduate education and organisations that employ nurses (Deans, 2004; Farrell & Mann, 2014; Luck et al., 2009).

**Recommendations for future research**

This study involved participants at the start of their career who displayed much of the optimism and hope that could be expected at this stage. While their exposure to WPVA was significant, over a period of time they would have increased exposure and participants may feel differently. A longitudinal study with a similar aim would capture the effects of long-term exposure to WPVA so providing greater understanding of the compounding effects of exposure over a period of time and an indication of how to mitigate these effects.

Similarly, a larger study with a mixed methods approach (quantitative and qualitative methods) including nurses who have been educated in institutes across the country would
provide a broader perspective. Such a study could build on an earlier study (McKenna et al., 2004) conducted in NZ and have a similar aim – not only highlight the issues but provide recommendations to improve preparation of nurses in partnership with professional bodies, educators and employers of nurses.

Recent developments in NZ are likely to see an increase in nurses dealing with violent and aggressive individuals. A memorandum of understanding between NZ police and the Ministry of Health will see a phasing out of police detaining mentally ill or those suspected of having a mental illness while awaiting medical assessment. Instead, these individuals will be transported to a health facility to be assessed and treated (stuff.co.nz, Feb 21st, 2016). The challenge of preparing nurses to respond to WPVA, drawing on sound theoretical and practical education will be greater than ever.

**Conclusion**

The purpose of this chapter was to discuss the findings of this study in relation to existing research and literature which was accessed to provide background to the current study. Largely, the findings were found to be consistent with the background information, however there were notable differences associated with the population group studied (new graduates) and the context in which they were working (older persons, general medical / surgical and mental health). A discussion on the strengths and limitations of this study, implications and recommendations for further research was included.
CHAPTER SEVEN: Conclusion

The aim of this study was to explore new graduate nurses’ experiences of WPVA and their sense of readiness to respond to this. This final chapter brings the thesis to a conclusion by summarising the key points achieved at each stage of the research process and reflecting on the degree to which the aim and objectives of this study have been achieved.

A search of the substantial body of research and literature that already exists on WPVA found that there were several aspects to the topic that provided useful background and context for this study. These included definitions of WPVA, prevalence, contributing factors, the impact and consequences and approaches to the prevention and management of WPVA. Specific to this study, information on new graduate nurses and the education and preparation that they undertake within the NZ context was included.

The study drew on a qualitative descriptive approach to ensure that the voice and insight of new graduate nurses would be reflected. In keeping with this approach, data was collected by the use of semi structured, face-to-face interviews conducted and transcribed by the researcher. It was analysed using a step-by-step thematic analysis resulting in the identification of three themes.

Firstly, that WPVA was ‘Part of the Journey’ to becoming a nurse and included exposure to physical and verbal abuse from clients and other health professionals. This was accompanied by attempts to make sense of these experiences drawing on an understanding of the internal and external factors that contribute to WPVA. Secondly, these experiences contributed to the participants heading ‘Towards Self-Efficacy’. The impact of WPVA was largely negative, with a significant psychological effect that was far reaching and impacted on relationships with clients and colleagues. However, combined with the positive aspects identified, such as increased risk awareness and greater understanding of client-focused care, participants increased their self-efficacy. As a result of their experiences, participants were able to identify possible improvements to the preparation of nurses including an awareness that WPVA can occur in all areas of the health sector and that nurses could benefit from being empowered to deal with it rather than fearful. Finally, these participants described efforts toward ‘Maintaining Integrity’. They spoke of the vulnerability new graduates experience when exposed to WPVA associated with the reporting of events and their attempts to ‘fit in’ with their teams. They were able to mobilise coping strategies including reflective practices and support of others to maintain integrity and moderate the effects of WPVA.
Each theme was discussed in relation to the existing literature and the stated aim and the six objectives that guided this study. Theme one, ‘Part of the Journey’ addressed two objectives of the study: to establish the nature of the WPVA this cohort had experienced and to identify those involved in WPVA directed at nurses. The second theme, ‘Towards Self Efficacy’ addressed three objectives of the study which were to establish the effects of exposure to WPVA, explore participants sense of readiness and identify possible improvements to preparation of nurses. The third theme, ‘Maintaining Integrity’ addressed two objectives of the study; what happened after the incident and further possible improvements to preparation for nurses.

Strengths and limitations of this study were identified and these related to sample size, selection process, participants recall and subjectivity, inconsistencies in data and participant’s relationship to the researcher. Overall, this study has implications for nurses, providers of nursing education and organisations that employ nurses; this suggests that the responsibility for enabling nurses to respond to WPVA needs to be seen as a shared undertaking. Further research exploring the long term effects of exposure and researching a larger, more diverse population is recommended to support greater understanding of WPVA, improved preparation and effective mitigation of the effects.

The intention of this study was to contribute to the existing body of knowledge on WPVA by providing a perspective that was contemporary and NZ based, and gave voice to new graduate nurses. This was addressed on several levels. Firstly, an attempt was made to identify and utilise existing NZ research and literature, however, a large number of international studies provided additional information. Secondly, priority was given to literature that was less than ten years old, however, several exceptions were made due to the relevance of older work. Thirdly, the new graduates that participated in this study were recently educated by an approved provider of nursing education. While there is no standard curriculum for nursing education in NZ, curriculums are approved and monitored by Nursing Council to ensure they meet the required standard. At the time of participation, participants were in their first year of employment and had all experienced WPVA. This put them in an ideal position to reflect on the preparation they had received to date for dealing with such events and to identify possible improvements.
REFERENCES


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Appendix One: University of Otago – Board of Studies

July 13, 2012

Christine Ball
26 Tasman Street
Nelson 7010
New Zealand

Dear Christine,

Research Proposal: Master of Health Sciences (Nursing)

Thank you for submitting your research proposal. The Board of Graduate Studies in Health Sciences is pleased to approve your research proposal and supervisory arrangements as follows:

Title: “It’s part of the job, isn’t it? A study of undergraduate nursing students’ experience of violence and aggression in clinical practice.”

Supervisors: Virginia Maskill
Paul Saunders

While approving your proposal, the members of the Board assigned to review it suggest the following as areas for consideration by the student and supervisor:

1. “Horizontal violence” needs to be defined.
2. An invitation to participate will be sent to all undergraduate nursing students – is the sampling frame NZ wide this could be further defined.
3. Purposive sampling will be undertaken; one variable to consider would be the nature of the WPVA to interview people with a range of experiences and severity.

Memorandum of Understanding for Supervision

The Board strongly encourages you to develop a formal Memorandum of Understanding with your supervisors outlining the supervisory relationship and responsibilities so that expectations are clear and documented for all parties. A template Memorandum is enclosed for your use. Please feel free to modify it to suit your individual situation.

Ethical approval

You are reminded that your research cannot begin until ethical approval, where appropriate, has been granted. Once granted, a copy of the ethics approval must be sent to the Postgraduate Programmes Administrator, Health Sciences Divisional Office, to be filed along with your research proposal.

Taking a break from study

Please complete an application for a period of temporary withdrawal if you need to take a break from your studies. This will help to protect the length of time you are allowed to
Appendix Two: University of Otago Human Ethics Application – Category A

Ms V Maskill
Centre for Postgraduate Nursing Studies (Chch)
72 Oxford Terrace, Levels 2 and 3
University of Otago, Christchurch

Dear Ms Maskill,

I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled “Are we ready? A study of new graduate nurses’ experience of workplace violence and aggression and their sense of readiness”.

As a result of that consideration, the current status of your proposal is: Approved.

For your future reference, the Ethics Committee’s reference code for this project is: 13/181.

The comments and views expressed by the Ethics Committee concerning your proposal are as follows:

While approving the application, the Committee would be grateful if you would respond to the following:

The Committee would be grateful if you could provide evidence of locality authorisation from Nelson-Marlborough DHB.

The Committee recommends that any references be removed from the body of an application and/or Information Sheet and only provided as a footnote at the end.

The Committee commends you on the information provided at Section 14 of the application, which covers all bases succinctly.

Please provide the Committee with copies of the updated documents, if changes have been necessary.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.
Yours sincerely.

[Signature]
[Signature]

Mr Gary Witte  
**Manager, Academic Committees**  
Tel: 479 8256  
Email: gary.witte@otago.ac.nz

c.c. Assoc. Prof. L Whitehead  
Director  
Centre for Postgraduate Nursing Studies (Chch)
Appendix Three: University of Otago: Research Manager – Maori

3 December 2012

Ms Virginia Maskill
Centre for Postgraduate Nursing Studies
University of Otago, Christchurch

Mā te rangahau hauora e tautoko te whakapíkít ake te hauora Māori
All health research in Aotearoa New Zealand benefits the hauora (health and wellbeing) of tangata whenua

Tena koe Virginia,

Thank you for arranging a teleconference for Christine Ball to discuss with me at the University of Otago, Christchurch on Wednesday 28 November 2012, to discuss your research study titled:

It is still part of the job, isn’t it? A study of new graduate nurses’ experience of workplace violence and aggression (WPVA) and their level of preparedness.

I note that your research is a Masters thesis to explore the experience and preparedness of graduate students who have been exposed to WPVA.

It was apparent in your research summary, that there could be a small number of Maori participants and that this research may have impact on the results. Although you did mention you would be meeting with iwi representatives.

We also discussed the relevance of the research in regard to improving Maori health status and referred to the 1. HRC’s Ngaa Pou Rangahau Hauora Kia Whakapíkit Ake Te Hauora Maori 2004-2008, 2. The Health Research Strategy to Improve Maori Health and Well Being 2004-2008. The other reference that is available is 3. Hauora Maori Standards of Health IV: A Study of the Years 2000-2005 by Bridget Robson and Ricci Harris, Maori Health Research Unit, Wellington School of Medicine, University of Otago, Wellington. All provide Maori specific information on a range of health issues.

The recent publication Takau Kahukura: Maori Health Chart Book 2010, Ministry of Health, 2010 (2nd edition), is an update relating to the socio economic determinants of health, health status and service utilisation of the Maori population. Further references are available from the HRC’s Guidelines for Researchers on Health Research Involving Maori (page 22), www.hrc.govt.nz

It was agreed that there is a need to acknowledge the issues pertaining to ethnicity and to consider how ethnicity data will be collected in your study. Also, given the poor ethnicity data collection in hospital databases, this information is collected in demographic information and supplied to the Ministry of Health, as part of the research. Through our discussion, the Census 2006 ethnicity question was considered to be the preferred tool in recording ethnicity.

As stated in the HRC’s Guidelines for Researchers on Health Research Involving Maori, it is important that research results contribute to Maori development. In some instances where Maori have been powerless to stop the inappropriate dissemination of information, this has generated unease within Maori communities. Researchers must take care to ensure that Maori participants understand and agree on which information is to be published.

It is a requirement of the ethics approval process, that a final report be submitted when the research is complete. A copy of the report should also be supplied to me at that time, as findings from this project may contribute to the development of future research hypotheses or projects. It is therefore important that appropriate Maori organisations, Maori health professionals and Maori researchers are aware of your findings. The Research Office of the University of Otago, Christchurch and in particular myself as the Research Manager - Maori would be willing to assist in the dissemination of your findings once your project has reached a successful conclusion.

My suggestions do not necessarily relate to ethical issues with your research, including methodology. Other committees may also provide feedback in these areas. Please contact me should you need any other information that may not have been included in this letter that was relevant to our conversation.

I wish you well in your research.

"Mo tetou a mo ka uri a muri ake nei" Ngai Tahu 2025
For us and our children after us

Ka nui tonu nga mihi

Elizabeth Cunningham
Research Manager - Maori
Appendix Four: XXDHB: Research Approval Committee

Gaylene Corlett

From: Pom Stinton-Whetnall
Sent: Thursday, 7 November 2013 11:47 a.m.
To: Chris Fleming
Cc: Gaylene Corlett
Subject: Staff-based Research proposal sign-off lease
Attachments: 10-Research applcn lt:docx; 10-Research proposal.docx

Good morning Chris

Christine put forward her proposal for research which was discussed and endorsed at Q&SGC 11/10/2013. It has Robyn Henderson’s approval. Q&SGC asked that it now go to you for final sign-off.

Regards
Pom

Approved
Appendix Five: XXDHB: Iwi Health Board Approval

23 September 2013

Christine Ball
26 Tasman Street
NELSON

Tēnā koe Christine,

Letter of Support for Research Study: Are we ready? A study of new graduate nurses’ experience of workplace violence and aggression (WPVA) and their sense of readiness.

Your request for support was considered by Karake Consultancy on behalf of the Iwi Health Board after an evaluation of the information that you provided. The Iwi Health Board supports your research proposal with the request that regular updates are provided in terms of the study findings and outcomes, including any ethnicity data that might emerge from the research specific to Maori and other information collected regarding the local Maori population.

The Iwi Health Board understands that this study is being undertaken in collaboration with the Nelson Marlborough District Health Board (NMDHB) and is the basis of a thesis to complete Master of Health Sciences (University of Otago). You have indicated that you are currently employed as a senior academic staff member (mental health nursing) at Nelson Marlborough Institute of Technology (NMIT).

In terms of justification and methodology for the research the following has been stated: There is overwhelming evidence to indicate that workplace violence and aggression (WPVA) is a significant worldwide phenomenon for nurses where ever they work (Hegney, Tuckett, Parker & Eley, 2010). The intention of this study is to establish the adequacy of undergraduate nursing education in Aotearoa New Zealand in preparing nurses to address WPVA in a professional and safe manner. It is anticipated that possible improvements for the preparation of nurses will emerge. To do this twelve new graduate nurses will be asked to share their experience of WPVA. For the purposes of this study WPVA is defined as an intimidating act of verbal or physical abuse that either directly or indirectly creates stress, fear and loss of confidence in the victim (Thomas, 2010).

It is understood that:

1. Participants will be asked to provide demographic data relating to their ethnicity using the NZ Census (2006) format;
2. Data will be collected from a small sample (12 – 14 people) and the findings will be analysed by ethnicity. Comparisons will be made between Māori and other groups however due to the small sample size comparisons will be limited and Māori participants will not be regarded as representative of Māori nurses as a whole;

3. It is hoped that the support and suggestions from Māori through the consultation process to date will lead to increased recruitment of Māori participants and perhaps more importantly assist the researcher to ensure Māori participants and the data they provide will be treated in a culturally respectful and safe manner;

4. While this study does not specifically address Māori health it will add to the existing body of knowledge surrounding WPVA by providing a contemporary and culturally relevant perspective. As a qualitative study, each participant’s story is valued and respected and increases the understanding of the impact of WPVA on nurses. It is anticipated that the findings from this study will contribute to improvement in several areas: greater awareness of the challenges facing new graduates, increased safety of nurses, safe and professional responses to WPVA, a possible reduction in the occurrence of WPVA and better health outcomes for clients / tangata whai ora and their families/whānau;

5. Participants will be provided with an information sheet outlining the aims of the study, the questions that they will be asked, expectations regarding their participation, responsibilities of the researcher, risks and benefits of participation and the voluntary nature of the study;

6. The researcher will uphold participants right to self determination by ensuring participants understand that they are free to participate or not participate without any prejudicial consequences, that they have the right to ask questions or refuse to give information including the right to withdraw from the study at any stage;

7. Various confidentiality procedures will be implemented to maintain participant anonymity including the secure storage of electronic and hard copy information, maintaining anonymity through the use of pseudonyms and the exclusion of any data that could identify participants, others involved or the clinical practice area where event has occurred. Should any information come to light that is of a more serious nature and deems further action then this will be discussed with the participant and supervisor. Similarly, there is an awareness of the need to maintain the anonymity of organisations, such as DHBs and tertiary institutions which may be identified by participants; and
8. The researcher believes that people’s stories are primarily owned by them and should be regarded as a precious gift. The sharing of personal stories first hand is a privileged and fortunate position for the researcher to be in, particularly when these come from tangata whenua. The onus is on the researcher to hear these stories and share this gift with others in a manner that upholds the authenticity of the participant’s experience, respects the participant’s experience and upholds the rigor of the research methodology.

Thank-you for submitting your research proposal for consultation, please contact Karake Consultancy if any further assistance is required regarding this study.

Please forward updates for the IHB to the NMDHB Director of Maori Health,

Naku na,

[Signature]

Dr Melissa Cragg
Appendix Six: Research Study: provision of contact details

RESEARCH STUDY:

Are we ready? A study of new graduate nurses’ experience of workplace violence and aggression and their sense of readiness

I am interested in this research study and agree to being contacted by the researcher to find out more information

Please contact me at the following email address:

Name:  Signature:
Appendix Seven: Research Study: Volunteers Required

RESEARCH STUDY: VOLUNTEERS REQUIRED

Are we ready? A study of new graduate nurses’ experience of workplace violence and aggression and their sense of readiness

The purpose of this research study is to establish if undergraduate nursing education in New Zealand adequately prepares nurses to address workplace violence and aggression (WPVA) in a professional manner.

For this research study, I am seeking new graduate nurses who have had or have witnessed an experience of WPVA and are willing to share this. For the purpose of this study WPVA is defined as an intimidating verbal or physical abuse that either directly or indirectly creates stress, fear and loss of confidence in the victim. Participants need to have undergone their undergraduate nursing education in New Zealand and be enrolled in a New Entry to Practice programme. The first 12 respondents who meet these criteria will be invited to participate in the study, which requires participants to share their experiences by attending a 45-minute interview with the researcher which will be audiotaped.

Studies have demonstrated that while sharing one’s story of a painful or difficult time can be distressing it can also be helpful to personal and professional growth. The researcher is committed to work in a supportive and respectful manner. In addition, this is an opportunity for new graduates to be actively involved in nursing research.

Interested? Please attend a brief 15min presentation on this study or contact researcher directly (see below)

Date: March 8th Time: 1300 Venue: XXX

Attendance at this presentation is voluntary and in no way places attendees under any obligation to participate in the study.

The student researcher: Christine Ball, Health and Social Sciences, Nelson Marlborough Institute of Technology. Phone: 03 5469175 email: Christine.ball@nmit.ac.nz

The research study Supervisor: Virginia Maskill, Post graduate Health Sciences, University of Otago (Chch) Phone: 03 3643861 email: Virginia.maskill@otago.ac.nz

The University of Otago Human Ethics Committee has approved this study [Reference Number: 13/181]. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix Eight: Information Sheet for participants

Research Study Title: Are we ready? A study of new graduate nurses’ experience of workplace violence and aggression and their sense of readiness

INFORMATION SHEET FOR PARTICIPANTS

Thank you for showing an interest in this research project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate, thank you. If you decide not to take part there will be no disadvantage to you and thank you for considering my request.

What is the aim of this study?

The aim of this study is to establish if undergraduate nursing education in New Zealand adequately prepares nurses to address workplace violence and aggression (WPVA) in a professional and safe manner. For the purposes of this study WPVA is defined as the experience of an intimidating act of verbal or physical abuse that either directly or indirectly creates stress, fear and loss of confidence in the victim (Thomas, 2010). This includes witnessing of such events and WPVA perpetrated from patients, families and other health professionals.

This study explores an area of particular interest to the researcher and is being undertaken as part of the requirements for Masters in Health Sciences.

Can I take part?

To ensure that the aim of study is achieved participants need to have undergone their undergraduate nursing education in New Zealand, currently hold a practicing certificate and have been a registered nurse for less than 2 years, enrolled in a NETP programme and have had an experience of WPVA that they wish to discuss.
What will I be asked to do?

Should you agree to take part in this project, you will be asked to attend a 30 – 45 minute interview. The interview will be conducted by the researcher using prepared questions and prompts. The general line of questioning includes the nature of WPVA experienced, the perpetrators of the WPVA, the effect of WPVA on you, the followup after the incident, your sense of preparedness / readiness for dealing with WPVA and any suggestions you may have on to better prepare nurses of the future.

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind.

Studies have demonstrated that while sharing one’s story of a painful or difficult time can be distressing it can also be helpful to personal and professional growth. The researcher is committed to working with participants in a supportive and respectful manner. Additional support from the Employee Assistance Programme will be available and is free of charge.

In addition, this is an opportunity for new graduates to be actively involved in nursing research.

What happens to the information I provide?

You will be asked to share your experiences of WPVA and to consider how well your undergraduate nursing education prepared you to respond to these situations. The interview will be audio taped and then transcribed into written text. The researcher, transcriber and Supervisors will have access to this information. The reviewed transcriptions will then be thematically analysed and form the basis of the research project.

How will information be securely managed, stored and destroyed?

Electronic data will be stored in password-protected files. Hard copy information will be stored in a locked filing cabinet in a locked office at researcher’s place of work. Data obtained as a result of the research will be retained for at least 5 years in secure storage. Any personal information held on the participants will be destroyed at the completion of the research.

What information will be reflected in the completed research?

All efforts will be made to preserve participants personal information which will include the use of pseudonyms and the exclusion of any data that could identify participants or others involved. There is
also a need to maintain anonymity of the organisations, such as DHBs or tertiary institutes by the use of general terms (such as a DHB mental health service) which may be identified by participants.

Will I have the opportunity to correct or withdraw the data/information?

All participants will have the opportunity to correct or withdraw the transcribed information that relates to them as soon as it is available and prior to it being analysed by researcher.

Will I be provided with the results of the study?

All participants will be provided with a summary of the results of the study if they wish for this to occur.

Can I change my mind and withdraw from the project?

You may withdraw from the project at any time and without any disadvantage to yourself of any kind. In the event of this happening it would be appreciated if either the student researcher or the research project supervisor are notified as soon as possible. Please see contact details below.

What if I have any Questions?

If you have any questions or comments about our project, either now or in the future, please feel free to contact either:

**The student researcher:** Christine Ball, Health and Social Sciences, Nelson Marlborough Institute of Technology.

**Phone:** 03 5469175    **email:** Christine.ball@nmit.ac.nz

**The research study Supervisor:** Virginia Maskill, Post graduate Health Sciences, University of Otago (Chch)

**Phone:** 03 3643861    **email:** Virginia.maskill@otago.ac.nz

This study has been approved by the University of Otago Human Ethics Committee [Reference: 13/181]. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

April 2013
Appendix Nine: Consent form for participants

Are we ready? A study of new graduate nurses’ experience of workplace violence and aggression and their sense of readiness.

Consent Form for Participants

Please circle Yes or No

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<th>Yes</th>
<th>No</th>
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<td>I have read and understood the information sheet concerning this study dated April 2013 and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>I know that my participation in the project is entirely voluntary (my choice) and that I am free to withdraw from the study at any time and this will in no way affect me in any way.</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>I have had the opportunity to use whanau support or a friend to help me ask questions and understand the study.</td>
<td>Yes</td>
<td>No</td>
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<td>I have had time to consider whether to take part in this study.</td>
<td>Yes</td>
<td>No</td>
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<td>I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.</td>
<td>Yes</td>
<td>No</td>
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<td>I know that, in case I decide to withdraw from this study, all data collected from me will be destroyed and will not be included in the study.</td>
<td>Yes</td>
<td>No</td>
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<td>I know that the results of the study may be published and will be available in the library but every attempt will be made to preserve my anonymity.</td>
<td>Yes</td>
<td>No</td>
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<td>I know who to contact if I have any questions about the study.</td>
<td>Yes</td>
<td>No</td>
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<td>I wish to receive a summary of the results upon completion of the study.</td>
<td>Yes</td>
<td>No</td>
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<td>If I am selected for the interview, I consent to the interview being audio-taped.</td>
<td>Yes</td>
<td>No</td>
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<td>I know that the information provided (audio-tapes and transcripts) will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for up to 5 years, after which it will be destroyed.</td>
<td>Yes</td>
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<td>I know that the interview involves an open-questioning technique where the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops.</td>
<td>Yes</td>
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I know that, in the event that a line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the study without any disadvantage of any kind.  

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<td>I know that I may request the audiotape be turned off at any stage and I may decline to answer any particular questions.</td>
<td>Yes</td>
<td>No</td>
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<td>I have been given the opportunity to discuss this consent form and any concerns I may have about the study with the researcher before consenting to participate in this study.</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>I understand that should any information come to light that exposes a serious breach of ethical, professional or legal codes of conduct and deems further action then this will be discussed with the participant and research supervisor.</td>
<td>Yes</td>
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I _______________________________________________________________ (full name) hereby consent to take part in this study.

Signature of participant:                     Date:

Email:
Mobile Phone:
Phone:

**The student researcher:** Christine Ball, Health and Social Sciences, Nelson Marlborough Institute of Technology.

**Phone:** 03 5469175    **email:** Christine.ball@nmit.ac.nz

**The research study Supervisor:** Virginia Maskill, Post graduate Health Sciences, University of Otago (Chch)

**Phone:** 03 3643861    **email:** Virginia.maskill@otago.ac.nz

This study has been approved by the University of Otago Human Ethics Committee [Reference: 13/181]. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
## Appendix Ten: Interview guide

Participant check list

<table>
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<th>Prompt</th>
<th>Answer</th>
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<td>Participant information reviewed and consented</td>
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<td>Confidentiality discussed</td>
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<tr>
<td>Agreed to recording</td>
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Prompts:

What sorts of violence / aggression have you experienced in your nursing career to date (such as physical, verbal horizontal, sexual)

Please describe the most significant incident you have experienced?

Who was involved in this incident? (such as clients, visitors, nurses, other health professionals)

How did these experiences affect you? How did you react? (immediate: first 24hrs, short term: within a month, long term: more than a month)

What happened after the incident / incidents in terms of follow up / support for you? (such as reporting, support, managerial response)

What enabled / hindered you from talking about these incidents? (to whom? At the time? Later?)

What preparation have you had as an undergraduate nurse to deal with these experiences? (such as personal safety training, theoretical understanding, communication skills, policies, reporting processes)

Do you have any suggestions on how nurses could be better prepared for dealing with violence and aggression?

Is there anything else you would like to add?
Appendix Eleven: Demographic Information

Name: 

Date: 

Please circle your age group:

a. 18-25 years  
b. 26-29 years  
c. 30-34 years  
d. 35-39 years  
e. 40-44 years  
f. 45-49 years

2. Please circle your ethnicity:

a. NZ European  
b. NZ Maori  
c. Pacifica  
d. Other:

3. Please circle your gender

a. male  
b. female

4. Year of registration:

5. Area for NETP: such as mental health, biophysical, primary health
Appendix Twelve: Transcript framework

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<th>Name of Participant:</th>
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Appendix Thirteen: List of questions to guide theme development

What: What course of events is mentioned? What is happening? What is the concern? What assumptions are being made? What is being omitted?

Who: Who is involved and what is their role? Who is interacting with who?

How: How do participants talk about and understand what has happened? How significant is it to them? How often is it mentioned?

When and where: When and where did experience (s) happen and what is the contextual relevance?

Why: what rationale is provided? What are some other possibilities / perspectives?

Which: which choices were made?

Broader questions to ask myself as the researcher: What surprises me? (to become aware of my assumptions), What intrigued me? (to understand my positionality) What disturbed me? (to identify tensions within my own attitudes, values and beliefs)

Appendix Fourteen: Evidence of Safe-Assign Plagiarism Check

Whole thesis
Christine Ball
on Fri, Sep 23 2016, 9:17 AM
6% highest match
Submission ID: 6b39749d-1e4-4876-95c5-7b5296e20f1

Attachments (1)
final draft 190916.docx 6%
Word Count: 52,546, Attachment ID: 134451100

final draft 190916.docx