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Giving Voice: Pediatric Nurses' Perception of Workplace Violence

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Abstract

The aim of this study was to examine the lived experience of pediatric nurses who work on inpatient hospital units that are exposed to workplace violence from patients and visitors. Workplace violence directed at nurses is an alarming phenomenon and has been understudied in regard to pediatric nurses who work on inpatient hospital units. Qualitative research was used to describe nurses' experience with workplace violence by directly examining their perceptions of the problem. An interpretive phenomenological approach of inquiry was used as a strategy for this qualitative study. Twenty-four nurses who work at a Magnet teaching hospital in Upstate New York were the participants. The participants volunteered for the study and semi-structured, face-to-face interviews were conducted and audio-taped. The participants' narratives were transcribed and analyzed. An inductive inquiry process was used to interpret and structure meanings from the interview data. The narratives were coded for general themes. Validity and trustworthiness was demonstrated through use of triangulation, bracketing, and participant review of the transcripts to ensure truthfulness. Eight themes were identified and are as follows: # 1 Its part of the job, # 2 They were there for me, # 3 Conflicted about pressing charges, # 4 Learn to prevent and deal with it, # 5 Workplace violence negatively impacts our job, # 6 Fear for our safety, # 7 Nurses go it alone and # 8 Feeling badly for others. The results of this study may have implications for future nursing research, nursing practice, nursing education, organizational policies and procedures, and healthcare policies. Recommendations were made for all of these areas in order to provide: Workplace Violence Prevention Programs; reporting mechanisms for workplace violence; empowerment for nurses; system changes to help extinguish oppression and patriarchal approaches to management and decision making; the establishment of a law similar to New York State's Violence Against Nurses law to help prevent and prosecute perpetrators of workplace violence; interdisciplinary responsibility for preventing and dealing with workplace violence; and patient and family education regarding their responsibility of safe behavior while in the hospital; and education of the public about the role of the nurse. The results of this study indicate that workplace violence exists and there is much to be done to prevent and manage workplace violence against nurses who work on inpatient pediatric hospital units.

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Dedication

This dissertation is dedicated to my mother, Justine Friel, R.N. who died too young and her nursing colleague, Sophie Nolan, R.N. who befriended my mother when they were in nursing school and cared for her at the end of her life.

Biographical Sketch

Bonnie Strollo, Ed.D., M.S.Ed., A.P.R.N.- B.C., N.P.P. currently works as a psychiatric mental health nurse practitioner at a teaching hospital in Upstate New York. She is the coordinator of the psychiatric consultation liaison team to the pediatric inpatient hospital units. She holds masters degrees in community mental health counseling and psychiatric mental health nursing. Bonnie is certified by the American Nurses Credentialing Center as a Family and Mental Health Psychiatric Nurse Practitioner.

Bonnie graduated from Northeastern University with a B.S. in nursing and worked at Boston Children's Hospital as a pediatric nurse for five years before moving to New York to obtain her master degrees. She has worked as a nurse for more than 32 years on both inpatient psychiatric hospital units and pediatric hospital units. Her titles in the past include: Senior Staff Nurse, Nurse Manager, Nurse Leader and Director of Psychiatric Nursing Education. She has volunteered as a camp nurse at Camp Good Days and Special Times, a camp for children with cancer. She also volunteers doing equine therapy for children with physical and mental health challenges.

Bonnie attended St. John Fisher College, Ed.D. Program in Executive Leadership where her area of research was workplace violence against pediatric nurses from patients and visitors. Her academic advisor was Michael Wischnowski, Ph.D.. She graduated with her doctorate degree in August 2011.

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First and foremost, I would like to thank the 24 nurse participants who volunteered their time to tell their stories. How we learn about ourselves and others is the heart of the research journey. It is my hope that the participants' perceptions about workplace violence inform and help to shape nursing practice, research, policy, and education.

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I would like to acknowledge the many patients and their families for helping me to learn what nursing is about and what is important in life. Finally, I would like to thank my family for their love, encouragement, sense of humor, and support during this dissertation journey. My husband and sons are my inspiration in life.

Abstract

The aim of this study was to examine the lived experience of pediatric nurses who work on inpatient hospital units that are exposed to workplace violence from patients and visitors. Workplace violence directed at nurses is an alarming phenomenon and has been understudied in regard to pediatric nurses who work on inpatient hospital units. Qualitative research was used to describe nurses' experience with workplace violence by directly examining their perceptions of the problem. An interpretive phenomenological approach of inquiry was used as a strategy for this qualitative study. Twenty-four nurses who work at a Magnet teaching hospital in Upstate New York were the participants. The participants volunteered for the study and semi-structured, face-to-face interviews were conducted and audio-taped. The participants' narratives were transcribed and analyzed.

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order to provide: Workplace Violence Prevention Programs; reporting mechanisms for workplace violence; empowerment for nurses; system changes to help extinguish oppression and patriarchal approaches to management and decision making; the establishment of a law similar to New York State's Violence Against Nurses law to help prevent and prosecute perpetrators of workplace violence; interdisciplinary responsibility for preventing and dealing with workplace violence; and patient and family education regarding their responsibility of safe behavior while in the hospital; and education of the public about the role of the nurse. The results of this study indicate that workplace violence exists and there is much to be done to prevent and manage workplace violence against nurses who work on inpatient pediatric hospital units.

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Chapter 1: Introduction

The U. S. Department of Labor, (2002) indicates that workplace violence is the third leading cause of all occupational deaths and the second leading cause of occupational deaths in women. Besides death from workplace injury, nurses also have a nonfatal assault rate of 31.1 per 10,000 as compared to the private occupational sector as a whole, which has 2.8 nonfatal assaults per 10,000 (Trinkoff et al., 2008). Given these statistics, it is not surprising that a 2001 survey of 4826 nurses conducted by the American Nurses Association revealed that 17% reported that they had been physically assaulted and 57% reported that they had been verbally threatened or abused in the previous year (Gilmore-Hall & Worthington, 2001).

Problem Statement

Pediatric nurses who work on inpatient hospital units have been understudied in regard to their perception of workplace violence. Few studies have been found in the literature that focus on workplace violence towards pediatric nurses from patients and visitors. Workplace violence (WPV) is broadly defined in the literature as including physical assaults, sexual assaults, verbal threats, and abuse from peers (i.e., horizontal violence) as well as from consumers (American Psychiatric Nurses Association, 2008). This study was an interpretive phenomenological study that explored the lived experience of pediatric nurses who were exposed to workplace violence from patients and visitors while working on inpatient hospital units. Interpretive phenomenology (hermeneutics) focuses on the meaning and interpretation of the lived experience to better understand

social, cultural, political, and historical context (Williamson, 2009). This study gained access to participants who provided rich descriptions from in-depth interviews to gather the information that was needed to describe the phenomenon of WPV. This study may help to contribute to the knowledge and practice of pediatric nurses whose voice has been lacking in the literature.

Registered nurses (RNs) constitute the largest healthcare profession in the United States with approximately 60% of the RN jobs in hospitals (American Psychiatric Nurses' Association, 2008). The RN is responsible for treating patients with various medical and psychological conditions by providing emotional support, making diagnoses, administering treatments, performing diagnostic tests, administering medication, and educating about health promotion and prevention of illness. The pervasive use of RN skills is needed in health care and, therefore, needed in today's health care industry. Maintaining nurses in the workforce by addressing the problem of WPV should be a concern of all healthcare leadership. In order to effectively manage the delivery of safe, quality patient care, nurses need to have safe working environments.

Today's nurses are concerned about safety in the workplace. Research has shown that nursing is becoming a dangerous occupation (Chapman, Perry, Styles, & Coombs 2009; Gallant-Roman, 2008). To provide optimal care, nurses must have access to safe work environments. Creating practice environments that promote the retention and recruitment of nurses is becoming a significant initiative for many hospitals (Thompson, 2008).

The nursing shortage is expected to increase; recruitment and retention of qualified staff nurses may be deterred by WPV. Maintaining safe workplaces may

influence the recruitment and retention of nurses. The demand for nurses will increase 40% and a 400,000 hour full-time equivalent RN shortfall may occur by 2020 (Gallant, 2008). With President Obama's plan to overhaul the healthcare system, the demand for nurses could surpass the 40% need by 2020 due to the increase in health insurance coverage for the previously uninsured (Rother & Lavizzo-Mourey, 2009). A reformed healthcare system must include an adequate supply of well educated nurses who can deliver care to all Americans.

The number of needed RN jobs is expected to increase by 21-23% by the year 2016 (Windle, 2008). The United States Bureau of Labor Statistics projects that more that 1.2 million new and replacement nurses will be needed by 2014 (United States Department of Health and Human Services, 2008). The average age of a nurse in the United States is approximately 46 and the majority of the nurses, 95%, are women (Windle, 2008). These statistics indicate that the majority of professional nurses are middle-age women who work in hospitals and that there is a projected need for RNs in the future. To help improve the state of nursing, healthcare leaders must examine the reasons for the projected nursing shortage and develop strategies to improve the state of the profession.

Governor David Patterson (New York) signed a bill in August 2010 that may help to improve safety of the nurses in this state. The bill, The Violence Against Nurses (A.3103- S.4018), was signed into law making it a felony to assault a registered nurse (RN) or a licensed practical nurse (LPN) while on duty. The Violence Against Nurses bill may help to deter potential attackers by making them think before they assault a nurse on duty, which is a positive step towards increased safety for everyone. Having the bill

signed into law may also encourage hospital administrators to take action to address WPV as well as encourage nurses to speak up about violence they experience. The bill may also help to maintain nurses in the workforce.

Jackson, Clare, and Mannix (2002) report that due to the concern about a declining nursing workforce and a climate where violence and hostility is part of the day-to- day lives of some nurses, it is timely to name violence as a major factor in recruitment and retention of RNs. Nurses are four times more likely to be the victims of violence than the average employee in the United States workforce (Duhart, 2001).

Workplace violence (WPV) toward staff in general healthcare and mental healthcare settings is an under-reported and frequent problem. The under-reporting of workplace violence limits full understanding of the extent of this problem. Nurses have the highest rate of attacks from WPV out of all health care workers (Peek-Asa et al., 2007). Nearly two-thirds of nonfatal assaults occur in the healthcare industry, with patient and co-workers as the perpetrators costing American business approximately $4.2 billion a year (Miller, 1999; Smith, 2002).

Pediatric nurses' perception of workplace violence in the inpatient hospital setting was the focus of this dissertation. The pediatric inpatient setting where this study occurred is located in the Upstate New York area and consists of four general patient care units, two intensive care units, a neonatal intensive care unit, and a pediatric emergency room. The setting was chosen because this author works in the setting as a nurse practitioner and has witnessed workplace violence against nurses. Another reason this setting was chosen for the study is that few qualitative studies have been done giving voice to pediatric nurses who work in inpatient hospital settings and have experienced

workplace violence. The majority of the research related to workplace violence in pediatrics has occurred in emergency rooms and psychiatric settings. The research for this study occurred with RNs who work on the four general pediatric inpatient units. Horizontal violence was not part of this study. The focus was on WPV from patients and visitors.

Recognizing that violence in the workplace is a pressing occupational concern for all RNs, a theoretical framework was needed to provide a foundation and structure to the study in an attempt to illuminate the history and possible causes. Feminist theory was used as a lens to view workplace violence against nurses.

Theoretical Rationale

Feminist theory was used as the theoretical rationale for this study. The term *"feminism"* often refers to political activism by women on behalf of women. Feminist theorists have used the term variously to refer to women's ways of knowing, women's experience, or women's knowledge. Liberal feminists address the subordination of women and how it is embedded in legal, economic, and cultural constraints that have blocked women's access to many opportunities that are available to men (Enns, 2004). Feminist theorists of color ground their theory in the assumption that one cannot understand women's lives without also understanding the role of race/ethnicity in shaping their experience (Kolmar & Bartkowski, 2005). Materialist feminist theories pay more attention to the ways that economic and social conditions contribute to gender inequality. As one can see, there are many interpretations of feminism under the rubric of "*feminist theory*". The feminist theories, in general, will be used to inform this dissertation.

Among the many feminist perspectives, women's own lived experiences are centered and respected (Im, 2010). The basic issue that has concerned feminist theory is women's inequality, subordination, or domination by men. For many feminists, their main focus is to examine and try to explain all structures of dominations, whether based on gender, race, class, age, sexuality, nation, or some other difference (Kolmanr & Bartkowski, 2005).

It is clear from reviewing the literature that there is no standard definition of feminism. For the purposes of understanding workplace violence and aggression against nurses, Chinn & Wheeler (1985) speculate that using feminist theory can help to provide a perspective on women's reality in the workplace. There are similarities between nursing and feminism: for example, reverence for life, for the environment, and for the individual's uniqueness (Chinn & Wheeler, 1985). Feminism and nursing both hold true to the following themes: (a) the personal is political, and (b) problems and symptoms both arise as methods of coping and surviving in oppressive circumstances (Enns, 2004).

Feminist theory can help nurses learn to identify their problems by associating them with the universal problems of women. Violence against women is a worldwide problem, and what is happening with the nursing profession is often a microcosm of what is happening to women throughout the world. Since most nurses are women, they have in common their sexual development and socialization processes (Muff, 1982). Learning about what and who subjects women to violence, how they are subjected, and why they allow themselves to be victims may help nurses learn ways to stop the cycle of violence. Giving voice to nurses may help them to articulate their perception of violence in the workplace and may give them insight about the phenomena.

Theoretical explanations of violence are seldom considered when investigating it in relation to nursing. The majority of the studies found in the literature review for this dissertation did not use a theoretical framework in which to view WPV. Using feminist theory, as was done with this dissertation, can provide a lens to examine violence against nurses. A feminist perspective places emphasis on vulnerable populations, social analysis and critiques, and emancipator action to promote social justice in the context of women's issues (Luck, Jackson, & Usher, 2006). Hawkesworth (2000) suggests that using feminist theory can help place women's experiences at the center of analysis and can use gender as an analytic category to develop a comprehensive analysis of women's oppression and to identify strategies for egalitarian social transformation. Since the majority of nurses are women, using feminist theory to guide an overall perspective of workplace violence may offer insight to this phenomenon as a possible example of women's oppression. Two tenets of feminism include the idea that power is based on gender differences and that men's illegitimate power over women taints all aspects of society including the medical profession that has men as occupying the majority of leadership roles (Muff, 1982). Nursing is a female dominated profession that has not been considered as dangerous as traditionally male dominated professions, such as law enforcement or the emergency medical response field.

Research studies using any type of theoretical framework as a guide to understanding workplace violence are rarely found in the literature. Gathering together the many feminist perspectives and definitions help to make up the fabric of feminist theory. By using a feminist perspective to frame the problem of workplace violence

against nurses as done in this study, nurses may begin to learn to obtain power to change themselves and their situations.

Significance of the Study

Data supports the fact that RNs have been the recipients of an alarming increase in workplace violence. In Nursing Management's 2008 Workplace Violence Survey, 1,377 of 1,400 respondents claimed that employee safety in health care is inadequate (Hader, 2008). Approximately 74% of respondents experienced some form of violence in the work setting. This survey occurred across the United States and in 17 other countries, including Afghanistan, Taiwan, and Saudi Arabia. Women made up 92.8% of the respondents; the gender distribution was consistent with the nursing population as a whole. The majority of the respondents worked in a hospital setting, followed by outpatient facilities, community health, academia, and rehabilitation. The types of violence encountered were: 51% to 75% bullying, intimidation, and harassment. Close to 26% of respondents reported physical violence. Weapons were involved in 5.6% to 7.5% of the incidents. Perpetrators of violence against respondents included patients (53.2%), colleagues (51.9%), physicians (49%), visitors (47%), and other health care workers (37.7%). The results of this study demonstrate that violence from consumers, colleagues, and workplace visitors is a significant occupational health hazard for nurses in all countries that were surveyed. Even through the countries in this study differ significantly in regards to the role of women; the statistics are staggering for the types and incidents of violence.

Barriers to effectively address the problem of WPV persist and include inconsistent regulatory protections, underreporting the incidents, varying types of

prevention programs lacking in evidence based research, and the belief that violence is "*part of the job*" (American Psychiatric Nurses' Association, 2008). There is also a lack of standardized operational definitions, benchmarking, and monitoring of violence and aggression in the workplace. A number of reasons are cited in the literature for the underreporting of WPV that include: peer pressure not to report; ambiguity in defining violence; excusing the behavior of *"ill"* patients, perception that violence comes with the job; organizational culture; stigma of victimization; fear of job loss; fear of being blamed for provoking the assault; victim's self-blame; time consuming, ineffective , or gender-biased reporting mechanisms; no benefit of reporting; and unhelpful experience with prior reporting (ANA, 2008).

Recently, the National Institute for Occupational Safety and Health and the United States Department of Labor's Occupational and Health Administration have increased their efforts to study workplace violence and provide resources for employers. In January 2009, the Joint Commission of the Accreditation of Healthcare Organizations (Joint Commission) began to require accredited health care organizations to have a formal process for managing the behavior of staff that is seen as unacceptable. A code of conduct and policies that support zero tolerance for violence and bullying are results of the Joint Commission's requirement that are being developed in health care settings. However, policies such as *"zero tolerance"* often remain unclear to workers, for specific procedures detailing how to enact the policies are lacking. Also lacking are policies to address violence from patients and visitors.

Without education and support from healthcare leaders, a mandatory training requirement for all interdisciplinary staff and identification of staff perceptions about

WPV, efforts to address the violence will not be effective. It is not only the responsibility of the government and state agencies to reduce the incidence of violence in the workplace but also of healthcare institutions. Healthcare institutions should require interdisciplinary education and training of their staff and development of specific policies and procedures for safety in order to prevent workplace violence.

Purpose of the Study

The purpose of this interpretive phenomenological study was to describe the lived experience of pediatric nurses who were exposed to workplace violence from patients and visitors on inpatient hospital units. An interpretive phenomenological study focuses on the meaning and interpretation of the lived experience to better understand social, cultural, political, and historical context (Williamson, 2009). An interpretive phenomenological study was important because the aim of this research was to impart meaning of the human experience of the pediatric nurses and understand how the nurses thought and felt about their circumstances with WPV. This researcher used a holistic approach in an attempt to uncover truths and understand the nurses' reality with WPV through face-to-face interviews with the pediatric nurses. Few studies in the literature have used an interpretive phenomenological study to describe the lived experience of pediatric nurses with workplace violence.

A feminist perspective was used to place the pediatric nurses' lived experience with workplace violence as the main focus of the narrative interview. This researcher considered the nurses' diverse situations within the context of the hospital and factors that influence those situations (Im, 2010). Individual interviews occurred with the nurses to gather the essence of their experience with workplace violence.

Research Question

The research question for this study is as follows: What is the lived experience of pediatric nurses who work on inpatient hospital units and are exposed to workplace violence from patients and visitors?

Definition of Terms

Aggression- behavior with intent that is directed at doing harm to a living being, whether harm results or not, or with willful blindness as to whether harm would result (Rippon, 2000).

Clinical Nurse Specialist- a registered nurse with a master's degree who provides expert clinical services that are focused on the assurance of excellence in practice; the adherence to hospital and nursing policies, procedures, and practice standards; and the development of staff and team relationships with a program or unit.

Feminism- ascribes to concepts that are concerned with equality and justice for all women that seek to eliminate systems of inequality and injustice in all aspect of women's lives (McCann & Seung-Kyung, 2003).

Feminist theory- "a body of writing that attempts to describe, explain, and analyze the conditions of women's lives" (Kolmar & Bartkowski, 2005, p.3).

Horizontal violence- occurs when staff, themselves, are the instigators of aggression and violence against other staff through bullying and harassment (APNA, 2008).

Interpretive Phenomenology (hermeneutics) - focuses on the meaning and interpretation of the lived experience to better understand social, cultural, political, and historical context (Williamson, 2009).

Interpretive process- procedure that is necessarily circular, moving back and forth between part and whole and between the initial forestructure and what is being revealed in the data inquiry (Benner, 1994).

Lived experience- engaging in world with concerns, habits, skills, know-how, meaning, situated actions, caring, and shared understanding of what it means to be human (Benner, 1994).

Nurse Leader- a registered nurse who is accountable for supporting the standards of care and providing consultation and expertise in the delivery of patient care. The nurse leader participates in the management of human resources, the development and evaluation of recruitment and retention strategies, and the monitoring of patient outcomes.

Nurse Manager- a registered nurse who oversees and directs unit activities, including standards development, unit-based research and performance improvement, new program development and implementation, and communication within nursing practice and across disciplines and departments.

Nurse Practitioner- a registered nurse with a master's degree who works in a collaborative relationship with a physician provider to oversee the care delivered to a patient population. The nurse practitioner is responsible for direct patient care; documentation of care delivered: and, adherence to hospital and nursing policies, procedures, and practice standards.

Pediatric Nurse- a registered nurse, under the direction of the Nurse Manager, who is accountable for provision of competent patient care for children and adolescents based on established standards.

Phenomenological research- a qualitative strategy in which the researcher identifies the essence of human experiences about a phenomenon as described by the participants in the study (Creswell, 2009).

Workplace violence (WPV)- incidents where staff are abused, threatened, or assaulted in circumstances related to their work, including commuting to and from work and, involving an explicit or implicit challenge to their safety, well being, or health (World Health Organization, (n.d.).

Chapter Summary

Workplace violence is on the rise and nurses are being impacted by this phenomenon at a higher rate than the private occupational sector. Pediatric nurses who work on inpatient hospital units have been understudied in regards to their perception of WPV. This interpretive phenomenological study explored the lived experience of pediatric nurses who were exposed to WPV from patients and visitors while using a feminist lens. Registered nurses are the largest segment of the healthcare workforce and patients primary professional caregivers. The need for nurses in the workforce is expected to increase by 40% by 2020 (Gallant, 2002). Giving voice to pediatric nurses may help to bring awareness to this problem, thus, encouraging research to develop ways to recruit and maintain nurses in the healthcare system.

Summary of Remaining Chapters

Chapter 2: Review of the Literature. This chapter provides a summary of the relevant literature regarding workplace violence against nurses.

Chapter 3: Research Design Methodology. This chapter describes the research questions, participants, and data collection and analysis procedures used in this study.

Chapter 4: Results. This chapter provides the results of the study.

Chapter 5: This chapter provides a discussion and interpretation of the results of the study found in Chapter 4.

Chapter 2: Review of the Literature

Evidence obtained in an extensive review of the literature is presented to describe the state of the science regarding workplace violence (WPV) against nurses. The focus of this review was on violence towards nurses from patients and visitors to health care settings. However, several of the studies mentioned survey results that include violence experienced by nurses from physicians, peers, and supervisors as well as from visitors and family members. A synopsis of the research studies related to workplace violence against nurses was offered and included interpretation of the studies' findings along with a summary of the review. The studies were evidence-based, informative, and contributive to an understanding of workplace violence against nurses. The majority of the studies did not mention using a theoretical framework in which to view WPV. Each study was organized according to one of the following categories: incidence, prevention, or studies that use feminist theory as a way of framing problems that confront women. Several studies using a phenomenological approach to qualitative research were also reviewed because this type of approach was used to guide this dissertation.

Research Studies Investigating Types and Incidence of Workplace Violence

Gillespie (2008) conducted a qualitative study to identify the process that occurs with (WPV) by patients and visitors in an urban pediatric emergency department (PED) by reviewing the negative effects it has on PED workers. The conceptual model for this

study was the workplace violence model by Gillespie. The research questions were related to describing the context of WPV, person, workplace, and community/ environmental factors for WPV; consequences for workers, perpetrators of violence, patients, and the healthcare employer following WPV; and potential interventions to reduce the incidence and negative consequences of WPV. Interviews with 31 PED workers were audio-taped and transcribed verbatim. A modified form of constant comparative analysis was used to analyze the data (Gillespi). The constant comparative method is a component of Grounded Theory. Triangulation of interview data was performed using non-participant observations and a review of medical center policies and continuing education offerings. The study results indicate that physical violence was primarily perpetrated by psychiatric patients, whereas, verbal violence was primarily perpetrated by patients' family members. Consequences reported by participants included worker stress and injury, patients being restrained, parental eviction from the emergency department, delays in patient care, and perceived negative image of the medical center by parents and visitors. Interventions suggested were de-escalation training, early recognition and intervention for WPV, and creation of a specialized psychiatric PED.

Study findings (Gillespie, 2008) indicate that all patients and visitors should be treated as though they have the potential to be violent. Results of the study suggest that employers need to: recognize the effects that violence has on workers' ability to provide patient care and provide debriefings for staff following violent events. The study results indicate that employees need to participate in education to learn how violence affects patient care, the importance of calling for help when violence occurs, and strategies to prevent violence.

This study (Gillespie, 2008) has significance for nurses as it reports on a relationship between workplace violence (WPV) and patient care. Few studies in the literature investigate this relationship. Understanding the relationship between WPV and its impact on patient care is important because research findings could motivate hospital administrators to implement violence prevention programs. While there is evidence in the literature regarding the cost of workers' compensation (from WPV injuries) to institutions, evidence has not yet motivated institutions to respond to the need for prevention of WPV programs (Gillespie).

One study that could be used to help hospital administrators understand the impact and incidence of workplace violence and its impact on nurses was done by the Massachusetts Nurses' Association (MNA). The MNA (2004) conducted a survey on workplace violence to gauge the degree to which violence is a problem in the workplace for their members. The survey was conducted to capture data on the experiences of MNA members in relation to violence and to learn of the nurses' suggestions to change working conditions and environments to help reduce violence. This study is important to review because it examines how nurses were given an opportunity to provide their own thoughts about the phenomena of WPV. These nurses reported on real events that impact the way they provide patient care. The MNA also took the time to report the phenomena in the literature to help make the problem of WPV public. The survey asked about several areas of concern: (a) incidence of workplace violence/abuse: Frequency and types of assaults; (b) reporting and follow-up: How nurses report violence and employers follow-up with solutions; and (c) solutions: Nurses' suggestions for workplace violence prevention and support for injured workers. The survey assessed the demographics of the respondents, as

well as issues related to employer policies. The survey was limited to events and issues of workplace violence and abuse within the two year period of the survey. The survey was distributed by local union representatives to MNA members in three acute-care hospitals. A total of 172 surveys were completed and returned to the University of Massachusetts-Amherst Labor Center for statistical analysis (Massachusetts Nurse's Association, 2004).

The method of statistical analysis of the findings was not reported in the article. However, percentages for the respondents' reports were included. It would have been helpful if the statistical information were included for validity and reliability.

Respondents were representing community hospitals, inner-city teaching hospitals, and other hospitals with MNA affiliation. The majority of the respondents were females, only 7% were male. The majority of the respondents, 37%, were 51 to 60 years of age. Twenty-nine specialty areas of nursing practice were represented by the respondents.

Survey results for the incidence and understanding of workplace violence found that the majority of the respondents, 68%, indicated WPV to be a serious or very serious problem and that 39% of respondents reported all incidents to management and 18% of the respondents did not report incidents.

Seventy percent of the respondents who reported an incidence of violence to management reported that the management was supportive. The majority of the group that said management was supportive also noted that nothing was done to solve the problem. This phenomenon is commonly reported in the literature. The non-response of management to complaints of WPV by nurses may be one of the factors that lead nurses to under-report the incidences and perhaps leave an organization (MNA, 2004).

Improving staff ratios was the number one solution identified by respondents for reducing violent events. Other solutions to reducing violent events included (a) indentifying legal rights training about violence, (b) indentify adequate time to assess and intervene with patients and families to prevent a crisis, and (c) indentifying policy and procedures to address violence. Lastly, just 50% of those surveyed reported that they have had training related to WPV prevention that was provided by their employers.

Clearly, the results of this study point out that workplace violence (WPV) is a serious problem for nurses and the health care industry in general. Nurses are experiencing high rates of verbal abuse and threats as well as high incidences of physical harm. This study also informs us that the numbers of nurses reported incidences of harm are low and that administrative response to the reports in lacking (MNA, 2004). Finally, the report demonstrates how nurses do have ideas about how to prevent the problem of WPV and that the interventions for prevention need administrative support in order to be implemented (MNA, 2004).

Estryn-Behar, et al., (2008) conducted a study to identify the prevalence of violence in nursing in order to provide a basis for appropriate interventions. The study aimed (a) to investigate the prevalence of violence from patients/relatives in different clinical areas, (b) to test the influence of teamwork characteristics upon violence, (c) to examine the relationship between violence and burnout and intent to leave nursing and intent to change employer, and (d) to examine changes in levels of violence over time. The authors hypothesized that relatively high levels of violence would be present in psychiatric settings, geriatric settings, and emergency units (Hypothesis 1). Hypothesis 2 was that a lack of high-quality teamwork would be associated with a higher level of

violence. Hypothesis 3 was that exposure to violence would subsequently be associated with higher levels of burnout, intent to leave the nursing profession, and intent to change employer. The study's findings indicate that prevalence of WPV in health care is increasing and that it strongly influences the recruitment and retention of nurses as well as sick leave and burnout levels. These authors' findings, although reflective of European countries, are similar to the WPV research studies conducted in the United States.

Nurses from 10 European countries answered a questionnaire and responded to follow-up assessment. In total, 13,820 (41%) nurses participated in both measurements. Teamwork characteristics, frequency of violence, and several outcome indicators were compared across factors, such as country, nursing grade, clinical area where the nurse was employed, age and gender of the nurse, and time pressure (amount of time to complete tasks). For the prediction of violence rates at baseline, multivariate analyses, adjusted for gender and age, were performed. The results indicate that 22% of nurses reported suffering from frequent violent episodes from patients and relatives. Episodes of violence were significantly ($P < 0.001$) more prevalent in psychiatric settings, geriatric settings, and emergency departments. Nursing aides comprised 30% of the sample in areas of high prevalence of violence, that is, geriatrics, long-term care, and nursing homes. After controlling for only age and gender, quality of teamwork was strongly related to violence. Psychiatric, geriatric, and emergency units appeared to have a higher risk for frequent violent episodes. Working part-time was associated with less-violent incidences, while working the night shift and shift work was significantly associated with more violent incidents. Low quality of teamwork appeared to be a major factor related to violence. Uncertainty regarding patients' treatments was also linked with violence.

Dissatisfaction with shift handovers and frequent interruptions were associated with violence. Time pressure and the amount of physical skills needed to be performed were associated with violence. Those who reported a higher amount of harassment from superiors also reported more violent events. After controlling for only age and gender, violence appears to be strongly related to intention to leave nursing, intention to change institutions, and burnout. In multivariate analysis, violence from patients/relatives was a moderate risk factor for intention to leave nursing. Each of the teamwork variables was also significantly linked with intention to leave nursing except for satisfaction with shift handover. Being a specialist nurse, male, and younger than 45 years were factors associated with intention to leave the organization (Estryn-Behar et al.). For intention to change employer, the outcomes were similar to the ones for intention to leave the profession (Estryn-Behar et al.). Violence from patients/ relatives was significantly related to intention to change employer (Estryn-Behar, et al.). Being a head nurse, being female, and being older were found to be significantly associated with less intention to change institution (Estryn-Behar et al.).

The results of the follow-up assessment show that 1814 (60%) of the nurses who reported that they were *"seldom"* confronted with aggressive patients were of the same opinion one year later, while 967 (32%) shifted up to the *"sometime,"* and 242 (8%) to the *"often"* categories, respectively (Estryn-Behar et al.). Further, 3330 (60%) of the nurses who reported *"sometimes"* at baseline assessment gave the same answer in the follow-up measurement, while 1055 (19%) shifted up to the *"often"* category (Estryn-Behar et al.). Lastly, 2892 (63%) of the nurses who reported *"often"* at baseline gave the same answer one year later, while only 275 (6%) shifted down to the *"seldom"* category

(Estryn-Behar et al.). In total, 386 (51%) of the nurses who reported low quality of teamwork at baseline were often confronted with aggressive patients one year later (Estryn-Behar et al.).

In summary, of the 13, 537 nurses (Norway and the UK did not participate in the follow-up phase of the study), 22 % reported exposure to frequent violent events from patients and relatives. The highest prevalence of violence was reported in psychiatric, geriatric, and emergency units, which supports the authors' hypothesis that there are relatively high levels of violence present in these hospital settings. In addition, the nurses who reported exposure to violence had higher levels of burnout and reported more intentions to either leave nursing or change employer, which also supports the hypothesis that exposure to violence and burnout and intentions to leave nursing or change employer are associated. To prevent the high rate of WPV and burnout, nurses could benefit from support from their colleagues and knowledge of how to prevent and or handle aggressive situations (Estryn-Behar et al.).

Another study that examined the incidence of WPV experienced by nurses was conducted by Sofield and Salmond (2003). The purpose of this study was to describe nurses' experience of verbal abuse in a large multihospital system and determine the relationship of verbal abuse with intent to leave the organization. The design of the study was a descriptive correlation design using mailed questionnaires. A randomized sample of 1000 nurses received questionnaires with a 46% response rate. The final useable sample was 461 surveys.

Of the respondents, 91% had experienced verbal abuse in the past month. The physician was the most frequent source of verbal abuse, followed by patients, patient

families, peers, supervisors, and subordinates. More than 50% of the respondents did not feel competent in responding to verbal abuse. The amount of abuse and intent to leave were significantly related ($r = .211$, $P < .01$).

The results of this study once again support the need for organizations to adopt zero-tolerance policies for verbal abuse which is an example of workplace violence. Education and coaching are needed to help nurses to improve their skills when responding to patient-to-nurse and professional-to-professional verbal abuse (Sofield & Salmond, 2003).

Research Studies Focusing on Prevention of Workplace Violence

Shat and Kelloway (2003) investigated the buffering effects of two types of organizational support, instrumental and informational, on the relationship between workplace violence/aggression and both personal and organizational outcomes. Instrumental support is defined by the authors as "involving instrumental behaviors that directly help the person in need" (p. 113). An example of directly helping a person in need might include providing a nurse with assistance in performing a task, such as giving a medication to a patient who is anxious. An example of informational support might include providing a person with information that the person can use to help with coping with problems. Much of the empirical research on the outcomes of workplace violence has used a traditional work stress framework that distinguishes stressors (objective environmental events), stress (subjective, experiences of these events), and strain (outcomes of stress) (Pratt & Barling, 1988). The authors of this study extend this framework by hypothesizing that social support acts as a moderator affecting the links between the stressor (i.e., violence and aggression) and both stress and strain outcomes.

The data for Shat and Kelloway's (2003) study were collected from a sample of employees working in health care settings in the Province of Ontario, Canada. Survey packets were sent to prospective respondents using internal mail. In total, 863 survey packets were sent with 229 being returned for a response rate of 26.5%. Four cases with missing data were deleted leaving a final sample of $N = 225$. Eighty-seven percent of the sample was women and 13% was men. Various occupations were represented in the sample, with the largest groups being nurses and health care aides (44.5%). Three different dimensions of workplace violence (physical violence, psychological aggression, and vicarious violence), two types of organizational support (instrumental and informational), and five work-related outcome variables (fear of future workplace violence, emotional wellbeing, somatic health, job-related affect, and job neglect) were studied. A series of moderated multiple regression analyses demonstrated that organizational support moderated the effects of physical violence, vicariously experienced violence, and psychological aggression on emotional well-being, somatic health, and job related affect, but not on fear of future workplace violence and job neglect. Instrumental support was found to significantly moderate the effects of WPV on emotional well being, somatic health, and job-related affect but not on fear or job neglect. Informational support significantly moderated the effects of WPV on emotional being but not the other four criteria. The results of this study provide some supportive evidence for the hypotheses that instrumental and informational support from within the organization would moderate the effects of the three dimensions of WPV on health and work-related outcomes (Shat & Kelloway).

This study's findings are significant because few previous research studies have examined whether the effects of direct physical violence or psychological aggression can be moderated by organizational support (Shat & Kelloway, 2003). The major practical implication of the research indicates that negative health -related consequences of workplace violence could be mitigated by interventions that enhance the availability of instrumental or informational support for employees experiencing workplace violence (Shat & Kelloway).

A second study that investigated prevention of workplace violence by comparing workplace violence programs in high-risk emergency departments was conducted by Peek-Asa et al., (2007). A representative sample of 116 hospitals in California and 50 hospitals in New Jersey were included in the study. The methods included: a collection of information via interviews with nurse managers, security directors, and risk management officers of each hospital; a facility walk-through; and review of written policies, procedures, and training material. Programs were scored on the components of training, policies and procedures, security, and environmental approaches. Data analysis was performed by comparing the individual workplace security program components of California and New Jersey using Pearson chi-square tests. Scores were compared based on hospital characteristics including size, type, ownership, and emergency department volume. There was a statistically significant increase ($P< 0.001$) in the score for security components that included workplace violence training and hospital safety policies and procedures. Results found that California hospital emergency departments were significantly more likely than New Jersey emergency departments to provide workplace violence training to employees ($P = 0.001$) (Peek-Asa et al., 2007).Over 91% of

California hospital emergency departments provided workplace violence training to emergency room employees and in New Jersey, 72.0% of the hospitals provided workplace violence training (Peek-Asa et al.). California had significantly higher scores for training and policies and procedures, but there was no difference for security and environmental approaches. It is important to point out that California has the CA Hospital Security Act and New Jersey does not. The legislative training act requires all employees who regularly work in an emergency department to participate in workplace violence training. The results of the study indicated that program component scores were not highly correlated. For example, hospitals with a strong training program were not more likely to have strong policies and procedures. Most hospitals in California and New Jersey had implemented a WPV prevention program, but important gaps were found. Gaps included exclusion of some employees in the prevention training programs, insufficient time to cover all the necessary training material, lack of inclusion of specific hospital policies and procedures, and potential risk factors in the training programs.

The study's findings are significant for they indicate that no workplace violence training program included all the topics specifically required in the act or guidelines, and that there were no significant differences between California and New Jersey in the presence of specific topics among hospitals that had training programs. Out of a total of 14 components of a WPV prevention training program, California had implemented an average of 9.4 and New Jersey had implemented an average of 7.7 ($P = 0.02$). Nearly half of the training programs lasted one hour or less, which is insufficient to cover all the necessary material. It was common for hospitals to use existing packaged training programs that do not include information about the hospital's specific policies,

procedures, and potential risk factors. Hospitals also failed to include many employees in the required training. Most often, physicians were excluded from the training despite the high frequency of verbal threats and physical assaults that they report (Kowalenko, Walters, & Khare, 2005). There was no mention of using a theoretical framework for the study.

This study has practical implications for it helps to illustrate how most hospital disciplines are not required to participate in WPV prevention training programs. Another point highlighted by the study is the need to have the specific hospital's policies and procedures included in workplace violence prevention training programs. The Occupational Safety & Health Administration (2004) reports that a written program for job safety and security be incorporated into organizations' overall safety and health program and those organizations develop a clear policy of zero tolerance for workplace violence.

Chapman, Perry, Styles, Shane, and Combs (2009) conducted a study of nurses' experience of workplace violence and identified those factors and behaviors that nurses reported as indicating that an episode of workplace violence was likely to occur. A case study approach was used involving quantitative survey and qualitative interview data. No theoretical framework was offered for this study. One hundred and thirteen surveys were completed and 20 interviews were conducted. The respondents in this study were mainly female, in their early 40s, had been registered in the profession between 6 months and 40 years (mean 17.8 years), and mainly worked part-time in several areas of a non-teaching hospital. Of the 113 survey respondents, 35 (31%) nurses consented to be interviewed. Semi-structured interviews were conducted. Saturation was reached after 20 interviews,

which may be due to the wide variation in the range of experience of the participants, that is, 6months to 40 years of professional practice. Nurses identified nine behaviors and factors that assist them to predict workplace violence. The first five factors and behaviors that were identified were staring, tone of voice, anxiety, mumbling and pacing (STAMP) (Chapman et al., 2009). The last four factors and behaviors were emotions, disease process, assertive/ nonassertive behavior, and resources (EDAR) (Chapman et al.). Therefore, the acronym STAMPEDAR was used to classify the nine components.

The authors of the study acknowledged that the return rate of the surveys was low and that may have compromised the reliability of the data. The reliability of the study is limited because the study provided only a small sample of nurses' perceptions of WPV at one nonteaching hospital. Thus, the generalizability of findings to other hospitals is limited. However, the findings of this study may help nurses learn to be alert to behaviors and factors that may predict that an episode of workplace violence is likely to occur. In order to effectively manage and control incidents of workplace violence (WPV), nurses need to recognize the behaviors of themselves, as well as any organizational factors that precede a violent event. If nurses are to learn prevention regarding WPV, a well developed educational plan must be developed that includes the policies and procedures of the institution as also noted in the article by Peek-Asa et al., (2007). To be effective, the institution must also be supportive of the educational plan.

Studies Using Feminist Theory to Frame Problems Women Confront

Laschinger and Finegan (2005) used Rosabeth Kanter's (1993) theoretical framework of organizational empowerment, to survey a sample of 273 medical-surgical and critical care nurses about the effects of employee empowerment on perceptions of

organizational justice, respect, and trust in management. Ultimately, the study evaluated job satisfaction and organizational commitment. Kanter's model of organizational empowerment offers a framework for creating meaningful work environments for professional nurses (Laschinger and Finegan). Kanter argues that situational aspects of the workplace influence employee attitudes and behaviors to a greater extent than personal predispositions. Kanter describes various "power tools" that enable employees to accomplish their work in meaningful ways: access to information, support, resources, and the opportunity to learn and grow. According to the model, employees with access to these power tools are more motivated at work than those without access. Employees also experience greater job satisfaction and commitment to the organization. Managers can play an important role in providing access to these empowering conditions in the work setting.

Kanter's (1993) model of organizational empowerment closely resembles feminist theory for both attempts to create meaningful work environments. Put simply, feminist theory is a body of writing that attempts to describe, explain, and analyze the conditions of women's lives (Kolmar & Batkowski, 2005). Both theories also attempt to help people understand their lives. The structural empowerment model, however, focuses on people's lives, specifically in their place of employment. Laschinger and Finegan (2005) speculate that work settings that are structurally empowering are more likely to have management practices that increase employees' feelings of organizational justice, respect, and trust in management.

Laschinger and Finegan (2005) expected that structural empowerment would directly predict both trust in management and perceptions of interactional justice; that is,

managers who empower their employees are likely to be seen as trustworthy and are also likely to treat employees justly. This fair treatment should lead employees to believe that management respects them, which in turn, would further enhance feelings of trust in management. The authors expected that trust in management would predict job satisfaction, reasoning that if employees trusted their manager, they would be able to complete their work without fear that management might undermine their actions. Job satisfaction, in turn, would predict organizational commitment. Many expected outcomes, it seems, are contingent upon previous successful relationships.

A non-experimental predictive design was used to test Kanter's (1993) model in a random sample of 490 staff nurses working in urban teaching hospitals across Ontario, Canada. A questionnaire package was mailed to the nurses' homes. Two hundred and eighty-nine questionnaires were returned. The final return rate was 59%. Of these, 273 cases were used for analysis in the study. Most nurses worked either full time (59.7%) or part time (40.3%). The majority (63%) were diploma prepared, and 37% held baccalaureate degrees. Nurses averaged 33 years of age, with 9 years of nursing experience, and 2 years of experience on their current unit. All items were rated on a Likert Scale, and scores were created by summing and averaging items pertaining to each scale.

Descriptive statistics results indicated that nurses in the study felt their work environments were only somewhat empowering. The most empowering aspects of their work environments were access to opportunities for challenging work and positive informal alliances; the least empowering structure was formal power; that is, flexibility in how their work is completed. The nurses also reported only moderate amounts of

interactional justice. The authors define interactional justice as referring to perceptions of the quality of interactions among individuals involved in or affected by decisions. Interpersonal justice was greater than informational justice. According to Laschinger and Finegan (2005), interpersonal justice refers to the extent to which individuals are treated with respect and dignity. Informational justice is the extent to which individuals are provided with information or rationale for how decisions that affect them are made (Laschinger & Finegan). Nurses did not report high levels of trust in management. Nurses rated management the lowest on honesty and demonstration of concern for employees. Lastly, nurses in this study reported only moderate degrees of job satisfaction and organizational commitment, averaging just above the midpoint of the scale.

The results of the test of the original theoretical model suggested a poor fit of the data to the hypothesized model. However, an inspection of the parameter estimates and t-values supported in the basic relationships in the original hypothesized model (Laschinger & Finegan, 2005). All paths were significant and in the hypothesized direction. Modification indices suggested that the model's fit would improve significantly if direct paths were added (a) from structural empowerment to respect, job satisfaction, and commitments, and (b) from justice to trust (Laschinger and Finegan).

The respecified model showed an improved fit over the hypothesized model. The structural empowerment had a direct, positive effect on interactional justice, which in turn, had a direct effect on perceived respect and organizational trust. Empowerment had both a direct effect and an indirect effect on trust in management. Respect had a direct effect on organizational trust, which in turn, had a direct effect on job satisfaction; job satisfaction had a strong direct effect on organizational commitment. Structural

empowerment had significant direct effects on all subsequent variables in the model: respect, trust, job satisfaction, and organizational commitment, suggesting that it affects organizational outcomes both directly and indirectly.

The results of this study are important for future research related to workplace violence (WPV) and nurses. This study demonstrates how staff nurse empowerment has an impact on their perceptions of fair management practices, feelings of being respected in their work settings, and their trust in management, which ultimately influence their job satisfaction and organizational commitment.

Power, is a nursing issue (Muff, 1982). Muff believes that power is gained through doing extraordinary tasks, being visible, having relevance to organizational goals, and forming alliances. Giving voice to pediatric nurses about their perceptions of WPV may help to empower nurses to bring about safer work environments.

Nurse educators have increasingly advocated the use of feminist pedagogies to empower nursing students and their patients. An example of using feminist pedagogy is when nurses use their power of diversity to ensure that not only their thoughts and feelings are heard but also that they encourage their patients to use their voices so they learn to represent themselves in the healthcare arena (Gray, 1995). Empirical evidence is lacking in the literature regarding the effectiveness of the empowering potential of feminist pedagogy. Falk-Rafael, Chinn, Anderson, Laschinger, and Rubotzky (2004) conducted a study to determine whether a pedagogy grounded in feminist ideals has the potential to empower students to make changes consistent with those ideals in their personal and professional lives. For the study, empowerment was conceptualized as

individuals' becoming aware of the conditions that constrain their freedom and taking action to change those conditions (Falk-Rafael et al.).

The pedagogical approach used by the investigators was informed by Chinn's (2001) Peace and Power Process, which integrates the tenets of both feminist pedagogy and empowerment. The principles central to this study were:

1) The power of responsibility, which translated into the teacher's responsibility to demystify the processes involved in evaluation and grading.
2) The power of diversity to ensure all students' voices was heard.
3) The power of sharing to create a community of learners in which teachers and students share their talents, skills, and abilities to enhance the learning of all.

The study was conducted in two phases. Phase 1 used a reflective, descriptive design to elicit students' reflections on a course in which a specific feminist-based pedagogy was used. Findings were used to select an appropriate tool to measure empowerment in the pretest and post-test design of Phase 2. Phase 2 examined student empowerment using Barrett and Caroselli's (1998) Power as Knowing Participation in Change Tool (PKPCT).

Phase1: E-mail questionnaires were sent at the end of the term to students in three 4th-year baccalaureate nursing leadership courses, which were taught by two of the investigators using the feminist pedagogical approach. Open-ended questions were used to elicit information about students' ability to contribute in class, barriers to participation, and the degree to which their awareness of the social and political factors that influence nurses' power had increased. Students were then asked whether they believed they had gained the skills and knowledge needed to change their personal and work lives, and if so, to provide examples. Response rates to the e-mail questionnaire were low (30% in

small classes at each site and only 1% in a large class at one site). Responses did confirm the investigators' earlier experiential knowledge of student responses to feminist pedagogy (Falk-Rafael et al., 2004). Phases 2: Two hypotheses were formulated: (a) Empowerment would increase during the course of the class in which feminist pedagogical principles were used, and (b) there would be a significant relationship between empowerment in the classroom and overall empowerment.

A total of 218 students participated in seven course offerings, four classroom (*n* =198) and three clinical (*n*= 20) in three baccalaureate nursing programs in Canada and the United States. Response rates varied across sites (Site 1: 33.5%, Site 2: 80%, Site 3: 100%, and total 46%). Ninety-five percent of respondents were women, and 40% were post-RN students. The average age of respondents was 24.2 years.

The first hypothesis was tested using two-way, analysis of variance (ANOVA) with a repeated factor to analyze student's pretest and post-test scores on the Power of Knowing Participation in Change Test (PKPCT) and classroom empowerment (CE) for Sites 1 and 2. Significant increases in mean scores on both measures occurred over time (Falk-Rafael et al., 2004). Interactions between time and site were significant on the PKPCT, but site alone was not a significant factor. Because the clinical setting of Site 3 was very different from that of the two leadership classes, results from that site were not included in this analysis. Paired *t* tests were used to analyze the results from Site 3 and reported that a mean PKPCT and CE scores were significantly higher there as well. Using only Sites 1 and 2, a regression model tested the second hypothesis.

In Model 1, forward multiple regression was conducted to examine the influence of the pretest PKPCT and pretest CE scores on the post-test PKPCT score. Regression

results indicated an overall model that significantly predicts overall empowerment accounting for 50.9% of variance in overall empowerment. Regression results indicated a stronger model that significantly predicts overall empowerment and accounts for a higher percentage of variance in overall empowerment. The second hypothesis was supported.

Student's empowerment scores, as measured by the PKPCT and the CE, increased significantly during courses taught from a feminist pedagogical perspective. This study is significant for it provides evidence that a feminist pedagogical perspective can be developed through education, which can help to empower nurses. Through empowerment, nurses have the potential to fully engage the problem of workplace violence. Empowerment is essential for nurses to be successful, and to be empowered, nurses must have hope and optimism in the workplace. Research on nurses' resilience, indicates that hope and optimism is vital to help the profession continue to survive and be successful in the health care industry.

A recent international ethnographic research project on nurses' and midwives' resilience, hope, and optimism in their workplace was conducted by Glass (2007) using a feminist postmodern theoretical model. According to Glass, the model acknowledges the unique sociopolitical experience for each of the nurses in the study. The model validates the participant's individual differences and diversity. The project helped nurses to deconstruct, reconstruct, and reframe their stories of experiences through use of storytelling and narrative.

Nurses need to tell their stories since they are experiencing ineffective interdisciplinary communication such as bullying and violence in the workplace related to unrealistic pressures and competitiveness (Hutchinson, Vickers, Jackson, & Wilkes,

2008). In this study, some of the respondents reported experiences of horizontal violence in their responses. While the study was not specifically investigating horizontal violence, participants appeared to link both types of experiences (violence from patients and visitors and peers) together. The study was conducted in 9 sites within 4 countries and investigated the professional development experience of 53 nurse academics in their main work setting. The findings revealed that professional development was deeply located within multifaceted contexts that were competitive, male-dominated, non-supportive, and primarily destructive. Workplace violence and vulnerability were exposed as major areas of concern. These experiences culminated in the need for active healing interventions and strategies (Hutchinson, Vickers, Jackson, and Wilkes).

From a feminist perspective, the study recognizes the role that past and present oppressions have on current work experiences which is essential in understanding workplace violence against nurses (Glass, 2007). There are many feminist perspectives and definitions that when gathered together, make up the fabric of feminist theory. Feminist researchers often go beyond the category of gender to speak to issues of class, ethnicity, locality, and constructed identities that may help to address the problem of workplace violence against nurses.

Studies Using a Phenomenological Method of Research

An example of research using the descriptive phenomenological approach method to research is Beck's (1992) study of the lived experience of women with postpartum depression. The descriptive (eidetic) phenomenological approach is described by Husserl (1970). Husserl believed that subjective information should be important to scientists seeking to understand human motivation because human actions are influenced by what

people perceive to be real. Husserl also believed that a scientific approach was needed to bring out the essential components of the lived experiences specific to a group of people. Also important in Husserlian phenomenology is the belief that it is essential for the researcher to shed all prior personal knowledge to grasp the essential lived experiences of those being studied (Husserl).

The research question of Beck's study is: What is the essential structure of postpartum depression? (Beck, 1970). The research question is consistent with the descriptive approach in assuming that there is an essential form to postpartum depression that can be derived from the data and that this structure is independent of context. No guiding framework is specified which is also a characteristic of descriptive phenomenology. Seven women who had experienced postpartum depression were asked to describe in detail a situation in which they had experienced postpartum depression. The women's narratives were analyzed and findings were reported as 11 theme clusters with examples of participant comments that supported the themes. Discussion of the relevance of the findings to practice involved a comparison of the 11 themes to the 21 items included in a standardized depression screening tool, the Beck Depression Inventory. It was noted that only three of the themes in Beck's study were present in the Beck Depression Inventory. Beck concluded that research is needed to develop a screening instrument that identifies postpartum depression accurately. Beck did not link the women's experiences to context, nor are patterns in the data identified. The findings are used primarily as an aid to refining the measurement of the construct of postpartum depression, which is in accordance with the descriptive approach to phenomenology.

Svedlund, Danielson, and Norberg (1994) conducted a hermeneutical phenomenological study that described women's subjective experiences during the acute stage of myocardial infarction. Heidegger, who was a student of Husserl, developed ideas that comprised the interpretive or hermeneutic research tradition (Caelli, 2001). Caelli describes a process and method for bringing out and making manifest what is normally hidden in human experience and human relations. The hermeneutic approach goes beyond mere description of core concepts and essences to look for meanings embedded in common life practices that could be very beneficial ways for nurses to help find meaning in their practice. It is not the pure content of human subjectivity that is the focus of a hermeneutic inquiry but, rather, what the individual's narratives imply about what he or she experiences every day (Heidegger, 1962).

Svedlund, Danielson, and Norberg (1994) interviewed ten women before their discharge from a hospital. The authors of this study used Ricoeur's (1976) philosophy for the basis of the study, which is an orienting framework and a methodology. Ricoeur advocated that narratives be scrutinized not only of content themes but also for what the narratives imply about the welfare of the participants. The aim of the analysis is a critical understanding of the experience. Three themes were generated from the data: (a) oneself as vulnerable, (b) oneself at a distance, and (c) oneself as making sense. The researchers discussed at length these themes in relation to the problems and needs of women undergoing acute myocardial infarction. An important finding is that women experienced feelings of shame and guilt at being incapacitated in the illness role, and they were unable to share these feelings. Because these feeling were so uncomfortable, women tended to distance themselves from the reality of the illness and to avoid talking about it or

discussing it with health care providers or with family. Eventually, the participants were able to begin to make sense of the experience and to think of about the lifestyle alterations they would encounter, but it took time to work through the feelings of shame and guilt. The researchers concluded that nurses who are cognizant of these common experiences of women in the acute state of myocardial infarction should be able to give more support to women and their families by reaching out to them with empathy and information as needed. This support should enable women and their families to express their fears and receive emotional and informational support early on, which should increase effective communication and lessen the distancing process (Svedlund, Danielson & Norberg).

This study adheres to the philosophical assumptions of interpretive inquiry. The narratives of the participants are analyzed with respect to what they can tell us about contextual features of the experience and their lifeworld. Heidegger (1962) used the term *lifeworld* to express the idea that individuals' realities are invariably influenced by the world in which they live. Recommendations for practice are based on altering the behaviors of nurses who are the key people interacting with these women during the acute stage of illness (Svedlund, Danielson & Norberg, 1994). The hermeneutic interpretations of the narratives tell us more than the abstracted themes imply. The result is a description of what a woman experiences during acute myocardial infarction and some clear directives for practice.

These two articles attempt to identify critical differences between descriptive and interpretive approaches for doing phenomenological research in nursing. These two

studies show how each approach is operationalized and how each approach can contribute to nursing science and knowledge development that can inform practice.

Summary of the Literature

Internationally, workplace violence (WPV) within the health care sector is acknowledged as a serious and increasing problem. Workplace safety is a primary concern for nurses and impacts their decision to continue working in the nursing profession. A crisis related to a nursing shortage is now ubiquitous in most countries in the Western World (Glass, 2007). The shortage cannot be attributed solely to a lack of qualified professionals. Rather, the shortage is associated with qualified professionals choosing to leave health sectors because of the stressful conditions, eroding self-concept, distrust of management, and unsafe working environments (Chapman, Perry, Styles, & Combs, 2009).

Safe environments for nurses are possible via strategic planning and implementation of policies and educational programs in the workplace with support from institutional leadership. To effectively manage and control incidents of WPV, nurses need to recognize the behaviors of the perpetrators and themselves, as well as any organizational factors that precede a violent event. Frameworks to help nurses predict episodes of WPV are available in the literature (Chapman, Perry, Styles, & Combs, 2009; Luck et al., 2007). Development of tools to increase health care providers' awareness of potential violent incident is necessary. By effectively predicting the risk of WPV, nurses may gain a much greater sense of control and, as a consequence, experience more job satisfaction.

Research indicates that to prevent WPV, health care workers need to participate in education to learn how violence affects not only themselves, but also patient care. A majority of health care settings lack formalized, evidence-based WPV educational programs. Many of today's WPV programs are not regulated nor are they targeted to multidisciplinary workforce staff. The literature indicates that key members of the health care force, such as physicians, are often exempt from attending WPV prevention programs. Support from institutional leadership is also important for these programs to be successful. Providing nursing staff with evidence-based knowledge and skills to manage patients and/or visitors with the potential for violence could be a key to help these professionals remain in the workforce.

Providing nurses with a theoretical framework in which to view the problem of WPV is essential for their knowledge base as well as to help them to articulate their feelings. A pedagogy grounded in feminist ideals has the potential to empower nurses to make changes in themselves and environments in order to stay safe in the workplace (Falk-Rafael et al., 2004). Feminist theory can help nurses acknowledge that not only do oppressive environments in the workplace significantly contribute to individual's powerlessness, but also that nurses can help others become empowered by raising their awareness of WPV and enhancing their confidence and skills to knowingly effect transformative change.

It is important for researchers to carefully consider the philosophical foundations of phenomenological research to inform their studies. Researchers must choose an approach to knowledge development that will achieve most effectively the objectives of the proposed inquiry and add substance to what is already known or not known about a

phenomenon of interest such as pediatric nurses' perception of workplace violence. This researcher will use interpretive phenomenology for this dissertation to contribute to the nursing literature.

Chapter 3: Research Design Methodology

This chapter provides an overview of the general perspective of this study, the research context, research participants, the instruments used in data collection, the procedures used, the data analysis, and a summary of the methodology.

The General Perspective-Problem Statement

Workplace violence in the healthcare setting is increasing. According to the International Council of Nurses, two million people die each year as the result of violence (Keely, 2002). Most violent acts are committed against female nurses, both in the workplace and at home, although males have experienced abuse and violence in the workplace as well (Wilder & Sorenson, 2001). Most cases of violence in the healthcare setting go unreported. The literature contains many studies that have documented injuries and deaths related to rise of workplace violence (WPV) (Keely). Few studies in the literature have been found that document WPV against nurses who work on inpatient pediatric hospital units. Giving voice to nurses who experience WPV may be a first step in the process of dealing with the phenomenon.

The problem statement is: The perspectives of pediatric nurses who work on inpatient pediatric hospital units in regards to WPV is unknown. The research question for this qualitative study is: What is the lived experience of pediatric nurses who work on inpatient hospital units that are exposed to WPV from patients and visitors? Qualitative

research was used to describe nurses' experience with workplace violence by directly examining their reporting of the problem (Galtthorn & Joyner, 2005).

The qualitative research method was used as a means for exploring and understanding the meaning that individuals ascribed to a human problem (Creswell, 2009). As explained by Creswell, "the process of qualitative research involves emerging questions and procedures, data typically collected in the participants' setting, data analysis, inductively building from particulars to general themes, and the researcher making interpretations of the meaning of the data" (p.4). A phenomenological approach of inquiry was used as a strategy for this qualitative study. Patton (2002) describes the phenomenological approach as a method of examining the perceptions of the study's participants. Cottrell and McKenzie (2005) view the phenomenological study as one that tries to understand a small, selected group of people's perceptions, understandings, and beliefs concerning a particular situation or event.

The rationale for choosing a phenomenological study of pediatric nurses' who work on inpatient hospital units and experience workplace violence is that there are few studies that examine this population's perception of the problem in this setting in the literature. The majority of studies in the literature examine the perceptions of nurses who work in emergency rooms and psychiatric units of hospitals (Anderson, 2002; Gillespie, Gates, Miller & Howard, 2010; Lanza, Zeiss, & Riedan, 2006). Studying nurses who work on inpatient pediatric hospital units may help to give voice to pediatric nurses' subjective human experience with workplace violence. Nurses giving voice to their own experiences with WPV may help to build a more complete understanding of the reality of the problem as it is perceived to help uncover the truths that exist (Williamson, 2009).

This researcher focused on uncovering knowledge about how nurses thought and felt about the circumstances related to WPV in which they found themselves.

Creswell (2007) summarized nine unique characteristics of qualitative research which are as follows:

1) Qualitative research occurs in natural settings, where human behavior and events occurs.
2) Qualitative research is based on assumptions that are very different from quantitative designs. Theory or hypotheses are not established a priori.
3) The researcher is the primary instrument in data collection.
4) The data that emerge from a qualitative study are descriptive.
5) The focus of qualitative research is on participants' perceptions and experiences, and the way they make sense of their lives.
6) Qualitative research focuses on the process that is occurring as well as the product or outcome.
7) Attention is paid to the particulars; and data is interpreted in regard to the particulars of the case rather that generalizations.
8) Qualitative research is an emergent design in its negotiated outcomes.
9) This research tradition relies on the utilization of tacit knowledge (intuitive and felt knowledge) because often the nuances of the multiple realities can be appreciated most in this way.

All of the nine unique characteristics identified by Creswell are applicable to this study. The central characteristics related to his study are: the topic needs to be explored, a

detailed view of the topic is needed, the study participants are in a natural setting, and the study emphasizes the researcher's role as an active learner.

The Research Context

The research took place at a teaching hospital which is part of a university in Upstate New York. The hospital is also part of a regional medical center that is a national magnet for research, teaching, patient care, and community service. A hospital is awarded the prestigious Magnet rating by the America Nurses Credentialing Center (ANCC) if the following 14 dimensions are present and are rated exemplary: nursing leadership, personnel policies and programs, quality nursing care, organizational culture, management style, professional models of care, continuous quality improvement, consultation and resources, nurse autonomy, nurses as teachers, community presence, professional development, the image of nursing, and interdisciplinary collaboration (Armstrong & Laschinger, 2006). The hospital has committed to Patient and Family Centered Care. The principles of Patient and Family Centered Care focus on what the employees are responsible for and include: treating patients and families with compassion, dignity and respect; turning to patients to define their family in order to initiate a partnership in care; educating, supporting, and encouraging patients and their families to be involved in all aspects of their care; being sensitive to the beliefs and diversity of each patient and family; listening to and valuing patients and their families in a clear and timely manner , and openly sharing all patient information.

Within this Magnet Teaching Hospital is a Children's Hospital that provides care for pediatric patients. The Children's Hospital consists of an emergency room, a cardiac intensive care unit, a neonatal intensive care unit, a general intensive care unit, an

outpatient clinic, and three general patient care units. The study occurred with pediatric nurses from the three general care units and the general intensive care unit. There are approximately 120 nurses who work on the three general pediatric care units and general intensive care unit. Each of the general care units has approximately 22 patient beds, and the general intensive care unit has 22 patient beds.

The Research Participants

According to Creswell (2007), a researcher might use one or more sampling strategies in a single study. The types of sampling for this study were: convenient, purposive, and voluntary. The strategy of convenience that was used in this study was a sample that represented a site and individuals from which this researcher had access and ability to collect data (Creswell). Samples of convenience often allow the researcher to use an accessible group because of the proximity the researcher has to the participants. This researcher works at the Children's Hospital and had access to the participants. Volunteer sampling was also used for this study. Cottrell and McKenzie (2005) define a volunteer sample as one that includes participants motivated enough to self-select for the study. The participants were invited to take part in the study via a letter detailing the study and asking for a purposive sample. According to Cottrell and McKenzie, a purposive sample is used when subjects are intentionally selected to represent the predefined characteristic or trait. Nurses who had experience with workplace violence were selected to participate in the study. Thus, the sampling for this study was convenient, purposive and voluntary.

Nurses with various educational backgrounds were the study participants. Both male and female nurses of all ages who work on the three general pediatric hospital units

and the general intensive care unit were asked to volunteer to participate in the study. The sample size in a qualitative study is left to the judgment of the researcher (Cottrell & McKenzie, 2005). Once *saturation* or nothing new was learned from the participants the sample size was determined for this study. Twenty-four nurses participated in the study. The nurses were asked to provide information about their age, race/ethnicity, job titles, years of employment as a nurse, and years worked as a full time/part-time nurse.

Instruments Used in Data Collection

Data for this phenomenological research was obtained through face-to-face, one-on-one interviews. Informed consent was obtained from the participating nurses at the beginning of the study. Semi-structured interviews using open-ended questions occurred. This researcher was cognizant of the ethical issues involved with data collection. Respect of both the participants and the research site was maintained. This interviewer considered how the interview will improve the human situation as well as how the interview could impact the interviewees. As a result, the interviewer was aware of how a sensitive interview interaction may be stressful for the participants; was aware of whether participants have a say in how their statements are interpreted; was sensitive to how critically the interviewees might be questioned; was aware of what the consequences of the interview may be for the interviewees and the group to which they belong, and was mindful of how the interview could possibly cause harm due to intimate information being disclosed (Creswell, 2009).

The use of an interview protocol (see Appendix A), a predesigned form to help with recording of information collected during the interview process, was also used. Creswell (2007) describes the predesigned protocol as a form used to record information collected

during the interview to document response of the interviewee, to help the researcher organize thoughts on items such as headings, to help with starting the interview, to conclude ideas, and to assist with ending the interview and thanking the respondent. The participants' responses were audio-taped. The demographic profiles of the nurses were collected from the nurses before the interviews occurred (see Appendix B).The interview questions are as follows:

- Tell me about an experience you may have had with workplace violence from patients and or visitors to the hospital. Tell me more about that.
- Have you had any other experiences with WPV? Tell about those…
- Describe your response to WPV.
- Tell me about your feelings about the incident/s…..
- How did the experience affect you personally?
- How did the experience affect you professionally?
- Is there anything that would have helped you in this situation? Anything else?
- Did you do anything differently after your experience with WPV?
- What did you or would you tell other nurses about the issue WPV on the hospital units?
- What did you or would you tell management about WPV on the hospital units?
- How did these incidents make you feel about working here?

Procedures Used

An institutional review board (IRB) approval was obtained from St. John Fisher College to submit to the Children's Hospital in order to begin the process of obtaining approval to do this research study. Once the IRB approval was obtained, permission from

the Associate Director of Pediatric Nursing, as required by the hospital's Nursing Research Committee's protocol, was obtained. Once permission was obtained from the Associate Director, this candidate met with the nurse managers of the general hospital units and the intensive care unit during a leadership meeting to explain the purpose of the research study, including how the participants would be recruited, how confidentiality would be maintained, how the data would be collected and protected, and how the results of the study would be reported.

The pediatric nurses were asked to participate in the study via an invitation (see Appendix C) explaining the details of the study. The invitation was mailed to the nurses' e-mail addresses. Once participants were identified, informed consent (see Appendix D) was obtained. Interviewee confidentiality was promised and the nurses were told that hard copies and audio tape recordings of the interviews would be kept in file cabinets and password protected documentation would be stored on a computer. The typed data had no identifying information and only this researcher could connect the data to the participant.

Data Analysis

Data analysis is the process of moving from raw interview to evidence-based interpretations that are the foundation for published reports (Rubin & Rubin, 2005). The objective of qualitative data analysis was to discover variation, portray shades of meaning, and examine complexity (Rubin & Rubin). The goals, then, of the data analysis as seen by Rubin and Rubin were to reflect the complexity of human interaction by portraying it in the words of the interviewees through actual events and to make that complexity understandable to others. In order to reflect the complexity of human interaction, this researcher used a combination of hermeneutic and feminist approaches to

analyze texts used in this phenomenological study. The approaches will now be described.

This phenomenological inquiry focused on exploring how participants made sense of the experience of workplace violence, transformed the experience into consciousness, and began to understand the nature or meaning of the experience (Patton, 2002). Interpretive phenomenology (hermeneutics) focuses on the meaning and interpretation of the lived experience to better understand social, cultural, political, and historical context (Patton). As described by Benner (1994), hermeneutics is a methodology that aims to understand the significance of practical activities in our everyday lives. In hermeneutic work, words have meanings related to their original sources and also related to contemporary use (Caelli, 2001). Caelli refers to participants' "stories" as *narratives* because they derive directly from the participants' accounts of their experiences. The participants' accounts of their experiences with workplace violence were derived from their transcribed reporting of stories about workplace violence. As seen by Caelli, this process is called "deriving narrative from transcripts" (p.274). The participants were given the narratives to clarify and validate the data from the interviews, which according to Creswell (2009) is known as *member checking*.

There are limitations with hermeneutic phenomenology. Benner (1994) reports that hermeneutic phenomenology is best suited for answering questions about human issues and concerns which are primarily the "*what*" and "*how*" questions in life. This phenomenology will not aid in prediction (Benner). Another limitation as seen by Benner is the risk of this methodology being biased toward the investigator's knowledge and experience and for not being true to the participant's lived experience. This investigator

tried to address this risk by remaining close to the original text and by uncovering biases for scrutiny (Benner). Being self-aware helped this researcher avoid projecting her own personal beliefs and feelings or preconceived notions onto the text. *Bracketing* is a technique used in qualitative research to prevent bias by limiting the interpreter's projection of his or her world onto the text (Benner). This researcher frequently used bracketing during the research process.

A feminist phenomenological approach to data analysis was also used in this study. A feminist approach searched for the deep meaning of the nurses' experiences. A common theme in the feminist pedagogy literature is that the feminist researcher embraces inclusiveness, cooperation and collaboration, mutual respect and trust, multiple ways of knowing, and collective action that challenges the marginalization and silencing of women (and disenfranchised others) reinforced by conventional (patriarchal) approaches to research, teaching, and learning (Doran & Cameron, 1998). Within this feminist approach, attention was drawn to how learning institutions, such as the Children's Hospital which is a teaching hospital, may organize to privilege and encourage masculine traits such as competition that could have detrimental effects on nurses' learning. A major strength of a feminist approach is the emphasis on social justice and cooperation in the context of learning (Ironside, 2001). This feminist researcher strived to contribute to the nursing literature through this study to help overcome any hierarchy among staff and replace it with dialogue that fosters partnerships between and among hospital leadership to encourage men and women's full participation in helping to resolve workplace violence. Next, the process of data analysis will be reviewed.

Data from each participant who had experienced the phenomenon of workplace violence from patients and visitors was collected. This researcher independently analyzed each transcript through immersion into the content by repeatedly reading the transcripts to gain a sense of the data as a whole. Next, the data was sorted by similar ideas and then sorted into similar categories. Coding schemes were formed and a composite description of the experience was developed. The description consists of "*what*" they experienced and "*how*" they experienced workplace violence (Moustakas, 1994). Essentially, the interviews were conducted to allow statements, meaning, units, and textural and structural descriptions to emerge in order to describe the *"essence"* of the nurses' experience with workplace violence (Creswell, 2007). The output of the interviews is a narrative account by the participant of his or her knowledge and experiences related to WPV. An inductive inquiry process was used to interpret and structure the meanings that were derived from the data. Generally, inductive reasoning uses the data to generate ideas. Sjostrom and Dahlgren (2002) view inductive reasoning as a way of uncovering or deconstructing the meanings of a phenomenon. The data was analyzed for themes or perspectives and the major themes were reported or generated into meaning units. Moustakas (1994) calls these units *essence description*. Creswell describes the process of data analysis as being best illustrated by a spiral image depicting how the researcher engages in analytic circles rather than using a fixed linear approach. The spiral of data analysis is summarized as follows: (Creswell, p.15).

1) Data management- Researchers organize their data into file folders, index cards, or computer files. The researcher converts their files to appropriate text units for analysis by hand or by computer.

2) Reading, memoing- The researcher continues analysis by getting a sense of the whole database. The researcher does this by reading the transcripts in their entirety several times. The researcher immerses him/herself in the details and attempts to get a sense of the whole before breaking it into parts. Writing memos in the margins of field notes or transcripts helps in this process. The researcher will look for major organizing ideas. Initial categories can then be formed.
3) Describing, classifying, interpreting- The process then consists of moving from the reading and memoing loop into the spiral of describing, classifying, and interpreting loop. The researcher then codes and or forms categories by describing in detail the themes or dimensions through some classification system. The researcher provides interpretation in light of their own view of perspectives in the literature. Themes are then identified from the code segments to represent dimensions of information.
4) Representing, visualizing- The final phase of the spiral, researchers present the data by presenting narration of the "*essence*" of the experience; in tables, figures, or discussion.

Ensuring validity and trustworthiness are also important steps in qualitative research. The qualitative process contributes to the rigor or trustworthiness of the data. Speziale and Carpenter (2003) report that the goal of qualitative research is to accurately represent the participants' experiences. The qualitative attributes of validity include credibility, dependability, confirmability, transferability, and authenticity (Miles & Huberman, 1994; Speziale & Carpenter, 2003). This researcher attempted to achieve trustworthiness in this study by consciously "*bracketing*" herself in terms of the perspectives of the participants when they were being interviewed and again during the

transcription of the interview. Cottrell and McKenzie (2005) caution that in order to be open to the phenomenon, researchers need to set aside all preconceived notions, personal beliefs, feelings, and perceptions, and this process is known as bracketing. Participants received a copy of the text to validate that it reflected their perspectives regarding workplace violence.

Another method to ensure trustworthiness of this study was the use of triangulation. Triangulation involves using multiple sources and perspectives to reduce the chance of systematic bias (Creswell, 2009). One type of triangulation that was used by this researcher involved the use of more than one researcher to analyze the data and to help test the coding scheme which is known according to Creswell as *intercoder agreement*. The participants themselves were also asked to review the data for content validity. This researcher used *member checking* to determine the accuracy of the qualitative findings by taking the final themes back to the participants to determine whether the participants felt that they were accurate (Crewell).

Interpreting the findings involves making meaning of the data. Interpretive phenomenology involves the researcher bringing to the study his or her own culture, history, and experiences. This researcher works for the pediatric service where this study took place. Her expertise as a nurse educator working to prevent workplace violence will be a factor in analyzing the participants' narratives. Therefore, this researcher could not completely remove herself from the interpretation of the narratives.

Summary of the Methodology

An overview of the process of designing the methodology for this study was provided. This interpretive phenomenological study used feminist and hermeneutic

approaches to help bring out and make manifest the phenomena of workplace violence against pediatric nurses who work in a children's hospital. The problem statement for this study was: The perspectives of pediatric nurses who work on inpatient hospital units in regards to workplace violence is unknown. The research question was: What is the lived experience of pediatric nurses who work on inpatient hospital units who are exposed to WPV from patients and visitors? Participants were recruited from a pediatric teaching hospital in Upstate New York. Semi-structured, face-to-face interviews were conducted. The interviews were conducted with 24 participants until saturation or nothing new was heard from the participant narratives. An IRB approval was obtained followed by informed consent before the research began. The data was kept confidential (nurse's names were not listed in the data) and were stored in a locked file and was also password protected on a computer. The participants were assured that their narratives would not be identifiable and that their individual narratives would be coded for general themes. The participants were informed that the results of the data analysis would be shared with pediatric nursing leadership at the hospital but that their individual narratives would not be shared. The participants were informed that the narratives would be coded with a number, not a name. An inductive inquiry process was used to interpret and structure meanings from the interview data. Validity and trustworthiness was demonstrated through use of triangulation, bracketing, and participant review of the transcripts to ensure truthfulness.

Nurses giving voice to their own experiences with WPV may help to build a more complete understanding of the reality of the problem as it is perceived to help uncover the truths that exist (Williamson, 2009). This researcher was concerned about uncovering

knowledge about how nurses think and feel about the circumstances related to WPV in which they find themselves.

Chapter 4: Results

The results of this study are included in this chapter. A summary of the participants' demographics is provided; the data analysis and findings from the study are provided followed by a summary of the analysis. Essentially, this chapter involves making sense out the text from the participants' interviews (Creswell, 2003).

Participant Summary

The research question for this study was: What is the lived experience of pediatric nurses who work on inpatient hospital units that are exposed to workplace violence (WPV) from patients and visitors? A summary of the participants' demographics is provided in Appendix E.

An overview of the participants' gender, age, and ethnicity is found in Table 4.1 and the summary is as follows. Twenty-four nurses participated in the study. There were four (17%) male nurses and 20 (83%) female nurses ranging in age from 24 to 59 years. The majority of the participants were between 25 to 30 years of age. The participants' races/ethnicities were: 23 nurses were white (96%) and one nurse (4%) was of mixed race.

Table 4.1
Participants by Gender, Age, and Race / Ethnicity

Gender	#	%
Male	4	17%
Female	20	83%
Age	**#**	**%**
20 to 25 years	1	4%
25 to 30 years	7	29%
30 to 35 years	3	13%
35 to 40 years	1	4%
40 to 45 years	2	8%
45 to 50 years	4	17%
Over 50 years	6	25%
Race / Ethnicity	**#**	**%**
Asian / Pac. Islander	0	-
Black	0	-
Native American	0	-
White	23	96%
Multiple Race	1	4%
Hispanic / Latino	0	-
N=24		

A summary of the participants' levels of education and job titles is found in Table 4.2. The levels of education of the participants were: one (4%) had a diploma degree, two nurses (8%) had associate degrees, 14 (58%) had baccalaureate degrees, and seven (29%) had masters degrees. The job titles of the participants were: 15 (63%) were staff nurses, one (4%) was a nurse practitioner, six (25%) were nurse leaders, two (8%) were nurse managers, one (4%) was a clinical nurse specialist, and one (4%) was an assistant professor.

Table 4.2

Participants by Level of Education and Job Title

Level of Education	#	%
Associate Degree	2	8%
Baccalaureate Degree	14	58%
Masters Degree	7	29%
Doctoral Degree	0	-
Other (Diploma)	1	4%
Job Title **	**#**	**%**
Staff Nurse	15	63%
Nurse Practitioner	1	4%
Nurse Leader	6	25%
Nurse Manger	2	8%
Clinical Nurse Specialist	1	4%
Other (Assistant Professor)	1	4%

*** Multiple responses allowed, percentages do not total to 100%*

A summary of the participants years worked as a nurse and years worked as pediatric nurses is found in Table 4.3. The years the participants worked as a nurse were: seven (29%) worked less than five years, nine (38%) worked five to 20 years, and eight (33%) worked 20 years and over. The years worked in pediatrics as a nurse were: seven (29%) worked under five years, nine (38%) worked five to 20 years, and eight (33%) worked 20 years and over.

Table 4.3
Participants by Years Worked

Years Worked	As a Nurse	As a Pediatric Nurse
	#	#
1-2 years	2	2
3-5 years	5	5
5-10 years	5	5
10-15 years	3	3
15-20 years	2	1
20-25 years	3	3
25-30 years	1	1
30-35 years	4	4
35-40 years	1	1
N=24		

Data Analysis and Findings

Giving voice to the pediatric nurses' experience of workplace violence helped them to describe their personal knowledge, perspective, and interpretation of the phenomena. A summary of the findings from the 24 interviews with the pediatric nurses are arranged according to themes followed by direct quotes from the participants to

illustrate the themes. The themes identified key issues that were discussed by the participants and the themes are interpreted by this researcher. Seven major themes were identified with the aim of being faithful to the participants. The themes and quotes and interpretations are listed below.

Theme # 1*: It's part of the job*

This participant quote emerged as a theme because of the consistency of this experience among a number of the participants. One nurse participant (P) responded with a discouraged tone to his voice when asked about his experience with workplace violence as indicated in the following:

> P: So you know, I think at times we as nurses don't do well and we accept that workplace violence (WPV) is part of the job when it happens and that being verbally assaulted or physically assaulted at times is acceptable. I have witnessed some of the staff just brush it off and not report it (WPV).

This nurse reported how he was surprised that the nurses he works with seem to expect workplace violence to be nothing out of the ordinary which may indicate that nurses are tolerating and accepting the phenomena in their every day practice. Perhaps workplace violence is occurring so frequently that nurses are becoming desensitized to its occurrence and therefore feel that they are expected to accept the violence. Another nurse participant explained how she felt about her experience of workplace violence.

> P: I'm here for the kids (patients). I mean I've thought about how dangerous the potential for violence is but it's never made me hesitant to come to work or anything, because it's just kind of part of the job and I'm there for the kids, you know.

P: We had this patient's father who was hitting staff and really hurting everyone who came to help. I remember I felt sorry for this man whose son was chronically ill. So, workplace violence can be scary, but I think you have to understand that it's part of the job then it doesn't stop you from doing your job.

In the above statements, the nurses seems to have rationalized that if as a nurse one expects workplace violence to be part of the job then it is will be easier to cope with the violence. This type of thinking may be an example of *internalized oppression* which occurs according to McIntosh (2006) when a group or individual who are oppressed, believe the stereotypes and attitudes that are directed at them. Some nurses may feel that the attitudes are correct and fitting when it comes to believing that nurses should accept workplace violence as part of their job. Internalized oppression is an important concept not only for understanding the process of oppression but, but also for thinking about creating change for nurses.

However, not all of the participants felt the same way about the experience of workplace violence:

P: Workplace violence happens all the time and the administration needs to support the staff. They need to be willing to say it shouldn't happen and we will press charges. I think that it should be mandated that if someone lays a hand on you, you press charges. I mean the one incident where the nurse got hit, she didn't press charges and I really think she should have. The threat from the visitor to the nurse in the other incident, that visitor should have been made to leave the hospital and been charged with the threat. I mean if someone is going to make a threat to you, they should be gone (from the hospital).

Theme # 2*: They were there for me.*

This theme was cited by a nurse participant who had many years experience working in pediatrics. She refers to her responsibility as a leader.

> P: The situation of workplace violence felt out of control. Being a Nurse Leader on the unit, I felt like I needed to protect my co-workers and so that is why I intervened and also called security for help. Most of the time I was also scared and anxious for the safety of my staff. When staff sees me handling these types of situations and they go well, I feel like I am doing a good job of role modeling and it makes me feel better professionally.

The situation mentioned above involved a very violent incident where a staff nurse was assaulted by an adolescent patient. The nurse who was assaulted sustained a concussion, a black eye, and needed to be out of work on workman's compensation. This participant displayed a great amount of emotional concern and a deep meaning of her staff nurse's experience. Other examples of nurses supporting nurses follows.

> P: I didn't have to call her (Nurse Manager) about the situation (workplace violence incident) the charge nurse had already called her. I talked to the Nurse Manger the next day and she wanted to know about the entire situation. She asked if I wanted to press charges because the patient's grandmother bumped me in the chest. I said no, I'm ok with it. So, nursing management was very supportive and we developed a plan to address the angry grandmother.
>
> P: I feel personally supported. I don't ever feel like anybody in nursing leadership in this department of pediatrics would ever want a nurse dealing with this on their own.

P: On my unit, we let nursing management know if any violence happens. They are very supportive and we know each other well enough that if I had a concern, I would go to them.

The theme of support from nursing leadership that was voiced by the majority of the nurse participants was important because it acknowledged that nurses at the bedside of patients do have some support in their practice areas. To move forward to a place of empowerment, nurses need to share information, problems, solutions, and hopes. It seems that the issue of workplace violence is being contained somewhat on each individual unit in the pediatric service. This assessment comes from this researcher who works for the pediatric service and who has experience with educating nurses about violence prevention. Nurses cannot afford to be isolated with the issue of violence. The nurses need to bring the issue of violence to light within the larger hospital system in order to be kept safe. The reason for the containment of violence on the individual hospital units may be related to the next theme that was uncovered.

Theme # 3*: Conflicted about pressing charges*

P: My response to workplace violence is sometimes physical like the fight or flight thing. I usually withdraw from the room. In the past, I never pressed charges. I think most of my peers would not press charges either because it is just something we never think about and we usually don't get involved with the legal stuff.

P: This visitor made threatening remarks to me and other nurses and our security officers were involved and the Rochester City Police. We were thinking about pressing charges then we never did.

P: Well I think it was our security service that told me I could go to The Rochester City Police Department and press charges for what happened to me. I needed help from them but they were not really seeing the whole picture and they were out of the picture because they said there was nothing more they could do. I never pressed charges. I don't know, I probably should have.

Many of the participants reported felling conflicted about the idea of pressing charges while providing "patient and family centered care" which is one of the goals of the hospital. Pressing charges for the offense of violence is not going against the goal of providing patient and family centered care. In fact, pressing charges may help to maintain a safe environment in order to provide patient and family centered care. The nurses perceived however that reporting violence and providing patient and family centered care where exclusive to each other. This researcher speculates that the participants were somewhat fearful of pressing charges because they were afraid of being judged poorly by hospital administrators as not providing patient and family centered care.

Due to under-reporting and lack of pressing charges, the occurrence of physical and verbal violence toward nurses is not understood. This issue of not pressing charges may be an example of how nurses in general, like women, are socialized to be passive, dependent and nurturing which often limits their options for self-care. Identity and self-esteem, which are derived in part from the socialization process, play an important role in the achievement-related and self-care difficulties of women (Muff, 1982).

Theme # 4*: Learn to prevent and deal with it.*

P: I think that workplace violence actually makes me stronger as a nurse

because I can say that I have dealt with some pretty challenging patients. I do believe that nurses need to be educated about how to deal with challenging patients and their families. Nurses don't just come out of college knowing how to deal angry people.

P: I kind of felt challenged to re-address how I deal with patients who may become violent. I feel like no matter where I'm going to be in nursing especially if I continue to work with adolescents, I need to learn how to handle violent situations. Then adding parents who are upset, frustrated and tired along with a sick child who is frustrated and tired, and lost all their independence, I kind of expect that it (violence) is going to be present, but just learning how to deal with it better and prevent as much as I can before it gets to a bad point would help. Maybe have some type of classes for us to learn about what to do in those types of situations would be good.

P: I think any kind of course or in-service on how to better communicate with patients and families who are in crisis and angry and who are taking it out on you would be tremendously helpful.

P: I had a class once in orientation about violence but that was years and years ago and times have changed.

These participants were aware of their need for education in order to prevent and address workplace violence. They were looking for strategies to promote a culture of safety in their environments. Since the majority of nurses are female, the lack of formalized education regarding workplace violence could be an issue about woman's need for knowledge and achievement. The work role in female-dominated occupations

such as nursing is closely identified with the feminine role and is structured in a manner similar to the woman's role in the family (Muff, 1982). If an institution such as a hospital views nurses' role behavior to be patient and family centered at all costs, the idea of providing access to knowledge in the form of educational opportunities may not even be considered. In addition, if patient and family centered care is viewed by the institution only from the positive aspects of care delivery and ignores the negative behaviors of patients, families, and visitors, then it is negating problem issues with the patient and family.

This researcher suspects that the institution where the participants work does not provide mandatory workplace violence education for all disciplines because the discipline of nursing has been dealing silently with the issue for decades. Nursing holds a professional position within the institution that contains conflicting structural role demands meaning that nurses are responsible for saving lives and providing patient and family centered care without the power to have a formalized workplace violence prevention program. How this nurturing and caring practice of nursing is studied, promoted, and disseminated has been influenced by the sexism inherent in paternalistic hospital structures and healthcare agencies (Kane & Thomas, 2000).

Theme # 5*: Workplace violence negatively impacts our job.*

P: This teenage patient just punched me in the face when I went into his room to see why he was yelling. I had to go down to be seen in the emergency room. I had a concussion and this huge black eye and they sent me home. It affected me personally and I left my peers with having to cover my patients so I felt bad about that…leaving them short staffed. Then, I was out (of work) on

workmen's comp. for a few days. It was very embarrassing for me to have my husband and the other nurses to see me like that.

This participant had difficulty recounting the event while talking with this researcher. It was as though the nurse was talking about someone else until she spoke about feeling badly about having her peers assume her patient assignment. The nurse needed to leave work due to her injuries on the day of the attack. She did become emotional also when describing how embarrassed she was about having to face her peers and her husband with her physical injuries. It seemed like she was valuing others before herself which is often an issue related to women. She was also implying responsibility for the short staffing. Embarrassment was expressed instead of anger which contains a connection to lack of self-worth. Another participant described an emotional and unsafe circumstance as follows:

P: I had this patient in the ICU and her mother was there at the bedside. The mother was very assertive and didn't like what I was doing to her child so I explained the nursing care. But, the mother was getting angrier and angrier and she finally said that if I didn't walk out of the room she was going to grab me and hit me until she could throw me out of the room. I left the room and got my Nurse Manger to help but for days after that I was on edge at work. I was always on edge when I was there when this patient and mother were there and it was hard to concentrate because I was afraid it would all start up again.

As the above quotes suggest, workplace violence adversely impacts a nurse's job performance which may lead to poor patient care outcomes. Examples of how the violence impacted them include: difficulty with concentration; missed days on the job;

avoidance of having some patients on their assignments; feeling afraid for their safety, feeling anxious; displaying their sad and angry moods; and having thoughts of wanting to leave the nursing profession.

Nurses have enormous responsibilities each time they begin a shift at the hospital. Providing treatments, dispensing medications, evaluating patient outcomes, and offering emotional support are just some of their responsibilities. Couple those responsibilities with the task of de-escalating a potentially violent patient, visitor, and or family member and a formula for distress occurs and the safety of the patient and nurse are at risk.

Nurses give selflessly, even to their own detriment (Rosenow, 1982). It seemed that the participants did not mention asking members from other disciplines, other than the security officers, to assist them in managing the violent situations. The nurses placed most of the responsibility for maintaining staff and patient safety upon themselves. Not only do these nurses assume responsibility for dealing with workplace violence but the institution endorses this expectation by failing to address the issue. The issue could be addressed if the institution used consultants to assist staff in dealing with workplace violence. The consultants should have a formalized role dedicated to assisting and educating staff when needed.

Theme # 6*: Fear for our safety.*

P: I had this young girl as a patient who had surgery. Her father arrived in her room after she was back from surgery. The patient was in a little bit of pain so I gave her pain medication and before the medication even had a chance to work, the father started screaming at me. He was angry his daughter was in pain. I tried to explain how the medication would take some time to work but he did not want

to listen. He asked me for my name and wrote it down and told me that he would take care of the situation and that I was incompetent. He was saying that he wanted to take his daughter to a different hospital. I had to call in the Nurse Manager and security. The patient ended up doing fine and went to sleep shortly after the medication kicked in. The father was still angry even after his daughter went to sleep. So, I mean, I was terrified. You know, I'm in the directory. You can Google my address and I live by myself. I didn't know what this man was going to do, he was very aggressive.

P: There was the night that one male visitor made threats to the nurses on duty as he walked off the unit. He said "I'll find out where you live". So you walk out of work and you are in the parking garage, he could have been in that garage, you don't know, you don't think he knows your car. Who's to say he wouldn't be out there waiting, you know? It's concerning.

P: I had a patient who was a victim of violence and was a gang member here in The City of Rochester and I worried about how to keep the other patients safe and my staff protected when he became threatening. I used security a lot to help diffuse the situation.

This participant like other participants, feared for the safety of both the staff and patients on her unit when a victim of violence (patient with a stab wound or a gun-shot wound as the result of an assault) was admitted to the hospital. Many of the participants feared retaliation from an opposing gang member when a known gang member was a patient on one of the units due to a gun- shot wound or a stab wound.

Fear for their personal safety while at work and outside the workplace was a major concern for the majority of the participants. Having the participants' last name listed on their name tags was an issue for many nurses. The nurses' fear of being harmed speaks to their sense of feeling powerless. Muff (1982) describes power as bringing greater power, and powerlessness as generating powerlessness. It seemed that some of the participants were dependent upon others to deal with workplace violence. The nurses were aware in part of their dependence and were frustrated about not being able to extinguish their dependence.

Theme # 7*: Nurses go it alone*

P: I have to be totally honest; I know we don't do the best job of screening people who have access to the hospital at either the unit level or at the larger hospital level. I know that there are a lot of open areas where people can just walk in and then do whatever so I think it makes everyone on the unit a little bit more nervous when we have a patient who has been a victim of violence who has been shot for example and the person doing the shooting hasn't been caught. I think we all worry about the person coming up to the unit. I think we can have more in the way of secure entrances. I think we could be more diligent on the security front. The hospital administrators need to get more involved with safety on the units.

P: I think workplace violence is made to be a nursing issue. I feel that physicians don't get involved with the violent situations nor do the hospital administrators. They (physicians and hospital administrators) kind of back off and let the nurses take care of the difficult situations.

While the majority of the participants felt supported by their direct nursing supervisors, they did not feel the same amount of support from the hospital administrators and physicians. The participants described the administrators and physicians as being disconnected from the reality of workplace violence. Many participants were also concerned about not having the rules and expectations of the hospital explained to and available (in a hard copy format) for the patients, families, and visitors. The institutional commitment to patient and family centered care is at times at odds with keeping the environment free from workplace violence

Access to the units was also a concern of this nurse who believed that there are too many ways for families and visitors to access the units without being monitored. This nurse believed that he and his peers were vulnerable to unwanted visitors due to open access to the units.

Theme # 8*: Feeling badly for others*

P: I would say that workplace violence has not really affected me. I still like what I do. You know, I've heard stories about other workplace violence incidents which has made me a little bit, you know, hesitant about certain situations, kind of made me open my eyes up to certain things I had thought would never happen that have happened. But for the most part, I mean you're dealing with families who don't know quite how to handle a situation they have no control of. I kind of feel badly for them even when they get out of control and demand certain things. It is their way of controlling things I guess.

This participant is making allowances for disruptive behavior in families based on their emotional distress. Nurses have been socialized to focus on others at the

expense of themselves. Allowances for a patient's sick role have been taught to nurses for decades. Now it seems that it is being extended to family behavior. Some family members do not seem to have well developed anger management or coping skills.

> P: So, I don't even believe in such a thing as "patient violence against a nurse" because there should be a justification for it" or a "medical justification for it", and then that becomes part of the job to deal with that.

Once again, this participant is making allowances for the patient's mental health status and trying to justify an act of aggression. She then thinks she should assume responsibility for dealing with patient violence as part of her role.

> P: I had a patient who was notoriously difficult to work with and was often hard to wake up and there would be occasions where you'd go in to try to get him to do treatments or medications, or whatever and he would like swing at you with a hand and he kicked you with his feet from the bed and kind of give you that get out of here, use swear words or whatever to persuade you from coming near him (shrugs shoulders). But, it was no big deal and in way, I took it because I felt sorry for him.

This participant is excusing inappropriate behavior. Perhaps the development of a code of conduct for patients, families, and visitor would help to maintain safety in hospitals.

> P: The patient's father had a very angry outburst in which he acted verbally violent to our staff and then he progressed and we weren't able to do anything to back him down. His son had died. He actually picked up one of our chairs over his head and slammed it into the ground. We called security, this and that,

> because the patient's mother was still in the room. Then it was one of our sliding glass door rooms and he actually came to the window and actually smashed the window out. The Rochester City police were involved. He had to be restrained. Later, we brought the father back into his son's (the patient) room to his baby, to say goodbye.

In the above examples of theme # 8 *feeing badly for others,* the participants provided examples of their modus operandi which in part has been self-sacrifice and pleasing others. Assertiveness can be very difficult for nurses who have been socialized into passive, self-abrogating, subservient roles of following orders even when their own safety is at risk. Being passive was for many years part of the socialization of the nursing role.

Summary of Analysis

The 24 nurses shared their lived experiences with workplace violence from which eight themes were identified. The first theme identified that the nurses viewed workplace violence (WPV) as to be expected and as *part of their jobs*. None of the nurses were surprised that WPV happened on a fairly regular basis. The second theme: *they were there for me* revealed how the nurses were supported by their nurse managers and nurse leaders which provided them with some sense of comfort during difficult events. The nurse participants did not however feel supported by the higher level hospital administrators who were identified as not getting involved in violent situations which was theme # 7 *nurses go it alone*. The third theme: *conflicted about pressing charges* highlighted how the nurses where conflicted or received uneven support for pressing legal charges after they are assaulted. The nurses seemed to minimize and make excuses

for not pressing charges. Nursing leadership did however encourage their staff to file charges when the nurses were assaulted. The nurses identified a need for education to help prevent and deal with WPV which was the fourth theme: *learn to prevent and deal with it*. Knowing how to address the issue of WPV did not come naturally to the nurses and they frequently identified the need for mandatory classes to be offered to them by their employer. The fifth theme: *workplace violence negatively impacts our job* indicated how WPV negatively impacts a nurse's job performance resulting in missed days on the job due to physical and emotional trauma. Some nurses also had difficulty concentrating while at work due to WPV which could impact patient outcomes. The next theme: # 6 *fear for our safety* identified was that nurses fear for their safety at both at work and outside of work as a result of WPV. The nurses expressed their fear of being harmed by the perpetrators of WPV while at work and after they left the job site. The nurses were also concerned about the safety of their peers and other patients on their units when WPV occurred. The eighth and final theme: *feeling badly for others* revealed how many of the nurses felt badly for the perpetrators of violence. This theme identified how the nurses identified a sense of empathy for their attackers. Because the perpetrators were patients or family members, nurses have been socialized to accept their coping behaviors, even if these behaviors are unsafe for other patients and for nurses themselves. This socialization makes it easier for the larger institution to impose patient and family centered care even at the expense of nurses' safety. The themes did reflect the lived experiences of the pediatric nurses who witnessed workplace violence form patients and visitors. Finally, the themes provided a better understanding of the issues and concerns of the nurses thus deepening the meaning of their experiences.

The next and final chapter provides a discussion and interpretation of the results of the study. Implications of the findings are offered along with the limitations of the study. And finally, recommendations for future research are discussed.

Chapter 5: Discussion

Introduction

A feminist theoretical framework will be used to discuss and interpret the results of this study. The problem statement for this study was: Pediatric nurses who work on inpatient hospital units have been understudied in regard to their perception of workplace violence. The research question was: What is the lived experience of pediatric nurses who work on inpatient hospital units and are exposed to workplace violence from patients and visitors? The research question was answered by giving voice to the study participants and using interpretive phenomenology as an approach to focus on the meaning and interpretation of the lived experiences of the nurses. The limitations of this research study will be reviewed along with recommendations for future policy, practice and research. A conclusion to summarize the study based on this researcher's analysis and results will be presented.

Implications of Findings

The 24 nurse participants who volunteered to be interviewed for this research study provided rich data in the form of narratives to describe their perceptions of workplace violence in a pediatric hospital setting. Their lived experiences may help to inform the literature about realities of workplace violence that occur in professional practice settings. This researcher engaged in the world of the nurses as they described and interpreted their *life world* as related to workplace violence. The best possible account of the narratives and *being with* the participants during their recounting of their perceptions

guided the interpretation and analysis. Self-knowledge was required of this researcher to avoid extremes of idealizing and villainizing the perceptions of the nurses (Benner, 1994).

A feminist framework was used as a lens to help understand the human conditions, commonalities and differences among the participants. Creswell (2007) reports that feminist research addresses woman's problematic situations in institutions that frame those situations. The majority of the participants were woman as is most of the nursing workforce in the United States. Feminism however is particularly concerned with equality and justice for all and seeks to eliminate systems of inequality and injustice. Because feminism is politics of equality, it anticipates a future that guarantees human dignity (Shaw & Lee, 2009). The need to maintain human dignity is reflected in the themes identified in this study.

Looking at the eight themes derived from the narratives: *It's part of the job; They were there for me; Conflicted about pressing charges; Learn to prevent and deal with it; Workplace violence negatively impacts our job; Fear for our safety; Nurses go it alone;* and *Feeling badly for others,* this researcher believes that nurses are socialized to gender biased roles and therefore place others' needs before their own. Placing others' needs first is a basic organizing principle that often shapes the conditions of nurses' lives. Collectively, the themes described what the participants had in common as they experienced workplace violence. The themes reduced the individual experiences of workplace violence to a universal essence which is a grasp of the very nature of the phenomena. Given the intricacies of power and gender in the field of healthcare, using a feminist lens is necessary to obtain an understanding of the results of this study. The

majority of the positions of power in the hospital where this study occurred are held by white men.

Understanding the different forms of oppression and privilege helps to analyze how these concepts play out in nurses' professional practice. Since oppression is a structural phenomenon that devalues the work, experiences, and voices of members of marginalized social groups, it might be said that oppression is experienced by persons because they are members of particular groups (Baily, 2009). Privilege on the other hand literally means private or individual law (Baily, 2009). Privileges are special rights belonging to the individual or class, and not to the mass. Understanding how oppression and privilege are based on group membership helps to us to understand how stereotypes such as "nurses are angles in white" teach us to make assumptions about nurses, regardless of their complex role responsibilities. Only when the public, hospital administrators, and nurses themselves become aware of the boxes nurses are put in, can the assumptions about the role of the nurse be challenged. The theme from this study *"it's part of the job"* is found in current nursing literature (Chinn & Wheeler, 1985; Gallant-Roman, 2008; Gilmore-Hall, 2001; Hader, 2008; Jackson, 2008; & Kelly, 2001) and may be interpreted as: nurses are often in subordinate roles thus expect themselves to tolerate violence. Only when nurses see how they connect to the problem of inequality such as: *"its (workplace violence) part of the job"* can they work towards equality.

Andrist (2006) indicates that it has taken nursing over 100 years to understand that women's issues are nurses' issues and that the "personal" struggles of nursing are indeed "political" issues. The majority of the themes from this study are political issues.

The core issues imbedded in the themes are: *devaluing of knowledge; lack of support from the organization, women supporting woman; oppression; lack of access to knowledge; powerlessness; fear; and lack of power.* These issues may be explained by looking at theories of difference and inequality that fall under the broad umbrella of *social constructionism*. *Social constructionist* approaches emphasize the role of human interaction and culture in shaping classifications of difference and producing inequality (Feber, Jimenes, Herrera, & Samuels, 2009).The construction of social identities is inherently political and tied to relations of power. Certain institutions such as science, medicine, law, and government played a certain role in creating classification systems and enforcing them (Feber, Jimenes, Herrera, & Samuels). Inequality as experienced in the field of nursing is in part the result of oppression and privilege.

One of the themes from the study indicated that nurses identified the need for educational opportunities to learn about violence. The theme "*Learn to prevent and deal with it"* reflected the nurses' need for knowledge about how to address workplace violence. Being denied access to education may have influenced nurses to belief that they were meant to deal with the violence as it occurs. The institution in which they work may be helping to frame the nurses' situations with workplace violence leaving them to believe that the violence was indeed part of their job.

In keeping with the theme, *it's part of the job*, the nurses in the study were often faced with situations of violence where their options were reduced to choices that exposed them to censure and deprivation. The nurses reported that frequently, they were the only profession who were responding to WPV episodes. Other professional such as physicians, social workers, and physical therapists did not assist with violent events that

occurred on the hospital units. The nurses perceived a lack of support from hospital administration during the workplace violence episodes and they were fearful of being labeled as not providing patient and family centered care if they reported the events. The nurses felt supported by their direct nursing leaders but support from hospital administration was lacking. Fye (1983) explains that the reason people fail to see or understand oppression is that they focus on particular attitudes, events, and actions that strike them as harmful, but they do not see these in relation to the social and political systems that create and enable them. Sexist barriers are systematically related to one another although it can be difficult to see the broader interwoven system when focused only on one aspect, such as providing patient and family centered care (Fye, 1983). When nurses begin to see how the damaging norms (provide patient and family centered care at all costs) are negatively impacting their practice, then the tenets of oppression may become clear.

Support of nurses from their direct nursing leadership is a reflection of the importance of women supporting women. Nurses, who have been socialized for the most part as females, reach out for support from those who understand their situated circumstances. The theme *"They were there for me"* which spoke to the nurses feeling supported by their Nurse Managers and Nurse Leaders during violent situations reflected this understanding. Oppression and the core concept of patriarchy-systems of male domination and female subordination- are closely associated. Hunnicutt (2009) believes that the concept of patriarchy holds promise for theorizing violence against women because it keeps the theoretical focus on domination, gender, and power. The concept of patriarchy also anchors the problem of violence against nurses in work conditions rather

than individual attributes of nurses. Understanding feminist perspectives of patriarchy may help nurses continue to support each other and to begin to find ways to rise above systems of dominations and female subordination. There are varieties of patriarchy and overlapping types of hierarchies such as race, class, and age, so noting how these interlocking hierarchies work together will be important for nurses to understand. It is also important that nurses understand the power relations in their workplaces, not in top-down but instead learning to recognize the multiple "sites" of power.

Nurses identified their lack of power through their expression of fear and acceptance of workplace violence. Both male and female nurses in this study shared their experiences with power relationships and how they are constructed by them. This is not to say that the entire workforce of nursing nor that the pediatric nursing service where this study occurred are oppressed and subservient but that the majority of participants in this study identified forms of powerlessness when describing their situations with workplace violence. The themes "*Conflicted about pressing charges*", "*Nurses go it alone*", and "*Fear for our safety*" speak to the issue of powerlessness these nurses were experiencing in the face of workplace violence.

Nurses in the study were truly conflicted about pressing charges against the workplace violence they experienced. This lack of pressing charges is reflected in the nursing literature. Most of the nurse participants in the study did not report the violence. It is the belief of this researcher that the nurses felt that if they reported the episodes of violence and pressed charges that nothing would be done from an institutional level to curtail future events of workplace violence. This speaks to helplessness and the lack of value of nursing. On some level, the nurses themselves felt that they would be viewed as

less than “patient and family centered” providers of care if they reported the violence. So, the nurses “go it alone” and take on the responsibility and duty of managing and preventing violence even when they fear for their safety and the safety of other patients and families at the hospital. Patient and family centered care is of utmost importance to nurses. By not reporting and pressing charges against workplace violence, the nurses are inadvertently perpetuating workplace violence. And by not taking a stand against workplace violence, the institution is perpetuating the oppression of nurses.

The idea that nurses should not report workplace violence because it could be construed as not being patient and family centered may be attributed to what is known as *institutionalized privilege.* It may be that hospitals and churches are viewed as safe haven by nurses, patients, and families. Ferber, Jimenez, O’Reilly Herrera and Samuels (2009) report that institutionalized privilege occurs in society and springs from institutions that have been founded on a mythical norm, and they discriminate against anyone who is not part of the norm. Nurses agree that salaries, status, autonomy, and power are negatively influenced by as a result of gender discrimination (Kane & Thomas, 2009). Nurses are often viewed as angels in white who will sacrifice all for the sake of the patient, family, and visitors. Those who actually understand the role of the nurse, knows that this antiquated view is untrue. Nurses are highly educated scientists and healers who must continue to recognize how power relations in the workplace impact their practice in order to bring about change. Workplace violence against nurses is in part a product of patriarchal social arrangements and ideologies that are sustained and reinforced by systems of domination.

Limitations

Interpretive phenomenology was used in this research study. As with any research study, there are limits to which one can use the results. This study was concerned with the lived experienced of pediatric nurses who work on inpatient hospital units and witnessed workplace violence from patients and visitors. The participants helped to shed light on essential themes which constituted the nature of their human issues and concerns. Phenomenology is best suited for answering questions such as "what" and "how" as related to the human experience. This phenomenolgic study will not aid in prediction. However, gaining an understanding of the issues and concerns of nurses related to workplace violence may help to anticipate future workplace violence events and aid in an understanding of the significance of workplace violence.

Another limitation of this study is the lack of diversity of participants in regard to race. There were 96% white participants and 4% or one mixed race participant. In 2008, there were 83% white registered nurses (RNs) in the United States and 16.8% non-white or Hispanic RNs (U.S. Department of Health and Human Services Health Resources and Services Administration, 2010). This study's participants did not reflect the RN workforce in the United States as related to race. The sample is reflective of the institution and the participants did volunteer for the study. A more diverse group of participants may have provided different perspectives about experiences with workplace violence. Male and female nurses of color may have provided valuable insights regarding workplace violence.

Recommendations

The universal themes from this study came from the particular lived experiences of the nurse participants. Based on what the pediatric nurse participants voiced regarding their perceptions of workplace violence experienced on inpatient hospital units from patients and visitors and the interpretation of their experiences, this researcher will expound on a number of recommendations. The recommendations are related to nursing research, nursing education, nursing practice, organizational policies and health care policies.

Nursing research. The first recommendation for is for researchers to utilize feminist theory as a lens to view problems related to nursing practice. Feminist are committed to conducting studies that challenge power and oppression and produce research that is useful and contributes to social justice (Hesse-Biber & Piatelli, 2007).

The second recommendation is for nurse researchers who study workplace violence to acknowledge and apply nursing knowledge based on the experiential and intuitive evidence accumulated throughout nursing history to help alter the traditional, paternalist healthcare systems. Nurses are placed in unique positions by their close contact with large numbers of community, to challenge negative stereotypes of the role of the nurse and replace them with positive impressions.

The third recommendation is for qualitative research to be conducted to investigate hospital administrators' perceptions of workplace violence against nurses. It would be interesting to compare and contrast the perceptions between the nursing staff and the hospital administrators' views of workplace violence in hospital settings. Numerous studies have been cited in the literature that provide evidence about the amount and types of workplace violence against nurses that occurs in healthcare settings

but there is a lack of studies that investigate what hospital administrators perceive about this phenomena. This type of research may help to illuminate the hospital administrators' world as related to workplace violence against nurses. It may also serve to help bring the issue of workplace violence more into focus for hospital administrators.

The fourth recommendation for nursing research is to conduct studies to investigate the quality and effectiveness of existing workplace violence prevention programs to determine not only their effectiveness but also begin to rate the quality of these existing programs. Nurses need evidence based research about violence prevention programs in order to model programs after valid and reliable examples.

The fifth and final recommendation for future research is to investigate ways hospitalized patients and their families can develop better coping skills.

Nursing education. Women can be knowers and this implies that subjective knowledge is valid and informants as the participants in this study are experts in their own lives (Stanley & Wise, 1990). One of the themes from this study indicated that the participants recognized their need for formal education regarding ways to prevent and manage workplace violence. The first recommendation to help improve nursing education is to provide feminist theory in the undergraduate nursing curriculum. Inclusion of feminist theory during the formative years of nursing education and in graduate programs may help nurses to promote a future workforce who singularly and collectively will initiate and promote nursing within a feminist framework. Feminist theory would help to generate knowledge about oppression and privilege in the profession of nursing and begin to question the status quo, highlighting conflicts within the hierarchal hospital systems.

The second educational recommendation that may help keep staff safe is to have nursing departments in healthcare agencies develop educational classes that teach nurses how to prevent and manage workplace violence. Educational classes that teach patient and family centered care while simultaneously providing patients and families with organizational rules and expectations of safe behavior are needed. Several of the participants of this study have approached this researcher and asked her to teach them classes on how to set limits with patients and families who display aggression and violence. Theses participants were also interested in learning how to develop effective communication skills to de-escalate potentially violent patients, family members, or visitors.

The third educational recommendation is for the Quality and Safety Education for Nurses Project (QSEN). The overall goal of QSEN project is to meet the challenge of preparing future nurses who will have the knowledge, skills and attitudes necessary to continuously improve the quality of the healthcare systems within which they work. QSEN has been funded since its inception in October, 2005, by the Robert Wood Johnson Foundation (QSEN, 2011). One of the main goals, 2009-2012, of QSEN is to develop the faculty expertise necessary to assist the learning and assessment of achievement of quality and safety competencies in all types of nursing programs (QSEN, 2011). It is recommended by this researcher that QSEN incorporate a workplace violence prevention program into their curricula to help faculty develop expertise to assist with safety competencies in nursing programs.

The fourth educational recommendation is to teach nurses, patients, and families about the New York State law against assaulting a nurse. The education of nurses about

such laws can occur during their entrance into all nursing education programs and upon entrance into healthcare systems. Information to educate nurses who have been in practice for years is also important. Patients and families can be educated about this law during the admission process to the hospital and other healthcare systems.

The fifth and final nursing education recommendation is for nurses to consistently explain their role and responsibilities to patients and families to help them to know and understand the complexities of professional nursing. If patients their families and other care providers learn about the role of the nurse, they may develop a sense of respect. A sense of respect for nurses may help patients and families from acting out.

Nursing practice. Nurses who demonstrate ability, knowledge, and the skills to prevent and manage workplace violence have usually developed this competency over time. These nurses should help to mentor other nurses with whom they work to assist them in developing in the same way. Nurses can help to empower each other. Nursing leaders can help their staff become empowered to become more independent in their decision making by encouraging them to make safe decisions in their everyday encounters with patients and families. Nursing leaders can empower their nursing staff to set limits with patients and families who displays negative, threatening and unsafe behaviors in order to maintain safe care environments.

Another recommendation is to have Professional Nursing Counsels in hospital systems develop workplace violence tracking and trending report mechanisms. The Professional Nursing Counsels can include as a standing agenda item for their meetings a report on workplace violence which can address the number of, type of and response to workplace violence incidents.

Organizational policies. Hospital violence is a growing concern but little is known about existing violence prevention programs (Peek-Asa et al., 2007). The hospital were this study occurred does have some departments such as the Department of Psychiatric Nursing which offers orientation classes and annual updates on workplace violence prevention .There is no universal requirement to provide and attend a workplace violence prevention program at the hospital where the study occurred.

Therefore, it is the recommendation of this researcher that a Workplace Violence Prevention Program be created by a hospital interdisciplinary taskforce and that attendance at this program is an annual requirement for all employees to attend. Another recommendation is to have hospital administrators develop and expand upon a policy of "Zero Tolerance of Workplace Violence". The policy must include procedures on how to enforce zero tolerance of workplace violence which may include: staff attendance at a Workplace Violence Prevention Program including annual class updates; mandatory reporting of (including a mechanism for reporting) workplace violence episodes; and posting of the Zero Tolerance of Workplace Violence Policy for staff, patients and visitor to view. It is recommended that The Zero Tolerance of Workplace Violence Policy be supported and enforced by senior-level administrators and medical staff. Development of a tracking and trending report mechanism for incidents of workplace violence is another recommendation for organizational policy implementation. Posting of the tracking and trending reports of workplace violence incidents via organizational e-mail for all disciplines to view may also be of help in preventing and decreasing workplace violence.

Another recommendation would be to have Human Resources and Employee Assistance Programs direct and support individuals who experienced workplace violence

to understand their legal recourse. Another recommendation is to have healthcare agencies provide formal debriefings for victims of workplace violence. And finally, it is recommended that healthcare agencies provide secure access to healthcare environments in order to ensure that only those personnel, visitors, and patients who are supposed to be on site are allowed entrance to the healthcare facilities.

The final organizational recommendation is to have hospitals and other healthcare organizations develop a code of conduct for patients and families. If patients and families know and begin to understand what behaviors are expected of them, they may agree to behave in accordance with the expectations.

Healthcare policies. In New York, The New York State Nurses' Association was instrumental in supporting the inception of a law that makes it a felony to assault nurses who are on duty. The Violence Against Nurses Law (A.3103-S.4018) took effect in November of 2010. Nine other states have enacted legislation to strengthen or increase penalties for acts of workplace violence affecting nurses. The other states include: Alabama, Arizona, Colorado, Hawaii, Illinois, Nevada, North Carolina, New Mexico, and West Virginia. Other state nursing organizations should work to have law passed in their state to provide legal recourse for workplace violence against nurses. Other recommendations to improve safety in the workplace are related to accrediting healthcare agencies.

As mentioned earlier, Magnet status is a recognition awarded by the American Nurses' Credentialing Center (ANCC), an affiliate of the American Nurses Association to hospitals that exemplify a set of criteria designed to measure the strength and quality of their nursing. The idea is that Magnet nursing leaders value staff nurses, involve them in

shaping research-based nursing practice, and encourage and reward them for advancing nursing practice (The Center for Nursing Advocacy, 2008). It is the recommendation of this researcher that ANCC include in the criteria to obtain Magnet status the documentation and enactment of a Workplace Violence Prevention Program in hospitals and in that program, a formalized method of reporting workplace violence with follow-up interventions be included. If the Magnet program is effectively promoting its important nurse empowerment goals, then the program should consider implementing workplace safety criteria for hospitals to receive the prestigious status.

The final recommendation is for the Joint Commission. The Joint Commission accredits and certifies more than 19,000 health care organizations and program in the United States. (The Joint Commission, 2011).The Joint Commission's mission is continuously improve healthcare for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value (The Joint Commission, 2011). It is recommended that The Joint Commission also make it mandatory for health care agencies to provide a Workplace Violence Prevention Program that includes a reporting of workplace violence mechanism, collection and reporting of data on workplace violence incidents and a method to follow-up and improve safety measures for staff. In order to provide safe patient and family care, staff must have safe in practice environments.

Conclusions

Workplace violence (WPV) is becoming increasingly common in the healthcare systems. Today's nurses are concerned about safety in the workplace because nursing is

becoming a dangerous occupation. In the literature, nurses identify: difficulty in preventing and managing workplace violence; difficulty reporting WPV; and indicate a general nonresponsiveness to WPV by administration (Sofield & Salmond, 2003). Workplace violence is the third leading cause of all occupational deaths and the second leading cause of occupational deaths in women (The U.S. Department of Labor, 2002).

Registered nurses (RNs) constitute the largest healthcare profession in the United States with approximately 60% of the RN jobs in hospitals (American Psychiatric Nurses' Association, 2008). Nurses treat patients with various medical and psychological conditions by making diagnoses, developing care plans, performing and interpreting diagnostic tests, administering medications, providing emotional support, and educating about health promotion and prevention of illness. The demand for nurses will increase 40% and a 400, 000 hour full-time equivalent of RN shortfall may occur by 2020 (Gallant, 2008). Maintaining nurses in the workforce by addressing the problem of WPV should be a concern for all healthcare leadership. Nurse need to have safe work environments in order to effectively manage the delivery of safe, quality patient care.

The phenomena of workplace violence against nurses has been studied extensively in psychiatric and emergency departments in hospitals. There is a need to study WPV in other healthcare settings. The problem statement for this research study was: Pediatric nurses who work on inpatient hospital units have been understudied in regard to their perception of workplace violence. Workplace violence is broadly defined as including physical assaults, sexual assaults, verbal threats, and abuse from peers (i.e. horizontal violence) as well as from consumers (American Psychiatric Nurses Association, 2008). The purpose of this study was to describe the lived experience of

pediatric nurses who were exposed to workplace violence from patients and visitors on inpatient hospital units.

Research indicates that to prevent WPV, healthcare workers need to participate in education to learn how violence affects not only themselves, but also patient care. A majority of healthcare settings lack formalized, evidence-based WPV educational programs. Many of today's WPV program are not regulated nor are they targeted to multidisciplinary workforce staff. The literature also indicates that key members of the healthcare workforce, such as physicians, are often exempt from attending WPV prevention programs. Support from institutional leadership is also important for WPV prevention programs to be successful. A theoretical framework in which to view the problem of WPV is essential for nurses to increase their knowledge base as well as to help them to articulate their feelings. A pedagogy grounded in feminist ideal has the potential to empower nurses to make changes in themselves and environments in order to stay safe in the workplace (Falk-Rafael et al., 2004).

This interpretive phenomenological study was done using a feminist lens to place the pediatric nurses' lived experience with workplace violence as the main focus of the narrative interview. The research question for this qualitative study was: What is the lived experience of pediatric nurses who work on inpatient hospital units that are exposed to workplace violence form patients and visitors? A phenomenological study is one that tries to understand a small group of people's perception, understandings, and beliefs concerning a particular situation or event (Cottrell & McKenzie, 2005).

The research occurred at a Magnet teaching hospital in Upstate New York in the Pediatric Inpatient Department of the Children's Hospital which is part of this Magnet

hospital. Twenty-four pediatric nurses volunteered to be participants in the study. The types of sampling for this study were: convenient, purposive, and voluntary. This researcher works at this hospital and had access to the participants.

The participants had various educational backgrounds, were both male and female, the majority were Caucasian, ranged from 25 to 59 years of age, and practiced as a nurse between one and 38 years. The participants held various job titles. The participants practice on the general pediatric units or in the pediatric intensive care unit. The sample size in a qualitative study is left to the researcher and once *saturation* or nothing new was learned from the participants, the sample sized was determined. Twenty four participants participated in this study. Data for this phenomenological research was obtained through face-to-face, semi-structured interviews using open ended questions. The participants' responses were audio-taped and the narratives where then professionally transcribed. The data were then analyzed. The goals of data analysis are to reflect the complexity of human interaction by portraying it in the words of the interviewees through actual events and to make that complexity understandable to others (Rubin & Rubin, 2005).

This researcher analyzed each transcript through immersion into the content by repeatedly reading the concepts to gain a sense of the data as a whole. Some participants were given the narratives to clarify and validate the data from the interviews, which is known as *member checking*. *Bracketing* was also used to prevent bias by limiting this interpreter's projection of her world onto the text. The data were then sorted by similar ideas and then sorted into categories. Coding schemes were formed and a composite description of the experience of workplace violence was developed. Inductive reasoning

was used to as a way of uncovering the meanings of the phenomenon. The data were analyzed for themes or perspectives and the major themes were reported. Moustakas (1994) calls these themes or units *essence description.*

Eight major themes were uncovered from the 24 participant narratives and are as follows: # 1 *It's part of the job*, # 2 *They were there for me*, # 3 *Conflicted about pressing charges*, # 4 *Learn to prevent and deal with it*, # 5 *Workplace violence negatively impacts our job*, # 6 *Fear for our safety*, # 7 *Nurses go it alone* and # 8 *Feeling badly for others.* A feminist lens was used to interpret these themes. In general, the themes spoke of feelings of: inequality, injustice, lack of respect, gender bias, being devalued, lack of power, oppression, lack of support, woman supporting woman, fear, lack of access to knowledge and being marginalized as a profession. These feelings may be explained by looking at theories of difference and inequality. *Social constructionism* is a broad umbrella of theories that examine difference and inequality. The construction of social identities is political and tied to relations of power. Certain institutions such as medicine and government played a role in creating classification systems and enforcing them (Feber, Jimenes, Herrera, & Samuels). Inequality as experience in the field of nursing is in part the result of oppression and privilege.

The results of this study include recommendations for: nursing research, nursing practice, nursing education, organizational policies, and healthcare policies. The recommendations are summarized as follows:

Nursing Research

1) Utilize feminist theory as a framework to view problems related to nursing practice.

2) Apply nursing knowledge based on the experiential and intuitive evidence accumulated throughout nursing history as a guide when studying workplace violence to help alter the traditional, paternalistic healthcare systems.
3) Utilize qualitative research to investigate the perceptions of hospital administrator's perceptions of workplace violence.
4) Conduct studies to investigate the quality and effectiveness of existing workplace violence prevention programs to determine not only their effectiveness but also to rate the quality of these existing programs.

Nursing Education

1) Provide feminist theory in all nursing program curriculum.
2) Have nursing departments in healthcare agencies develop workplace violence prevention and management programs.
3) Have the Quality and Safety Education for Nurses Project (QSEN) incorporate a workplace violence prevention program into their curricula to help faculty develop expertise to assist with safety competencies in nursing programs.

Nursing Practice

1) Have nurses who are competent in Workplace Violence prevention and management mentor their peers to help them develop this competency.
2) Have nursing leaders help their staff become empowered to make independent patient care decisions and empower their staff to set limits with patients who display negative, threatening, and unsafe behaviors.
3) Have Professional Nurse Counsels in hospital systems develop workplace violence tracking, trending and reporting systems.

4) Have Professional Nurse Counsels discuss the WPV tracking, trending, and reporting during their monthly meetings.

Organizational Policies

1) Have interdisciplinary teams develop Workplace Violence Prevention Programs and make attendance an annual requirement for staff to attend.
2) Have hospital administrators develop Zero Tolerance of Workplace Violence policies and procedures for how to enforce the policies.
3) Have hospital administrators post the Zero Tolerance of Workplace Violence policies and procedures for staff, patients, families, and visitors to view.
4) Provide formal debriefing for staff involved in workplace violence incidents.
5) Provide secure access to healthcare environments

Healthcare Policies

1) Nursing organizations should work to educate healthcare providers and nurses about existing laws about assaulting a nurse and if their state is without such a law making it a felony to assault a nurse, they should lobby to have a law adopted.
2) Have The American Nurses Association include in their criteria to obtain Magnet status, the documentation and enactment of a Workplace Violence Prevention Program and also a formalized method of reporting workplace violence with follow-up interventions included in the program.
3) Have the Joint Commission for hospital accreditation make it mandatory for healthcare agencies to provide a Workplace Violence Prevention Program that includes a reporting mechanism, collection and reporting of data on workplace

violence incidents and a method to follow-up to improve safety measures for staff.

In conclusion, the “essence” of the nurse participants’ experiences is the most important piece to understand to obtain meaning of this study. Nurses are educated scientists and artists who require safe environments in order to provide safe patient and family centered care. It is the hope of this researcher that this study will help to inform hospital administrators and policy makers about the need to provide safe hospital work environments.

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Appendix A

Interview Protocol

Interview Protocol: Giving Voice: Pediatric Nurse's Perception of Workplace Violence

Time of interview:

Date:

Interviewer:

Interviewee:

Place:

Position of interviewee:

Interview Questions:

- Tell me about an experience you may have had with workplace violence from patients and or visitors to the hospital. Tell me more about that.
- Have you had any other experiences with WPV? Tell about those…
- Describe your response to WPV.
- Tell me about your feelings about the incident/s…..
- How did the experience affect you personally?
- How did the experience affect you professionally?
- Is there anything that would have helped you in this situation? Anything else?
- Did you do anything differently after your experience with workplace violence?
- What did you or would you tell other nurses about the issue WPV on the hospital units?
- What did you or would you tell management about WPV on the hospital units?
- How did these incidents make you feel about working here?

(Thank the nurse for participating in this interview. Assure him or her of confidentiality of responses and potential future interviews and discuss what will happen with the results.)

Appendix B

Demographic Profile Form

Participant Identification Number (entered by researcher) _____

Directions: Fill in the blanks and mark the choices that apply.

1. Age: _____

2. Highest educational level:

   Associate degree _____
   Baccalaureate degree _____
   Masters degree _____
   Doctoral degree _____

3. Gender: Male _____
   Female_____

4. Race:

   Black or African American _____
   Asian _____
   Native Hawaiian or Pacific Islander _____
   More than one race _____
   Hispanic or Latino _____
   White _____
   American Indian/ Alaskan Native _____
   Decline to answer _____

5. Job position:

   Staff nurse _____
   Nurse Practitioner _____
   Nurse Leader _____
   Nurse Manger _____
   Clinical Nurse Specialist _____
   Other _____

6. How many years have you worked as a nurse? _____
   How many years have you worked part-time as a nurse? _____
   How many years have you worked full-time as a nurse? _____
   How many years have you worked as a nurse in pediatrics? _____
   How long have you worked in this children's hospital? _____

Appendix C

Letter of Introduction to Participants and Invitation to Participate in Study

Introductory Letter and Invitation to Participate in Research Study

Bonnie Strollo, R.N., M.S.Ed., M.S., N.P. Date:
XXXXX Children's Hospital
Box 619-11
Phone: xxx-xxxx
RE: Invitation to pediatric inpatient nurses to participate in a qualitative research study

Dear pediatric nurse:

As a nurse and a doctoral candidate at St. John Fisher College, I am interested in learning about the lived experience of workplace violence against pediatric nurses by patients and visitors. I will be conducting a qualitative research study using face- to -face, one-on-one nurse interviews with pediatric nurses to collect the data. The interviews will take approximately one hour and will occur in a private room in a location near your unit during non-work hours. One or two interviews per nurse will be required. The interviews will be audio taped and heard only by the researcher and transcriber. No names will be used to ensure confidentiality. Informed consent will be obtained before the interviews occur. St. John Fisher College's Institutional Review Board reviewed and approved this research study. The information shared by you during the interview may help researchers gain a better understanding of the experience and impact of workplace violence against nurses who work on inpatient pediatric hospital units.

Participation is entirely voluntary and any pediatric nurse who has had experience with workplace violence from a patient or a visitor is eligible to participate. If you would like to participate in the research study, please call: xxx-xxxx and leave a detailed message regarding how and when you would like to be contacted.

I hope that you will be interested in being part of this study. This opportunity to discuss your experience with workplace violence may help others in the future.

Sincerely,

_____

Bonnie Strollo, Researcher

Appendix D

Informed Consent Form

St. John Fisher College
INFORMED CONSENT FORM

Title of study: Giving Voice: Pediatric Nurse's Perception of Workplace Violence

Name of researcher: Bonnie Strollo (585) xxx-xxxx or xxx-xxxx

Faculty Supervisor: Dr. Mary Collins, PhD, RN, FAAN Phone for further information: 585) 385-8397

Purpose of study: This qualitative study will explore and understand the meaning that pediatric nurses who work on inpatient hospital units ascribe to the phenomenon of workplace violence from patients and visitors. The lived experiences of the pediatric nurses with workplace violence (WPV) will be explored to obtain a composite description and interpretation of the phenomenon in order to hear nurse's perspectives and give voice to their narratives.

Approval of study: This study has been reviewed and approved by the St. John Fisher College Institutional Review Board (IRB).

Place of study: xxxxxxx Children's Hospital xxxxxx, New York
Length of participation: 6 months

Risks and benefits: The expected risks and benefits of participation in this study are explained below:

The risks and discomforts to you for participation are related to the personal time that you must be willing to give up outside of your work schedule and the possible emotional distress that can be associated with talking about workplace violence experiences. There may be risk associated with knowing that you are discussing a negative workplace experience with this researcher who is an employee of pediatric nursing and part of the leadership team (confidentiality will be maintained). The Wellness Centre at 385-8280 is available for support of the participant if needed.

The benefits will be that you may be helping nurses learn to voice their perceptions about workplace violence. You may also be helping to bring awareness to hospital leadership regarding your insights about the need for safety and prevention of WPV. This study will also add to the nursing literature regarding the phenomena of workplace violence in hopes of creating an understanding of this problem and to encourage future research.

Method for protecting confidentiality/privacy:

As a research participant, your name will not be included in any documentation of this research study.

As a research participant, you will be assured anonymity by being assigned a number to identify your information during the audio taping of the research questions and responses. The audio tapes of the interviews will be coded by numbers and transcribed by a transcriptionist.

The audio tapes and any hard copies of documentation will be kept under lock and key in a cabinet and will be destroyed upon completion of the research study.

Any documentation done via computer will be placed in files and password protected Face-to-face interviews will be done one-on-one in a private room to ensure privacy. Individual nursing interviews will NOT be shared with nursing leadership at the hospital.

* It should be noted that this researcher is employed by the hospital where the research is being conducted and has NO supervisory responsibilities related to the research participants. The results of the research will be shared with nursing leadership in pediatrics. However, there will be no participant or specific work area identifiers attached to the data.

There will be no cost involved to you for participation in this study and there will be no payment for your participation.

Your rights: As a research participant, you have the right to:

1. Have the purpose of the study, and the expected risks and benefits fully explained to you before you choose to participate.
2. Withdraw from participation at any time without penalty.
3. Refuse to answer a particular question without penalty.
4. Be informed of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to you.
5. Be informed of the results of the study.

I have read the above, received a copy of this form, and I agree to participate in the above-named study.

Print name: (Participant) **Signature:**
Date:

Print name: (Investigator) Bonnie Strollo **Signature:**
Date:

If you have any further questions regarding this study, please contact the researcher listed above. If you experience emotional or physical discomfort due to participation in this study, please contact the Office of Academic Affairs at 385-8034 or the Wellness Center at 385-8280 for appropriate referrals.

Appendix E

Participant Demographics

						Years worked				
Participant (by pseudonym)	**Age**	**Education**	**Gender**	**Race / Ethnicity**	**Job Position**	**As a Nurse**	**Part-Time**	**Full-Time**	**Nurse in Pediatrics**	**In this children's hospital**
Participant 1	54	Associate	Female	White/Caucasian	Staff nurse	14	1	13	14	13
Participant 2	41	Baccalaureate	Female	White/Caucasian	Nurse Leader	19	0	19	14	12
Participant 3	30	Baccalaureate	Female	White/Caucasian	Staff nurse	3	0	3	3	3
Participant 4	54	Masters	Female	White/Caucasian	Staff nurse	33	29	4	33	3
Participant 5	30	Masters	Male	White/Caucasian	Clinical Nurse Specialist	9	1.5	7.5	9	9
Participant 6	29	Baccalaureate	Female	White/Caucasian	Nurse Leader	7	0	7	7	6
Participant 7	28	Baccalaureate	Male	White/Caucasian	Staff nurse	1	0	1	1	1
Participant 8	27	Masters	Female	White/Caucasian	Staff nurse	4	0	4	4	4
Participant 9	36	Associate	Female	Mixed Race Asian/White	Staff nurse	6	0	6	6	6
Participant 10	40	Baccalaureate	Male	White/Caucasian	Nurse Leader	17	0	17	17	17
Participant 11	25	Baccalaureate	Female	White/Caucasian	Staff Nurse	3	0	3	3	3
Participant 12	27	Baccalaureate	Female	White/Caucasian	Staff Nurse	4	0	4	4	4
Participant 13	26	Baccalaureate	Female	White/Caucasian	Staff Nurse	5	0	5	5	5
Participant 14	46	Baccalaureate	Female	White/Caucasian	Nurse Leader	23	0	23	23	23
Participant 15	59	Baccalaureate	Female	White/Caucasian	Nurse Manager	38	0	37	29	29
Participant 16	54	Masters	Female	White/Caucasian	Staff Nurse, Nurse Practioner, Assistant Professor	31	0	31	31	29

						Years worked				
Participant (by pseudonym)	**Age**	**Education**	**Gender**	**Race / Ethnicity**	**Job Position**	**As a Nurse**	**Part-Time**	**Full-Time**	**Nurse in Pediatrics**	**In this children's hospital**
Participant 17	45	Masters	Female	White/Caucasian	Nurse Leader	23	0	23	20	11
Participant 18	52	Diploma	Female	White/Caucasian	Staff Nurse	31	8	23	30	28
Participant 19	26	Baccalaureate	Female	White/Caucasian	Staff Nurse	2	0	2	2	2
Participant 20	55	Baccalaureate	Female	White/Caucasian	Nurse Manager	30	15	15	30	30
Participant 21	45	Baccalaureate	Female	White/Caucasian	Staff Nurse	13	10	3	13	13
Participant 22	32	Masters	Male	White/Caucasian	Nurse Leader	7	0	7	7	7
Participant 23	45	Masters	Female	White/Caucasian	Staff Nurse	23	0	23	23	23
Participant 24	24	Baccalaureate	Female	White/Caucasian	Staff nurse	3	0	3	3	3
N=24										