TITLE PAGE

NURSING STAFF EXPERIENCES AND RESPONSES TO VIOLENCE AND AGGRESSION IN THE EMERGENCY DEPARTMENT: A GROUNDED THEORY STUDY

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A thesis submitted in partial fulfilment of the requirements of the University of Greenwich for the Degree of Doctor of Education.

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DECLARATION

"I certify that this work has not been accepted in substance for any degree, and is not concurrently being submitted for any degree other than that of Doctor of Education being studied at the University of Greenwich. I also declare that this work is the result of my own investigations except where otherwise identified by references and that I have not plagiarised the work of others".

Signed by student…………………………………………………………………......

Signed by supervisor 1……………………………………………………………….

Signed by supervisor 2……………………………………………………………….

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ABSTRACT

Aims

The aims of the study were to explore how emergency department (ED) nursing staff conceptualise the terms that encompass violence and aggression in the clinical area; to explore the formal reporting practices of nursing staff following such experiences and to explore situational factors at play, relating to the development of violent and aggressive incidents in the ED setting.

Background

Violence and aggression experienced by ED nursing staff is a well recognised, global phenomenon. Published research exploring ED violence and aggression however is limited, both numerically, and in terms of quality and sophistication. The literature review conducted for this study identified very few studies that considered defining violence and aggression in the ED setting. The literature suggests that ED nursing staff frequently fail to formally report experiences of violence and aggression and factors influencing reporting practices tend to be speculated upon rather than researched. A wide variety of situational factors are identified in the literature as contributing towards violence and aggression in the ED setting, although, only a limited number of original research papers have contributed new knowledge in this field. This study was subsequently conducted for the award of a Doctorate of Education and focuses upon educational factors, within the context of the research aims and emerging themes that can be perceived as relevant to the phenomenon of ED violence.

Methodology and research design

The study was undertaken from August 2007 to May 2009 at a site specific, National Health Service (NHS), acute hospital ED in the south of England. Adopting an interpretive paradigm, data was collected and analysed within a grounded theory framework. Data triangulation was employed, with the researcher conducting a

retrospective documentary inspection of ED violent incidents forms completed by nursing staff (n=38), semi-structured interviews with ED nursing staff (n=9) and periods of non- participant, unstructured observation (n=17).

Findings

The study identified multiple examples of conflict in the ED, including nursing staff personally experiencing, witnessing, or being aware of physical assaults on staff. This included both physical assaults involving weapons, along with high levels of verbal abuse. The study also identified the phenomenon of service user-on-service user conflict, an issue previously not considered in ED literature.

The findings highlighted that individual nursing participants considered a variety of complex factors when subjectively and inconsistently defining, assessing, managing, responding to and reporting workplace conflict. A wide variety of inter-related factors contributed to how participants defined violence and aggression, although the dominant theme that emerged related to inconsistent practice. A failure to clarify the concepts encompassing violence and aggression contributed towards a culture of under-reporting of incidents; although incident frequency and a perception by participants that formal reporting was a futile exercise that did not lead to change, were also highlighted.

Some participants expressed a disempowered attitude towards working conditions, which limited a proactive approach to maximising personal safety in the department studied. A cocktail of potential situational factors was in addition identified, as contributing to conflict in the ED studied, in particular: poor corporate security, poor departmental design and infrastructure, negative service user attitude and behaviour. Stress, service user demographics, confrontational staff communication strategies and a limited proactive approach to managing violence and aggression in a professional manner at both personal and corporate levels were also cited.

Although the study had 3 pre-determined research aims; from an educational perspective, 4 key themes emerged. These related to a limited evidence-based approach to managing ED violence, due to a paucity of research; particularly research

conducted by clinical nursing staff. Inconsistent practice in assessment, management and reporting of ED violence, challenging working conditions compromising personal safety and stifling potential research opportunities, and a disempowered attitude displayed by some participants in relation to managing their occupational circumstances proactively. The data collected, during this study, in addition, highlighted multiple examples of participants being aware of, or potentially being involved in, practices that contravene the Nursing and Midwifery Council (2008) *Code of conduct, performance and ethics for nurses and midwives.*

Conclusion

The data collected during this study can be interpreted as suggesting that ED violence and aggression is poorly documented; the subject matter remains unclarified in clinical practice; specific incidents of violence and aggression are inconsistently assessed and managed and that there is a cocktail of factors which contributes towards the development of conflict in the ED.

Two central, core categories were identified during this work; and labelled as professional nursing identity, and professional maturity. The findings of this site specific study challenge the foundations of the nursing profession in terms of claims of professional status, as the data collected is incongruent with the characterisation of the attributes and traits of professional status.

Nursing identity relates to participants expressing widely differing views relating to the actual role of the ED nurse. This subsequently manifests as variations in the documentation, assessment, management and attitude of staff towards service users involved in conflict with staff.

Professional maturity relates to the limited research literature available examining this field, particularly research conducted by clinical nursing staff. This can be interpreted as reflecting a wider professional failing to embed a genuine research culture into the nursing profession. Professional maturity also relates to participants complying with the NMC code (2008).

One can propose that as the nursing profession develops and matures, individual members may project enhanced professional values which could lead to improved workplace circumstances. Currently, ambiguity and inconsistent practice characterise the nursing response to ED violence. This may be potentially rectified through a variety of higher educational (HE) initiatives designed to proactively and positively influence the two central core categories identified above.

Educational recommendations relate to encouraging a policy shift in the HE sector to promote the development of genuine professional autonomy. This could be achieved through placing emphasis on facilitating the development of under-graduate nursing students as potential future researchers; by formally requiring under-graduate degree nursing students to engage in original data collection research activities. HE institutions should also strive to empower under-graduate nursing students to challenge current occupational workplace conditions, through a transformational leadership approach emphasising the development of confident, assertive, and politically astute nurses of the future.

Clarification relating to defining violence and aggression in the healthcare context, a review of current formal reporting procedures, a review of corporate security at the site examined, a wider debate relating to the role of the ED nurse, and increased research and education focusing upon ED violence and aggression are all suggested as further recommendations.

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CHAPTER 1: INTRODUCTION

1.1) Chapter introduction

The first chapter begins by outlining the focus and professional context of the study. This is followed by a brief introduction to the chosen research methodology and research method, and concludes by stating and providing rationale for the research aims.

1.2) Justifying the focus and professional context of the study

Published literature emphasises that violence experienced by emergency department (ED) staff is a well-recognised and serious issue (Lau and Magarey 2006). Besides the impact on health staff and organisations, violence also directly and indirectly affects the quality of service user care, the satisfaction of service users in terms of service delivery and inevitably contributes to an escalation of healthcare costs (Lau, Magarey and McCutcheon 2005).

I have decided to conduct this study for a number of reasons. Firstly, I have focussed on the ED setting because the ED has traditionally been viewed as an area where violence frequently occurs; and there is a perception, internationally, that violence against staff practising in EDs is increasing (Meuleners, Lee, Shao and Intrapanya 2004, Fernandes, Bouthillette, Raboud, Bullock, Moore, Christenson, Grafstein, Rae, Ouellet, Gillrie, and Way 1999, Jenkins, Rocke, McNicholl and Hughes 1998). The literature also suggests that of all healthcare occupational groups, nursing staff are at greatest risk of experiencing workplace violence (Wells and Bowers 2002, Whittington, Shuttleworth and Hill 1996).

Secondly, only a limited number of high quality academic papers examining nursing staff`s experiences of violence in the ED are currently available. The knowledge base consequently related to ED violence is very small and therefore a doctoral study exploring aspects of nursing staff experiences of ED violence has the potential to contribute to new knowledge in this field.

Thirdly, as a lecturer in HE part of my current responsibilities involve preparing student nurses for under-graduate practice experience, facilitated within EDs in the local area as well as facilitating post-graduate teaching related to ED violence. Appendix 1 is a list of examples of my publications and conference presentations related to this area. The personal safety of the ED nursing staff and students is an important priority and the new knowledge gained through this study may contribute to curriculum development enhancing the safety of nursing students and of staff practising in the ED setting as well as service users.

Finally, recent reforms implemented for emergency services emphasise the government agenda, that publicly espouses delivering a comprehensive, patient-focused emergency care system that transcends the conventional boundaries of primary, secondary and social care (Department of Health (DoH) 2004). The DoH (2004) recently described the changes in emergency care services as "*really remarkable*" and "*by international standards…outstanding*" (DoH 2004 pages 8 and 9). It can be suggested that one measure of an improved service could be a reduction in staff experiences of conflict with service users; and positive (or negative) policy initiatives may be measured against the experiences of ED nursing staff delivering care in practice.

1.3) A brief introduction of the chosen methodology and method

This study is categorised as adopting an interpretivist methodology. The interpretivist approach acknowledges that researchers are only able to gleam perspectives of research participants lives and the approach to inquiry acknowledges the subjective, emotional component of the human being. Hence research is speculative in nature. This fits well with the phenomenon under investigation as violence is a subjective concept.

The chosen method of data collection and analysis is based around the Strauss and Corbin (1998) approach to grounded theory. Data collection utilised triangulation with the researcher conducting a retrospective documentary inspection of ED violent incidents forms (n=38), audio recorded, semi-structured interviews with ED nursing

staff (n=9), and periods of non-participant, unstructured observation (n=17), recording observations with a field journal and research diary.

1.4) Rationale for research aims

Research literature suggests that the terms violence and aggression, although having differing definitions, are frequently used interchangeably in the nursing literature (Wells and Bowers 2002). Subsequently, it is well recognised in the nursing literature that researching workplace interpersonal conflict within healthcare organisations is problematic due to the conflation of abuse with assault and differing operational definitions of terminology (Needham, Abderhalden, Halfens, Fischer and Dassen 2005). Conceptualising terms therefore, encompassing violence and aggression, within the context of emergency nursing practice, forms an important aim of this study.

It is also widely accepted that incident under-reporting in the ED is widespread (National Audit Office 2003, Levin, Hewitt, and Misner 1998) and this influences both understanding and policy development. Exploring factors therefore that influence the formal reporting practices of ED nursing staff is the second aim of this study.

Literature also suggests that there is increasing consensus that situational factors play an important role in the development of violent and aggressive confrontations across a wide range of locations (Bjorkly 1999, Leather and Lawrence 1995). This study therefore aims to explore the situational interactions at play relating to violent and aggressive experiences of ED nursing staff.

Finally, prior to the study commencing, I had facilitated a number of teaching sessions revolving around the concept of ED violence; and informal discussions with ED nursing staff did suggest that the stated aims of this thesis are areas of concern that could form the focus of a research study.

To conclude, this research aims to explore how emergency department (ED) nursing staff conceptualise the terms that encompass violence and aggression in the clinical area. It aims to explore the formal reporting practices of nursing staff, following such

experiences, and to explore situational factors at play relating to the development of violent and aggressive incidents in the ED setting. The qualitative nature of the study: adopting a grounded theory approach, resulted in 4 other themes emerging which contributed to the uniqueness of the research. The above aims and emerging themes have received only minimal attention in the ED nursing literature and consequently this thesis has the potential to contribute new knowledge in each area under investigation.

Having introduced the study the following chapter provides a literature review that summarises and critiques the current ED literature in relation to the identified research aims.

CHAPTER 2: LITERATURE REVIEW

2.1) Introduction

This literature review summarises and critiques the current literature in relation to the identified research aims. The aim of this literature review is to set out the broad context of the study, critically appraise and examine research methods examining violence occurring in the ED, and to synthesise the current state of knowledge relating to violence towards emergency nursing staff. Literature reviews make the case for a proposed study and enhance studies because the preliminary review enhances theoretical sensitivity, offers a useful secondary source of the data, gives rise to questions about the data, contributes important means of theoretical sampling and offers an approach to validating the theory (Sandelowski and Barroso 2003, Denzin and Lincoln 2000).

2.2) Search method and critiquing framework

The literature search was conducted via internet, database and hand/manual searches of published literature checking reference lists. The primary search engine used for the internet searches was provided by "*Yahoo*" at http://www.yahoo.com. Internet searches mainly identified resources from international, national, government or nursing organisations.

2.2.1) Primary databases

The primary databases used for the literature search were the Cochrane Database of Systematic Reviews, Medline (PUB-MED online), the British Nursing Index, the Cumulative Index of Nursing and Allied Health Literature (CINAHL), and the Kings Fund and EMBASE.

2.2.2) Key words

Accident and emergency, emergency room, emergency department, violence, aggression, abuse, victimisation, injury, security, nursing, healthcare, staff, psychological, workplace violence, general hospital, patient aggression, verbal abuse, risk management and interpersonal conflict were all used. Synonyms, truncation and Boolean search phrases were used as appropriate, for example, the term violence was used and combined with physical assault, battery, aggression, homicide, murder, injury, verbal abuse, non-physical assault, verbal violence, verbal assault, emotional abuse, harassment, intimidation, absenteeism, sickness, stress, recruitment, retention, attrition, career change, quitting and leaving.

2.2.3) Inclusion criteria

- When searching for data related to the subject matter no time frames were employed.
- Language limitations involved identifying only text that was originally published or translated later into English.
- Only articles, primarily focusing on violence and aggression experienced by ED nursing staff, were considered, unless the focus was on the ED environment. (For example, papers considering the presentation of service users with weapons).
- The major inclusion requirement was that only articles that could demonstrate the generation of original audit or research data, that contributed towards new knowledge in the field being investigated, would be considered.
- No specific definition of violence was employed, due to a lack of consistency in the literature related to physical assault, verbal abuse, abuse, violence or aggression. Such terms were frequently used interchangeably although having differing meanings.

2.2.4) Exclusion criteria

- Articles containing no empirical data or containing insufficient description of methodology and instruments were excluded.

The final total number of papers identified through the literature search were categorised as thirty seven presenting quantitative data, seven qualitative data and one mixed method study respectively. These papers are summarised in appendices 2 and 3.

2.2.5) Critiquing frameworks

The primary critiquing frameworks adopted during the process of critical analysis, were frameworks offered by Lincoln and Guba (1989), Cormack (1996 p 80-81), Greenhaulgh and Donald (2000), Hek, Judd and Moule (2006 appendix 3 130-133) and guidance offered by Endacott (2007) and Botti and Endacott (2007).

2.3) Dilemmas when critiquing the available literature

Undertaking a literature search of research related to violence and aggression in the ED is fraught with difficulties. Firstly, one needs to appreciate the widely differing cultures within which healthcare facilities function. It is generally accepted, for example, that the United States of America (USA), Canada, Australia and the UK have significant differences in relation to a perceived gun culture; and healthcare facilities cannot be isolated from the societies within which they function and the local communities they serve (Fulde 2005, Henry and Ginn 2002). Papers examining ED violence and weapons utilisation in the ED originating from, for example, the USA, need to be considered within the social context of the ED setting, and this raises concerns relating to international, external validity.

Secondly, a lack of consistent definitions and categorisations of violence; variations in characteristics of study sites, variety of time periods considered, under-reporting and varying reporting standards, added to inconsistencies regarding sampling generalisations, self selection bias, publications without peer review, no randomised

control studies and high non response rates complicates the issue of comparing studies and the credibility or trustworthiness of studies considered (McKenna, Poole, Smith, Coverdale and Gale, 2003, Wells and Bowers 2002, Merchant and Lundell 2001).

Research examining violence and aggression, within the healthcare system, has subsequently been criticised in relation to validity, reliability and objectivity within a positivist epistemology. As the research approach, adopted by this researcher, is interpretative, an emphasis will be placed, throughout the presentation, on the methodological instruments and presentation of theoretical propositions chapters on the credibility, transferability, confirmability and dependability of the study. Focus will be placed on these qualitative terms which can be interpreted to correspond to internal validity, external validity, objectivity and reliability respectively (Graneheim and Lundman 2004, Finlay 2001).

The majority of studies discussed and identified in this text, adopt self reporting retrospective surveys requiring retrospective recall of potentially stressful lived events; meaning that subjectivity, bias, the vagaries of memory, and the possible contamination of data by current events may all alter the data (Lau and Magarey 2006, Celik and Bayraktar 2004, Jackson, Clare and Mannix 2002).

Only the perceptions of the staff involved (or documenting the event) are offered in the studies critiqued as rarely have the service user perceptions of aggression been investigated (Lau and Magarey 2006). Actors accused of verbal or physical violence have no defence or opportunity to state their case.

Methodological concerns include a frequent lack of referral to ethical approval, or the lack of application of pilot studies (appendices 2 and 3). Ethical approval and piloted work frequently offers an aspect of quality assurance, although the lack of such evidence may possibly be due to limitations placed by publishers on space or word count (Hart 1998).

A lack of a co-ordinated, systematic approach to investigating ED violence can be identified through the small number of original research papers (9) that confirmed funding or grant support (appendices 2 and 3). Hek et al (2006) state that identifying

sponsorship for funding is important when appraising published research literature; yet on inspection, only two papers critiqued, led by nurse researchers, confirmed research grant funding with none of the papers presenting qualitative data, explicitly stating any.

A number of authors suggest that part of the process of critiquing research literature, involves analysing the background and qualifications of researchers in order to make a judgement, related to the credibility or appropriateness of the researcher personnel (Flick 1998, Cormack 1996). Of one hundred and thirty four authors, identified through the critiquing process by statements related to their profession or qualifications (fifteen authors professions/qualifications were not offered), twenty three could be classified as clinical nursing staff, thirty one as nursing academics, four as nurse researchers, four as nurse managers, forty five as medical doctors and twelve as others (e.g. non nursing academics/ science officers).

Hek et al (2006) suggest that researchers should be appropriately qualified/supported to undertake research projects, but on closer inspection only Keep, Glibert, Winstanley, Whittington, Fernandes, Raboud, Christenson, Bouthilitte, Bullock, Ouellet, Moore, Schneiden and Marren-Bell had published more than one original paper examining ED violence. This raises possible concerns, relating to the knowledge base and experience of the majority of researchers and may partly explain the lack of sophistication of individual studies critiqued, which from a quantitative data collection perspective, manifest a failure to adopt inferential statistical analysis of data; or from a quantitative data perspective fail to state a clear methodological underpinning. Interestingly none of the qualitative research papers involved medical personnel (who have conducted the majority of research examining ED violence concerning nursing staff).

The literature does highlight that there are concerns relating to a lack of clinical nurse research activity (Kajermo, Nordstrom, Krusebrant and Lutzen 2001, Nilsson Kajermo, Nordstrom, Krusebrant and Bjorvell 2000). This review raises concerns relating to the small number of clinical nursing staff contributing to publishing in this field. The lack of nursing-led research in this field however, may be partly explained by the subjectivity and perhaps unattractiveness of the research field to the positivist

epistemological position. This may be primarily due to dilemmas in attempting to measure subjective concepts such as violence, verbal abuse or post-incident feelings.

Limited nurse-led research in this field, may reflect a wider failure of a genuine research culture, and supportive organisational infrastructure, being embedded into the career structure of nursing staff. A concern this raises is that a lack of nursing research in this field may reflect a potential lack of research opportunities for clinical nursing staff as opposed to a lack of enthusiasm or interest. At this point the first educational theme emerging from this study relates to the limited number of original research papers published by nurses`, particularly those written by clinical nursing staff, related to ED violence and aggression. This theme will be discussed in greater detail in chapter 7.

Instruments for data collection have included analysis of violent incident forms, questionnaires/surveys, face to face interviews, focus groups, telephone interviews, reviews of medical records and field observations (appendices 2 and 3). Studies of incident books allowed auditors to look back over fourteen (Ordog, Wasserberger, and Salness 1993) or ten years (Cembrowicz and Shepherd 1992) whilst data collection conducted at site-specific departments ranged from 5 days, (Hesketh et al 2003, Graydon, Kasta and Khan 1994) to 3 months` (Winstanley and Whittington 2002) or several years (Akerstrom 1997). Studies also collected data that covered specific time frames, for example Morgan and Steedman (1985) conducted a 6 month prospective study of ED violence, while retrospectively Mahoney (1991) collected data related to the career experiences of ED staff. These differing approaches result in wide variations in relation to collected data available for analysis.

The majority of articles presenting quantitative data published in the 1980s and early 1990s utilise raw data, percentages and bar chart graphics only. More recent studies however, have increasingly utilised inferential statistics (appendix 2). A parallel can be drawn whereby the historical development of the sophistication of the research papers, presenting quantitative data can be identified, as recent studies increasingly utilise inferential statistics. In contrast, no such development can be demonstrated in the development of the papers presented in a qualitative format as early papers

frequently omitted a methodological framework, and remains largely unaddressed in the more recent literature.

2.4) Defining violence in the ED

The definition of what constitutes a violent act varies from person to person and between groups and cultural settings (Lau et al 2005). The World Health Organisation (2002 page 4) defines violence as;

"The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation"

Although this definition incorporates both physical and verbal violence, the use of the term "*intentional*" removes the phenomenon of occupational injury from those who project challenging behaviour as a consequence of their medical presentation or service users who are hypoxic or confused, for example. As this literature review will demonstrate, nursing staff practising in the ED are at risk of both intentional and unintentional physical injury during interactions with service users; and subsequently perhaps a more appropriate definition of violence when applied to the emergency setting is the definition of violence agreed by the European Commission (Wynne, Clarkin, Cox and Griffiths 1997);

"Incidents where persons are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health"

Studies by authors such as Crilly, Chaboyer and Creedy (2004) or Hislop and Melby (2003) indicate that nursing staff frequently use the term violence interchangeably, as an umbrella term, conceptualising aggression, physical assault, verbal abuse, or witnessing physical assault and verbal abuse together under the term violence. Wells and Bowers (2002) identify the consistent conflation in the literature between the terms violence and aggression, making comparisons and generalisations problematic. The terminology therefore on aggressive behaviour varies considerably, with differing

operational definitions rendering data collection and comparison of aggression rates difficult (Needham et al 2005).

Specific authors use different operational frames of reference. For example Cooke Higgins and Bridge (2000 p17) ask for data related to "*attacks*" while Rose (1997 p 216) defines physical assault as "*any physical contact that results in a feeling of personal threat*"; actual injury therefore was not required. Such discrepancies can influence the credibility, transferability, confirmability, and dependability of data obtained. How individuals define or interpret violence furthermore, will influence their response to violent experiences; and subsequently identifying how nursing staff define violence and aggression in the clinical area is a major aim of this thesis.

2.5) A historical overview

The first academic paper identifying violence in the ED was published in 1982 by Ochitill and Kreiger (1982). They analysed and published data collected from the San Francisco General Hospital between 1976 and 1978 and identified twenty nine reports of violence. The authors concluded that the majority of service users, involved in violent incidents, were drug/alcohol abusers and that male substance abusers in their mid 30s or younger appeared the most likely to commit an act of violence in the general hospital. The demographics of potential aggressors, identified in this study, as young, male, substance abusers receives considerable support from studies conducted generally in emergency settings (Jenkins et al 1998, Schneiden and Marren-Bell 1995) and these variables will be considered later in the text.

Ochitill and Kreiger (1982) identified 2 important limitations to their study; firstly the study relied solely on individual staff reporting incidents and secondly there was concern that data may also have been contaminated as, historically, administrators not present at the incidents may have completed and filed reports making conclusions problematic (Vanderslott 1998). Yin (2003a) identifies that reviewing documentation does have advantages, because the data is stable, unobtrusive and potentially exact. Weaknesses however to this approach include biased researcher selection and bias on the part of those completing the documentation (Gangeness and Yorkovich 2006).

In the UK, the first formal study exploring ED violence was conducted by Morgan and Steedman at the Edinburgh Royal Infirmary. As correctly noted by Lavoie, Carter, Danzi, and Berg (1988) previous work by Coffey (1976), Cowper-Smith (1977), the Royal College of Nursing (1977), Gosnold (1978), Wakeley (1978), Winterbottom (1979a, 1979b) and Cardwell (1984) all involved anecdotal reports that more closely resemble reflective journalism than original research . The above papers were excluded from this literature review due to either a lack of sufficient description of methods, or a lack of empirical data presentation.

Morgan and Steedman's (1985) study is important, not only because of its original focus but also because the study was prospective, which is unusual in this field. Only studies by Knott, Bennett, Rawet and Tayor (2005), Crilly et al (2004), Fernandes, Raboud, Christenson, Bouthilette, Bullock, Ouellet and Moore (2002) and Winstanley and Whittington (2002) match this prospective approach.

Morgan and Steedman (1985) classified a violent episode as a threatened or actual act of physical aggression and reported fifty one episodes of physical attacks, forty nine incidents of verbal abuse and 10 incidents of damage to hospital property over a 6 month period. The paper met the original aim of the study, in relation to quantifying the frequency of incidents, although, as noted, relying solely on data completed from written incident forms may be problematic.

The Health Service Advisory Committee (1987) followed this study with a report that surveyed five thousand healthcare workers, from 5 health districts. Receiving a 60% response rate (Sample n=3000), the report identified that 21% of ED staff responding to the survey, had sustained an injury following a service user assault in the previous year. In relation to physical injuries Cembrowicz and Shepherd (1992) examined a violent incident record book and security officer records over a 10 year period at the Bristol Royal Infirmary, and reported four hundred and seven incidents, including staff experiencing thirty three episodes of punching, sixteen of kicking, 7 staff were grabbed, 4 stabbed, 4 scratched, 3 slapped, 2 head butted, 1 strangled, 1 had their hair pulled and thirty one injuries remained unspecified.

Physical injuries to staff reported, included fractured ribs, superficial stab wounds and attempted strangulations, while other injuries tended to be bruises and lacerations (Cembrowicz and Shepherd 1992). Although Wells and Bowers (2002) criticised this work as offering very little useful data it can be suggested that the knowledge gained was not previously available, thus justifying the purpose of the study and the importance of the research. One theme highlighted by Cembrowicz and Shepherd (1992) relates to variables of ED nursing staff, presented by the literature, as victims of violence which allows one to begin the development of identifying themes that emerged from the literature critiquing process. The themes identified through the literature review are summarised through a framework offered by LeBlanc and Barling (2004) (figure 1) at the end of this chapter.

2.6) Victim characteristics/variations

The following section summarises characteristics relating to nursing staff who have been victims of violence in the clinical area.

2.6.1) Gender

Cembrowicz and Shepherd (1992) identified that of one hundred and two incidents reported by staff, 50% of incidents were reported by nursing staff, (thirty five female, twenty six male). This is interesting as numerically the nursing workforce is female dominated (RCN 2002) and one could expect an over representation of female nursing staff involved in ED violence. A dilemma with the paper offered by Cembrowicz and Shepherd (1992) is that the majority of the discussion is speculative and the results and analysis are not explicitly linked back to the original question, as gender variations are identified in the results section but not addressed in the discussion.

Gender variations however, have been considered by Mahoney (1991) who conducted a postal questionnaire survey of ED registered nursing staff practising in Pennsylvania (n=1209 rr 60%). Mahoney (1991) identified that 97.7% of respondents had experienced some type of victimisation during their careers. The strength of this paper lies in the relatively high response rate (60%) and the attention paid to the instrument utilised; the content validity of which was enhanced by the author by adapting

previously published survey instruments from other fields with a focus group to develop and pilot the final questionnaire. This was also the first published paper, identified during the literature search, to utilise inferential statistics in order to enhance results. One cause for concern however, is that the paper utilised a ninety one item survey that could have induced responder fatigue. Limitations of utilising questionnaires, as data collection tools, include researchers being unable to ensure respondents follow instructions, comply with skip patterns, provide confirmable correct answers or complete all questions asked (Drennan 2003).

Mahoney (1991) identified a significant relationship between respondents` gender and frequency of assaults ($p<0.001$) and verbal abuse ($p<0.005$), with male respondents reporting greater frequencies of all types of victimisations than did females. An over-representation of male ED nursing staff as victims is supported by Atawneh, Zahid, Al-Sahlawi, Shahid and Al-Farrah (2003) and Ryan and Maguire (2006). In contrast no statistically significant effect for gender was reported by Winstanley and Whittington (2002), Fernandes et al (2002), Whittington et al (1996) or Graydon et al (1994).

No explanation for gender effects are offered in the ED literature but the mental health literature suggests that a possible reason female nursing staff are at less risk of experiencing violence relates to female staff communicating in a less macho, confrontational or provoking way (Tannen 1994).

2.6.2) Age

Ryan and Maguire (1996) (n=37 rr 46%), in an Irish study, identified that age emerged as a significant association with nursing staff experiences of violence and aggression as individuals of a younger age were significantly associated with having what they describe as experiences of "*single or multiple sources of mild violence*" ($p=0.002$).

In contrast Erkol, Gokdogan and Erkol (2007), Crilly et al (2004) and Fernandes et al (2002) reported no statistically significant association related to age. Graydon et al (1994) conducted a study of abuse, experienced by nursing staff practising in 3

hospitals (teaching, psychiatric and community) in Toronto, Canada. A postal survey of two thousand three hundred and forty four nurses resulted in a 25.7% response rate (n=603). Graydon et al (1994) reported no statistically significant effect for age however they did report that respondents who had experienced abuse had been working in the hospital for a shorter period of time (mean 5.9 years) than those who did not experience abuse (mean 7.4 years), and this was statistically significant (p<0.004). However, Graydon et al (1994) did not specify this variable in relation to ED staff alone but generalised to all respondents, so presented results were not ED specific.

Ergun and Karadakovan (2005) (n=66 rr 72%) conducted a questionnaire survey of 4 ED`s in Turkey and identified that as age and years in the ED increased, the relative number of verbal violence incidents also increased (p=0.000). Physical violence experienced by ED nurse responders had a similar relationship with age (p=0.006) and years in the ED (p=0.001).

Unfortunately authors such as Schneiden and Marren-Bell (1995), although collecting demographic details such as age did not apply or report on statistical tests examining this variable. The only authors developing this issue were Whittington et al (1996), who conducted a mixed method study of violence in a northern England ED through conducting both interviews (n=52 rr 53%) and a postal questionnaire (n=343 rr 38%). Although a large study only 7 ED staff responded to the postal survey and the paper does not identify if any ED staff were interviewed. The authors however, suggested age is an important factor based upon the premise that either younger nurses are more likely to report incidents or younger nurses actually experience more incidents. Adib, Al-Shatti, Kamal, El-Gerges and Al-Raqem (2002) from the ED setting further proposed that clinical experience seems to provide longer serving nurses with an empirical sense for predicting and avoiding violent outbursts which is lacked by less experienced ones.

The wider, predominantly mental health literature, suggests that there is consensus that student nurses, younger nurses, less experienced staff and less educated nursing staff are more vulnerable to patient violence (Little 1999, Grenade and Macdonald 1995). Authors such as Ardelt (2000) propose that older staff gain a more mature

perspective on the world through increased knowledge and wisdom and Deikman (2001) suggests that older staff value the recognition of the importance of establishing meaningful relationships with people and thus become less self centred.

It can be suggested that older, more experienced staff may develop increased knowledge and clinical ability meaning they can more positively manage potentially violent confrontations with service users, or prevent the development of such confrontations through providing a high standard of nursing intervention. However, prolonged careers in the ED setting may mean that, due to the nature of ED work, at some point individual staff will inevitably experience potentially violent situations.

2.6.3) Race and ethnicity

The NHS is the largest employer of black and ethnic minority workers in the UK (Coker 2001) and it is widely accepted that differences in ability, age, ethnicity, gender, religion and sexuality permeate the multicultural society (Cortis 2003). The impact of ever increasing ethnic and cultural diversity within our general population creates significant challenges for healthcare providers, because the management of interpersonal conflict is difficult and becomes more challenging when actors come from racially diverse backgrounds (Thomas 1993, Waters 1992, Van London, Joseph, Ameling, and Hengeveld 1990).

A national Kuwaiti study by Adib et al (2002) (n=5876 rr 84%) reported a significant risk factor for experiencing recent physical violence included non-Kuwaiti nationals when compared with those who had never experienced such assaults. From the USA May and Grubbs (2002) reported that 42% (n=86 rr 68.8%) of ED nursing respondents believed that racial tension was a contributory factor to staff/service user confrontations.

From the UK however, Whittington et al (1996) identified lower rates of abuse for non white than white staff although the very small sample size was too low for meaningful statistical analysis (non white responders 6, n=343). With the exception of these papers the role of race and ethnicity in the development of staff and service user confrontations has not been addressed in the ED literature.

2.6.4) Staff education and training

The benefits of high quality training and education programmes can result, it is suggested, in a reduction in the number of violent incidents, a reduction in the seriousness of incidents, a reduction in the psychological effects of incidents, an improved response to incidents and an improvement in staff morale, although the exact content of such programmes is disputed ((Lynch, Appelboam, and McQuillan 2003, Cutcliffe 1999, Little 1999, HSAC 1997).

The importance of appropriate training within the ED literature has been emphasised by Erickson and Williams-Evans (2000) (n=55 rr 98%) who reported that attendance at an assault prevention class was inversely related to subsequent assaults. Nurses who had attended an assault prevention class were less likely to be assaulted although the authors concede such results must be treated with caution due to the wide range of variables influencing both assault rates and reporting behaviours.

Despite research literature promoting the benefits of education and training the international literature consistently indicates that in relation to managing violence and aggression in the ED, staff training and support is disorganised, sporadic, uncoordinated, varying in frequency, duration, quality and content and ultimately leading to staff feeling diffident in dealing with conflict situations (Ryan and Maguire 2006, Presley 2002, Lee 2001, Lyneham 2000).

Defining “*training and education*” however, is problematic as a wide variety of nurse education takes place at the bed side as work based learning, role play, debriefing or case study approaches and it can be suggested that any teaching session, formal or informal, ring-fenced or not, that improves the quality and ability of ED nursing staff would be contributing towards minimising confrontation in the clinical area through improving individual ability, one`s individual contribution to the nursing team and subsequent care delivery.

Studies presenting qualitative data have also addressed the issue of training and education. Levin et al (1998) conducted 4 focus group interviews, comprising of

twenty two nursing staff practising in EDs in one large metropolitan area in the USA. The use of an ecological occupational health framework contributed to the quality of the presentation of themes offered as results, although the paper could have paid more attention to developing conclusions and recommendations and lacked any clear reference to study limitations. Findings suggested however that the respondents expressed insight when commenting that when staff lacked aggression management skills incidents were more common. Participants also complained that training was not generally provided and was not specific to managing aggression in the ED.

2.6.5) Judging service users and the attitudes of emergency workers

One focus of the literature examining ED violence relates to the attitudes and behaviour of ED staff themselves towards service users. The emergency literature does devote considerable time to the issue of inappropriate ED attenders, that is, individuals attending ED`s for invalid reasons. In a seminal study by Roth (1971) few emergency service users were genuine emergencies regarded as urgent and only approximately 40% of service users were completely new attenders. More recently, Nunez, Garcia-Martin and Aguirre-Jaime (2000) suggest that the high number of service users presenting at departments who are subsequently discharged suggest that the ED is "*abused*" by the community.

Inappropriate attenders may play a larger role in staff assaults than is currently considered, as in a study by Crilly et al (2004) (n=71 rr 66%) one quarter of violent incidents involved service users who did not wait to see a Doctor. Lavoie et al (1988) also identified that approximately 67% of service users who exhibited violent behaviour did not wait for treatment. These are service users who present at the ED for a variety of reasons, yet are fit enough to behave violently and leave prior to treatment.

Blank and Mascitti-Mazur (1991) report that interviewed nurses (n=7) cite lengthy waiting times, overcrowded waiting rooms, previous problematic ED encounters and perceptions of staff ignoring service users as variables related to negative interpersonal encounters. Authors have reported nurses as describing the waiting room area as "*thick with hatred*" (Hislop and Melby 2003) where staff could "*smell the*

tension because it is a four hour wait and everybody is drunk" (Levin et al 1998). In such circumstances violence is viewed "*as a foregone conclusion*" (Hislop and Melby 2003). Hislop and Melby (2003) report that responders complain about service users and relatives who are described as "*selfish*", treating nurses "*like dirt*" with nurses wanting to "*scream and say how dare you*".

The issue of service access is very important, because service users are the most likely group to be involved in conflict with ED staff and subsequently service user demographics are potentially an important variable. Most acts of violence occur against those lacking power, both socially and economically (Zedner 1994) and the literature suggests that those on the fringes of society are the most likely to experience violence and hence emergency care (Howe and Crilly, Townsend, Phillimore and Beattie 1998, British Crime Survey 1998). Kemshall (2002) argues that the socially excluded are increasingly assessed in terms of the risk they pose to society and subsequently ED violence is a public health issue because it is social and economic circumstances that influence those who access the service and those who do not.

The attitude of ED staff towards service users has been addressed by Jeffery (1979) who used data from seven months` participant examination in an English city. Although focusing primarily on medical staff the quality of Jeffery's (1979) work warranted inclusion in this thesis due to the data presentation and subsequent intellectual analysis. Jeffery (1979) suggested that doctors (he also implied nurses) broadly discriminate emergency service users into two categories; good and interesting or bad and rubbish. Good service users offered the following characteristics:

- they allowed medical staff to practice skills necessary for passing professional examinations.
- they allowed staff to practice their chosen speciality.
- they tested the general competence and maturity of the staff.

Such service users were, for example, labelled as head injuries, cardiac arrests or multiple trauma admissions (Jeffery 1979). It could be argued that the stereotypical

violent emergency attendee directly challenges the above profile. Intoxicated service users for example may be seen as time wasters, who present with trivial medical issues, may resist giving medical histories, may frequently contradict themselves and may appear irrational. Furthermore they may break social norms by shouting and complaining.

Jeffery (1979) went on to consider bad or rubbish service users who were grouped into four general categories:

- trivia
- drunks
- overdoses
- homeless

Such service users were referred to in terms such as "*tramps, nutcases, obese, dross, dregs, crumble or grot*" (Jeffery 1979). Throughout the literature such individuals frequently receive little empathy or compassion. Aggressive service users are referred to as nuisances, trouble makers and the plain bloody minded (Cowper-Smith 1977), tramps (Dimond 1994) or addicts, drunks or senile (Akerstrom 1997). More recently Lyneham`s (2000) study suggests that nurses can see some service users as "*gomers*" (get out of my emergency room). Jeffery (1979) suggested that such service users are viewed negatively primarily because these groups break one or more of the following rules:

- service users must not be responsible; either for their own illness or for getting better, medical staff can only be held responsible if, in addition, they are able to treat the illness.
- service users should be restricted in their reasonable activities by the illnesses they report with.
- service users should see illness as an undesirable state.
- service users should co-operate with competent agencies in trying to get well.

Jeffery (1979) noted that bad service users were treated by emergency staff with verbal hostility, vigorous restraining and when uncooperative, were ignored.

Within the ED literature Shepherd (1998) accepts that some emergency care doctors believe that frequently the injured are largely responsible for their own injuries. Importantly nurses have a professional and moral responsibility to offer high quality care in an unprejudiced manner (Nursing and Midwifery Council (NMC) 2008) yet a recent qualitative paper by Luck, Jackson and Usher (2007) also highlights that nurses in their study judged the individual legitimacy of service user presentation, offering empathy, tolerance or the setting of firm boundaries based on their subjective assessment. Luck et al (2007) conducted a qualitative study utilising semi-structured interviews (n=20) and participant observation, a triangulated approach to data collection that enhanced the scientific rigour of the study.

Nurses, in a study by Levin et al (1998), suggest that attitude and body language contribute more to aggressive incidents rather than to arbitrary issues related to size or age. One nurse stated, "*Just be more compassionate, sometimes if you respond softly to an angry service user, you can defuse a situation*" (Levin et al 1998). Lyneham (2000) also cautions staff who mimic the poor attitudes of colleagues, and emphasises that nurses should not meet aggression with aggression. Mahoney (1991) also reports how nurses wondered if their attitudes, changed over time, might also incite some instances of victimisation and both May and Grubbs (2002) and Knott et al (2005) note that aggressive incidents can be triggered through overzealous enforcement of hospital policies.

Britten and Shaw (1994) emphasise that a lack of a caring attitude towards service users can produce negative service user experiences and although the issue of staff provocation is under researched in the emergency field, it is a controversial but relatively significant phenomenon in mental health settings (Secker, Benson, Balfe, Lipsedge, Robinson, and Walker 2004). It has been emphasised, in addition, that many service users work hard at being undemanding and compliant with the aim of being good service users, hiding personal disappointment at the quality of care and waiting stoically for treatment (Nairn, Whotton, Marshal, Roberts and Swann 2004, Akerstrom 1997).

To conclude this section, very little information is available related to ED staff demographic characteristics in relation to risk of experiencing violence; and the available data is contradictory. It can be reasonably suggested that individual nursing staff's knowledge, clinical experience and attitudes towards service users may influence the development of negative interactions. Subsequently a primary aim of this thesis is to examine situational factors at play in the development of service user/staff conflict.

2.7) Levels of violence experienced by ED nursing staff

The following section summarises levels of violence experienced by nursing staff in the clinical area.

2.7.1) Weapon utilisation by ED service users

A second study from Pennsylvania by Blank and Mascitti-Mazur (1991) further identifies concerns relating to violence in USA EDs. Through a telephone survey of 7 ED nurse managers the study identified concerns relating to a lack of a state wide, comprehensive, holistic security policy and the presentation of attenders presenting with traditional weapons that endanger life or weapons customised for maximum impact.

The paper is informative but the informal nature, small sample size and over reliance on anecdotal evidence to develop the discussion, affects the papers quality. No attempt to explain the sampling technique applied is offered and the paper offers an overly simplistic summary of respondent concerns, lacking evidence of in-depth analysis. The paper does raise a number of important issues however, in particular weapons utilisation by ED attenders which is a theme addressed by the literature.

A study presented as a systematic review of violence in EDs by Stirling, Higgins and Cooke (2001), stated that no articles were found relating to the use of weapons in UK EDs. Morgan and Steedman (1985) however, comment that no evidence of weapons utilisation were identified during their six month prospective study while Cembrowicz and Shepherd (1992), reviewing four hundred and seven incidents over a 10 year

period, revealed staff reported that they had experienced episodes of objects used as weapons such as furniture and fittings sixteen times, knives 6 times, wheelchairs 2 times, broken bottles, broken glass, scaffold poles, planks, scissors, stretcher poles and syringes and needles once. Stirling et al`s (2001) comment may merely reflect the individual perception of how one defines a weapon in the UK rather than an actual absence of weapons-related incidents.

The prevalence and experience of nursing staff encountering weapons differs widely internationally. From a Kuwaiti, site specific, retrospective, questionnaire survey study, Atawneh et al (2003) (n=81 rr 94%) reported no incidents of nurses being assaulted or threatened with weapons. However, Atawneh et al (2003) identified thirty three incidents of nurses having items thrown at them, thirteen incidents of being pushed or grabbed, 5 incidents of being slapped and forty eight incidents of nurses witnessing individuals kicking or hitting something. Sixteen percent of nurses reported actual physical attacks with the authors concluding that a significant number of nurses in the study experienced violence at work.

From Australia, Brayley, Lange, Baggoley, Bond and Harvey (1994) reported no incidents of weapons when reviewing two hundred and eighty two incidents attended by a site specific Violence Management Team. In contrast, a second, state wide New South Wales Australian study by Lyneham (2000) (n=226 rr 11.9%), reported respondents identified ninety two incidents involving weapons that had the potential to cause immediate loss of life (guns or knives).

Lyneham (2000) also comments on the ready availability of items within EDs that can be used by assailants as weapons, reporting not only the use of guns or knives but hospital equipment such as intravenous equipment including poles, syringes and furniture being utilised by aggressors. The use of opportunistic weapons by aggressors has also been highlighted by Adib et al (2002) (n=5876 rr 84%) who identified aggressors used sticks and knives in 2% and 1% of incidents of physical violence respectively, but 21% of incidents involved physical violence with aggressors using sundry instruments such as headgear laces, sandals and shoes as weapons. Both Lyneham (2000) and Adib et al`s (2002) studies mirror Cembrowicz and Shepherds (1992) study suggesting that individuals are highly unlikely to approach nursing staff

practising in UK EDs with formal weapons, customised baseball bats, guns or knives, for example, but may adapt routine hospital equipment, opportunistically into make shift weapons as they see fit.

In contrast, from the USA, numerous authors report the violent deaths of emergency room nurses, a significant prevalence of automatic weapons, guns, knives and the phenomena of service users presenting at the ED with weapons customised for maximum impact (Erickson and Williams-Evans 2000, Mayer et al 1999, Rankins and Hendey 1999, Christensen 1998 Ordog, Wasserberger, Ordog, Ackroyd, and Atluri 1993)

Ordog et al (1993) for example, conducted a fourteen year retrospective review of ED security records at a site specific urban ED. One hundred and fifteen weapons-related incidents were recorded, including incidents of security staff shooting and killing a knife wielding patient, police officers shooting and killing an armed patient, patients being shot by rival gang members, staff being held hostage at gunpoint, a member of the medical personnel being stabbed by a colleague, a car exploding scattering bullets from an automatic assault rifle left in it and a car being driven into the department at high speed.

Conclusions and recommendations offered are informative and are based on the results of the study, however generalising to an international audience would not be appropriate as many countries have a much lower gun culture level. Interestingly the study was the first paper critiqued to address Institutional Review Board approval (ethical approval); stating approval was not required because the study involved retrospective analysis of existing security data.

One variable, identified in the literature, relates to hospital location and weapons-related incidents suggesting that the catchment area which departments serve may be an important factor related to the occurrence of weapons-related incidents. Mahoney (1991), utilising a postal survey (n=1209 rr 60%), identified a significant relationship ($p < 0.01$) between locality and career percentage of nursing victimisations involving weapons with 23.9% of rural nurses reporting at least one victimisation during their career involving weapons. Suburban nurses reported 29.1% victimisations involving

weapons in their careers and urban nurses reported 36.3% of victimisations involving weapons during their careers although specific data related to weapons use is not offered.

The literature suggests that the UK and USA differ immensely in relation to nurses` experiencing service users armed with weapons; in the UK staff may deal with individuals who will reach for a weapon opportunistically, while in the USA, service users may present with lethal weapons customised for maximum impact. Consequently a critique of the literature suggests that physical assault is less prevalent and less serious in UK departments as opposed to the USA. It cannot be confidently concluded that violence is or is not more prevalent in other countries EDs due to a lack of data.

2.7.2) Physical violence excluding weapons

Whilst excluding weapons-related violence, a number of authors have also considered other forms of violence experienced by ED staff. In the UK Schneiden and Marren-Bell conducted the first of two studies in 1992. Utilising a questionnaire approach of attenders present at an RCN Accident and Emergency Association conference (n=58 rr 58%), 17.3% of responders stated they had never experienced physical violence, 44.8% had rarely experienced physical violence, 32.8% had sometimes and 5.2% had experienced violence often. This report led to a further, wider study in 1995 (n=196 rr 65%) of nursing staff practising in emergency settings which reported that only 9.1% of respondents had never experienced physical violence.

An Irish, site specific questionnaire study by Rose (1997) (n=27 rr 75%), reported that 60% of staff responding to her survey reported career experiences of physical assault at least once. Data from a study by Jenkins et al (1998) (n=273 rr 84%), who conducted a postal questionnaire of ED consultants in the UK and Ireland revealed that departments reported that physical violence occurred several times daily in one department; 2% reported daily incidents, 12% weekly and 51% monthly. Jenkins et al (1998), however, asked respondents to speculate across a wide range of issues and as Lavoie et al (1988) note tallied responses are the subjective interpretations of Doctors and have little objectivity.

From Australia Crilly et al (2004) conducted a descriptive, longitudinal cohort design at 2 site specific EDs (n=71, rr 66%). The research instrument was a 4 part questionnaire that was piloted and adapted from a violence questionnaire utilised previously by mental health researchers Murray and Snyder (1991). Test retest reliability for the questionnaire was established by determining stability over time and the percentage of agreement was 91%, indicating good consistency. Respondents reported being pushed, slapped and kicked, hit or having objects thrown at them. Seventy percent of nurses responding to the survey reported experiencing violence resulting in the authors concluding that ED nurses are at risk of violent attacks. Lyneham (2000) (n=226 rr 11.9%) also reported that 14% of staff reported physical intimidation or assault.

Hesketh et al (2003) also conducted a postal survey of all registered nurses practising in Alberta, Canada. Utilising a postal questionnaire 12,332 nurses were invited to participate resulting in 6,526 responses (n= 6526 rr 52.8%). Of this sample 671 staff worked in the ED setting. The results reported that 21.9% of respondents had experienced physical assault and 39.9% verbal threats. The reliability of the study was enhanced as respondents were offered specific definitions of the categories of violence under investigation, for example Hesketh et al (2003), defined physical assault as being spat on, bitten, hit or pushed with 20.3% of staff reporting physical assault (32.2% of these incidents occurred within the previous 5 shifts).

A major dilemma that must be considered is that generalisations, applying results from site specific departments nationally or internationally, become problematic, as a dominant factor is the study site chosen for researching. Consequently authors from the UK differ in their conclusions relating to the dangers of nurses experiencing physical violence in the ED. Morgan and Steedman (1985) conclude that by its very nature staff in EDs are exposed to violence, Cembrowicz and Shepherd (1992) state that violence is an established part of emergency room care and Jenkins et al (1998) conclude that physical assaults of staff is a major problem with staff experiencing regular physical abuse. In contrast Schneiden and Marren-Bell (1992, 1995) concluded that serious physical violence in the general hospital ED setting is rare and most injuries to staff are minor. Overwhelmingly the international literature consistently finds high levels of physical violence experienced by ED nursing staff

with inconsistencies related more to frequency of incidents rather than individual occurrence.

2.7.3) Emergency staff experiences of verbal abuse

Throughout the literature verbal abuse of ED nursing staff appears to be a global phenomenon and a number of studies have identified that verbal abuse is the most common form of violence experienced by emergency nurses (Crilly et al 2004, Lyneham 2000, Jenkins et al 1998 and Graydon et al 1994).

From the UK Schneiden and Marren-Bell (1995) conducted a postal survey of 300 nurses randomly chosen from the Accident and Emergency Register of the Royal College of Nursing (n=196 rr 65%) Although the sampling is random, only individuals affiliated to the Royal College of Nursing could be selected which is a cause for concern related to the representativeness of the sample. Furthermore a good range of literature should be thoroughly searched to put studies into context and although focussing on ED nursing staff, the supporting literature is over reliant on studies from the mental health setting and to the uninformed reader this could suggest or imply previous studies identified were conducted in the emergency setting when they were not. This may well reflect the lack of papers available to the authors at the time of writing.

Results presented reported that only 2.5% of respondents had never experienced verbal violence and 86.6% of nurses reported they had experienced verbal violence sometimes or often. The verbal violence most frequently encountered was obscenities (48.6%), non specific threats (28.1%), threats to the person (8.1%) sexual harassment, (7.9%) and personal threats (7.9%). Direct quotations whereby respondents were given the opportunity to state in full the language they experienced may have enhanced the results section and subsequent discussion.

A key opportunity for more in depth statistical analysis was missed, as although demographic data was requested from respondents, inferential analysis such as

undertaking one way ANOVAs or chi-square analysis was not conducted. This also applies to later studies conducted by Gates et al (2006) and Erkol et al (2007). There is an ethical concern relating to collecting respondent data and then not using that data appropriately.

In Jenkins et al`s (1998) survey (n=273 rr 84%) verbal abuse reportedly occurred several times a day in 16% of departments with 35% of respondents reporting verbal abuse daily, 33% weekly with 4% somewhere in between. Eight percent of departments replied that verbal abuse occurred monthly and 3% that it occurred less often than this. Subsequently the literature suggests that verbal abuse of ED staff is an overly prevalent phenomenon in UK EDs although confirming specific figures is problematic.

From Canada Graydon et al (1994) (n= 603 rr 25.7%) reported that 33% of responders had experienced abuse in the previous 5 working days. The majority of abuse was verbal and most frequently occurred in extended and emergency care areas, confirmed through a chi square test as highly significant ($p < 0.0001$). The paper explains how the postal survey was piloted, confirms ethical approval and offers a summary of literature relating to nursing staff experiences of verbal abuse, primarily sourced from mental health literature.

The response rate however is relatively low (25.7%), raising concerns related to bias and an unrepresentative sample (Burns and Groves 2001). Results are not clearly presented and it is not possible to identify either the specific number of emergency nursing staff responding, their demographic details or the specific nature of their experiences. The paper lacks depth in terms of both literature critiquing and result analysis. Furthermore although justifying the 5 day time span respondents were asked to consider through reference to other published work this short time span may have had a major impact on the data collected.

Further studies from Turkey, (Ergun and Karadakovan 2005), Australia (Crilly et al 2004), Kuwait, (Atawneh et al 2003) and New Zealand, (Lee 2001) consistently identify high levels of verbal abuse experienced by ED nursing staff. In particular Levin et al (1998) (n=22) raised the issue of staff being harassed on entering and

leaving work and Crilly et al (2004), the involvement of verbal abuse immediately prior to physical assault .

One of the dilemmas to consider when attempting to clarify the current situation in relation to violence in the ED, is to separate fact from perception. Internationally the situation is referred to as a crisis (Levin et al 1998), a pandemic (Lyneham 2000), and staff are referred to as working on the frontline of a battle-zone (Presley 2002) with all emergency nurses facing violence on a daily basis (Madden 2004). Trying to separate the actual risk of staff experiencing violent physical assault from the perception of risk is extremely challenging.

2.7.4) The frequency of violent incidents

One method of assessing the current situation is to examine the literature in relation to the frequency of incidents. Brayley et al (1994) reported one hundred and fifteen incidents sourced to the ED over forty four months which equates to thirty one episodes per year. Crilly et al (2004) reported, over a 5 month that period eighty six service users were responsible for one hundred and ten violent incidents. This was a rate of violence of 0.2%, or, 2 episodes of violence for every one thousand service users who presented (approximately 5 violent incidents per week). Lyneham (2000) (n=226 rr 11.0%) also reported that 56% of respondents experienced abuse by phone, physical intimidation or assault, or threats, at least weekly.

From the USA Erickson and Williams-Evans (2000) reported a mean assault rate of 1.83 and 3.08 per nurse per career within the two departments studied. Presley (1998) conducted a postal questionnaire (n=101) of ED staff working in departments in Austin, Texas. Although published as an abstract the questionnaire utilised a previous design by Poster and Ryan (1986), adding to the validity of the study. Presley (1998) reported that 10% of responders reported being assaulted more than 10 times in their careers and 68% of responders had been assaulted in the past 6 months. The presentation of the paper however, as an abstract, prevents in-depth analysis and although offering results that support other papers, the contribution to new knowledge in the field of ED violence is extremely limited.

In the same journal Christensen (1998) produced a paper presenting qualitative data through conducting a content analysis of transcribed semi-structured interviews of emergency nursing staff (n=9). The paper confirms a variety of manifestations of patient violence including respondent experiences of staff being spat on (also identified by both Hesketh et al 2003 and Foust and Rhee 1993) and suggests violence is a frequent phenomenon. As with the previous paper, word limit however detracts from the paper`s quality.

From the UK, Jenkins et al (1998) (n=273 rr 88%) reported that 85% of respondents believed verbal abuse was increasing and 60% also felt that physical violence was more likely than 5 years previously. Landy (2005) conducted a site specific questionnaire survey, and although examining a relatively small sample size, (n=40, rr 53%, ED nursing staff participating 13), reported that when comparing experiences of violence and aggression in three different specific clinical areas, emergency, intensive care and medical departments the number of incidents reported by each department was not statistically significantly. Emergency staff responding however, perceived a greater, statistically significant risk within their own department compared with the others although the P value was not reported.

To examine differing perceptions of levels and severity of violence in the UK Dickson, Price, Maclaren, and Stein (2004), compared the perceptions of risk of violence between nursing staff and managers working in the emergency field utilising a questionnaire approach. Reporting on the perceptions of one hundred and ten nursing staff (n=110, response rate 41%) and one hundred and thirty two managers (n=132 response rate 32%), working in 5 UK acute hospitals, Dickson et al (2004) reported that nurse responders perceived a higher risk than did managers. Dickson et al (2004) offered two contrasting possible explanations, one related to managers being distanced from the clinical area, the other of over assessment of risk by the nurses themselves. The validity of the study, however, could have been enhanced by triangulating the data with hospital records of violent incidents.

One possible explanation relating to ED nursing staff fears could be that, although in the UK serious violent assault and severe injury of staff appears relatively uncommon, the level of verbal abuse, threats and intimidation that does not develop into violent

assaults may create a perception of a dangerous working environment. If staff are threatened often enough they may well conclude that it is only a matter of time before threats become reality.

The international literature consequently, overwhelmingly concludes that verbal abuse, threats, verbal intimidation and harassment are a common feature of ED nursing. Studies by a variety of authors identify multiple career experiences of verbal abuse, threats and intimidation of staff, that at the extreme, involve multiple experiences per shift and may involve confrontations immediately outside departments as staff enter and leave work. Limited evidence further suggests that there also appears to be an association between verbal abuse and accompanying physical assault.

When examining the prevalence of weapons` use, physical assault and verbal abuse of ED staff a further theme emerged. Adib et al (2002) (n=5876 rr 84%) reported that only 56% of verbal incidents and 72% of physical incidents were formally reported. This allows one to consider a further theme, the phenomenon of under-reporting of violent incidents by ED nursing staff.

2.8) The phenomenon of under-reporting of violent and aggressive incidents

The phenomenon of under-reporting of violent and aggressive incidents is an important issue in the ED (NAO 2003) and under-reporting is a theme identified throughout the ED literature. This was highlighted, through the literature review, by both quantitative studies, Erkol et al (2007), Gates et al (2006), Landy (2005), Ergun and Karadakovan (2005), Hesketh et al (2003), Atawneh et al (2003), Fernandes et al (2002), Adib et al (2002), May and Grubbs (2002), Erickson and Williams-Evans (2000), Presley (1998), Jenkins et al (1998), Rose (1997), Schneiden and Marren-Bell (1995), Graydon et al (1994), Cembrowicz and Shepherd (1992), Mahoney (1991), Pane et al (1991) as well as qualitative, Luck et al (2007), Hislop and Melby (2003), Levin et al (1998) literature. This is the sum total of ED papers addressing this issue.

From the UK, the Health Service Advisory Committee (1987) published a report suggesting that official recording of violent incidents occurred in 70% of cases of major injury, 35% in cases of minor injury, 31% involving threats with a weapon and 18% in the case of verbal threats. This report examined the incidence of violence by surveying five thousand healthcare workers from 5 health districts receiving a response rate of 60% (n=3000). It can be reasonably suggested that verbal abuse may well be much less likely to be reported than physical assault because physical assault is viewed as a more serious experience than a verbal exchange. **T**he study did not focus specifically upon the ED setting and it was not until a wider national study by Jenkins et al (1998) (n=273, rr 88%), which surveyed the opinions of two hundred and seventy three UK and Republic of Ireland ED consultants, that a picture of the national scope of the problem could be assessed.

Respondents to Jenkins et al (1998) study reported that all incidents of verbal abuse were reported in 17% of EDs, sometimes in 45% of departments, occasionally in 30% of departments and never in 7% of departments. Seventy seven percent of departments always recorded episodes of physical violence, 14% usually, 6% occasionally and one never. Critical analysis of the study however, identifies that the study is limited, as already noted, by the utilisation of the subjective, tallied opinion of the respondents, by a lack of any evidence of a formal literature review and an over emphasis on highlighting the results rather than developing a discussion of the findings.

Prior to the study by Jenkins et al (1998), studies had been small scale and site specific calling into question the generalisability of findings. For example, in a questionnaire study by Rose (1997) (n=27 rr 75%) conducted in a site specific Irish ED, two thirds of staff did not formally report the latest incident of verbal abuse which they experienced and 21% did not report their latest incident of physical assault. The paper publishes the questionnaire utilised and the author, in the method section, defines both verbal abuse and physical assault. On inspection however, no definitions of verbal abuse or physical assault were offered on the questionnaire and so there is no way of telling if the respondents framed their responses within the definitions offered by the author which subsequently compromise the validity of the study. The paper also collected data related to respondent demographics but failed to utilise inferential statistics.

The failure to proactively manage violent incidents was also highlighted through a study by Schneiden and Marren-Bell (1995) (n=196, rr 65%) who identified that 81.1% of staff experiencing incidents of physical and verbal violence had the opportunity to discuss incidents with senior staff or managers but only 31% actually did.

Morgan and Steedman (1985) suggest that there is no doubt that the frequency of incidents of violence and aggression are underestimated in the ED, but estimating the exact scale of the problem is difficult and individual studies vary in relation to quantifying the scale of under-reporting. Internationally Erkol et al (2007) conducted a questionnaire survey of ED workers employed within 4 EDs in Turkey. A response rate of one hundred and twenty four (n=124) which included 44 (35.48%) nurses/midwives identified that 75.73% of aggressive/violent incidents were rarely or never reported.

From the USA Erickson and Williams-Evans (2000) reported that of 56% of respondents (n=55, rr 98%) assaulted in the previous year, 29% of incidents, had gone unreported. This retrospective questionnaire survey of RN`s practising in ED`s in the mid west USA was a high quality study using an instrument previously validated by Poster and Ryan (1989). It had a very high response rate and based sound recommendations on clearly presented results. Interestingly a significant correlation was found between the frequency of assaults and victim reporting. The study states that nurses who had a higher rate of patient assaults were less likely to report their assaults than nurses who were assaulted less frequently, however the inferential statistical evidence was not published.

Little progress seems to have been made in relation to reporting behaviours as a recent Australian study by Luck et al (2007) identified sixteen violent events over a 5 month period where nurses were the target of physical and/or non-physical violence and none of these incidents was formally reported.

Explanations offered by the emergency literature for under-reporting, include a denial and avoidance of violence, the sheer frequency of incidents and desensitisation Perceptions of failure and the pressures of time and circumstances, because of a lack

of actual injury, because of a lack of action following reporting incidents, toleration of minor incidents, individual embarrassment, fear of investigation, feeling sorry and understanding expressions of anger by service users or because staff did not want to be considered in some way to blame (May and Grubbs 2002, Levin et al 1998, Cembrowicz and Shepherd 1992). Such discussions however, tend to be purely speculative and very few studies have actually focussed on the reasons for under-reporting with studies focussing on estimating the prevalence of under-reporting rather than examining causative factors.

Qualitative studies however, have examined this issue in greater detail. Hislop and Melby (2003) conducted a phenomenological study utilising taped interviews of respondents (n=5), examining the experiences of nurses practising at a site specific Northern Ireland ED. The authors suggested that nurses felt that managers at higher levels did not really understand what staff in the ED faced on a daily basis, with staff complaining of reporting incidents and receiving no feedback, subsequently resulting in staff feeling isolated. Although describing the literature review as "*extensive*" many references were omitted from the background section and the very small sample size (n=5), although justified by the authors, and accepting phenomenological research, is not primarily designed to develop generalisable results. This is a cause for concern, particularly as the research procedure identified twenty six staff willing to participate although of these only 5 were randomly selected for interview.

The subjectivity of violent incidents was emphasised by Levin et al (1998), who identified a perception that some nursing staff believe that non-intentional assaults by service users, under the influence of drugs or alcohol, were viewed differently, more acceptably, than intentional assaults. The findings of Levin et al (1998) do find support as Budd (1999) acknowledge that nurses may not consider service users who are aggressive due to physical pain, alcohol intoxication, substance abuse, distress or mental health problems as committing a crime.

The psychiatric literature suggests that clinical presentations such as dementia, that lead to acts of aggression, do not warrant reporting in the eyes of some nursing staff and subsequently a major factor believed to contribute towards a culture of under-reporting is a concern for perpetrators (McKenna et al 2003). Luck et al (2007) have

recently suggested that ED nursing staff consider the perceived degree of service user self-responsibility and capacity during violent events, a view supported by Erickson and Williams-Evans (2000), whereby nurses make judgements regarding individual behaviour based on factors that influence presentation such as alcohol, age or medical condition.

A further factor considered by the ED literature relates to how managers and administrators process reported incidents. Lyneham (2000) (n=266 rr 11.9%) reported that only 26% of respondents were satisfied with the response of administrators when reporting violent incidents and 52% were dissatisfied. Lyneham (2000) reported that a number of respondents commented that administrators were punitive when reporting violence, blaming the staff for causing the situation. Keep and Glibert (1992) have also suggested that nurse managers play down the magnitude of violence staff experience, and exhibit attitudes and behaviours that may discourage staff from formally reporting incidents.

Under-reporting is an international phenomenon and is not merely a characteristic of emergency care. For example, the International Council of Nurses (1999) estimates that only 20% of violent incidents occurring in healthcare facilities, are reported and authors from a host of specialities ranging from learning disabilities (Vanderslott 1998), mental health (Beale Leather, Cox, and Fletcher 1999, Poster 1996), care of the older person (McKenna et al 2003), critical care (Lynch et al 2003, Ferns 2002) and general medical and surgical units (Astrom, Bucht, Eismann, Norberg and Saveman 2002, Rippon 2000) have offered numerous explanations for suggestions why nurses do not formally report violent or aggressive incidents (Table 1).

Table 1 Reasons for formal under-reporting of violent or aggressive incidents by nurses.

The frequency and number of incidents is so great that the issue goes unreported-experiencing aggression is a routine event.
Previous reporting of incidents has not led to change, so staff believe that committing to reporting incidents is not worthwhile.
The incident was over or resolved.
Reporting procedures are overly time-consuming.
Nurses may fear they will be accused of negligence and inadequate performance.
Nurses wishing to avoid blame by colleagues or administrators.
A lack of agreement on definitions of workplace violence.
Lack of awareness of the reporting system.
The belief that the incident was not serious enough to report.
The perception that nurses are hardened or desensitised to workplace violence and perceive it as "part of the job".
Excessive workloads.
Beliefs that the perpetrator was provoked by staff.
Staff not reporting "unintentional violence", for example, that involving confused or disorientated service users.
The nursing ethic of coping-literature suggests that nursing staff manage aggression passively, empathising with service users and hence avoiding blame.

(Table 1 references, Lynch et al 2003, Henry and Ginn 2002, Ferns 2002, Gournay, Wright and Parr 2002, Rippon 2000, Beal et al 1999, Vanderslott 1998, Poster 1996, Graydon et al 1994, Cembrowicz and Shepherd 1992).

When reviewing the general nursing literature, authors further suggest under-reporting is influenced by management philosophies and nursing culture and hierarchies (Bradley 1992). Echternacht (1999) notes that nurses are taught to put service users first and this phenomenon of misguided selflessness may be a significant contributory factor. The nursing paradigm of offering care and empathy may lead nurses to over-

compensate, reflecting a paternal perspective that subconsciously attempts to justify or make excuses for what wider society may deem as unacceptable behaviour.

Percival (2001) proposed that the general public consider nurses to be nice people and that nice people subsequently adapt their behaviour to match what people expect of them; subsequently nurses may be tolerant of violence because that is what is expected of them.

Nurse managers unfortunately, are repeatedly identified in the literature as a major source of bullying, intimidation or hostility (O'Connell 2000, McMillan 1995) and one could surmise that staff may not consider reporting incidents in a workplace culture of violence that is covertly supported through weak or unproactive management.

Work by Maier (1993) suggested that staff may respond to caring for aggressive service users by moving through a psychological continuum ranging from empathy and moving through various stages of anxiety, fear, anger, counter-aggression and finally frustration. Depending on the perceptions and relationships between the actors involved, reporting incidents may consequently become more or less likely.

Polk and Brown (1988) discuss "*affective dissonance*" whereby nurses are afraid to recognise violence in service users for fear of having to recognise it in themselves and their family. Gender variations in initiating and managing aggression due to childhood socialisation, childhood experiences of sexual or physical abuse or personal experiences of violence through being involved in domestic violence as either victims or aggressors may all influence one`s response to experiences of workplace conflict (Eysenck 2002, Little 1999, Ellis 1999).

A major aim of this thesis is therefore to examine factors that promote or hinder the formal reporting of incidents as Arnetz and Arnetz (2000) suggest that effective incident reporting processes and analysis of these reports can lead to an increased awareness of how to avoid negative interactions in the workplace and how to deal with incidents effectively.

2.9) The consequences of violence and aggression

The following section summarises the consequences for individual staff and organisations experiencing violence.

2.9.1) Personal, physical and psychological consequences of experiencing violence and aggression in the ED

In the UK, as already noted, physical injuries to staff, reported by researchers, included fractured ribs, superficial stab wounds, soft tissue injuries, attempted strangulations and bruises and lacerations (Jenkins et al 1998, Cembrowicz and Shepherd 1992). From the USA researchers have reported nurses experiencing physical, personal, emotional and professional consequences following experiencing violence with physical consequences including broken bones, muscle tension, body tension, headaches, wounds or long term chronic pain (Levin et al 1998, Mahoney 1991). Blank and Mascitti-Mazur (1991) reported the commonest injuries experienced by nursing staff to be cuts, scratches (not requiring suturing), fractured wrists and fractured forearms. As noted earlier studies from the USA also identify the impact of weapons-related injuries.

Violence and aggression can be both an antecedent and cause of stress which may manifest both physically and psychologically and a number of authors have identified psychological consequences of experiencing violence in the ED. For example, nursing staff have reported experiencing reliving the experience (flashbacks), stress, sleeplessness, nightmares, depression and fearfulness following violent experiences (Atawneh et al 2003, Fernandes et al 1999, Levin et al 1998). Fernandes et al (1999) (n=105 rr 65%), reporting on a site specific retrospective questionnaire survey, identified that 35% of responders were afraid of service users they perceived to have the potential for being violent, 24% were afraid of violent service users and 73% reported being afraid of service users generally. Forty nine percent of staff hid their identity from service users because of fear (Fernandes et al 1999). In a second study by Fernandes et al (2002) (n=687 rr 84%) nursing staff reported feelings of upset, blame, fear of being alone with service users, increased irritability and anger.

This second study was the first and only paper critiqued to discuss and explain how the sample size was powered in order to obtain sufficient data for inferential statistical analysis.

From the UK Hislop and Melby (2003) (n=5) interviewed staff who had experienced violence identifying three main themes encompassing:

- why me?
- a sense of isolation
- a sense of belonging to the nursing team

The study demonstrates evidence of thick description although feeding the results back to the respondents would have enhanced the trustworthiness of the study. Staff reported feeling embarrassed, powerless, frustrated, angry and fearful. Feelings also reported by Fernandes et al (2002), Fernandes et al (1999) and Levin et al (1998). Other feelings, reported by researchers, include bewilderment, loss of confidence, doubt of self worth and self blame (Erickson and Williams-Evans 2000, Fernandes et al 1999, Levin et al 1998, Mahoney 1991), helplessness (Chambers 1998, Mahoney 1991), fear, anxiety, shame, guilt, a loss of control and increased irritability and changed co-worker relationships (Lyneham 2000, Mahoney 1991).

The literature paints a disempowered, pessimistic, fatalistic, inevitability regarding the experiencing of violent incidents by ED nursing staff. This perspective is emphasised by Catlette (2005) who conducted 8 interviews of USA ED nursing staff practising within 2 EDs. Although a small sample size the themes identified through the study emphasised both the vulnerability to violence ED nursing staff feel and the concern that safety measures currently employed do not ensure ED nursing staff safety. To conclude this section the literature identifies a wide range of potential physical and psychological consequences for individual staff members which may affect both one`s professional and personal life.

2.9.2) Organisational consequences of practising in a violent/aggressive environment

Internationally, the cost of violence translates into billions of dollars worldwide and billions more for national economies in terms of days lost from work, law enforcement and lost investment (WHO 2002). The NAO (2003) suggests that the consequences of violence on staff and professionals working in NHS Trusts is approximately £69 million per year and estimate that the direct cost of work related violence excluding staff replacement, treatment costs and compensation claims to be approximately £173 million per annum.

Direct consequences of experiencing violence include lost work time, increased healthcare costs and increased sick leave which is confirmed internationally (Winstanley and Whittington 2004, Fernandes et al 2002, Adib et al 2002).

Researchers have highlighted damage to hospital property (Atawneh et al 2003, Cembrowicz and Shepherd 1992, Morgan and Steedman 1985) and potential organisational litigation (Lavoie et al 1988) as further economic consequences of violence. Furthermore, the wider social consequences of ED violence have been considered by Mahoney (1991) who identified that ED nurses experiencing violence, reported relationship changes with children or family, spouse or partners and co-workers. No studies conducted within the ED setting however, have attempted to specifically identify the economic consequences of ED violence.

Violence can also have a significant impact on staff recruitment and retention. A number of authors have identified a relationship between experiencing violence in the ED and reduced job satisfaction, individual staff considering career change, actually changing careers or terminating careers (Hesketh et al 2003, Mayer et al 1999, Fernandes et al 1999, Mahoney 1991).

An Emergency Nurse Association Report (1994) suggested however, that few ED managers reported their staff leaving emergency nursing due to violence. Graydon et

al (1994) reported that there was no difference in responders desire to change units or leave the hospitals studied, following experiences of abuse, but nurses who experienced a combination of verbal and physical abuse had significantly higher scores for wanting to leave nursing altogether than those who experienced either physical abuse ($p<0.01$) or verbal abuse ($p<0.05$) alone.

It can be argued that there is a plausible relationship between experiences of ED violence and individual career decision making and consequently violence has been identified as a direct cause of attrition from nursing. Examining the direct and indirect economic costs of ED violence is an important area for future research.

2.10) The characteristics/variables of potential aggressors presenting in the ED

The following section summarises the characteristics of perpetrators of violence in the clinical area.

2.10.1) legitimate service users

A general consensus of opinion from the literature is that the most likely aggressor, nurses will meet in the clinical area are service users or those accompanying service users (Winstanley and Whittington 2004, Hesketh et al 2003, May and Grubbs 2002).

This tends consequently, to place less emphasis on the probability of nurses being assaulted in the ED by intruders or criminals. This may be surprising when one considers that the literature frequently identifies the tempting aspects of emergency care that may lure the potential criminal (e.g. departments situated in inner-city settings or crime ridden urban areas, 24 hour access, accessibility of drugs, poor lighting, multiple entrances, poor security, a predominantly female nursing workforce, overcrowding, noise, perceived chaos and a high service user throughput) (Kuhn 1999, Drury 1997 Pane et al 1991 and Kurlowicz 1990).

Nurses are therefore more likely to experience violence from what can be described as legitimate service users (Le Blanc and Barling 2004); those presenting at the ED

expecting, wanting or requiring treatment. Subsequently authors have attempted to obtain demographic data relating to such individuals, emphasising that it is most likely that young males will be involved in violent confrontations with staff (Schneiden and Marren-Bell 1992, Cembrowicz and Shepherd 1992, Morgan and Steedman 1985).

In 2002 Sivarajasingam, Shepherd, Mathews and Jones published a study of victims of violence related injuries according to ED recorded data in England and Wales over a 5-year period (1995-2000). The study identified 353,443 assault victims of which three quarters were male (258,719) and almost half were aged 18-30. Literally hundreds of thousands of young male service users are processed through EDs in the UK and stereotyping aggressors is unhelpful as it can be suggested that the number of young males accessing the service vastly outnumbers the number of assaults occurring in the ED. Consequently it must be emphasised that the vast majority of young male service users presenting in the ED are not physically violent. In a study by Ganzini et al (1995) however, younger ED attenders were approximately ten times more likely to commit a violent act than older service users and this was demonstrated to be highly statistically significant ($df = 1$, $p < 0.001$).

2.10.2) A history of violence

Both ED research and the psychiatric literature suggest that the only significant variable predictor related to future violence is a previous history of violence (Knott et al 2005, Whittington 1997, Rice 1997, Drummond 1989, Lanza 1988). Furthermore there is a suggestion in the literature that a small number of offenders are involved in repeated incidents in the ED setting (Cembrowicz and Shepherd 1992, Cardwell 1984). This would mirror the perspective that in wider society a small group of offenders are responsible for the majority of crime (Harrower 1998). Subsequently it can be suggested that the most important variable in relation to the development of ED violence relates to the number of individuals entering the ED who project a violent persona.

2.10.3) Clinical Presentation

Service user presentation is a very important variable, particularly in relation to unintentional aggression. Table 2 lists common medical presentations offered by the literature that can result in individuals projecting aggression;

Table 2 Medical presentations associated with projecting aggression.

Head injuries, Cerebral Vascular Accidents, Cerebral Pathology, Organic Brain Dysfunction, Clinical Brain Injury
Diabetes (hypo or hyperglycaemia)
Hypoxia
Metabolic disorders/hyperglycaemia
Endocrine disorders
Seizures, frontal/temporal or limbic epilepsy
Psychiatric disorders, hallucinations, depression, anxiety, stress reactions, personality disorders, intermittent explosive disorders
History of post traumatic stress syndrome
Prescribed medication side effects
Intoxication
Drug Overdose
Drug/alcohol withdrawal
Age considerations, senile, dementia or adolescent, childhood disorders (conduct disorders, hyperkinetic disorders, autism, learning disability)
Sexual sadism
Premenstrual dysphoric disorder
Learning disability

(References for table 2, Saines 1999, Royal College of Psychiatrists Research Unit 1998, Drury 1997, Whykes 1994)

Unintentional aggression has been a phenomenon addressed by researchers in the general hospital setting, (Whitttington et al 1996, Brayley et al 1994, Travin, Lee and Bluestone 1990) and in the ED by May and Grubbs (2002) (n=86 rr 68.8%) who reported that 79.1% of responders believed that cognitive dysfunction such as head injuries, dementia and developmental delay were important factors in the development of potentially aggressive situations.

In 2002 Winstanley and Whittington conducted a study which took place on 7 medical and surgical wards and the ED of a general hospital located in northwest England. Through a prospective interview based study (n=48), participants highlighted the role which cognitive impairment may play in the development of aggressive incidents (confusion, psychosis or the effects of prescribed or illegal drugs); although the paper did not develop this theme extensively or clarify which results were ED specific.

Subsequently nursing staff may be at risk of injury from both intentional and unintentional assault depending on the characteristics of the client group cared for. It can be hypothesised that high quality staff delivering high quality care to such service users, identifying deterioration promptly, communicating effectively and initiating care pathways that are evidence-based and of the highest quality will be better equipped to manage aggression in such circumstances. Subsequently clinical ability may be a potential key variable influencing one`s risk of experiencing violence and aggression in the ED.

2.10.4) A psychiatric history

The psychiatric literature frequently emphasises the role of psychiatric illness as an antecedent to violence (Gudjonsson, Rabe-Hesketh, and Szmulker, 2004, McKenna et al 2003 and Nolan, Dallender, Soares, Thomsen, and Arnetz 1999). This aspect has however, received only minimal attention in research studies emanating from the UK. Internationally, studies by Knott et al (2005), Crilly et al (2004), Levin et al (1998), Ganzinin et al (1995), Brayley et al (1994), Keep and Glibert (1992) and Pane et al (1991) all report that emergency nurses are concerned that psychiatric illness is a factor in aggressive confrontations in the ED.

Ganzini et al (1995) for example, conducted a 5 year retrospective review of dangerous behaviour reports, cross-referencing with medical records at a USA urban Veterans Affair Medical Centre. Two hundred and thirty six reports were identified. The study identifies very clear objectives that could be realistically achieved. Of twenty one incidents involving elderly patients one third (n=21) of elderly service users involved in violent acts were found to demonstrate psychotic symptoms of schizophrenia, or age related psychotic disorders such as paranoid disorder or organic delusional disorder.

Authors such as Lyneham (2000) comment how nurse respondents, concerned regarding caring for psychiatric service users who are seen as potentially violent, raise the impact of deinstitutionalisation, which, it is argued, has increased the number of psychiatric service users presenting at the ED. The media frequently links care in the community and deinstitutionalisation to increased homicide rates involving the mentally ill, yet this is not supported by the data from the UK (Taylor and Gunn 1999). Homicides by people with serious mental illness are given wide media coverage, stigmatizing and promoting societal fear of people with such illness; and healthcare staff themselves may be influenced by this negative media coverage (Simpson, McKenna, Moskowitz, Skipworth, and Barry-Welsh 2004, Philo 1993, Factor 1991).

The majority of psychiatric service users are not violent, although Coyne (2001) suggests that the typical psychiatric service user of today is more likely to be young, male, with a diagnosis of psychosis, substance misuse and a forensic history. The literature does highlight conditions such as schizophrenia, personality disorders and mania that are common in the violent psychiatric service user (Gournay et al 2002, Dubin, Wilson, and Mercer 1988, Lion and Penna 1976), along with the role of dual diagnosis (alcohol/substance abuse combined with a psychiatric presentation (Gournay et al 2002).

The number of violent incidents involving psychiatric service users will ultimately be determined by the number of psychiatric service users accessing the ED service, but it can be hypothesised that staff who understand the consequences of psychiatric illness and instigate appropriate communicative strategies with such service users may be

less likely to experience violence from this group. As with medical presentation clinical ability of staff may be an important variable.

2.10.5) The alcohol- affected service user

Research from both the UK and internationally consistently identifies excessive alcohol consumption as being implicated in the development of violent incidents in the ED (Knott et al 2005, Crilly et al 2004, Lyneham 2000, Mayer et al 1999).

Authors have suggested that alcohol is rarely the cause of aggression but rather the association is mediated by situational and personality factors such as, for example, combining alcohol consumption with subsets of individuals who have a propensity to be aggressive (Pernanen 1998, Chermack and Taylor 1995, British Medical Association 1995, Martin 1993).

Although the exact pathway of effect remains unclear, a wide range of authors offer varying explanations related to the physical and psychological impact of alcohol (Graham and Wells 2003, Dolan and Holt 2000, Pernanen 1998 Graham, Wells and West 1997, Whittington 1997). Researchers suggest that alcohol ingestion can lead to individuals becoming sexually disinhibited, impetuous, with perceived increases in risk taking and feelings of bravery and courage (Graham and Wells 2003, Murphy, Monahan and Miller 1998). Nurses are projected by some sections of the media in terms of a negative, sexually available stereotype (Ferns and Chojnacka 2005, Jinks and Bradley 2004, Wilkinson and Meirs 1999). This is important because anger leads people to rely on stereotypes, which are easily processed, rather than effort-demanding cues (Bodenhausen, Sheppard and Kramer 1994). Consequently it can be suggested that the alcohol influenced, angry service user may quickly move towards insults derived from a stereotypical perspective and subsequently for some individuals, arguing or threatening nursing staff becomes a more attractive option when under the influence of alcohol.

It has been suggested by Adib et al (2002) that those who perceive nursing as a menial job may be tempted to treat nurses with some degree of disrespect. Jenkins et al (1998) also suggest that service users in the ED who seem prepared to be rude and

offensive to nurses are frequently much less aggressive when approached by a doctor. Furthermore there is a suggestion that wearing a uniform may result in people being targeted for violence, depending on the general attitudes of people towards uniformed employees (Chappell and Di Martino 2006, Standing and Nicolini 1997).

This could suggest that the attitude towards occupational roles is an important variable. The role of reputation may also be a factor as media projections of over stretched services may also contribute to how the service is accessed and considered by certain members of our society. Furthermore one`s risk of experiencing violence when caring for alcohol-affected service users may once again be influenced by one`s knowledge and understanding of the psychological and physical consequences of excessive alcohol ingestion.

2.10.6) Substance abuse

The term "*substance abuse*" can refer to a drug of abuse, a medication or a toxin; with alcohol, benzodiazepines, amphetamines, methamphetamines, crack cocaine and phencyclidine all having been associated with violence (Wynaden, Chapman, McGowan, McDonough, Finn and Hood 2003, Boles and Miotto 2003, Heslop, Elsom and Parker 2000). However, ED studies tend to bracket all illicit drug use under the umbrella term of "*substance abuse"* and no specific ED studies examining the role of the specific substances above could be identified.

In the UK twelve substance abusers (11.7% of total incidents), were identified in Morgan and Steedman`s (1985) study and responders to both Jenkins et al (1998) and Schneiden and Marren-Bell`s (1995) studies highlight the perception that substance abuse leads to service user violence. Internationally studies by authors such as Crilly et al (2004), May and Grubb (2002) or Lyneham (2000) highlight the perception of substance abuse being implicated in the development of ED violence. This area however, has received only minimal research attention.

2.10.7) Gang activity

The only ED studies considering gang activity are by Fernandes et al (1999), Levin et al (1998) and Keep and Glibert (1992). Responders to the Fernandes et al (1999) study raised concerns relating to gang activity and focus group members reported on by Levin et al (1998) (n=22) identified concerns related to gang activity actually highlighting that fellow employees sometimes put nurses at risk because of gang involvement.

Keep and Glibert (1992) suggested that the majority of EDs do not have gang and drug activity in the area served by the hospital, and yet still experience considerable violence, emphasising the multi factorial variables that contribute to ED violence. The authors suggest that it may be a myth that violence occurs primarily in areas where gangs and drugs flourish.

Bennett and Holloway (2004) suggest that there is some evidence from national newspapers and government reports that the number of gangs and gang members in the UK is increasing. However, no UK studies discussing gang activity and the impact on the ED could be identified.

2.11) Situational factors

The following section summarises situational factors implicated in the development of violent incidents in the clinical area.

2.11.1) Timing of incidents of violence

Both UK and international studies highlight the raised risk of nurses experiencing violence while working night or evening shifts (Knott et al 2005, Crilly et al 2004, Schneiden and Marren-Bell 1995, Brayley et al 1994, Mahoney 1991, Pane et al 1991, Morgan and Steedman 1985, Ochitill and Kreiger 1982).

Mahoney (1991) reported statistically significant results, identifying night shifts as high risk times for victimisation to occur ($p < 0.01$). Staff practising on longer twelve

hour shifts also experienced increased victimisation ($p < 0.001$). The only study found to dispute the general consensus that violence is more likely to occur outside 9-5 normal working hours was carried out by Mayer et al (1999) who reported that the majority of verbal abuse experienced by staff occurred during the day shift (54.9%). The authors surmised that this was due to an excessive number of service users presenting as substance abusers during the day as opposed to alcohol abusers, generally arriving at department doors intoxicated, late at night. The literature suggests that ED violence is almost certainly related to social patterns of substance abuse (Kennedy 2005).

2.11.2) The impact of waiting times

Studies examining waiting times reflect a powerful image of EDs which are full to over-flowing with nurses and other staff often unable to provide even the essentials of care (Ball, Dixon, Dolan, Holt and Wilkinson 2000). Consequently, the literature has examined the relationship between excessive waiting times and violent incidents. Studies by the Crilly et al (2004), the NAO (2003), May and Grubbs (2002), Levin et al (1998) Jenkins et al (1998), Schneiden and Marren-Bell (1995), and Blank and Mascitti-Mazur (1991) all report how staff link lengthy waiting times to violence.

For example the NAO (2003) reported that ED managers surveyed, suggested that causes of increased violence included the sheer volume of service users and consequent increased waiting times (48%), increased service user expectations (44%) and increased drug and alcohol related incidents (39%). Unrealistic service user expectations have also been suggested as a possible potential cause of increased violence by Levin et al (1998). Lyneham (2000) comments on the frustration and rolling impact of waiting times; initial waits to see medical staff, waiting to have tests done, waiting to see senior medical staff, waiting for results and waiting for a bed. Shrimpling (2002) also highlighted the perspective that the time service users spent having nothing done dramatically exceeded the time spent with emergency staff, which contributed to service user frustration.

Akerstrom (1997) used a mixed method approach, collecting data through field observations and semi-structured taped interviews with nursing staff to explore the

concept of ED waiting experiences. Akerstrom (1997) noted a strong theme that emerged from a study of Swedish emergency clinics was a perceived sense of hostility in the ED waiting room and the unwillingness/selfishness of some of the service users who presented with a minor injury to wait for treatment. May and Grubbs (2002) (n=86 rr 68.8%) also reported that anger related to service users` condition and situation (55.8%) and anger related to long waiting times and hospital visitation policies (38.4%) were thought to be the most common factors contributing to violence in the ED. It has been suggested by Lyneham (2000) that the general public's lack of understanding of the triage process and perceptions of unfair prioritising may play a role in the development of staff/service user confrontation.

However, in contrast, specific studies that have considered the role of waiting times dispute the general consensus that long waiting times lead to physical violence. Studies that have specifically audited service user arrival relating it to violent incident development by Morgan and Steedman (1985), Crilly et al (2004) and Knott et al (2005) reported the majority of incidents occurred within relatively short waiting times, ranging from 30 minutes to approximately one hour.

Whittington et al (1996) have suggested that three combined factors broadly influence the development of violent incidents:

- mental state
- close proximity of staff
- delays in receiving care.

Specifically within the ED setting, a service user`s mental state is extremely important, because those who do not want to assault staff will not do so unless aggression is a manifestation of their illness or treatment. Furthermore close proximity is very important because one cannot be assaulted if there is a significant physical distance between the aggressor and victim. Waiting times however, may play less of a role than suggested because those intent on being physically violent may project hostility as soon as they arrive, rather than waiting for excessive periods.

As Knott et al (2005) conclude acutely agitated subjects pose a threat to themselves and staff, with the majority arriving in a behaviourally disturbed state. This can partly be explained as those with a history of violence, who are comfortable with contributing to violent interactions, may turn to such strategies early as a first rather than last course of action.

2.11.3) The geographical location of violent incidents

Authors have also examined aspects of the environment to identify areas of departments or "*hot spots*" where incidents may be more or less likely to occur, identifying the waiting room area (Erkol et al 2007, Pane et al 1991), the triage and accident areas (Crilly et al 2004, Pane et al 1991) and immediately outside the department (Lyneham 2000, Pane et al 1991) as high risk areas.

A classic security tactic, initiated at organisational or personal level to improve staff safety involves target hardening. Target hardening follows the philosophy of rational choice, where violent individuals calculate the pros and cons of a chosen form of action (Alkers 1990). In recent years both in the UK and internationally EDs have increasingly adopted a fortification mentality, utilising organisational measures such as formal police presence/links, security presence, CCTV, coded access, teaching staff restraint techniques, issuing personal alarms, panic buttons and central alarm systems (Cooke et al 2000, Lyneham 2000, Jenkins et al 1998, Sains 1999).

The prevalence of weapons in USA EDs has clearly resulted in a more visible security presence, with departments utilising armed security guards wearing bullet proof vests, metal detectors, service user searches for weapons, weapons confiscations, controlled access, lock-downs, bullet proof glass and panic buttons (Levin et al 1998, Keep and Glibert 1992, Blank and Mascitti-Mazur 1991 and Lavoie et al 1988).

It is reported that nurses are wary of security personnel inflaming situations (Levin et al 1998) but presence and availability of security personnel does appear important. Despite these measures the literature suggests that, internationally, staff are concerned regarding security measures (Merfield 2003, May and Grubbs 2002). Merfield (2003) conducted a national questionnaire survey of directors of the Australasian College of

Medicine (n=70 rr 88%) identifying wide variations in security measures and concerns relating to organisational security measures. This paper was enhanced by the publication of the twelve point instrument utilised for the study and was the only paper to state that external statistical support had been utilised when analysing data. This is a cause for concern as it is widely accepted that complex quantitative analysis is enhanced by suitably qualified statistician input.

From the predominantly psychiatric literature, environmental factors such as hot temperatures, high humidity, poor lighting and air quality, high noise levels, an audience and crowding have all been linked to increased levels of human aggression (Anderson, Anderson and Deuser 1996, Baron 1994, Walsh 1986). Waiting areas in EDs can offer many of the above. Furthermore rational choice may become irrelevant when involving intoxicated, emotionally disturbed, substance abusers, unconcerned regarding the consequences of their behaviour.

2.12) Consequences for service users labelled as violent/aggressive

From the USA Lavoie et al (1988) reported that seventeen departments, responding to their study, reported that service users had been significantly injured (e.g. fractures, head injuries) during the restraint process in the previous 5 years and 1 service user had died due to strangulation. As noted earlier Ordog et al (1993) also reported on the violent deaths of service users.

From the psychiatric field Grassi, Peron and Maragoni (2001) and Soliman and Reza (2001) found that the mean length of hospital stay for violent service users was much longer than non-violent ones and there is a small amount of evidence suggesting this is also the case in the general hospital setting (Ochitill and Kreiger 1982). Brayley et al (1994) reported that service users were also detained in 52% of calls from the ED in comparison with 16% of calls in all other areas of the hospital, and in a study by Knott et al (2005) 47% of aggressive incidents resulted in psychiatric admission.

Emergency literature suggests that projecting an aggressive persona during acute illness can have significant consequences and may lead to delays in treatment,

misdiagnosis with potentially life-threatening consequences, physical restraint, chemical restraint and isolation (Martins 2006, Wand and Coulson 2006).

2.13) Staffing levels and profiles

Specifically from the ED only Levin et al (1998) (n=22) reported nursing staff concerns relating to staffing levels and ED violence, and this related to employing adequate numbers of security staff rather than nursing staff per se. Although there is a paucity of research related to the variable of staffing levels and skill profiles in the ED, and the development of violent incidents, there is a plethora of literature from the mental health setting demonstrating an association between an increased risk of violence and poor staffing level numbers and skill mix (Cowin, Davies, Estall, Berlin, Fitzgerald, and Hoot 2003, Clinton and Hazelton 2000).

2.14) Conclusion

In their original work Morgan and Steedman (1985) comment that neither the scale of the problem of ED violence nor the trend had been established; and nearly 2 decades later Winstanley and Whittington (2004) suggest that there seems to have been little progress towards actually explaining the prevalence of aggression in any health sector.

Reviews of the literature have been conducted (Ferns 2005, Wells and Bowers 2002, Stirling et al 2001) and authors have identified and discussed the following themes; severity and frequency of assaults, injuries sustained and weapons utilised by assailants, the characteristics of victims, the psychological, professional, social and organisational consequences of ED violence and the phenomenon of incidents not being formally reported.

Characteristics of aggressors and the influence of trigger/situational factors such as gender, age, a violent history, a psychiatric history, alcohol/substance abuse, treatment/management options, waiting times, hospital security, hospital catchment areas and staff education/training and attitude have also been considered within the literature. Although data relating to physical injury is inconclusive, violent physical

assault against nurses practising in the UK appears uncommon, and weapons use appears to be primarily opportunistic. In contrast verbal threats, abuse or intimidation does appear to be highly prevalent. Nursing staff are concerned regarding their personal safety but may overestimate the risk of actual physical injury.

Specific subsections of society are highlighted as being overly represented in the development of violent incidents in the ED. Staff preparation for managing violent incidents appears sporadic, poorly planned and organised, and studies examining the demographics of nurses as victim of ED violence are inconclusive.

The phenomenon of ED violence is under researched and the research aims addressed in this thesis have received only minimal attention in the literature. Subsequently a study of Doctoral quality has the potential to offer a significant contribution to current knowledge and understanding of this important issue.

As noted earlier the following diagram (figure 1) identifies the key areas that have been addressed by the literature. On the left is a strategy offered by Le Blanc and Barling (2004), based on the California Division of Occupational Safety (CA-OSHA) (1995) which differentiates potential workplace aggressors into four major groups (expanded upon in appendix 4):

- type 1 Intruders
- type 2 Legitimate Service Users (service users and those accompanying them)
- type 3 Current or former employees
- type 4 An associate of a staff member through a personal relationship

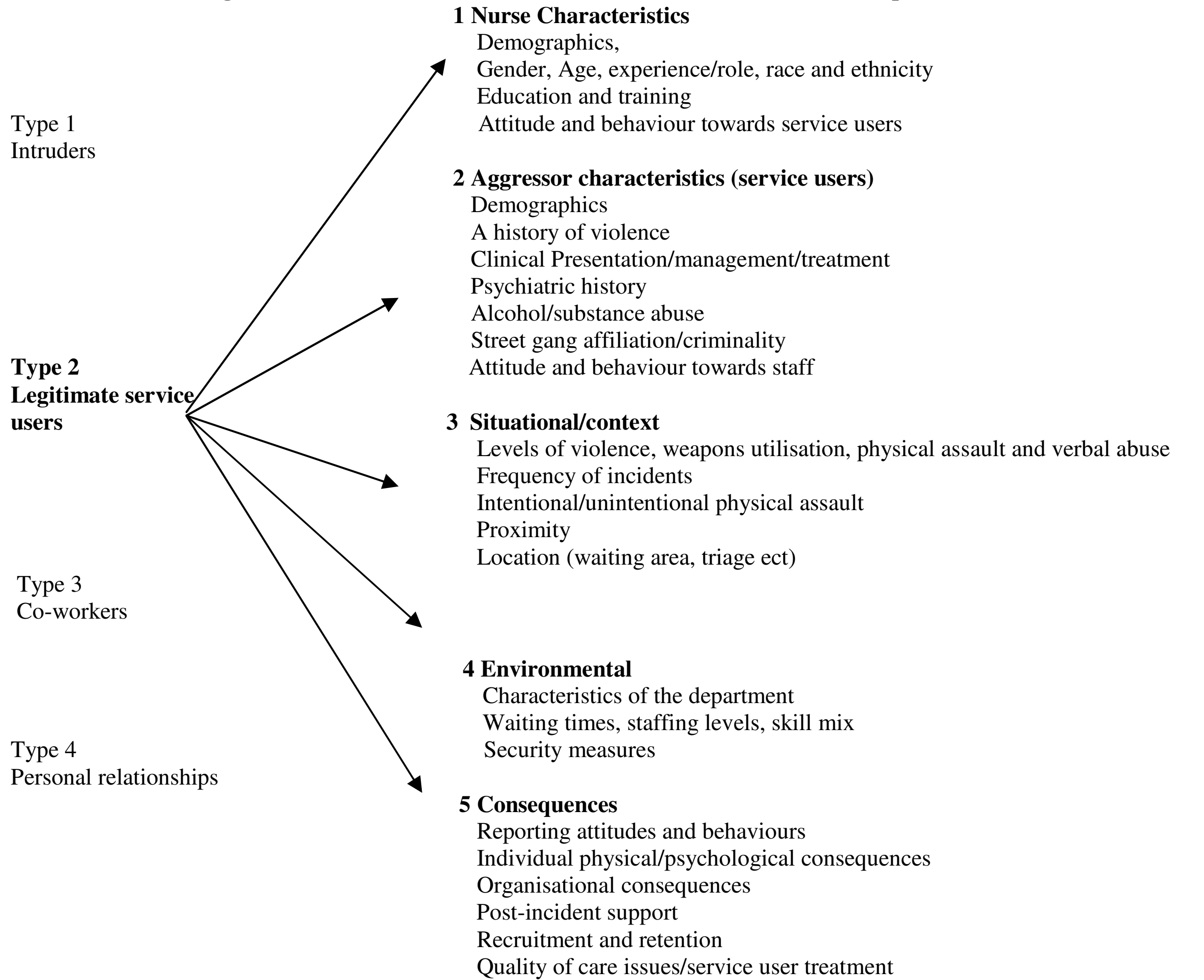
Importantly this thesis revolves around nursing staff interactions with legitimate service users (service users and those who accompany them), as the literature agrees that this group is the group most frequently engaged in conflict with nursing staff.

Having completed the literature review, the following chapter identifies and justifies the chosen research methodology and method and addresses research design, data analysis and research governance issues.

(Figure 1)
Classification
of aggressors in the ED
(Le Blanc and Barling 2004)

The legitimate service user in this context are patients or those accompanying patients.

Themes developed out of the literature review



CHAPTER 3: METHODOLOGY AND RESEARCH DESIGN

3.1) Introduction

This chapter describes the concept of research paradigms, identifies the adopted research methodology and method, summarises the adoption of triangulation in terms of data collection and addresses issues related to ethical approval. The chapter also addresses issues related to sampling and saturation, identifies the specific research instruments adopted to collect data and the process of data analysis. The chapter concludes with a summary related to the criteria utilised to ensure rigour. As noted earlier this study intends to explore how emergency department (ED) nursing staff conceptualise the terms that encompass violence and aggression in the clinical area, to explore the formal reporting practices of nursing staff following such experiences, and to explore situational factors at play relating to the development of violent and aggressive incidents in the ED setting.

3.2) The choice of research paradigm

Paradigms of inquiry are worldviews that signal distinctive ontological (view of reality), epistemological (view of knowing and the relationship between knower and to-be-known), methodological (view of enquiry model) and axiological (view of what is valuable) positions (Sandelowski 2000).

Epistemology concerns the nature of knowledge and, in particular, what justification can be offered in support of the beliefs that we hold are true; while methodological justification concerns the rationale given for the characteristic techniques used in the production of empirical evidence within a particular research tradition (Avis 2003).
The natural sciences are most closely associated with positivism, promoting the epistemological assumption that empirical science is based on the principles of verification, objectivity, reproducibility, detachment and scepticism (Avis 2003, Peplau 1991). The positivist perspective takes the position that progress and social reform depend on an orientation to facts (Morrison 2003). Consequently, quantitative

data collection techniques classify observed phenomena by their frequency and distribution and studies are designed to exclude variables and, as far as possible, the researcher`s influence, in an attempt to guarantee the objectivity of the study (Cormack 1996).

In contrast, qualitative data collection revolves around an in-depth study of human phenomena in order to understand their nature and the meanings for the individuals involved (Cormack 1996). Qualitative data collection is based on the perspective that there is no one singular universal truth, the social world is multifaceted, and it is the outcome of the interaction of human agents; a world that has no unequivocal reality (Ashworth 1997). Such a research study organises data collection information as narrative format so that phenomena can be described, and patterns of relationships can be discovered (Potter and Perry 1995).

Schatzman and Strauss (1973) suggest that researchers involved in qualitative data collection are observers of human events, who listen to how people in given situations present to themselves and others the realities and context of their lives. Adopting a qualitative approach to data collection was attractive as a hospital is a subjective research field embedded in social interaction and experiences of interpersonal conflict and are shrouded in subjectivity and perception (Duxbury 2002, Proctor 1998, Jeanette, Blumenreich, Lippmann and Bacani-Oropilla 1991).

When adopting the chosen research paradigm I was eventually attracted to interpretive inquiry which encompasses grounded theory, symbolic interaction, phenomenology, critical ethnography and ethnomethodology (Endacott 2007, Miller and Fredericks 1999, Creswell 1998, Stern 1994).

Qualitative research is most commonly part of interpretive inquiry and can be viewed as constructivist (Moule and Goodman 2009). Interpretivism developed from the constructivist paradigm, emerging in the 19th century as a reaction to the positivist quest for objectivity and theory and hypothesis testing (Holloway and Wheeler 2002).

An interpretive paradigm was used for this study as the focus was on the meaning of experiences and behaviours, which are context dependent (Casey 2006). As noted

earlier, a hospital is a subjective research field, embedded in social interaction, and experiences of interpersonal conflict are shrouded in subjectivity and perception (Duxbury 2002, Proctor 1998, Jeanette et al 1991). Interpretivist researchers focus on subjective experience, perception and language, in order to understand intention and motivation which can explain behaviour (Parahoo 2006). The interpretivist focus on subjective experience, perception and language, ideally fits with the research setting, (a site specific ED), the research aims and the research methods outlined later in this chapter. This approach is well suited to addressing the research aims and places the research aims, methodology and method in harmony.

Interpretive researchers acknowledge that there is not one objective truth but only a range of constructed truths, that there are multiple interpretations of the data, and the researcher`s inseparability from the research (Mason, 2002, Sparkes 1992). In order to study subjective perceptions and experiences, interpretive researchers cannot behave as detached observers and instead, through interactions, they can gain an insight into how and why people behave the way they do (Parahoo 2006). Consequently, when conducting interpretive research, the overt role of the researcher as a research instrument is emphasised. In this approach research is presented in the first person as researchers write themselves into their reports via reflexive accounts about the research process and decisions made through it (Mason 2002, Norton 1999). Within this over arching strategy a grounded theory (Glaser 1999, Strauss and Corbin 1998, 1990, Glaser and Strauss 1967) approach to data collection and analysis was employed.

3.3) Identifying the grounded theory research method

Methodology refers to the philosophical framework that must be approached, whereas method refers to the research technique and the procedure for carrying out the research (Van Manen 1990). I have placed grounded theory in the interpretive domain; a perspective supported by Endacott (2007), Sandelowski and Barroso (2003) and Annells (1996).

The epistemological assumptions of grounded theory are derived from symbolic interactionism, which explores the process of interaction between peoples` social roles

and behaviours (Higginson 2006). Interaction is symbolic, because these processes use symbols, words, interpretations and languages (Denzin and Lincoln 2000).

Grounded theory has become a type of central organising concept, characterised by the processes of systematic data collection and analysis, induction, abduction, deduction and verification, that serves to both direct the research process as well as providing a heuristic for data analysis and interpretation (McCann and Clarke 2003, Miller and Fredericks 1999, Norton 1999). Grounded theory's purpose is to explain a phenomenon (Miller and Fredericks 1999) and, as Glaser (1999) describes grounded theory, is a specific method on how to progress from systematically collecting data to producing a multivariate conceptual theory.

Miller and Fredericks (1999) however, maintain that grounded theory, in terms of providing explanations, is simply a different version of a standard inductive argument. Importantly Munhall and Boyd (1993) identify tellingly that the process of induction and qualitative data analysis depends on the singular creative process between the researcher and the data. The quality of the research will ultimately be influenced by the researcher's intellect, experience and interpretations.

McCann and Clarke (2003b) suggest that researchers need to consider which version of grounded theory-classical or Strauss and Corbin-they are going to use to inform their data collection and analysis. Strauss and Corbin (1998, 1990) have attempted to publish guidelines related to procedures for using grounded theory, emphasising that data analysis protocols are merely guides. Hence I adopted the Strauss and Corbin (1998) approach; but this approach was partly applied through individual interpretation when required, with a fundamental aim being to make each step of the research process transparent and capable of standing up to critical scrutiny through a demonstration of methodological rigour; an approach recommended by Higginbottom (2005) and Avis (2003). Strauss and Corbin's approach to grounded theory draws on social constructionist ontology and the poststructuralist paradigm, where reality cannot be known but can be interpreted (McCann and Clarke 2003a, Strauss and Corbin 1998).

There are a number of reasons why I have opted for a grounded theory approach. Grounded theory allows for the development of theory in areas where research is sparse (Strauss and Corbin 1998, Glaser and Strauss 1967) and grounded theory offers an approach towards building theory related to complex human phenomena (Strauss and Corbin 1990). The literature review identified only a limited number of research papers dedicated to examining violence in the ED, a complex phenomenon, and hence studying violence in the ED from a grounded theory perspective meets both of the above criteria. Although forty five papers were identified during the literature review, this is a relatively small number of research papers when compared with the vast knowledge base available when researching medical conditions, or in comparison with research examining violence in the psychiatric setting. The epistemological underpinnings of grounded theory also make it valuable in the study of nursing, which is premised on an interpersonal process between nurses and clients (McCann and Clarke 2003).

3.4) Data analysis

When adopting the grounded theory methodological package, a series of steps are taken by the researcher to collect and analyse data and these steps are summarised in the following sections.

3.4.1) Open Coding

Open coding aims to fragment or break down the data so that discrete concepts and categories can be identified and compared, resulting in the development of properties and dimensions (Higginson 2006, McCann and Clarke 2003b, Strauss and Corbin 1998). These categories are constructed through, for example, line by line analysis of transcribed text or documentary data (Higginson 2006, Durham 1999).

3.4.2) Axial Coding

Axial coding involves relating the generated categories to their subcategories (Strauss and Corbin 1998), through the processes of induction (Strauss and Corbin 1990) and abduction (Norton 1999).

3.4.3) Selective Coding

This is achieved via a four stage method called the constant comparative method: (discussed in section 3.7.4) a process whereby findings are verified and corrected on the basis of the data collected (Norton 1999 Strauss and Corbin 1998). The end point is the development of a discursive set of theoretical propositions framed within their properties and dimensions, as core central categories. The properties and dimensions are presented in chapter 5 and the core, central categories are presented, discussed and justified in chapter 7.

3.5) Adopting a triangulated approach to data collection

For this study I adopted data triangulation and between method triangulation, collecting and analysing multiple data sources to provide diverse information about the phenomenon under investigation (Shih 1998, Begley 1996). I decided on this strategy because triangulation receives widespread support in the literature, as multiple data sources contribute to the trustworthiness of the data (Endacott 2007, Baum 2002).

Glaser (1992) emphasises that to have a proper grounded theory study it is essential to conduct observations as well as interviews, to uncover the meanings of experiences. Subsequently for this research I was influenced by Bowling (2002) who recommends a triangulated approach, such as combining interviews and observations with record searches; and Polit and Hungler (2004) who suggest that quantitative data from, for example, hospital records, strengthens qualitative fieldwork. Subsequently three primary methods of data collection were utilised:

- Instrument 1: documentary research of hospital incident forms.
- Instrument 2: audio recorded, open ended, focused, semi-structured, themed exploratory interviews.
- Instrument 3: non-participant, time sampled, unstructured observation.

Table 3 A framework for describing the triangulation strategy adopted (adapted from Shih 1998).

Type of triangulation	*Approach*	*Purpose/goal*
1. Investigator	Single researcher	Consistency
2. Data source	Emergency nursing staff	Data collection
3. Theory	Interpretive Grounded theory	Generate substantive theory
4. Method/instrument	Between method Documentary research of incident forms cross referenced with the literature review	Baseline data collection and sensitivity to research themes
	Audio recorded, open ended, focused, semi-structured, themed exploratory interviews	Collect more in-depth data covering a broader spectrum regarding experiences of violence
	Non-participant,time sampled,unstructured observation Individual	Triangulate data collection, verification, sensitisation Collect data related to the phenomenon under investigation
5. Unit of analysis	Descriptive statistics	Focus individual experiences of violence
6. Analysis	Grounded theory Open coding Axial coding Selective coding	Obtain the completeness of the phenomenon

3.6) Ethical approval

Approval to conduct the study through the NHS Local Research Ethics Committee (LREC) and hospital trust Research and Development Department were pre-requisites, for conducting this study. Particularly important was the necessity for the study to comply with the Department of Health (2001) *Research Governance Framework for Health and Social Care* as the research involved approaching NHS employees and was not viewed as audit or evaluation. Furthermore, participation in human enquiry exposes participants to potential risk and inconvenience, no matter how slight (Working Group on Ethical Review of Student Research in the NHS 2005). Ethical research is underpinned by respecting humanity, and protecting human rights through placing an emphasis on doing good, avoiding harm and emphasising truthfulness, confidentiality, fairness and participant autonomy (Clark and McCann 2005, Bindless 2000, Friedman 1998, Holloway and Wheeler 1995).

3.6.1) Informed consent

As informed consent is at the heart of ethical research an emphasis was placed on the rights, safety, fair treatment and well being of participants, voluntary, valid, informed, written consent, freedom to participate, freedom to withdraw, the avoidance of coercion, the management of unequal power relationships and the right to privacy, confidentiality and anonymity (Medical Research Council (MRC) 2005, Clark and McCann 2005, Polit and Hungler 2004, DoH 2001)

Consent to extract and research the hospital violent incident forms (and commence the other data collection strategies) were granted by the LREC, the host organisation Research and Development Department, Personnel Department and Risk Management Departments respectively, and the medical and nursing ED leaders. LREC approval was confirmed in August 2007 and Research and Development/Risk Management /Personnel Department approval in December 2007. Individual consent from staff in relation to examining hospital incident forms was not required as the data was anonymised and this was supported by the above stakeholders. Participant information and consent forms for the observation and interview phases of the study are listed as appendix 5.

3.6.2) Data collection and storage

The retention and safeguard of accurately recorded and retrievable results is essential for ethical research (MRC 2005). Data was anonymised, transcriptions and data stored, and audio recordings destroyed in accordance with the Data Protection Act (1998). Retaining and storing written transcriptions, but erasing audio recordings was completed at the request of the LREC.

3.7) Describing the sampling technique applied when identifying participants

3.7.1) People

It has been suggested by Endacott (2007) that the researching of credible participants adds to the trustworthiness of research studies. Subsequently the sample consisted of qualified nursing staff practising within a site specific south of England ED. The inclusion criteria for participants was influenced by the following criteria adapted from Creedon (2005) that all participants should be:

- a registered nurse.
- employed as an emergency nurse with experience of caring and treating emergency service users.
- currently practising in the ED.
- willing to participate in the study.

3.7.2) Time

The study was undertaken from August 2007 to May 2009, at a site specific ED, in the south of England.

3.7.3) Context

Violence occurring in healthcare facilities often reflects the social circumstances of the locality (National Audit Office 2003, Hoag-Apel 1998) and there is a strong argument that violence experienced in healthcare facilities mirrors the degree and severity of violence in wider society in general. Consequently, an appreciation of the public health and social issues, related to the hospital catchment area,, forms an important part of the background information to this study and I have summarised this information in appendix 6.

As the setting for the observations was deliberately chosen by the investigator, the sampling technique was purposive (Bowling 2002). As the research progressed, grounded theory methodology demanded simultaneous data collection and analysis. Individuals who can contribute to the data collection process were recruited to the study as the research progressed and preliminary findings emerged; this is known as theoretical sampling (Charmaz 2000, Higginbottom 2005).

3.7.4) Sampling size and achieving saturation

In this type of research sample size is not determined by the need to ensure generalisability, but by a desire to investigate fully the chosen topic and provide information rich data because social phenomena need not be necessarily explained numerically (Basit 2003, Grbich 1999).

Constant comparison is a central feature of grounded theory procedures and theoretical saturation, which is a defining characteristic of grounded theory and relies on the process of constant comparison (Bowen 2010). The constant comparative method is a process whereby findings are verified and corrected on the basis of the data collected (Strauss and Corbin 1998). A cyclical approach to data collection and analysis was undertaken, during the collection of interview data, with these processes occurring simultaneously (McCann and Clarke 2003a). When adopting the grounded theory approach, Strauss and Corbin (1998), state that theoretical saturation is achieved at the point at which no new insights are obtained, no new themes are identified, and no issues arise regarding a category of data.

Data saturation entails bringing new participants continually into the study until the data set is complete. Data saturation is reached when the researcher gathers data to the point of diminished returns, when nothing new is being added (Bowen 2010). Consequently sample size, when adopting the grounded theory methodological package, is based on saturation, or ceasing data collection when data categories have been exhausted (Endacott 2007). In this sampling strategy, the researcher does not seek generalisability and therefore focuses less on sample size and more on sampling adequacy, in order to comply with the grounded theory methodological package. As Morse (1995) points out, saturation of all categories signifies the point at which to end the research.

3.8) Instrument 1; Documentary research of hospital incident forms.

The published organisational policy instructed nursing staff to formally document violent incidents, involving physical assaults or verbal abuse on a standardised clinical incident form. Completed forms were then reviewed by senior nursing staff in the department and forwarded to a security consultant who advised on whether the incident warranted police involvement. Copies of the forms were also forwarded to the legal, risk and health and safety departments within the organisation. Consequences for service users identified as being involved in such incidents could include written warnings, service exclusion or potential prosecution.

Reviewing violent incident forms is a strategy that has been adopted by previous researchers such as Cembrowicz and Shepherd (1992) and Pane et al (1991). Many settings have rich, and sometimes extensive, sources of data that are collected already and are either untapped for research purposes or else can be re-interpreted for different research (Finlay 2001). Jupp and Norris (1993) have identified that the interpretive tradition has historically utilised a documentary analysis approach to data collection, making no assumptions about the documents representing a reality. The advantages of utilising documentary evidence, within a research study, are related to cost, stability of the data, unobtrusiveness, non-reactivity and richness (Yin 2003, Robson 2002, Lincoln and Guba 1989).

The interpretive nature of this study is acknowledged, as data objectivity can also be viewed as problematic, in so far as the confidence with which such documentation reflects actual events (Sweeney and McAuley 2005). Consequently weaknesses to this approach, include biased researcher selection and bias on the part of those completing the documentation (Gangeness and Yorkovich 2006).

Incident form analysis can be viewed as problematic for two reasons. Firstly, as addressed in the literature review (chapter 2 2.8), widespread under-reporting of violent incidents is prevalent within the nursing profession and therefore the data available within the incident forms must be treated with a degree of scepticism and suspicion in relation to whether the forms represent the realities of clinical practice. It can be argued however, that the incident forms could offer some plausible and reasonable lines of investigation.

Secondly, the consistency, accuracy and quality of the data made available when considering the incident forms did raise cause for concern. Accepting that the incident forms reflect the subjective interpretation of events, a further dilemma related to the incomplete completion of various sections of the forms; a lack of clarity relating to the involvement in specific incidents of the individual completing forms; variations in the amount of detail relating to specific incidents and occasional use of abbreviations and colloquialism. Inconsistent documentation of events can be viewed as an important issue related to professionalism and occupational practices; themes that increasingly developed as the research progressed.

In this study I will primarily be considering the terms "*professional*" or "*professionalism*" as being conceptualised in terms of two components. Firstly, from a clinical practice perspective nursing professionalism relates to delivering care in accordance with the Nursing and Midwifery Council (2008) document, "*The Code: Standards of conduct, performance and ethics for nurses and midwives*". This code is the foundation of good nursing practice and makes statements related to the NMC expectations of behaviour for registered nurses.

Secondly, professionalism is considered from a broader perspective, in terms of characterising the occupational traits associated with professional status as outlined by

authors such as Rutty (1998). This perspective will be elaborated upon in chapter 7 (section 7.4).

3.8.1) The practical process of documentary data collection and analysis

Following meetings with the departmental nursing leaders and administrators, relating to the practicalities of examining the hospital incident forms available, the agreed procedure was as follows:

1. administrators identified a folder containing original incident forms completed by nursing staff dated between 1/02/2007 to 24/2/2008. This formed the exclusive time period over which incident forms were analysed. Subsequent incident forms completed after this time period were not included, due to the practicalities of analysing a fluid data set. Only incident forms involving qualified nursing staff were considered, as the aims of the study involved examining the reporting behaviours of emergency nursing staff.
2. incident forms labelled "violent" were examined by myself to identify incidents meeting the parameters of the research (incidents involving qualified ED nursing staff chapter 3, 3.8.1). Thirty eight incident forms were identified and analysed.
3. incident forms were subsequently numerically coded, photocopied, anonymised and stored in a locked cabinet at the university.
4. based on the themes developed from the literature review, and taking into account published advice offered by authors such as Endacott (2007), May (1999), Strauss and Corbin (1998), Lusk (1997), Hammersley and Atkinson (1995), Forster (1994) and Holsti (1969), I developed an excel spreadsheet coding and categorising the information as it was extracted.
5. incident form analysis was completed by May 2008.

3.8.2) Theorising the analysis of the incident forms

Strauss and Corbin (1998) emphasise that data analysis protocols are merely guides, not rules, and subsequently incident form analysis was framed through the Strauss and Corbin`s (1998) approach, along with the consideration of published general

frameworks and guidance offered by authors such as Endacott (2007), May (1999), Lusk (1997), Hammersley and Atkinson (1995), Forster (1994) and Holsti (1969). Subsequently this component of my research did not follow the purist coding process advocated by grounded theory that is elaborated on earlier in section 3.4. I can justify this approach, as Glaser and Strauss (1967) themselves comment that when using a cache of archival materials, incident forms, for example, then this is equivalent to a collection of interviews or field notes.

In particular I examined the data using the so-called flip-flop technique (Strauss and Corbin 1998), which involves turning a concept inside out or upside down to obtain a different perspective on an event, object or action/interaction. This is achieved by viewing data from multiple perspectives rather than simply accepting statements or documentation as fact.

In order to combat concerns related to forcing the data when conducting a grounded theory study I did not confine my analysis to the study aims or the literature review sub headings but attempted to approach the incident analysis as an intellectual challenge to be unconstrained and enjoyed.

3.9) Instrument 2; Audio recorded, open ended, focused, semi-structured, themed exploratory interviews

I chose interviewing as a data collection instrument, primarily because exploratory semi-structured and unstructured interviews tend to be the primary data collection method in grounded theory research (Norton 1999).

For this research I adopted a semi-structured, one-to-one interview approach, ruling out focus groups, primarily because each participant`s experience can be viewed as unique, particularly when one considers the scope of the phenomenon under investigation. Semi-structured interviews loosely follow an interview guide, allow for variation of the sequence of questioning and allow researchers to focus and probe different areas as required (Casey 2006, Holloway and Wheeler 2002, Bowling 2002, Clarke 1999, Kitzinger 1995).

From a grounded theory perspective, the context of the interview is intrinsic to understanding the data, and data trustworthiness is deemed sufficient when sufficient depth of discussion is attained, for a mutual understanding to have been achieved between interviewer and responder. The interview themes were developed from considering the research aims, an extensive literature search, the documentary researching of hospital incident forms and from data collected from interviews as the research developed.

However, there are multiple limitations that one needs to consider when adopting a semi-structured interview approach. During single interviews the relationship/interaction between interviewer and interviewee can be influenced by social class, race, gender, age, ethnic origin, religion, professional background and perceived knowledge and status, because actors bring their own pre-understandings and prejudices to the research process (Robson 1996, Rubin and Rubin 1995, Kleinman and Copp 1993, Gadamer 1976).

Angen (2000) emphasizes that the credibility of research partly resides in the competence and skill of the researcher, and the relationships between the interviewer and the participants is a crucial factor in determining the quality of data obtained. Subsequently creating the optimal interview environment and atmosphere were crucial and I considered the recommendations of a variety of authors in relation to providing a conducive environment, trouble shooting and checking recording equipment for potential malfunction (Maijala, Paavilainen and Astedt-Kurki 2005, Tuckett 2005a).

3.9.1) The interview data collection process

Following stakeholder approval, nursing staff meeting the participant criteria, were contacted via the hospital internal mail system. Staff were invited to participate and offered both participant information sheets and consent forms. Once participants responded and were identified, interviews were conducted, at a time mutually agreed between myself and the interviewees for convenience, with all interviews taking place in private, in offices within the ED setting. On completion of this work 9 interviews were conducted (n=9). Interviews were audio-recorded as this allows the researcher to

acquire verbatim accounts and to concentrate and focus more on what is being said (Holloway and Wheeler 2002, Sandelowski 1994).

3.9.2) Transcription

Interviews were audio recorded and transcribed personally by myself at the earliest opportunity to reduce the effect of researcher bias (Tuckett 2005a), and to ensure confidentiality. One dilemma I encountered with transcription related to recording pauses or silences. Silences are hard to transcribe but are vitally important within the interview process, because a powerful silence may speak more than words (Gillham 2000, Sorrell and Redmond 1995). I documented excessive silences or pauses in note form in the margin, alongside the transcribed text. Such an approach is important because pauses or silences could, for example, indicate a range of emotions ranging from reluctance to speak freely or a consideration of a previously unconsidered question or issue.

3.9.3) Theorising the analysis of interview data

As noted above data analysis followed the coding process of open coding, axial coding, selective coding (section 3.4) and constant comparison (section 3.7.4).

3.10) Instrument 3; Non-participant, time sampled, mobile observation

An observational approach was adopted, because of an epistemological position suggesting knowledge or evidence of the social world can be generated by observing in natural settings (Mason 2002). Systematic observation is the classic method of enquiry in natural science; it is also the mainstream method within the social sciences, particularly in organisational analysis such as the study of functioning of organisations, such as hospitals (Casey 2006, Bowling 2002).

Within Gold's (1958) typology, my approach was to remain as close as possible to the overt complete observer role. Non-participant observation enables researchers to gain

an emic view of the area under investigation; is first hand; allows researchers to examine the social reality of participants` experiences; and allows researchers to generate theoretical accuracy. It also allows researchers to verify interview data; allows researchers to address what is occurring in a given context, who is involved and where things happen and finally allows researchers to identify how participants act and interact (Holloway and Wheeler 2002, Jorgenson 1989). Combining observations and interviews to collect data, enables comparisons between reported and actual behaviour, provides diverse perspectives in seeking answers to the research question and helps strengthen the rigour of the study (Casey 2006, McCann and Clarke 2003b).

Utilising non-participant observation as a data collection strategy however, is potentially problematic for a number of reasons. Limitations include researcher bias, the potential for observations to be erratic, the problem of selective inattention; and how familiarity with the research setting can introduce language, sound and observational bias, related to the difference between a true situation and that observed, owing to observer variations in perceptions (i.e. interpretation) (Bowling 2002, Turnock and Gibson 2001, Spradley 1980). During my study I engaged in seventeen observation periods over a twelve week time period, resulting in fifty two hours of observation.

3.10.1) Piloting the observational periods

There is also the concern that participants being observed may alter their behaviour, (Yin 2003, Roethlisberger and Dickson 1939) although both Patton (2002) and Mulhall (2003) play down the influence of researcher presence on staff behaviour. To address this issue I piloted my observation periods in order to allow staff to become familiar with my presence. The observational period was piloted to develop a coding framework and to offer a degree of mutual acclimatisation, for the observer and staff. Following piloting my observations, I met with my supervisor to discuss ethical and practical issues related to data collection. No major changes to the process of data collection were required.

3.10.2) Timing and length of observations

While real time observations have the advantage of verisimilitude, time sampling has generally been the preferred method (Dowswell et al 2000). For this study, I initially adopted a time sampling and single approach, occupying one location and observing interactions for a specific time period. I began by conducting formal observations in the ED waiting area because this was an area highlighted through the literature review, where there was the potential for conflict. As data collection proceeded I adopted a multiple, mobile approach, moving around the study site and following people during a given activity or observational period: a strategy recommended by Casey (2006). Chang (1995) recommends that 2-3 hour observational periods are conducted to avoid observer drift and placing undue stress on participants. Consequently I adopted this strategy.

3.10.3) The observational data collection process

Once I had reached the stage of observational data collection, a period of one month was allocated to publicising this stage of the research, to familiarise staff in relation to the research aims and design, and to clearly identify which staff had consented to participation. All eligible staff were sent invitations to participate, participant information sheets and consent forms through the internal mail. For the actual observational event, I informed all nursing staff working a specific shift, of the planned activity, whilst reassuring practitioners that my presence was not to make judgements on individual practice. Spradley (1980) suggests that every social situation can be identified by considering: place and the context of the environment, actors, events as they occur and activities and interactions between nursing staff. These were the areas I addressed when conducting observations.

3.11) Theorising the analysis of observational findings

I framed the observational component of my study, with particular reference to guidance offered by Strauss and Corbin (1998), and through the consideration of published general frameworks and guidance offered by authors such as Endacott (2007), Polit and Hungler (2004), Mason (2002), Bowling (2002), Creswell (1998),

Hammersley and Atkinson (1995), Johnson (1975), Schatzman and Strauss (1973), Denzin (1970) and Gold (1958).

The actual process of collecting the observational data was guided by Maijala et al (2005) who suggest that as the grounded theory methodological package is followed, and a tentative theory begins to take shape the observational component is conducted through theoretical sampling and selective coding.

My broad intentions when conducting observations were to observe for variables pertinent to my research aims, observe for variables relating to themes identified during the literature review, and observe for specific factors identified through the incident form analysis and interview components of my study. In essence the role of the documentary analysis and interview components of the study was to partly narrow and focus the observational component: what Polit and Hungler (2004) describe as a process of progressive focussing.

As interpretive researchers are encouraged to write reflexively, at this point it is relevant to disclose that my thought processes began to increasingly revolve around two broad concepts: which I viewed as a further interpretation of progressive focussing. Through a deeper engagement with the data, I considered the broad nature of the concept of professionalism within the context of ED nursing. As noted in section 3.8, I am using the term "*professional*" in terms, on the one hand, of participants delivering nursing care through adherence to the NMC code (2008), and, on the other, to more broadly reflect the traits of professional status.

Throughout my Doctoral journey I was conscious that this work was being prepared within the scope of a professional doctorate. First, having chosen to explore the nature of professionalism as part of my taught doctorate programme, I have placed the issue of professionalism as a key component of the educational literature. During the process of literature critiquing the lack of research literature exploring ED violence, particularly research written by clinical nursing staff, has already been highlighted. This theme had emerged as part of the literature critiquing process and can be viewed as both an educational and research issue. Subsequently the nature of professionalism featured strongly when conducting the observational component of my study and

acted as a central component when developing a discussion of my findings in the final chapter. Second, as I had also undertaken a taught component of my doctorate that related to leadership, I also began to consider how the higher education sector could potentially lead in the proactive management of ED violence. Professionalism and leadership subsequently influenced the presentation of my discussion and recommendations in the final chapter.

3.12) Field notes and a research diary

During the periods of observation I also recorded field notes, a strategy utilised to contribute to the dependability and credibility of the research (Tuckett 2005a, Hodgson 2005, Polit and Hungler 2005). Furthermore, research governance protocols frequently require researchers, to build into their studies, support mechanisms for participants, but such support may be also be needed for researchers (Parnis, Mont and Gombay 2005). My own support network included support from supervisors and Doctoral colleagues and I adopted the use of a personal diary as recommended by Bowling (2002).

3.13) Rigour

Lincoln and Guba (1989) propose that the concepts of validity, reliability and objectivity, can be applied within the qualitative approach as trustworthiness, subdivided into transferability, confirmability, credibility and dependability. Transferability refers to the extent to which findings could be applied to other sites and revolves around the concept of thick description. Data was collected in a single ED and therefore further studies would be needed to assess transferability. Hammersley and Atkinson (1995) however, suggest that researchers can strive for plausibility, as truth claims are likely to be true given existing knowledge, and I propose that the results, recommendations and conclusions drawn from this study are plausible.

Confirmability can be demonstrated by maintaining an audit trail, mapping the research process, supervision, ethical approval, data collection and analysis. The literature does emphasise transparency through, for example, plainly written

transcriptions, audit trails or decision trails (Annells 1999, Koch 1994) and I have attempted to address confirmability throughout this work.

Lincoln and Guba (1989) propose that a study is credible when it presents faithful descriptions, and readers confronted with the work can recognise it. Credibility of the data was enhanced, as the data was reported back to the research participants, in line with what Guba and Lincoln (1989) refer to as member checking. The conclusions and recommendations were not dismissed but demonstrated a true reflection of the participants` experiences.

Finally, to summarise, Endacott (2007) suggests that strategies that can enhance trustworthiness include, triangulation, using credible informants, prolonged and persistent observation, continuous data analysis, searching for conflicting evidence, observing at different times of the day and acknowledging and documenting the impact of the researcher on the situation under investigation. All of these strategies was integrated into this thesis.

Having addressed methodological, method and research governance issues the following chapter summarises findings from the incident form analysis.

CHAPTER 4: INSTRUMENT 1; VIOLENT INCIDENT FORM FINDINGS

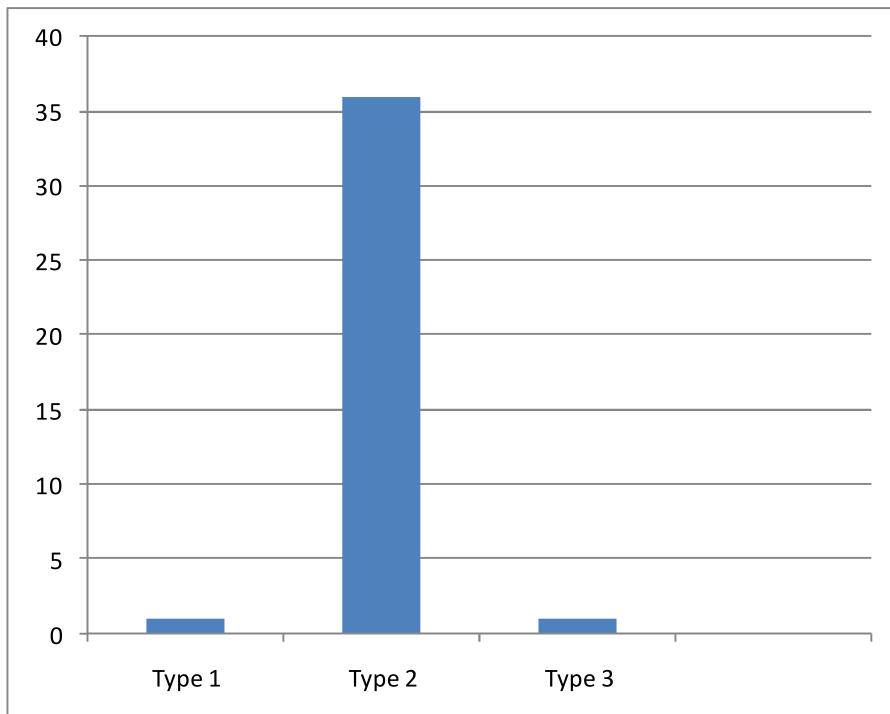
4.1) Introduction

This chapter presents the findings from the documentary analysis component of the study. The incident form analysis allowed me to identify what nursing staff document in relation to experiencing violence and aggression and this directly relates to my original aim of investigating reporting practices. It also allowed me to identify potential lines of investigation, when conducting future interviews and observations, related to how nursing staff define violence and aggression in the clinical area and what they perceive as situational factors contributing to violent and aggressive incidents. Thirty eight incident forms were considered as meeting the parameters of the research in terms of involving qualified nursing staff, and themes identified, through the literature review, were applied to the data.

4.2.1) *Categorising incidents within a Type 1-4 classification*

When adopting the LeBlank and Barling (2004) classification (Type1-4), of thirty eight reported incidents, thirty six (94.74% n=38) can be classified as Type 2 (involving legitimate service users/visitors). One incident (2.63% n=38) can be classified as Type 3 (involving co-workers). This incident related to one member of the nursing team completing an incident form which documented an alleged incident perpetrated by a colleague, and one (2.63% n=38) Type 1 (intruder) as an aggressor was searched and found in possession of a large hammer (Table 5). No Type 4 incidents were identified. Across the following tables the sample size is referred to through n=x and MD refers to missing data.

Table 5 Categorising incidents of conflict (Sample n=38).

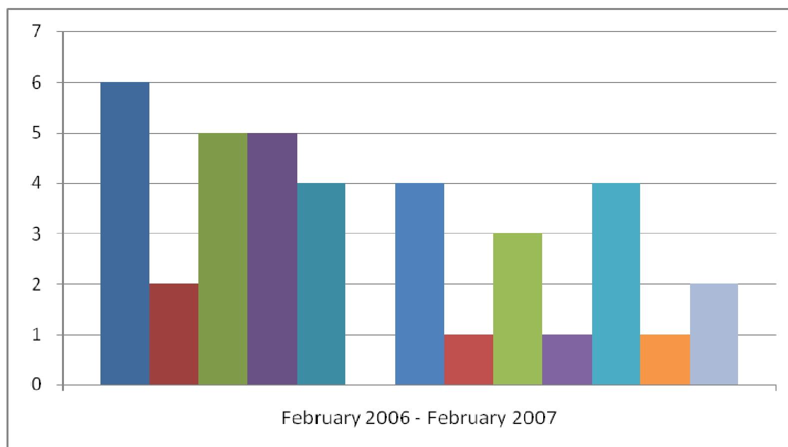


Furthermore, thirty four (89.47% n=38) appeared to involve service users (patients and visitors) in conflict with staff .The remaining four incidents involved one incident of patient on patient conflict, one incident of visitor on visitor conflict, one incident of visitor on patient conflict and as already noted a co-worker incident. Throughout the analysis the co-worker incident is included or omitted depending on relevance.

4.2.2) Timing of incidents

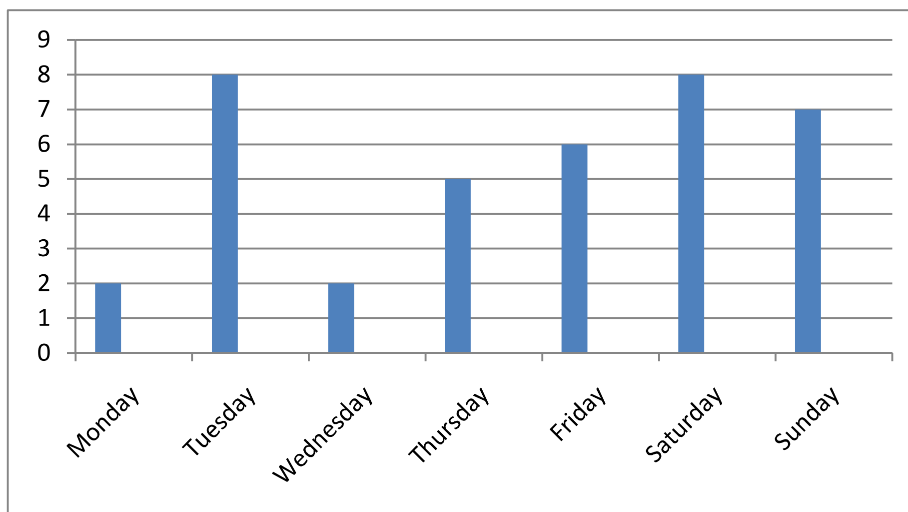
The timing of incidents may be influenced by a variety of variables, such as the characteristics of the service users accessing the service at any given time, the departmental throughput of service users, or issues relating to staffing levels. The literature makes reference to the spread of timing of incidents and subsequently the following analysis can be offered. Over the thirteen month time period considered, the following table shows the distribution of reported incidents by month.

Table 6 Distribution of incidents by month (n=38).



Incidents could be further broken down by the day of the week in which they were reported (Table 7).

Table 7 Incident reports by day of the week (n=38).



Fifteen incidents (40.54% n=37 Missing Data (MD) =1) were reported, occurring during week day shifts (8 am Monday -8 pm Friday) and twenty two incidents (59.46% n=37) were reported during weekend shifts (8.01 pm Friday-07.59 am Monday). As ED nursing is a twenty four hour service, incidents could be further reduced to reporting over a 24 hour time frame (Table 8), reporting outside traditional 9am until 5pm working hours (unsocial hours) (Table 9) and timing over eight hour

timeframes (Table 10). Over a twenty four hour time period, twenty incidents were reported as occurring between 20.00 and 08.30 (night shifts) and seventeen incidents were reported as occurring between 08.31 and 19.59 (day shifts) (MD=1).

Table 8 Timing of incidents over a 24 hour period (n=38 Missing Data (MD) =1).

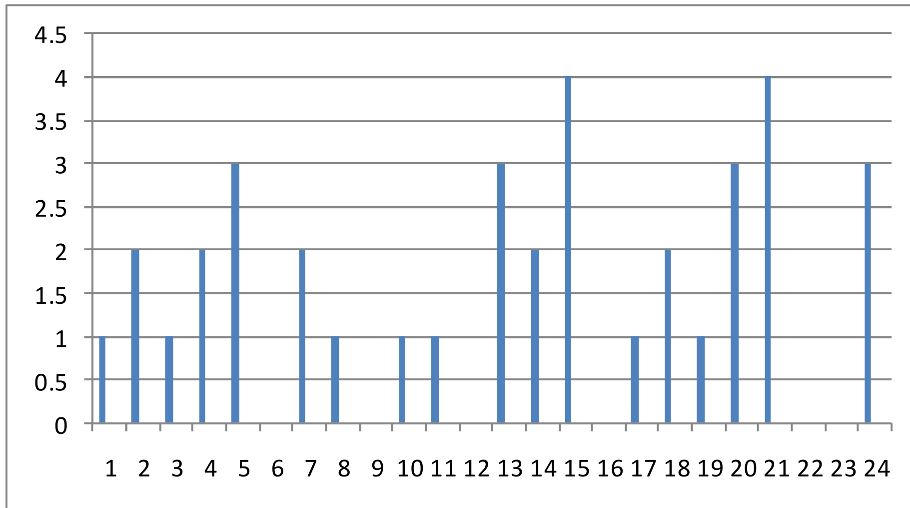


Table 9 Timing of incidents by unsocial hours (n=38 MD=1).

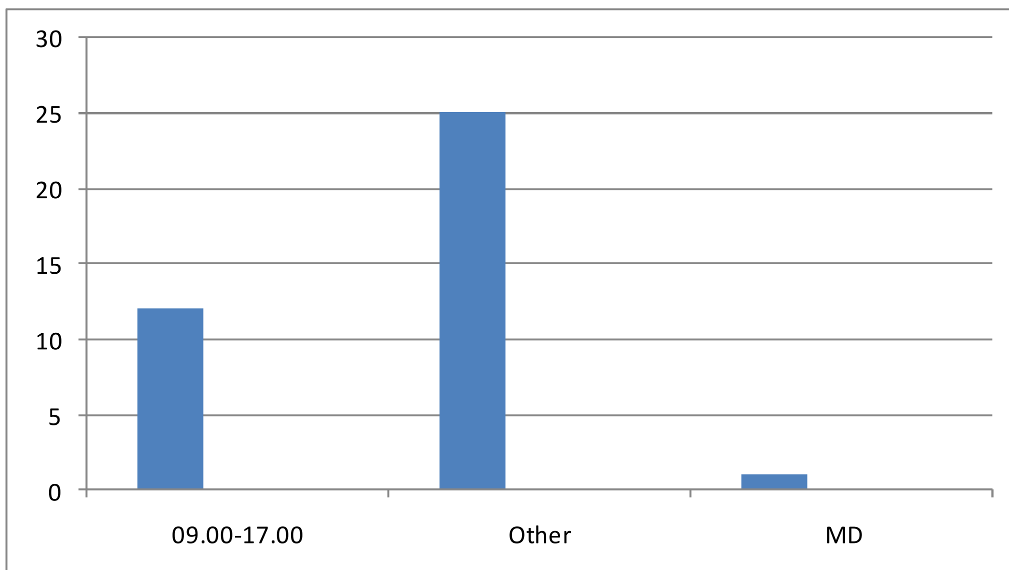
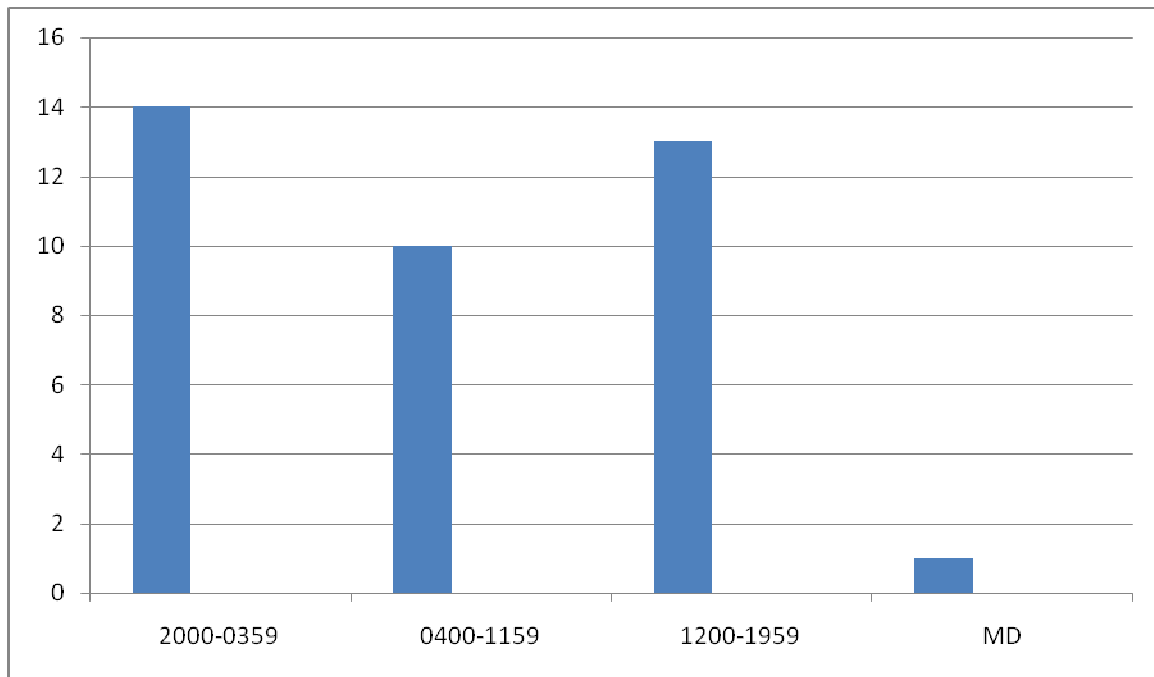


Table 10 Timing of incidents over 8 hour time periods (n=38 MD=1).



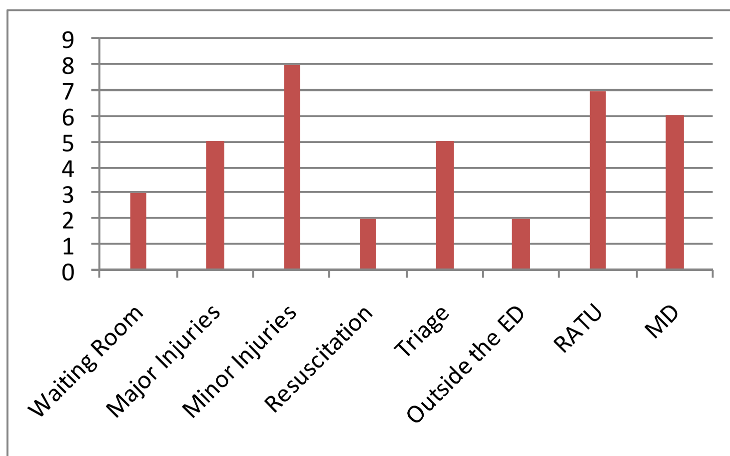
4.2.3) The geographical location of incidents

The department studied is divided into a number of distinct geographical areas. Minor injuries refers to an area of the department allocated for treating service users presenting with minor injuries; major injuries, an area for treating major injuries and RATU (Rapid Assessment and Treatment Unit), an area of prolonged clinical observation, assessment and medical/nursing management. Triage refers to an area where nursing staff grade service users by clinical need, following waiting in the waiting room; and resuscitation an area where life threatening presentations are managed. Analysis of the incident forms identified the geographical location of incidents (n=37 MD=6). The co-worker incident was omitted from this analysis explaining the sample size of thirty seven. This incident form related to one member of the nursing team completing an incident form which documented an alleged incident perpetrated by a colleague.

Only three incidents (8.10% n=37) involving service users, occurred in the waiting room despite this area being identified as an area of conflict in the literature. Two incidents (5.40% n=37) occurred directly outside the department (Table 11). Examining incidents by geographical location offers a potential line of investigation, as physical conflict between staff and service users requires close interpersonal

proximity. Physical contact between staff and service users differs in nature, depending on service user need and point of processing, at any given moment, as the patient is admitted, triaged, assessed and treated. For example, only one of the incidents reported could be confirmed as occurring after service users had been treated; all other incidents appeared to develop prior to, or during treatment (although this could not be confirmed on eight occasions).

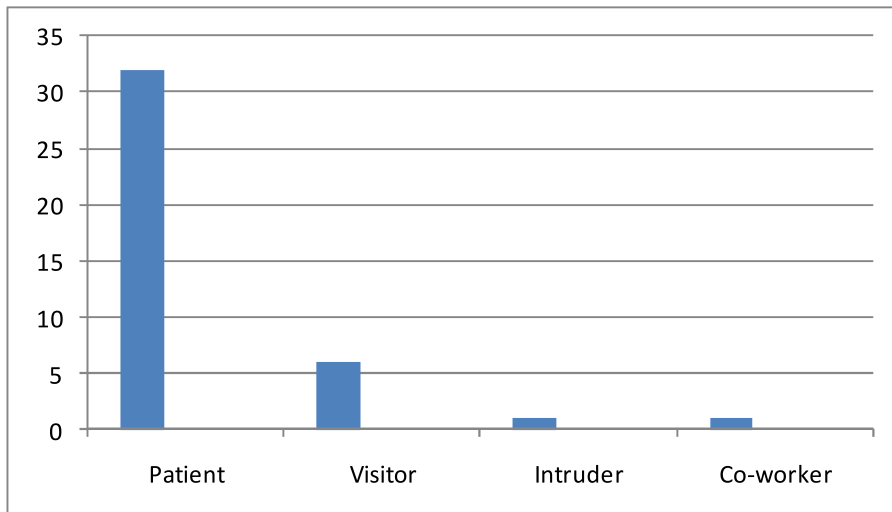
Table 11 Reporting by geographical area (n=37).



4.2.4) Aggressor demographics

Analysis of the incident forms identified forty individuals, involved in thirty eight incidents; as one incident involved two visitors accompanying a patient. Thirty two reported incidents involved patients (80.00% n=40), six (15% n=40) visitors, one (2.5% n=40) an intruder and one (2.5% n=40) a co-worker (Table 12).

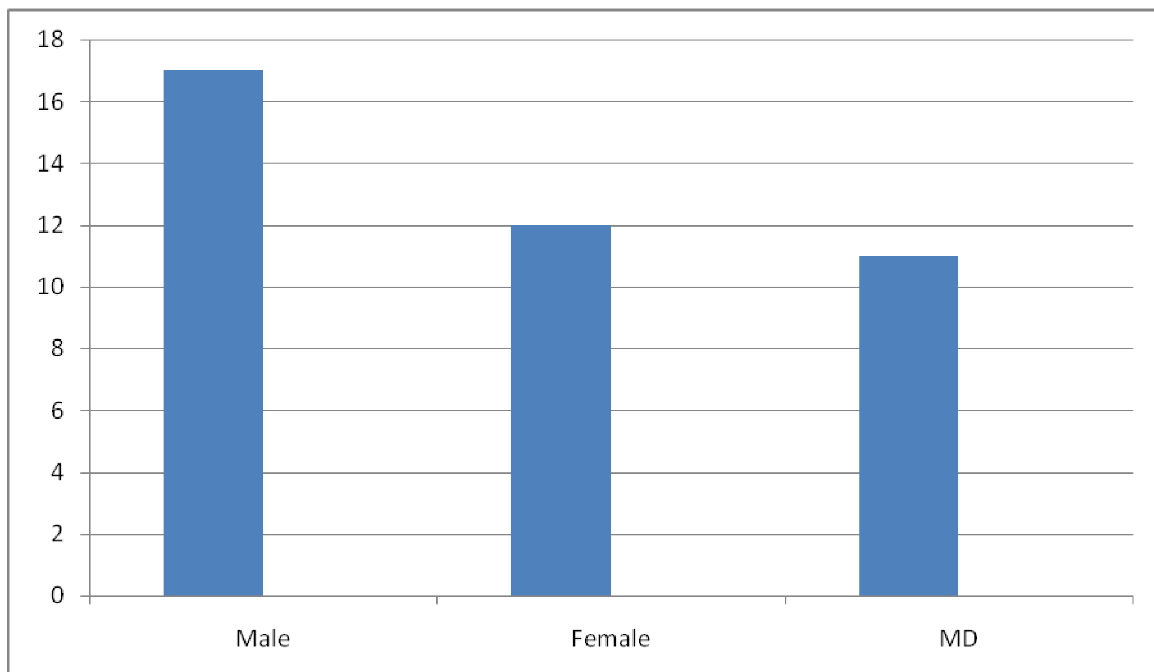
Table 12 Aggressors in the ED (n=40).



4.2.5) Gender of aggressors

Seventeen incidents involved male aggressors, twelve incidents involved female aggressors and in eleven incidents aggressor gender was not stated (table 13).

Table 13 Gender of aggressors (n=40 MD=11).



4.2.6) Age of aggressive patients and visitors

The age of aggressors was extractable from the incident forms in twenty one incidents (n=35, MD 14, two patients implicated twice) (table 14).

Table 14 Age range and number of aggressors (n=35 MD=14).

Age range (years)	Number
10-19	1
20-29	6
30-39	5
40-49	6
50-59	2
60-69	0
70-79	0
80+	2

4.3) Trigger factors contributing to conflict between service users and staff

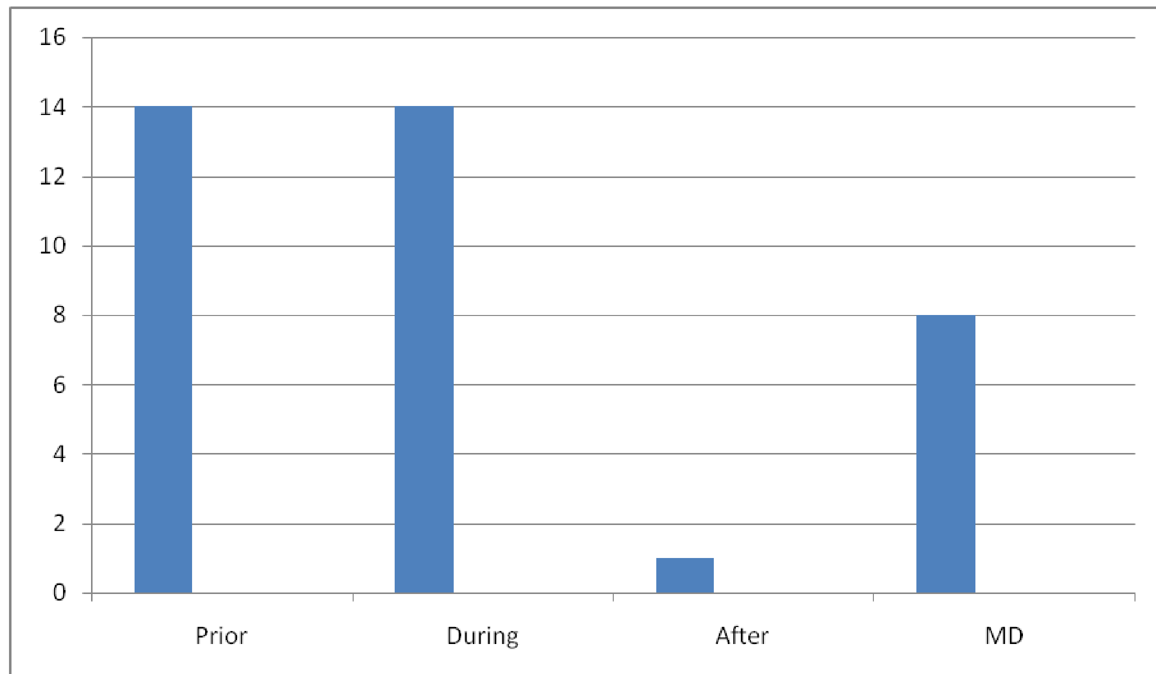
When reviewing the documentation the following trigger factors were highlighted as relevant to the incident;

4.3.1) Service users and waiting times

Three incident forms (8.10% n=37) specifically suggested waiting times were a trigger in the development of conflict with staff. In relation to incident development table 15 shows where incidents took place in terms of the service user treatment

journey. Only one incident (2.70% n=37) suggested conflict occurred after service users had been treated, although in eight cases, the documentation did not clearly indicate at what point the incident occurred.

Table 15 Incident development in relation to treatment (n=37 MD=8).



4.3.2) Service users and alcohol and/or substance abuse

Alcohol was implicated as a trigger factor in seven incidents involving service users (18.91% n=37). No reference was made in the incident forms to other forms of substance abuse.

4.3.3) Service users with a psychiatric history

Incidents reported, suggested 5 incidents (13.51% n=37) involved service users presenting with psychiatric histories; although the specific nature of these histories was omitted. Incidents involved one service user biting a staff member, one self harming and lashing out at staff, and service users issuing verbal threats and obscenities on three occasions.

4.3.4) Service users and clinical presentation

Four (10.81% n=37) references were made to service users presenting with clinical conditions (abdominal bleeding, confusion, a head injury and a laceration).

4.3.5) Service users with a history of conflict

In two incidents (5.40% n=37) service users were identified as being previously known to the department, and in two incidents (5.40% n=37) the same service user was involved.

4.3.6) Service users and dual diagnosis

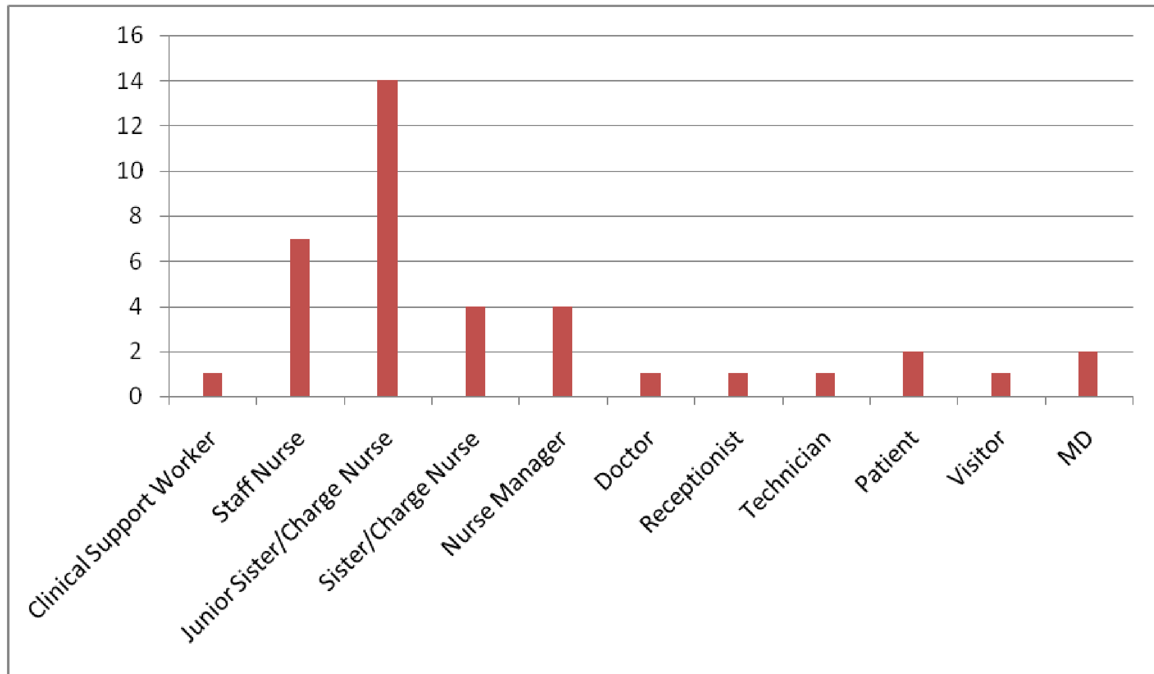
Only 4 incident forms offered information related to a clinical diagnosis (10.81% n=37). In only one incident did incident form analysis suggest a dual trigger of a psychiatric history and alcohol abuse.

4.4) Victim characteristics

When reviewing incidents the majority of victims identified were qualified nursing staff (29, 76.31% n=38 MD=2). When considering nursing grade seven described themselves as staff nurses, fourteen junior sisters, four sisters/charge nurses and four nurse managers. No references were made to student nurse involvement and only one reference was made to clinical support workers being victims. Only two incidents (5.26%, n=38) involving both medical staff and nursing staff were completed by medical staff. Thirty five (92.10% n=38) incident forms were completed by individuals, either directly involved or witnessing incidents.

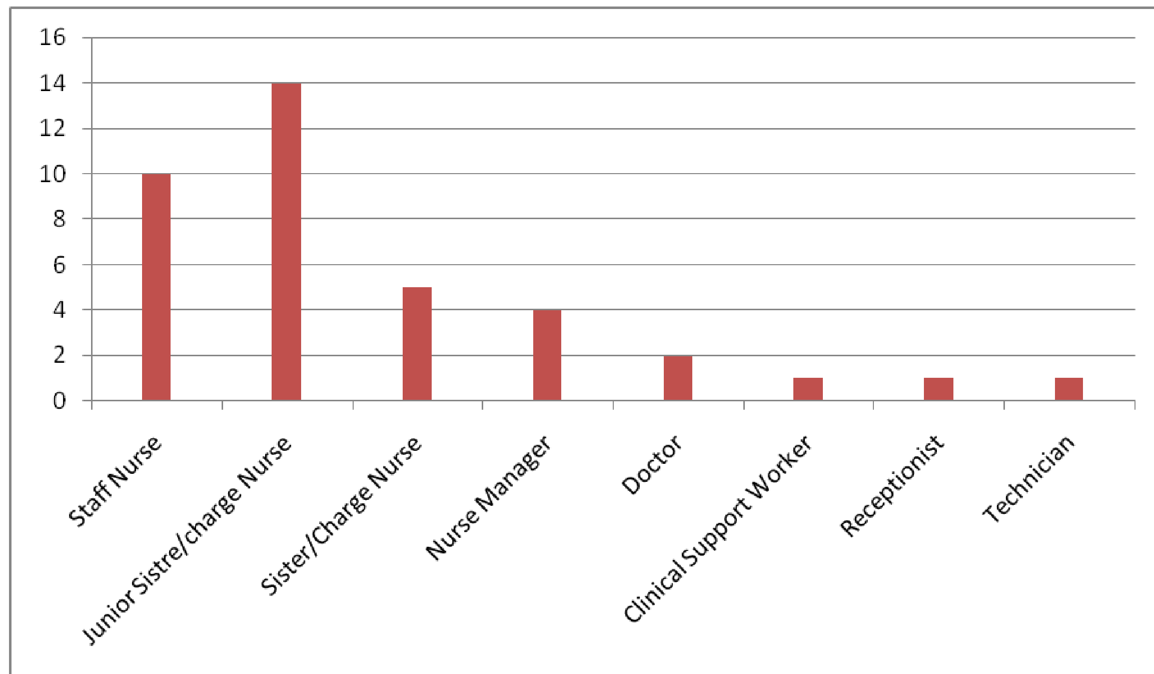
Three incidents (7.90% n=38) however, were completed by shift leaders or managers (table 16). Thirty six incidents (94.73% n=38) involved more than one member of staff, or were fully or partly witnessed by colleagues, but no clear pattern emerged relating to which personnel were responsible for completing incident forms. Furthermore only one incident form would be completed, per incident, despite occasions where multiple staff members were involved.

Table 16 Victims as identified by reporters (n=38 MD=2).



Incident forms also identified the grade/occupation of reporters (n=38) (Table 17)

Table 17 Reporting by occupation/grade (n=38).



4.5) Experiences of physical and verbal abuse

Nineteen (50%, n=38) incidents explicitly referred to direct physical contact, with patients hitting, punching, kicking, grabbing, pushing, pulling, slapping, lunging, lashing out at, spitting on and biting staff members. Six (15.78%, n=38) involved routine equipment (e.g. crutches, tables, portable lights, chairs) being used opportunistically by individuals as potential weapons and, as already noted, in one case a hammer was found on a patient.

Twenty (52.63% n=38) incident forms directly stated a variety of verbal threats experienced, characterised by shouting, swearing obscenities, racial abuse, sexual insults, death threats and threats to the person, occupational insults and threats to employment status. Six incident forms (16.21% n=37) directly reported service users approaching staff members, and encroaching on their personal space with threatening or intimidating non verbal gestures/eye contact.

4.6) Police and security involvement

Ten incidents (26.31% n=38) were referred to the police service. One incident related to a lack of attendance by police and three incidents implied service users were arrested. One incident involved a patient leaving with the police and another a patient leaving the department and not consenting to treatment. The individual returned later with the police. The other occasions involving the police, refer to the police being contacted but no further details are offered. Five incidents (13.15%, n=38) confirmed or implied aggressors presented with a current or known psychiatric history, including one incident of personal self harm. None of these incidents referred to police involvement.

Security staff were implicated in twenty two reports (59.45% n=37) for a variety of reasons. For example, in eight incidents, security staff removed service users (21.62% n=37). In two incidents (5.40% n=37) reporters commented on poor security response and in two incidents (5.40% n=37) respondents commented on failure of environmental security measures. For example, the department`s security infrastructure includes personal panic button "*pinpoint*" equipment. Incident forms made six references (16.21% n=37) to staff activating the system to call for security assistance; in two incidents the equipment failed. The remaining incidents indicated the presence of security staff during nursing staff/service user conflict.

4.7) Post-incident consequences for staff and service users

Only limited information could be extracted from the incident forms in terms of post-incident consequences. Reporters identified a variety of consequences, including additional medical and nursing interventions/observations, care and comfort to victims and first aid. Two incidents (5.40% n=37) reported, directly led to staff sickness although only one incident stated the time off required (3 days).

Two patients received banning letters and one a warning letter; although future consequences relating to organisational response may be underestimating the number of such letters as letters/action may have been sent later following investigation. In three incidents no action was taken; on two occasions aggressors had not offered

contact details and in one incident it was felt that contacting the aggressor via mail was not in the person`s interest.

4.8) The role of the nurse in the ED

Further themes emerged from the documentary analysis of the hospital incident forms that are better presented in narrative format and these are elaborated upon below. These concepts can be viewed as fluid and inter-related, being more or less relevant, depending on specific circumstances.

Conflict between ED nursing staff and service users requires close physical interaction and so a primary theme for investigation relates to proximity. Proximity is very important, because close proximity offers potential aggressors the opportunity to verbally abuse or physically assault nursing staff. There were a variety of factors however, that preceded or influenced close contact between staff and service users.

First, for example, conflict emerged, through the day to day practicalities of delivering nursing care. Incidents 3, 10, 12, 13, 15, 16, 25 and 26 all involved incidents developing while nursing staff were involved in routine nursing activities, such as assisting with changes to patients` physical position, assisting with personal hygiene, dressing wounds or conducting clinical assessments.

An important component of these situations relates to the motivation of the individual parties, and although identifying the motivation of the service users is problematic, the perspectives of the nursing staff could partly be extracted from the incident forms. In both incidents 3 and 15, for example, nursing staff described themselves as in the process of, or trying to, "*help*" the service user. Incident 16, describing an interaction between the nursing staff and a confused patient who had soiled the bed described the motivation of the nursing staff who "*needed to change him*". This relates to the ethos of nursing staff protecting service users, placing the service user safety above their own and interacting in a way that is designed to help service users. This created a potential line of investigation, relating to the caring component of nursing. Thus, helping patients, who may not want to be helped, creates a potential occupational risk of experiencing conflict, when service users and staff clash over perceived needs or

care requirements. This also created a potential line of investigation, relating to how nursing staff attribute the behaviour of service users or colleagues.

Second, proximity was also a factor relating to the broader management of service users. Incidents 5, 17, 32, 35 and 38 described situations where nursing staff and service users clashed over requirements for treatment. In these incidents staff and service users differed in relation to perceived needs; with patients attempting to climb off trolleys, refusing treatment, attempting to leave following clashing with staff or refusing to leave following clashing with staff. In these situations, physical contact appeared to be employed, in order for the course of action deemed necessary by the departmental staff to be addressed and completed. This created a potential line of investigation relating to how nursing staff prioritise treatment and care in the ED.

Third, proximity was also a factor in terms of nursing staff proactively leading the management of specific situations. Incidents 1, 2 and 22 all involved nursing staff projecting themselves as the victim`s advocate by proactive involvement following witnessing what can be perceived as acts of violence against others. These incidents reflected a courageous element of bravery, where individual nursing staff would confront aggressors they encountered, and enter dangerous situations that put their own personal safety at risk. This created a potential line of investigation, relating to how nursing staff perceive their role in the ED.

Fourth, the majority of incidents suggest that nursing staff were perceived as passive victims of violence and aggression, whereby aggressors took an active role in verbally abusing or physically assaulting staff when, for example, walking into the department. The onus, for aggressive behaviour, was frequently placed on the behaviour and attitude purely of the aggressors. Two themes emerged however, relating to this point. Not only did nursing staff enter into situations proactively upon witnessing violence, but they would also be involved in the development of incidents through either making a conscious decision to get involved in ongoing situations, or to set limits on the behaviour of others. Incidents 1, 2, 5, 6, 7, 22, 26, 28, 29, 36 and 38 all contained a component of limit-setting, through managing the perceived unacceptable behaviour of others. This created a potential line of investigation, related to how nursing staff view the internal policing of the department studied by the nursing staff themselves,

along with what motivates nursing staff to actively manage situations involving clashes with service users.

Fifth, incidents 1, 13 and 23 highlighted concerns of staff relating to the environmental security measures employed in the department, or the response of individuals following the development of incidents. For example incident twenty three stated;

"I rang the security office and asked them to attend RATU urgently and immediately. After 3 minutes (approx)…security guards walked up the corridor……Security did not attend urgently".

Subsequently, incident forms were used, for a variety of purposes, by nursing staff such as for formally reporting incidents involving confused patients, malicious aggression from relatives or complaints regarding colleagues. This created a potential line of investigation relating to how nursing staff use the formal reporting process, and what motivates nursing staff to complete incident reports. This is directly related to one of my original study aims.

Sixth, micro analysis of the thirty eight hospital incident forms considered, offered an important area of enquiry. Incident type was categorised as personal accident, violence (sub divided between the terms physical and verbal abuse), security, fire, ill health and other. Reporters described incidents in a variety of ways with aggressors, for example, being described as abusive, verbally abusive, intimidating, swearing, obstructive and physically threatening along with examples of aggressors hitting, kicking and biting staff. Interestingly twelve references were made towards aggressors actually being described as "*aggressive*" but in relation to "*violent*" the term violence was used only twice in the context of;

"shouting very aggressively and violently" (incident 1) and *"the patient issued threats of violence"* (incident 8).

This created a potential line of investigation focussing on nursing staff perceptions relating to terminology describing conflict with service users.

Finally, the wide variety of situational factors, cited earlier in the chapter, that could be extracted from the incident forms are relevant both, to how nursing staff define violence and aggression in the ED and what situational factors contribute to staff/service user conflict. Subsequently the analysis of the incident forms offered valuable lines of investigation, relating to the characteristics of aggressors and victims in the ED; situational and environmental factors contributing to violence and aggression in the ED; and the consequences of incidents for the parties involved, from both an organisational and personal perspective.

4.9) Conclusion

The documentary analysis identified what ED nursing staff, practising in the department studied, actually formally document in terms of experiencing violence or aggression. This process provided a spring board upon which to conceptualise and frame the second component of this research which involved conducting ED nursing staff interviews. In essence the literature review and documentary analysis can be viewed as a process leading to enhanced sensitisation relating to the research aims.

At this point the documentary analysis suggested, reporting practices appeared to be inconsistent and inconsistent practice began to emerge as a second educational theme. The first emerging theme of limited published research exploring ED violence, particularly research written by clinical nursing staff, emerged during the critique of the literature and has already been identified.

Having presented findings from the documentary analysis and identified the second emerging theme, the following chapter presents the findings from the interview component of the study.

CHAPTER 5: INSTRUMENT 2; INTERVIEW FINDINGS

5.1) Introduction

This chapter presents the findings from the interview component of the study. At this point only the findings of the interviews are presented in this chapter as chapter 7 will go on to discuss these findings in light of data triangulation. The interview component of the study allowed me to explore perceptions of staff, in relation to reporting incidents, defining violence and aggression and situational factors. Nine interviews (n=9) were conducted, prior to commencing the observational component of the study and details of the interviews are summarised in table 18.

Table 18 Summary of interviews conducted.

Participant	Date	Length
Participant 1	06/05/2008	75 minutes
Participant 2	13/05/2008	42 minutes
Participant 3	15/07/2008	37 minutes
Participant 4	15/07/2008	31 minutes
Participant 5	23/07/2008	37 minutes
Participant 6	30/07/2008	58 minutes
Participant 7	04/08/2008	52 minutes
Participant 8	06/08/2008	25 minutes
Participant 9	27/08/2008	43 minutes

5.2.1) *Conceptualising terms encompassing violence and aggression within the context of emergency nursing practice*

Following applying the grounded theory methodological package, data analysis specifically identified nine properties (figure 2) and thirty four dimensions (Table 19), relating to how participants conceptualised the terms *violence* and *aggression*. The properties and dimensions offered in the following sections, can be viewed as being on a fluid continuum; although certain properties and dimensions, in individual situations, had a greater or lesser role to play. It can be suggested that combining sets of circumstances and perceptions, created experiences that could be bracketed by

individual staff into either a violent or aggressive situation. Findings from the following sections will be discussed in much greater detail in chapter 7.

The majority of interview data summarised in the following sections, is presented in table form. The left hand side of the tables relates to the areas raised and discussed during the interviews and encompasses the questions I asked, the probing of interviewees and the area under discussion. The following column offers examples of the responses given by interviewees, while the right hand side of the tables refers to the properties and dimensions identified.

Figure 2 Conceptualising violence and aggression in terms of properties.

Table 19 Conceptualising violence and aggression in terms of properties and dimensions.

THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Defining violence and aggression	*"So that's an aggressive patient which is very different to a patient who is aggressive due to the lack of communication and staff perceptions" P3* *"Do you mean violence from mental health patients?"P1* *"People under the influence of alcohol or drugs" P2* *"We are seeing a bit more of that (gang violence) we never used to but now we are and that's frightening it can be frightening" P5* *"Bereaved relatives. Big one" P2* *"Hypoxic or hypoglycaemic patients" P6* *"Do you mean violence and waiting times?"P4*	Violence is defined in terms of situational trigger factors perceived to be stimulating aggressors	Staff perception Mental health Alcohol/substance abuse Street gang affiliation Bereavement/stress Clinical presentation Situational factors

Table 19 Conceptualising violence and aggression in terms of properties and dimensions.

THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Defining violence and aggression	*"Aggression as in maybe a mental health patient that's self harming"P3* *"I`ve had patients punch walls"P5*	Violence is defined in terms of channelled direction	Internal projection (e.g. self harm) External projection (e.g. inanimate objects or other people)
Defining violence and aggression	*"No I would say terminology is different but I think it means the same I think it remains the same…..it's an interchangeable thing isn't it"P5* *"No no no I think staff are much more aware now if it was if they meant violent they would put it"P5* **"** *I see a difference but I wouldn't see how to pinpoint it" P4*	Terminology; the terms violence and aggression have a variety of meanings to staff	The terms violence and aggression are used interchangeably by participants Respondents can clarify the difference between the terms Respondents find differentiating the terms problematic

Table 19 Conceptualising violence and aggression in terms of properties and dimensions.

THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Defining violence and aggression	*"I think most people would automatically assume that a violent is a physical injury he hit you he threw something at you"P6* *"Aggression is any form that could include shouting intimidation and possibly violence"P9* *"To my mind violence is any physical contact and aggression is shouting implied physical contact any as soon as they touch you and I do mean even touch you that's violence you know if they just shove you or even hit you lightly that's violence"P7* *"And people are aggressive towards you in various ways as well you know obviously people you have the swearing type of patient talking very loudly shouting at you or they are just being very aggressive in their manner or deliberately being quite threatening in their body language which you can feel quite threatened"P1* *"People can be extremely intimidating in their body language….. you can feel very physically scared sometimes"P1* *"I think violence is for me physical violence you know physically picking up things…. and attacking staff members"P2* *"I mean I've had just the other day this horrible drunken old get ......it was completely an extreme reaction and ridiculous he was half my size absolutely off his tits and you know there was no way he could have inflicted any harm on me but he did raise his*	Violence involves a physical element/threat	Actual physical contact The terms violence and aggression are viewed as fluid, on a continuum Degree of physical contact and potential injury A threatening persona Perceptions/fear/anxiety Potential for injury/weapons utilisation Disproportionality

	hand"P7		

Table 19 Conceptualising violence and aggression in terms of properties and dimensions.

THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Defining violence and aggression	This will be addressed when reviewing the second aim of the study but briefly participants suggested nursing staff make a variety of judgements based on the service user's presentation. *"I think it is to do I suppose with the intent"P1* *"If somebody hits you because they are confused you know somebody who is hypoxic somebody you know ere your elderly patient who has got confusion who is trying to bite you it is still you being physically assaulted but you understand that there is a reason behind it"P1* *"It`s like you know an asthmatic hypoxic your writhing on the trolley people have a better understanding of understanding the fact that that patients sick then you get the intoxicated young chap intoxicated swearing and becoming physically violent or whatever that then staff automatically I don't know if it's an automatic thinking process he is intoxicated, yeah he did it to himself so why should we have to tolerate this"P3* *"I would think you have more sympathy for the person that is ill yeah hypoxic due to an illness than you do for somebody that is aggressive due to alcohol"P5*	Defining violence involves attribution of behaviour	Identifying appropriate ED attenders Behaviour is deliberate and malicious The dilemma of contrasting the physical element with attributing motivation Violent behaviour lacks a justifying trigger Violent behaviour involves a lack of sympathy from staff

Table 19 Conceptualising violence and aggression in terms of properties and dimensions.

THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Defining violence and aggression	*"Somebody who is going to to be violent will probably come in like that and somebody who is really mouthy will come in like that"P5* *"You never know yourself how you are going to react to bereavement do you I know it's not my fault and I know they should not take it out on me cos it's not me who done it or whatever but you understand it you understand it or I do"P5*	Violence is defined in terms of real time situational factors	Rapid, predetermined violence Developmental, understandable aggression
Defining violence and aggression	*"To diagnose what they have done if you like because they have got a physical you know a proper condition you know dementure or whatever"P2* *"I guess on the cusp of it all they have both got medical problems because that patient`s intoxicated and is going to have a reaction they may have an underlying disease process yet the asthmatic is sick but we can treat both of those things"*  *"The person who comes in hollering and screaming there's nothing you do. You can`t reason with them and you have just said Mr Bloggs have a seat and we are just doing this or doing that and you can't reason with him you can't do anything about that situation"P4*	Defining violence involves medicalisation of presentation	Violent service users do not have a medical diagnosis Violence is a condition that would not be reversed through treatment Violent service users can be criminalised/behave unreasonably

Table 19 Conceptualising violence and aggression in terms of properties and dimensions.

THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Defining violence and aggression	*"I had one recently just a kid who was just wasting everybody's time was just drunk I woke him up and was deliberately rude.... I'm sure it was grossly unprofessional but you have to say something…..you have to say something I knew he was faking it faking unconsciousness. He wasn't a patient he was just a twat"P7* *"In relation to alcohol I know from experience they are also the ones that end you in trouble one day in the coroners court. I do try very very hard not to judge people…people judge too quickly"P9* *"The way you tend to learn to deal with things is by watching other people if you have good role models that is great but if you don't…." P1*	Defining violence has an experience element	Personal experience and judgemental confidence Role modelling

Table 19 Conceptualising violence and aggression in terms of properties and dimensions.

THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Defining violence and aggression	*" I mean an example from me would be is that I had an incident a couple of weeks ago where a patient was being verbally aggressive......you feel that now hang on if I've got to stand up and say that in court I'm going to be quite vulnerable."P2* *"Are you telling me I should be writing a form. I've had them punch walls I've had them throw a cup of tea over me ere but it's been a really it's been when when you are breaking bad news to them and its involved parents with their children and that do you put that on a bit of paper and then a couple of weeks down the line they get a letter from the hospital saying that on this occasion you were…" P5*	Defining violence involves a consideration of future consequences for actors involved	Staff consequences Service user consequences

5.2.2) *Exploring factors that influence the reporting practices of ED nursing staff when experiencing violence or aggression*

Interview analysis identified ten properties (figure 3) and twenty three dimensions, (Table 20) relating to factors influencing formal reporting practices. Reporting practices can broadly be divided into factors that potentially encourage, and factors that potentially discourage, the reporting of specific incidents and the results for this section are subsequently divided accordingly. How nursing staff define violence and aggression in the ED will impact on the formal reporting of incidents so the previous section is also relevant; however this section reports other, specific factors identified.

Figure 3 Conceptualising factors influencing formal reporting practices post interview analysis.

FACTORS ENCOURAGING REPORTING PRACTICES

- **Reporting encourages the development of environmental strategies to enhance personal safety**
- **Reporting encourages improved incident management**
- **Reporting is more likely to occur when situations involve specific circumstances**
- **Education and training initiatives encourage reporting of incidents**
- **The focus of the incident, victim/aggressor relationships influence reporting practices**

FACTORS DISCOURAGING REPORTING PRACTICES

- **A reporting process not fit for purpose discourages reporting**
- **Occupational factors discouraging reporting**
- **Post incident responses discouraging reporting**
- **Staff provocation**
- **Attribution of the aggressors behaviour discouraging reporting**

Table 20 Conceptualising factors influencing reporting practices in terms of properties and dimensions.

THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Factors encouraging formal reporting practices	*"Because we have highlighted a number of these incidents that we have now put things in place to for example pin point, 24 hour security here and cctv"P1*	Reporting encourages the development of environmental strategies to enhance personal safety	Target hardening
	"The trust has a reasonable um record of doing things like letters, they have taken people to ASBO's all sorts of stuff against people" P1		Service exclusion
	"So we can count how many incidents of a particular type and nature and hopefully at the end of the day once the information the statement forms are collated and corrected you can pinpoint any particular issues"P6		Hot spot analysis
	"I think for erm for learning and for changing things next time .... so that we can say if you do X Y can happen so don't do X anymore"P6		Education and training

Table 20 Conceptualising factors influencing reporting practices in terms of properties and dimensions.

THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Factors encouraging formal reporting practices	*"You know the response of people perhaps it was delayed perhaps it wasn't as good as it should be and perhaps it was inappropriate" P1*	Reporting encourages improved incident management	Using the reporting process to raise concerns regarding incident management
Factors encouraging formal reporting practices	*"He leapt of the trolley like you wouldn't believe and head butted me" P4*	Reporting is more likely to occur when situations involve specific circumstances	Actual physical contact/threat
Factors encouraging formal reporting practices	*"When we brought them in there was a number of workshops that they did......... so they do have some guidance but reading them you'd think they had none"P1*	Education and training initiatives encourage reporting of incidents	Defining violence and aggression
	"Intake of breath/. Ok ha hah ha incident forms quite often you might have picked this up by looking at them often the same person will....they are well versed in in risk they have done a lot of work in risk and they are confident and they feel confident to report something" P2		Risk training
	"I think to be honest some people like writing forms and some people don't"P7		Personal prioritisation

Table 20 Conceptualising factors influencing reporting practices in terms of properties and dimensions.

THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Factors encouraging formal reporting practices	This area will be explored in greater detail when addressing situational factors. *"I think that it is unusual yes although I dealt with one relatively recently and um that was a relative on relative" P1* *"Well I don't know it's funny because when it is relative on relative the nurse in charge said there is no need to do a clinical incident form it was only because I insisted that one was done that I was very grateful of because then 2 days later one of the relatives then actually came down wanting to make a complaint ….. and actually had found that she had an injury and she said she hadn't at the time and so I was glad I had at least there was some kind of record that the accident had took place" P1*	The focus of the incident, victim/aggressor relationships influence reporting practices	Service user advocacy Occupational defence

Table 20 Conceptualising factors influencing reporting practices in terms of properties and dimensions.

THEME	*SUPPORTING DATA*	PROPERTIES	DIMENSIONS
Factors discouraging formal reporting practices	*"I think it grossly under estimates"P1* *"Incidents are under-reported definitely yeah yeah yeah" P5* *"Yeah yeah a massive underestimation" P8* *"The form is dross" P5* *"Yeah-put the facts in and that's it but for what reason? Two lines in there attacked by patient" P3*	A reporting process not fit for purpose discourages reporting	Confirmed under-reporting
Factors discouraging formal reporting practices	*"My point of view it's definitely a time factor where I have thought maybe then 3 seconds later it's out of my mind because I have a list my height of tasks to do so especially like today if somebody is verbally aggressive today there is absolutely no way I'm going to have the time"* *"I think that as the paperwork stands at the moment it can be quite lengthy" P3* *"No maybe a time factor time it's probably the last thing on my mind cos it takes quite a long time to fill those forms out and it's*	Occupational factors discouraging reporting	The length of time required to complete documentation Simplifying the documentation Workload and prioritisation

	the last thing I have time for really because we have to get patients sorted"P4		
	"I think that under-reporting tends to be from specific groups, doctors definitely under-report......in particular Doctors had to be really careful about erm getting a good report at the end of their stint and I think that they thought that (reporting incidents) would affect it"P2		Occupational working practices
	"There is no clear guidelines as to who should fill in the incident forms" P1 *"It's a training thing but there're is no consistency at all"P7* *"I think it's whoever is least busy probably to be honest… Or whoever feels most strongly about it"P8*		Variations in reporting practices

Table 20 Conceptualising factors influencing reporting practices in terms of properties and dimensions.

THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Factors discouraging formal reporting practices	*"The partner got very angry and he held a it was actually like a radio thing in your car you press the button in the front and it comes off it was actually one of those cos it was silver and it happened really quick I thought it was a knife he put too my throat....... the police came and the police spoke to the man......I said what is happening and he went and they had not taken his name address nothing he was just told go away and calm down"P8*	Post-incident responses discouraging reporting	The Police response
	"They should make a difference I mean if you have enough incident forms saying we are vulnerable here security is very poor in terms of the set up management should come down and say you are right but they don't"P7 *"You fill in the form and you don't hear anything about it"*		The managerial response
	"It certainly is something to be concerned about their interpretation I mean if it was reported to the nurse in charge in the first place and they were the ones to fill in the incident forms it might not be a true reflection to what happened in the first place yet alone if it is then interpreted again by someone else" P1		Bureaucratic response through incident form editing
	"I know security here is ridiculously poor its poor in most A and E`s I've worked in.....it's just ridiculous there are 3 entrances they can walk into and there is no seal there is nothing no way to keep them out you can go anywhere"P7		A poor environmental

	"I think about six years ago I was assaulted in majors and I asked then for the doors to be locked it was like yeah yeah yeah its been done its being done and recently we had a young guy who was stabbed gang related thing all the gang members turned up and again it was brought up the issue of not secure and it was oh yeah the doors will be done next week and still nothing you do get disheartened. Well one day someone is going to get stabbed you can guarantee it someone staff member will get really badly hurt Nurse X was really badly hurt not long ago"P8		security infrastructure

Table 20 Conceptualising factors influencing reporting practices in terms of properties and dimensions.

THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Factors discouraging formal reporting practices	*"It just makes you think oh god please tell me you didn't say that ha ha ha ha ha....you read them and think no wonder he got upset" P2*	Staff Provocation	Staff contributing to the development of incidents
Factors discouraging formal reporting practices	*"I suspect that in those situations like bereavement most nurses not just even here most nurses in a situation of bereavement sudden death would unless they were quite badly injured would let that pass you would say ok their mum has just died they expected their mum to come home and cook tea and now she is dead and they are angry and upset and I think most people would let that pass I really do"P6*	Attribution of the aggressors behaviour discouraging reporting	An understandable trigger

5.2.3) ***Situational factors perceived by ED nursing staff as contributing towards staff/service user conflict***

Interview analysis identified ten properties and thirty four dimensions, (Tables, 21, 22 23 and 24) relating to situational factors perceived by respondents as contributing to the development of conflict in the ED studied. Situational factors, in this context, refer to factors participants viewed as relevant to the area of investigation. In Chapter 2 I framed the breakdown of variables relating to ED violence under the following headings with the tables on the right referring to the findings presented below:

- aggressor characteristics (Table 21)
- nursing staff characteristics (Table 22)
- situational/environmental context (Table 23)
- consequences (Table 24)

The data presentation will follow this approach; the overarching theme being situational factors with sub themes identified above. I begin with aggressor characteristics as this was perceived by participants to be important.

Table 21 Conceptualising aggressor characteristics in terms of properties and dimensions.

SUB-THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Aggressor characteristics	*"A lot of issues with bereaved relatives understandably. But you know that's quite a big thing"P2* *"Erm….I think people who manage to get themselves beaten up there are a lot of muggings locally those people are very angry" P6*	A contributory trigger factor	Stressful experiences
Aggressor characteristics	*"Confusion, confused patients"P4*	A contributory trigger factor	Clinical presentation
Aggressor characteristics	*"That is always always a difficult one cos there is always the is he mad or bad"P6* *"We do get a lot of Mental Health patients coming in which especially sometimes takes the psychiatric liaison nurse to come sometimes it can be longer than ideal and they do start getting very agitated and potentially aggressive as well"P4* *"Yeah I will always be wary of psychiatric patients and normally if they come and you just ring the psych staff they know them and they can tell you if they get violent and normally they do come here alot and the security staff ignore them"P7* *"If you have got someone who can`t be obviously removed like a drunk head injury or someone who has a wound that needs plastics for instance you can`t just say on your bike you have a duty of care haven't you?"P8*	A contributory trigger factor	Mental health Prolonged incidents

Table 21 Conceptualising aggressor characteristics in terms of properties and dimensions.

Aggressor characteristics	*"Ha I suppose what springs to my mind immediately would be alcohol wouldn't it because that probably one our biggest causes of violence and aggression" P1* *"I think perhaps people who would normally behave usually in a reasonable manner um to not only do they perhaps come in being very aggressive perhaps fuelled by alcohol also it becomes very difficult to try to reason with the person" P1*	A contributory trigger factor	Alcohol and substance abuse Altered communication
Aggressor characteristics	*"Well obviously the type of clientele we get round here tend to be people who will erm express their displeasure with the service verbally or physically rather than write a letter to their MP later…… erm the social and economic groups round here are perhaps lower in average than some places and people tend to scream and shout"P2*	A contributory trigger factor	Social class and communicating with staff
Aggressor characteristics	*"Patients who have had arguments with their boyfriends or close partners erm in cubicles in minors for example they come in and their dogs attacked then while they were having an argument, and they argue again in the cubicles" P4*	A contributory trigger factor	External conflict impacting on the department
Aggressor characteristics	*"Cos it's learned it might work for them elsewhere. It might not be that they have necessarily been here before but if that's how people behave in the supermarket on the bus anywhere else at school whatever that's your normal way of behaving and it works for you you might as well resort to that, you think I might as well I'm gonna be here forever no I'm not you know"P9* *"When they get here we are seen as an obstruction the nursing staff are seen as deliberately obstructive....most are like thank you so much Doctor finally that nurse is out of the way"P7*	A contributory trigger factor	A demand for prompt treatment The nursing barrier delaying medical treatment

Table 21 Conceptualising aggressor characteristics in terms of properties and dimensions.

Aggressor characteristics	*"I must admit I haven't witnessed a huge amount of racist stuff coming from patients but it does happen they will pick on anything age sex sexuality race......people call people the most outrageous things I mean racism I mean homophobia is another thing you know I have um you know been called various rather homophobic terms" P1*	A contributory trigger factor	Willing to project verbal insults/threats
Aggressor characteristics	*"He leapt of the trolley like you wouldn't believe and head butted me" P1*	A contributory trigger factor	Projecting physical violence
Aggressor characteristics	*"I mean there is quite a lot of gang warfare going on around here at the moment possibly you read in the papers .....and that's reflected in what we see..... I think it's definitely increasing round here" P2* *"Oh there's always a leader in the waiting room yeah absolutely there is always one trouble maker who wants to come and conquer"P3*	A contributory trigger factor	Gang criminality The waiting room gang
Aggressor characteristics	*"I`ve never seen such inappropriate attendances and I think it's just because of where it is its located right in a dense population housing area and people literally just walk past on a day off and just think I will pop in" P7* *"And its beyond me why they are here (the staff) because if you don't want to look after that group of people you should not come to work here" P9*	A contributory factor	Inappropriate access to the service A vulnerable group

Table 22 Staff characteristics in terms of properties and dimensions.

SUB-THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Staff characteristics	*"Yeah student nurses are removed from difficult situations"P3*	Staff role	The nursing hierarchy
	"Ermm its interesting because nursing staff do have the if this was a shop the nurse in change would be the duty manager you know and the medical staff are still seen as worker bees ere than anything else. The nurse in charge although the nurse in charge is more for duty management role therefore that's why they all get involved in incidents when you see while the senior doctor wouldn't....... Yeah I do think you have to confront it because people do need to be told that their behaviour is inappropriate particularly for the other patients sitting in the waiting room with someone with an aggressive manner"		Occupational role
	"The junior Doctors are here 4 months` they don't really involve themselves at all" P9		
	"I would say now the biggest contribution factor is staff attitude but that's probably not that popular" P9		A lack of communication
	"How much do the patients have to tolerate from the staff?"P3		
	"No I would not say that it's a certain type of person and a certain type of nurse as well, a certain type of nurse as well who gets a response. Some nurses love it they love the verbal don't they? Cos they are then able to give it back don't they? They love		

	to give it back" P5		
Staff characteristic	*"Erm so I think it's got a lot to do with who is on shift and how they communicate with the patients which I found a lack of communication or aggressive communication from staff to patients often makes violence more prevalent say"P3*		

Table 23 Situational/environmental characteristics in terms of properties and dimensions.

SUB-THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Situational/environmental characteristics	*"The department was designed for something like 80 thousand patients a year and um and last year we saw 146 thousand patients you know weight of numbers....and so for example we double up the cubicle which isn't great"P1*	Service throughput	Excessive service user numbers
Situational/environmental characteristics	*"But the environmental layout does not help at all ....pretty much anybody could look around freely around the department".....It's been talked about many, many, many, times and there is something about money, barriers swipe cards and all that type of thing." P1* *"It's a free for all people can walk in and demand to speak to whoever"P4* *"There`s no security box or guard or anything controlling the visitors and relatives coming in and out of a and e and erm there was an incident recently where a young gentlemen brought into the resus area and he was dragged out and stabbed erm on site"P4*	Physical barriers	Internal physical barriers reducing service user movement around the department External barriers controlling access

Situational/environmental characteristics	"Equally it's true we don't get that many incidents forms from the receptionists I mean they are relatively well protected"P2 "Unfortunately we have to go to the cubicle, we have to touch the patient, do their blood pressure, we don't have that luxury of a barrier between us"P1 "That's all the offices up there and I suppose there is quite sensitive information in the matrons/consultant"		Protecting occupations Protecting information

Table 23 Situational/environmental characteristics in terms of properties and dimensions.

Situational/environmental characteristics	*"And the environment of triage deserves to be an important. I don't think if does us any favours cause the nurse is quiet a distanced away for minors" P1*	Isolation	Vulnerability when isolated from the team
Situational/environmental characteristics	*"It was a young bloke came in and he didn't stay, he was 23 very drunk, very sad and he booked in saying I have a problem with my testicles but must have a female dr. Obviously thought it was hilarious, he pissed off without waiting to be seen its just tragic really, but I think someone like that would see a proper security door and think na I think I will actually go home and get a life"P7*	Target hardening	Deterrence
Situational/environmental characteristics	*"Possibly I think because I think at the front erm as I say the biggest thing is the waiting time and lack of information" P6* *"But I don't think it does have an effect and I know I'm harping back to the past but in the past when the patient numbers were still high and the staffing levels were much*	Waiting Times	A contributory factor?

	lower the waiting times were much longer it was an issue but I think in this day and age there is a lot more staff and there are loads more doctors and loads more people around".		

Table 24 Consequences of experiencing workplace conflict in terms of properties and dimensions.

SUB-THEME	SUPPORTING DATA	PROPERTIES	DIMENSIONS
Consequences of experiencing workplace conflict	*"I mean there was no security when I started relatives or patients would deal with it so if somebody was being mouthy somebody else would deal with it or you would just have to say we have elderly patients here or kids or whatever and they would say I'm sorry nurse"P5*	Service user consequences	Service user involvement as bystanders
	"If they are hugely problematic they are not allowed to come back they are barred I don't think people get barred easily enough"P7		Service exclusion
	"It's a sad reflection if somebody is really mouthy they tend to go through the system a lot quicker than wee Joe Smith the quiet person"		Quicker processing of individuals
	"These people are bullies they can tell the junior staff are less adept at dealing with this kind of thing. It does take experience, it's not a pleasant experience it takes practice. I've become very sort of hardened and unthreatened by it all but I don't like the fact I have, it's not something I went into the job for" P7	psychological consequences	Negative psychological consequences

5.3) Conclusion

The interview analysis provided a wide variety of perspectives, relating to violence and aggression in the ED, that specifically related to the thesis aims. Interviews also contributed to the documentary analysis of incident forms, as participants explained their perceptions relating to the reporting process. Interviews also contributed to the development of lines of investigations that are presented in the following chapter, related to the observational component of the study. Combining documentary analysis and interviews led me to consider that nursing staff appeared to be practising in extremely challenging occupational circumstances; and at times individual participants projected a disempowered attitude towards their occupational circumstances. For example, all participants articulated that reporting procedures failed to capture the realities of clinical practice. Participants raised concerns relating to poor corporate security and workload pressures, affecting their ability to document incidents or provide consistent, high quality care. Despite these concerns participants failed to identify proactive steps to improve their occupational circumstances. Along with the earlier educational themes of limited research and inconsistent practice, these themes also emerged as the research progressed and will be discussed in detail in the final chapter.

Having presented findings from the interview component of the data collection exercise, the following chapter presents the findings from the field observation component of the study.

CHAPTER 6: INSTRUMENT 3; OBSERVATIONAL FINDINGS

6.1) Introduction

This chapter presents the findings from the observational component of the study. The observational component of the study allowed me to explore factors pertinent to the study, identified through the literature review and the first two stages of data collection summarised in chapters 4 and 5. Seventeen separate observational periods were conducted, totalling fifty two hours over a twelve week time period (table 25 page 137).

I have identified the specific nature of the observational component below, with reference to the themes identified in chapter 4, and supported this with data presented in chapter 5, using the chapter six sub headings as reminders. Along with observational guidance, cited earlier, the summary below identifies the specific areas of investigation when conducting observations. To aid this process, I developed an "*observational strategy pack*", an example of which is listed as appendix 7. The observational component of the study was unstructured but I used this pack as a prompt when collecting observational data.

Table 25 Summary of observational periods conducted.

Observational period	Date	Time	Length
1 Monday	16/03/2009	10.00-12.00	2 hours
2 Tuesday	17/03/2009	14.30-17.00	2.5 hours
3 Wednesday	18/03/2009	11.20-13.20	3 hours
4 Tuesday	31/03/2009	13.00-15.00	3 hours
5 Wednesday	01/04/2009	08.30-12.00	3.5 hours
6 Saturday	11/04/2009	10.30-13.30	3 hours
7 Monday	20/04/2009	10.00-13.30	3.5 hours
8 Tuesday	21/04/2009	10.30-13.30	3 hours
9 Friday	24/04/2009	10.00-13.30	3.5 hours
10 Saturday	25/04/2009	21.00-2400	3 hours
11 Sunday	26/04/2009	19.00-22.00	3 hours
12 Monday	27/04/2009	21.00-24.00	3 hours
13 Sunday	03/05/2009	19.00-22.00	3 hours
14 Monday	11/05/2009	00.30-03.30	3 hours
15 Saturday	16/05/2009	21.00-24.00	3 hours
16 Friday	16/05/2009	20.00-24.00	4 hours
17 Monday	22/05/2009	20.00-23.00	3 hours

6.2.1) Categorising incidents within a Type 1-4 classification

The incident form analysis identified a variety of actors involved in conflict situations in the ED studied, not only staff/service user confrontations, but service user/service user confrontations. This area was also raised during the interviews and observing for such confrontations formed part of the observational process.

6.2.2) Timing of incidents

The incident form analysis suggested that the majority of incidents were reported during weekend shifts. An increased frequency of incidents; along with alcohol-affected service users accessing the service over the weekend, were also raised during the interviews. Observing for this trend formed part of the observational process.

6.2.3) The geographical location of incidents

The incident form analysis suggested that a minority of incidents occurred in the waiting area, with incidents more likely to occur when staff are engaged in routine nursing duties. This contrasts with the literature which frequently highlights the waiting area as a geographical location where conflict occurs. Interviewees highlighted that a potential source of staff/service user conflict related to poor communication, or what could be described as confrontational communication, particularly with service users waiting for treatment, and also highlighted that aggressors required close, personal contact with potential victims. Consequently observing the interaction between nursing staff and service users in the waiting area formed part of the observational process.

6.2.4) Aggressor demographics

Both the incident form analysis and the interview component of the study, highlighted a variety of potential trigger factors relating to aggressor characteristics, which were perceived by participants to be important in the development of staff/service user conflict. Examining the context of the environment and events as they occur were part of the observational process.

6.2.5) Victim characteristics

In relation to staff characteristics, incident form analysis and interviews raised a number of issues. Collected data suggested that a variety of nursing staff were involved in conflict with service users, but less experienced or junior staff were less likely to complete incident forms or care for potentially violent service users. Incident

form analysis highlighted that incidents frequently involved multiple staff members, occurred in public as overt confrontations, and lasted for prolonged periods. Interview data also suggested that nursing staff tended to take the lead in the management of conflict situations with service users, and that nursing staff potentially engaged in a variety of limit-setting strategies. Observing for such trends formed part of the observational process.

6.2.6) Experiences of physical and verbal abuse

Incident form analysis and participant interviews identified a variety of potential lines of investigation relating to nursing staff experiences of physical assault and verbal abuse. Observation has the potential to confirm that such incidents occur in the ED studied, particularly as the incident form data suggested the public nature of confrontations.

Interviews identified the perspective that violent individuals frequently arrived and commenced confrontations early, whereas aggressive confrontations developed and this could be observed for. Weapons use and damage to hospital property could also be observed. As discussed in the literature review, incidents of violence and aggression are shrouded in subjectivity. Consequently, for the purposes of the observational component, I utilised the following DoH CFSMS (2004) baseline definitions of physical assault and verbal abuse:

Physical Assault

"The intentional application of force to the person of another without lawful justification, resulting in physical injury or personal discomfort".

Non-Physical (verbal abuse)

"The use of inappropriate words or behaviour causing distress and or constituting harassment".

6.2.7) Police and security involvement

Observing for police and security staff involvement in conflict situations with service users, was not a primary goal of this work. However, as with observing the characteristics of aggressors, I took the perspective that as collected data suggested the public nature of incidents and the multiple involvement of staff; reporting on the variables of police and security staff involvement would only be considered in its broadest sense.

6.2.8) Post-incident consequences for service users and patients

Incident form analysis and participant interviews highlighted a variety of potential consequences, for actors involved in conflict situations in the ED. Although, throughout the observational component of the study, I put the safety of the participants as central to the study, and strove to avoid intrusiveness, observing for post-incident consequences for actors involved in conflict situations formed part of the observational process.

6.2.9) The role of the nurse in the ED

The observational component of the study also intended to examine the role of proximity and situational factors such as routine nursing activities, care delivery, client management and limit-setting. These factors are incorporated into the findings section throughout, rather than as a separate section.

6.3) Commencing observational data collection

The following sections summarise the observational findings.

6.3.1) The study hospital site

Although the formal observational component took place within the ED studied, a number of points can be made relating to the hospital site. Any study investigating corporate safety requires a cautious approach in relation to balancing scientifically

credible data collection and discussion, with an acknowledgement that such data collection exercises will result in potentially sensitive information being placed in the public domain. Corporate facility safety remained an ethical priority throughout this work and consequently security issues will only be referred to in a very general sense.

The literature review identified concerns relating to the level and consistency of corporate security in public hospitals in the UK; to concerns that violence and aggression in the ED are influenced by the catchment area and demographics of the population the hospital serves, and concerns relating to violence occurring immediately outside the ED doors.

Broadly, several findings can be offered relating to these issues. First, access to the corporate facility can be described at best as uncontrolled. Reviewing the perimeter security suggested that the facility could be accessed, by both vehicles and pedestrians, from multiple entrances that were not controlled by corporate staff. Perimeter fencing could also be viewed as poor, with areas of the facility fenced with railings that could easily be cleared by intruders.

Second, access to the internal, main hospital site was also unrestricted; members of the general public could enter the facility buildings from multiple, uncontrolled entrance points and appeared to be able to wander at will around the facility. Furthermore, on several occasions I toured the perimeter of the facility and I found open first floor windows and workshop doors and external doors propped open with evidence that such areas were used routinely by individuals to smoke despite the hospital being a no smoking site. This raises concerns not only surrounding the vulnerability of the facility to intruders but also concerns that some staff have not adopted an ethos that emphasises corporate security and adherence to hospital policies.

Third, frequently, on either entering or leaving the facility, I observed groups of people engaged in public alcohol consumption and anti-social behaviour; along with individuals engaged in behaviours such as looking in litter bins. This type of behaviour occurred adjacent to a facility, characterised by uncontrolled access to members of the general public and consequently potential intruders.

6.3.2) The study department

The department itself, could also be described as being characterised as vulnerable to intruders. The department could be accessed from several doors where access was not controlled. Individuals could, in theory, roam throughout the majority of the department, and the wider hospital, unchecked and unchallenged. Throughout my own study, I wandered around the wider facility and I was never challenged. On one occasion I was challenged in the department but that was after making myself known to individual security staff.

There were practical challenges to utilising an observational approach. My initial perception of the geographical layout of the department, was that the department was physically divided between public areas, such as the waiting room, and what could be referred to as the inner sanctum of the department, such as the resuscitation room, where nursing staff offered potentially intimate care. This geographical layout meant that line of sight was impeded and I could not view the entire department at any one time.

The department however, also had an additional inner sanctum, where access was controlled via coded security doors, which was an area housing senior medical staff offices, senior nursing staff offices, administrative support offices and the staff coffee room. Although offices in the treatment areas could be locked, and access to the triage area and department receptionists was restricted, there were no physical barriers preventing individuals from wandering around the wider department.

The idea of a physical barrier is highly symbolic as it could be suggested that secure areas are secured because they are potentially vulnerable to attack or because they house important or powerful possessions. I wondered why emergency department secretaries or medical receptionists worked in an environment of visible security whereas only limited barriers existed either for emergency department nurses or service users. This was an interesting area because this area of the department was hidden away, not visible to the average service user or visitor and yet was secured with security doors.

6.4) Observational findings

6.4.1) Categorising incidents within a Type 1-4 classification

At no point did I perceive that genuine, criminal, intruders were involved in a conflict situation in the department studied and consequently the observational component of this study did not identify any conflict situations between intruders and staff. Over the observational period I observed 1 direct and 2 potential incidents of type II (service user/staff) conflict but also 8 service user/service user conflict situations.

In relation to intruders however, the opportunity for such individuals to pose a threat to the department should not be underestimated. Two variables were identified relating to this issue. First, on one occasion the poor control of access allowed me to sit in the empty resuscitation room, which contains both controlled drugs and expensive equipment, for 10 minutes before a staff member stumbled across me. This highlighted the vulnerability of the department to criminality. Second, when observing immediately outside the department, I could overhear visitors discussing how easy it would be to enter the facility looking for other people. This highlights the vulnerability of the department to, for example, gang violence. It must be noted however, that although I observed groups of young men congregating outside the department, labelling such individuals as a gang, or merely a group of friends was problematic, and throughout the observational component of the study I cannot confirm or dismiss gang activity, within the hospital premises.

When observing in the waiting room, individuals would walk in, walk around the department and walk into the wider hospital. Individuals would also walk into the waiting room and take a seat. On multiple occasions I observed individuals asleep and snoring in the waiting room. My perception was, that at no specific time, could one confidently numerically confirm the number of service users, those accompanying service users or those accessing the department for any other reason. This issue was particularly significant when the department was busy.

Service user/service user conflict was an important finding. On multiple occasions I observed heated, verbal exchanges between service users and those accompanying them and service users and other people waiting for treatment. On these occasions no nursing staff were present. This occurred both immediately outside the department and in the waiting room, particularly when the department was busy. On several occasions I observed the waiting room full to capacity; people queuing outside the doors prior to being processed at reception; all the seats in the waiting area being used with members of the general public having to stand and several separate groups congregating immediately outside the department. On 2 occasions individuals standing outside the immediate department were accompanied by barking dogs.

When the department was empty individuals would frequently sit equidistant apart but, when the department was busy, people were required to sit next to others. Consequently "*mini gangs*" of dissatisfied service would form during busy periods and the topic of conversation quickly turned to the problems in the NHS or the length of time required, waiting to be seen. During such periods I frequently overheard individuals swearing when referring to staff and I actually observed people sharing prescribed medication with other people waiting. Nursing staff would be approached by service users, the staff would provide high quality communication, explain and answer queries and walk away, and service users would return to their seats and refer to the staff in a variety of derogatory insults. On the majority of occasions this revolved around treatment not being accessed quickly enough, due to a perception that the nursing staff were deliberately being obstructive. One service user turned to me and said *"That fucking nurse was an idiot. He is a cunt - making me sit here for nothing"*. Some individuals did articulate that nursing staff were making them wait without a suitable reason.

The waiting room appeared to be an uncontrolled area, with nursing staff conspicuous by their absence, where service users would complain, argue or threaten each other beyond the hearing of staff. Verbal conflict in the waiting area, consequently did frequently occur but as nursing staff would only access the area for limited periods, this would not be documented. Nursing staff would frequently stand on the peripheries of the waiting area when calling through service users. Eye contact would be kept to a minimal level as engaging with people waiting, frequently led to

discussions regarding waiting times. On no occasions did I observe public announcements by staff regarding waiting times although this may well have occurred during the triage process. Negative experiences observed for typical service users related to waiting, included a lack of communication between service users and staff, queuing to register at reception, no vacant seating, minimal personal space due to the large numbers of people in the waiting area and close proximity to others who could be agitated, distressed, frustrated, angry, intoxicated, swearing, complaining of pain or sleeping. On occasions the waiting area was also noisy, and other people waiting could smell of alcohol or urine.

Two further specific issues arose relating to the experiences of service users in the waiting room. When sitting in the waiting area I tended to position myself in a seat which was the furthest away from reception. Despite this physical distance, I could very clearly hear the discussions between receptionists and service users relating to complaints resulting in presentations, what mode of transport people had used to travel to the hospital, their names, ages, addresses and General Practitioner details. Individuals would then sit down and hear the same conversation relating to the next person who arrived.

Confidentially was a major concern as strangers would sit next to each other but be aware of a host of personal information. The issue of confidentiality had wider implications throughout the department. For example, when observing in the resuscitation room, 2 nurses were caring for 3 service users. During the observation a service user`s relative shouted, "*my mum's having a stoke*". Both the other service users present looked around and one stood up. One nurse told the service user to, *"please sit down*", then turned to the other nurse and said to her colleague in front of the service user, *"We have a man who is dying. Can you catheterise him?"*

Nursing staff would also call people through for treatment using a variety of titles. For example, Mr John Smith would be called John, John Smith, Mr John Smith or Mr Smith by nursing staff who would lean through an open triage door, at times with only their head visible to service users. Communication between staff and service users appeared to be purely factual and minimal in the waiting area. Furthermore service users would be directed to areas of the department labelled with a different name.

Frequently service users would be asked to report to the "*stretcher*" area when staff actually meant the main nurses station. Subsequently I concluded that the interaction between staff and service users could be characterised as minimal and inconsistent depending on the nurse present. In the context of these interactions, it was also observed that service users who did not have English as a first language could be observed sitting in the waiting room not knowing what to do. The whole process of taking service user details could be delayed therefore (which influenced the waiting times of many service users present) if non English speaking individuals were accessing the service. On several occasions this triggered complaints and comments amongst other English speaking service users that included racial remarks.

6.4.2) Timing of incidents

In order to enhance the rigour of the study I conducted observations on varying days and times of the week. Over these periods it did appear that the number of service users being processed through the department was an important variable. During quiet periods the behaviour of both staff and service users differed considerably from more busy periods. When only small numbers of service users were observed in the waiting room the atmosphere was quiet and subdued. Within the department, staff also appeared relaxed, frequently engaged in conversations with other staff. Indeed, my perception was that staff spent much more time communicating with each other, rather than communicating with service users.

A significant proportion of conversations amongst the nursing staff revolved around the processing of service users. In contrast the medical staff spent much more time discussing service user treatment options. In particular the assessment and management of service users, and the correct referral to other medical specialists were areas frequently discussed between senior medical staff and their junior colleagues. Medical education appeared to be a dominant factor in the department for the medical personnel with each service user viewed as a potential learning experience. One nurse did comment that a major issue relating to the smooth processing of service users related to, *"the fact is this is a training placement for medical staff"*.

In relation to nurse/service user interaction, on occasions nursing staff would talk over service users in front of them, explaining service user management whilst the service user in question listened. For example, on one occasion a nurse spoke to police officers regarding a service user they accompanied. The nurse explained to police that the service user could leave the department, giving eye contact to the police before walking away as the service user shouted, "*thank you*". At no point was the actual service user addressed.

During night shift observations, the atmosphere in the department appeared very different from day time. Staff functioned in a much more business like fashion, when an excessive number of service users were present. On one occasion the waiting room was full and ambulance staff accompanying service users on trolleys were queuing down the corridor to be admitted. Communication between staff would be short and straight to the point. Service users would be welcomed, assigned an area and offered care and treatment. During these periods nursing staff would sweep through the department constantly moving from one task to the next.

A number of points can be raised about these periods. First, my opinion, as an experienced, well qualified practitioner is that nursing care was compromised by both the staffing levels and the roles of the staff. Routine practice involved staff caring for multiple patients and it was simply not possible for staff to remain in constant attendance with individual service users. To emphasise this point, on one occasion a service user was being cared for in the resuscitation room. Attached to monitoring equipment, a monitoring alarm beeped for nine minutes before a member of staff, busy delivering care to another service user, was able to investigate. This had the potential to result in the late identification of the patient`s condition and in other circumstances could have led to life threatening consequences. On another occasion an extremely unwell service user in a life threatening situation, began fitting whilst the nurse caring for him answered telephone queries. In certain circumstances constant service user attendance and supervision was simply impossible.

My observations suggested that emergency care nursing in the department, involved multiple tasks. Nursing staff not only assessed, planned, implemented and evaluated care within a multidisciplinary team but, for example, liaised with other departments,

ordered clinical investigations, answered telephone calls and ordered portering services. These tasks took the individual nurse away from the immediate bedside which could compromise service user safety. On several occasions I observed nursing staff complaining they had left a service user and returned to find the service user had left the department or the immediate area. Continuous service user supervision was not a feature of routine practice.

In relation to alcohol-affected service users, I observed that on the majority of occasions alcohol-affected service users tended to be present in the evening and at the weekend. I did observe alcohol-affected service users during daytime observations but they were much more prevalent at night. Alcohol and substance abuse appeared to affect multiple service users. On one night time observation I could smell alcohol when I entered the department. Several people in the waiting area appeared intoxicated and on multiple occasions individuals would stand and wander around the department bumping into furniture and other service users. The potential for such situations to trigger conflict can be emphasised, when I observed one service user, who appeared to be intoxicated, bump into another service user and say, *"Sorry love"; "You will be"* replied the other person. The person who had been bumped into then got up and left the department. However, I did not observe any incidents where staff attempted to limit- set the behaviour of alcohol-affected service users in the waiting room. Indeed, such individuals, much like the majority of service users waiting for treatment, had what can only be described as minimal contact between themselves and the nursing staff.

6.4.3) The geographical location of incidents

As noted above, my observations suggested that verbal abuse, particularly between service users per se was much more common immediately outside the department and in the waiting room than the incident forms suggested. I was limited in the opportunity I had, to observe routine nursing care because of not wishing to invade the privacy of service users. During the observations I observed no incidents of confrontational communication emanating from nursing staff, and no attempts by nursing staff to encourage prospective service users not to wait for treatment.

From observing in the major and minor injuries areas of the department however, a number of points can be raised. My experiences differed considerably from one observation to the next, depending on the throughput of service users. For example, on one occasion observing from a seat opposite the nurses' station, 2 police officers stood in front of me and sat a handcuffed prisoner next to me. The prisoner said to me, "*Get fucked*". As I looked up and scanned the department, one elderly service user shuffled past me pushing a portable intravenous pole. He was dressed in a hospital gown and as he walked past he exposed his back, buttocks and legs because the gown was not tied correctly. In the distance, I could see a second service user lying on a trolley in a cubicle, he was shouting, "*Where the fuck`s the doctor*". This individual was sitting upright bare chested; the curtains that could have offered a degree of privacy pulled open. I could also hear another service user retching, vomiting and screaming in pain. As my gaze returned to the prisoner I overheard a relative saying to a nurse, "c*an my mum have a glass of water please*"? She looked straight at me and I wondered what her perception of the department would be? Within these few seconds I turned to hear the prisoner next to me snoring.

My perception was that people requiring emergency care were exposed to a cocktail of potentially negative experiences whilst at the same time experiencing extremely stressful personal experiences. Interestingly, on other occasions, the department would be very quiet and nursing staff would have the opportunity to deliver care, of the highest quality, in a controlled environment. Consequently individual service users would have very different perceptions of the department in question, based on the status of service user throughput at any given time.

I also observed that nursing care was strongly influenced by staff allocation, and what I would describe as personal motivation. In terms of allocation, staff would clearly ignore pleas from service users for care if they were involved in other duties. For example, nursing staff would walk past service users, literally begging for help, because such patients were viewed by the nursing staff as "*not my patient*". Staff would stand at the nurses' station, taking handover from colleagues, whilst patients could be clearly heard calling for help. On occasions several staff members would congregate at the nurses` station, and one member of staff would take it upon themselves to care for a specific service user who had called for assistance several

times; however this frequently appeared to be driven by personal choice, with other staff completely ignoring such pleas. The observational periods suggested that the throughput of service users at any given time, and the individual staff on duty at any given time would heavily influence the quality of the service user experience. My subsequent perception of this situation was that once again inconsistency was a characteristic of service delivery. It can be argued that such inconsistencies are not desirable variables when promoting a high quality service.

6.4.4) Aggressor demographics

In relation to service user presentation, two factors were identified through the observational period as important. First, on one occasion I arrived in the department and sat at the nurses` station. As I sat down I saw a lady standing in the doorway of one of the cubicles accompanied by 2 security guards. The lady was experiencing a mental health crisis and had been brought down to the department from one of the wards for a psychiatric evaluation. Over the next 2 hours she begged to see a doctor, complained of being in pain, screamed obscenities, called the medical staff, "*murderers*" and went through every conceivable human emotion ranging from anger, to crying, to begging for attention.

I found this observational period extremely unpleasant, I felt embarrassed, ashamed, disempowered and very upset by witnessing this situation. Over the following 2 hour period, a member of the psychiatric liaison team spent short periods of time with her, but the majority of time I observed her situation the perception I developed was that she was essentially being held against her will in a cubicle that was being utilised as a cell, with the security staff fulfilling the dual role of both jailers and carers. On only 2 occasions did nursing staff interact with her; on one occasion a member of the nursing team shouted across the department, "*sssshhhhhhh*`, and on another a member of the nursing staff asked the lady, *"how can I help"?* The lady asked for water and the nurse said she would get her some but did not return. During the medical handover at the nurses` station the lady was physically forced into the cubicle and the door closed so that her shouting would not interrupt the medical ward round. *"We can't have her disrupting them talking",* the security guard commented to me.

The security staff remained calm despite experiencing a tirade of abuse, but at the same time did articulate their frustration by attempting to quieten her down. The use of a tactic relating to other service users being present was used despite the lady clearly having little insight into her behaviour due to her mental health crisis. In this situation the department was being used for a purpose for which it was not designed. The cubicle utilised, for instance, contained a variety of objects (e.g. furniture and sharps bins) that could have been used by the lady to self harm or as opportunistic weapons against staff.

The compartmentalisation of nursing care became evident during this episode, with the dominant tactic of nursing staff not viewed as caring for the patient being one of simply walking past ignoring the lady's pleas as though she were invisible. One nurse commented, "*Who`s looking after her*?" before walking away with this lady's call for help presumably ringing in her ears. Eventually the lady in question was reviewed by members of the psychiatric team and she was escorted to the psychiatric department. This situation was a typical emergency department experience for mental health service users. One nurse commented, "*Well, where else could we put her but here…it takes them ages to get admitted*?" Mental illness was a clear demographic factor, implicated in the development of potential conflict between service users and staff.

The second dominant factor observed relating to service user demographics, revolved around the attitude of service users towards the role of the department. On multiple occasions I observed what could be described as, "*reluctant compliance*" from service users. I interpreted the behaviour of some service users to be heavily influenced by the goal of receiving treatment as quickly as possible so as not to disrupt their usual routine. Service users who appeared anxious to be treated quickly would pace the department, talking on their mobile phones as soon as they arrived, rather than take a seat and become increasingly hostile. One service user walked into the department, was processed through reception, sat down and said, "*Fuck this you bastards"* as he left. He was in the department less than 5 minutes. Individuals would walk in and out of the waiting area to make phone calls and return shouting across the department, "H*ave I missed my turn*?" to reception staff. Frequently individuals would swear, out loud or underneath their breath to show their displeasure. Such individuals could be

viewed as semi-compliant. They would only partially comply with requests of nursing staff to sit down or wait in a particular area and this was compounded by the fact that nursing staff frequently dealt with multiple service users and would leave such individuals unsupervised. On several occasions nurses would stand at the nurses` station complaining, "*I can't find Mr X*". On one occasion a nurse complained to me, "*The Doctor has asked me to do half hourly neurological observations on a gentleman and he is outside smoking a fag!!*"

Such reluctant, semi-compliant service users were a particularly problematic group for nursing staff to care for, because their attitude brought confrontation to the nurse/service user interaction. On several occasions agitated service users presented at the reception, but by the time such individuals interacted with the nursing staff they had regained a degree of self control and rationality.

The nature of emergency nursing is also relevant at this point. The interview component of my research raised the issue of bereaved or distressed relatives. My observations did identify individuals experiencing extreme stress. One relative spoke to another service user immediately outside the department saying, "*My son`s in there with a bleed on his brain, he is only seventeen, I think he`s dead*". She walked away crying. The other service user turned to me and said, *"What can you say to that? She`s been crying all morning".* Such extremely stressful experiences may clearly impact on service user/staff communication, or the mini relationships formed between service users accessing the service.

6.4.5) Victim characteristics

Only limited data can be offered relating to staff characteristics; however, the following points can be made. First, the verbal abuse I observed, emanating from service users to staff, was public and overt and resulted in any staff member who was in the line of sight of the abuser, receiving abuse. When service users were complaining regarding waiting, for example, I observed that the senior nursing staff would make a decision to approach the individual concerned and deal with the complaint. On one occasion a gentleman was complaining that he did not want to be admitted. The senior nurse simply walked over, introduced herself, and explained that

the medical staff had decided it was in his best interest to be admitted. She went on to point out that he could discuss this further when the medical staff were available, but then made it clear that the medical staff decide who is admitted not the nurses. The nurse in question walked back and said to a colleague, "*That's the way you do it, he`s happy now*".

In terms of treatment, close proximity appeared to be a significant risk factor. On one occasion in the resuscitation room, a semi-conscious service user was being turned onto his side by nursing staff. During this care period the service user began to fit and the staff struggled to hold the service user`s weight. In this situation unintentional injury to the staff or the service user could have been the end result.

Clinical ability also became relevant during the observational data collection exercise. On one occasion, I observed an extremely poor endo-tracheal intubation conducted by both experienced and inexperienced team members. In my professional opinion the situation was managed extremely poorly without adherence to published, national guidelines. The potential for poor care to be experienced or witnessed by service users, as a trigger that could result in conflict, was brought sharply into focus. The primary factor in this instance was that relatives of the service user being treated, had already been asked to leave the immediate area by the medical staff, while the procedure was undertaken, and consequently did not witness the care episode.

As already noted I observed an episode of verbal abuse that involved multiple staff members, occurred in public and lasted for a prolonged period. The majority of my observations however, identified that shorter bursts of verbal conflict occurred between service users, but such incidents tended to take place without nursing staff being present. In terms of limit-setting I did not observe a significant level of limit-setting emanating from nursing staff towards service users. The majority of limit-setting I observed involved security staff and will be addressed later in the text.

Relevant to this section is the opportunity potential staff victims may offer potential aggressors. During one period of observation I observed 4 nursing staff members with scissors or clamps protruding from their top pockets. Twelve medical staff also wandered around the department with stethoscopes hanging loosely around their

necks. Such practices do offer potential aggressors avoidable opportunities to introduce opportunistic weapons to confrontations.

6.4.6) Experiences of physical and verbal abuse

As already noted, over the observational period I observed 1 direct and 2 potential incidents of type II (service user/staff) conflict but also 8 service user/service user conflict situations. The potential incidents involved nursing, staff walking away from service users, who offered a verbal insult that was either ignored or not heard. The direct incident involved the service user presenting with a mental health crisis. Due to presentation it can be argued that this incident did not involve intentional action but was a manifestation of the service user`s underlying diagnosis. I also observed a fitting service user, resisting attempts to be physically positioned appropriately. Once again this incident was underpinned by a medical diagnosis rather than an intentional act on behalf of the service user.

I did not observe any incidents of physical assaults, threats with weapons, damage to hospital property or encroachment upon the personal space of nursing staff. As noted above, I did observe service users using racially defamatory words when complaining about other non-English speaking service users. All other incidents observed, involved verbal abuse with incidents involving service users abusing other service users. On these occasions swearing was the dominant tactic with one threat of physical violence offered. None of these incidents led to a physical confrontation. However, on 8 separate occasions nursing staff suggested I had missed a relevant incident with the words, "*You should have been here yesterday"* or "*You should have been here last night*".

6.4.7) Police and security involvement

During the observational period the police service were not called to deal with any incident in the department. The police however, would frequently attend the department, escorting individuals such as prisoners or victims of violence.

Security staff also took a very peripheral role during this research. Several points relating to the security staff however, can be made. Observations suggested that security staff provided an extremely balanced service. Dressed all in black, wearing knife proof vests with, "*SECURITY*" written across their uniform in bold, they did appear quite intimidating. Their communication with service users however, was very polite. Security staff would limit-set service users who parked inappropriately smoked, or, used their mobile phones. On one occasion I observed the security staff intervening as 2 service users argued. Throughout these episodes the staff were always courteous and polite. The approach to limit-setting adopted by security staff appeared to be pragmatic. For example, limit-setting relating to on site smoking and mobile phone use appeared to vary between night and day. At night security staff were much less likely to enforce hospital policies, to the extent that both security and ambulance staff smoked immediately opposite the department themselves. Such practices were not observed during the day time observations I conducted.

The most relevant issue, relating to security staff revolved around their role in the department. In relation to the lady experiencing the mental health crisis it became clear, as already noted, that security would fulfil the role of jailer and carer. The concern this raised relates to who is providing care to aggressive service users in the ED, security staff or qualified nurses?

6.4.8) Post-incident consequences for service users and patients

I did not observe any significant post-incident consequences for actors involved in the conflict I observed, except for the lady experiencing the mental health crisis who was admitted, with her consent. The majority of verbal exchanges between service users were resolved. On only one occasion did security staff intervene by asking service users to "*calm down*". This resulted in both parties sitting in their seats ignoring the other party. The primary reason for a lack of consequences, from a nursing staff perspective, is that only two incidents were witnessed and involved departmental staff. All other incidents were either ignored, not heard, or not witnessed by staff.

6.5) Conclusion

The observational data collection exercise provided an invaluable insight, related to environmental and situational factors implicated in the development of conflict in the ED studied. In particular, observations identified the important role of the departmental infrastructure and the behaviours of both nursing staff and service users in explaining the development of conflict.

Having presented the research findings from each component of data collection, the final chapter discusses the key limitations of the study, and then discusses the data collected in relation to the original aims of the study and the emerging themes. The original aims of the study were to explore how emergency department (ED) nursing staff conceptualise the terms that encompass violence and aggression in the clinical area; to explore the formal reporting practices of nursing staff following such experiences and to explore situational factors at play relating to the development of violent and aggressive incidents in the ED setting.

From an educational perspective the themes emerging from this study relate to limited research, particularly by clinical nursing staff, in relation to the subject matter, inconsistent practice, challenging working conditions and a disempowered attitude of some participants in relation to their occupational circumstances. The chapter then summarises the work`s original contribution to new knowledge and offers a summary and justification of recommendations. The central, core categories related to professional maturity and identity are then offered and justified to draw the research aims and emerging educational themes together. As noted earlier the concepts of professionalism and leadership will influence the forthcoming discussion.

CHAPTER 7: DISCUSSION AND RECOMMENDATIONS

7.1) Introduction

This chapter begins with a discussion identifying the key limitations of the study. The chapter then goes on to discuss the research aims, through examining the findings of this study and comparing the findings with the international literature. The original research aims related to exploring how emergency department (ED) nursing staff conceptualise the terms that encompass violence and aggression in the clinical area, to exploring the formal reporting practices of nursing staff following such experiences and to exploring situational factors at play relating to the development of violent and aggressive incidents in the ED setting.

From an educational perspective the themes emerging from this study relate to limited research, particularly by clinical nursing staff, in relation to the subject matter, inconsistent practice, challenging working conditions and a disempowered attitude of some participants in relation to their occupational circumstances. The discussion is then broadened and the findings of the study and emerging educational themes are presented within a professional context. This is achieved through exploring the nature of professionalism, contrasting the key findings and emerging educational themes of this study within the context of nursing staff adhering to the NMC code (2008) and through the literature`s summary of the characteristics of the traits of professional status. The chapter then summarises the work`s original contribution to new knowledge and offers a summary and justification of recommendations. The recommendations are underpinned through the work promoting the potential role higher education may play in leading an agenda designed to positively influence the subject matter. The central, core categories, related to professional maturity and identity are then offered and justified to draw the research aims and emerging educational themes together.

7.2) Study Limitations

A number of limitations need to be considered when critiquing this work. First, one needs to appreciate that the chosen research paradigm, methodology and research instruments are all open to a variety of criticisms. For example, the interpretivist philosophy has been criticised for an assumption that individuals are able to explain their attitudes and behaviours. Symbolic interaction, upon which grounded theory is based, has been criticised for lacking empirical testing and grounded theory itself has been dismissed as simply a different version of a standard inductive argument. The interpretive nature of this study is acknowledged, particularly my role in data collection and analysis, but one can take the perspective that the interpretive stance allows for a plausible presentation of the research findings along with a reasonable approach to discussing the findings within a professional context.

The wider scientific literature, related to violence and aggression also needs to be considered at this point. Violence and aggression theories have been investigated within the psychological, biological and social sciences with academic disciplines of political science, physiology, psychology, sociology, history, anthropology, criminology and psychiatry contributing to an understanding of human behaviour. A number of research strategies may have been adopted when conducting this work and what became apparent, particularly during the data collection component of the study, were the potentially exciting future lines of investigation that could be developed based around any of the disciplines outlined above.

Second, the data collection instruments themselves need to be viewed with caution. The documentary analysis was hampered by the relatively small number of original forms available for inspection (n=38) and the incomplete nature of this documentation. A prospective, future analysis of violent incident forms may be a suitable course of action in the future, to improve the quality of examined documentary evidence. Traditionally the interview and observational components of

this study are viewed as being enveloped in subjectivity and perception influencing both data collection and analysis.

Third, the site specific sample site also raises the dilemma of generalisability. Although generalisability (or transferability) is problematic when undertaking research such as this, it can be argued that the research audit trail contributed to the plausibility of the study; and the issues encountered and discussed during this work are issues that may be relevant to similar inner city, UK EDs. I would suggest that the department studied could be viewed as a typical inner city ED. I also accept however, that there are limits to how one can compare departments like for like, both nationally and internationally, particularly when the variable of the hospital catchment area which the department serves is considered.

7.3) Discussion

7.3.1) Study aim one

Discussing how ED nursing staff conceptualise the terms that encompass violence and aggression in the clinical area.

Data collected from the documentary analysis and interview components of the study, supported published literature by Crilly et al (2004), Hislop and Melby (2003) and Fernandes et al (1999) suggesting that nursing staff use the term violence interchangeably as an umbrella term conceptualising aggression, physical assault, verbal abuse, or witnessing physical assault and verbal abuse together, under the term violence.

Aspects of the WHO`s (2002) definition of violence could also be extracted from the data. The use of physical force was raised by all the interview respondents, with violent incidents characterised as involving the utilisation of weapons and a potential for serious injury, direct physical contact, non verbal gestures/eye contact and invasion of one`s personal space together with a perception of fear. When reviewing

the documentary analysis component of the study violent incidents were also characterised by the above.

Early in the study, it became clear that the terms violence and aggression rapidly became scientifically obsolete, because participants would apply personal belief systems and situational factors when conceptualising experiences that were discussed. For example, none of the participants referred to the literature when being probed, relating to defining violence and aggression in the ED, with the exception of vague references to the general literature. No references to operational definitions defining violence or aggression were raised and no references to specific literature such as the WHO`s (2002) definition were offered.

In terms of differentiating between violence and aggression, as noted in the literature review, one can suggest that violence can be viewed as at one extreme end of a continuum, with aggression viewed as a less serious interpersonal conflict situation. The data collected however, identified a variety of other factors that need to be considered when demystifying the participants` approach to defining violence and aggression in the clinical area. For example, although this work and the literature cited above proposes that nursing staff view violence as an umbrella term, that term varies from one participant to another, and is characterised as inconsistent.

A major area of contention related to the personal circumstances and personal responsibility of potential aggressors. Documentary analysis, interview data and observational data all suggested that the most probable aggressor nursing staff were likely to encounter in the clinical area studied were Type II service users. This work continues to support the literature cited in the literature review by authors such as Winstanley and Whittington (2004) or Hesketh et al (2003).These support the perspective that service users, and those accompanying service users, are the most likely groups to be engaged in conflict with staff. The healthcare environment dilemma, relates to defining and distinguishing between violent or aggressive individuals, when clinical presentation is added to the situational context because of the dilemma of attributing behaviour.

This also raises an important security issue because healthcare security exists in a unique environment. Simple security measures such as locking windows and doors, or locking away valuables become less relevant when aggressors are legitimate service, users who have ample opportunity to assault staff who are engaged in delivering nursing care. Close proximity between nursing staff and service users becomes a major issue, and subsequently security measures must encompass strategies aimed towards managing both legitimate service users and intruders.

In this study, violence was viewed as being externally projected towards staff or hospital property, by malicious, purposeful individuals who had made a premeditated, conscious decision to behave in an essentially criminal manner, with an underlying motive of personal gain. Violence was also partly described however, in terms of the aggressor's personal responsibility. This mirrors the work of authors such as Luck et al (2007) who commented that nurses in their study, judged the individual legitimacy of service user presentation, offering empathy, tolerance or the setting of firm boundaries based on their subjective assessment. An explanation of this perspective is offered by attribution theory which provides a set of ideas relating to how observers attribute the behaviour of others (Parkinson 2008). Work in the psychology field suggests that individuals behave differently towards others depending on whether they believe behaviour directed towards them was intentional or unintentional (Schachter and Singer 1962).

Interestingly the violent individual was generally viewed as a person whose violent tendencies were part of their psychological makeup; an attitude that would not respond to medical treatment. One explanation for staff referring to the personal responsibility of aggressors relates to the theory of rational choice (Elster 1970) whereby individuals choose the alternative that will come closest to getting them what they want, given the situation and available choices. Hospital security tends to follow the components of Rational Choice Theory (Elster 1970) with an emphasis on prevention, deterrence and punishment.

One could argue however, that rational choice becomes less relevant when aggressors are, for example, intoxicated. The World Health Organisation`s (2002) definition of violence contains the term, "*intentional*" and it can be argued that this work suggests

that some staff debate and consider the situational factors at play, when defining or labelling an incident as violent. This is also relevant when considering the service user presenting with a psychiatric crisis, as discussed in the previous chapter, or a clinical presentation that leads to manifestations of aggression. This work suggests that some participants view the degree of threat and potential for injury as a major component of violence and although one can argue that the stereotypical sword wielding schizophrenic is not behaving violently intentionally, some participants still label such situations as violent, due to the perceived threat to their own health.

The variables of experiences of physical contact, attribution of behaviour and individual situational factors and circumstances was a conundrum many of the participants wrestled with. Attributing behaviour in the above context is extremely problematic making creating specific definitions, a cornerstone of the natural sciences, extremely challenging. A major concern this raises, relates to the dilemma that inconsistent definitions relating to terminology, will mean that staff may report, react or manage incidents differently, creating an inconsistent approach to assessing, planning, implementing and evaluating nursing care.

Participants also articulated a covert coping mechanism, in relation to defining violence and aggression. When experiencing conflict with service users, participants suggested that prior to officially labelling, for example, through completing incident forms, or indeed documenting at all, conflict situations with service users, staff would consider the potential future consequences for themselves and the service user before deciding on an official course of action. Certain situations, like conflict developing during the breaking of bad news, were viewed much more leniently by participants as opposed to the service user involved in conflict with staff, who was viewed as an inappropriate attender.

In these circumstances the understandable nature of personal behaviour, differentiated violence from aggression, whereby violence was not only viewed as a physical act but considered in terms of a psychological reaction. Subsequently aggressive incidents could also involve a degree of physical confrontation but in the eyes of the participants that reaction, for example following bereavement, could be excused. A major situational factor becomes the subjective interpretation of the

nursing staff who assessed for malicious inexcusable violence in contrast to understandable, excusable aggression.

Violent incidents were viewed as rapid, extreme incidents lacking justification. Primarily seen as acts of physical and verbal abuse projected towards others that could not be viewed as behaviour, that could be justified as developing out of a clinical presentation, personal circumstances or an understandable trigger in the eyes of participants. Furthermore, not only did participants differ in their own belief systems regarding labelling incidents, but appeared to dismiss or condone behaviour purely on the grounds of clinical presentation. For example, real patients, those presenting with genuine health related problems, not self induced, whom participants labelled as deserving or justifying treatment, were unlikely to be viewed as being violent unless physical interactions became extreme.

Experienced staff however, were themselves divided between applying medicalisation and attribution to explain individual service user behaviour. On the one hand, some experienced participants reluctantly accepted that the intricate and complex nature of client diagnosis meant that some service users they encountered could behave, in their eyes, inappropriately, as their medical presentation offered a potential excuse for their behaviour. If such individuals however, could be identified and labelled as inappropriate attenders, a variety of negative tactics could be employed to encourage such individuals to vacate the premises, ranging from offering uncompassionate care to verbal confrontation. Evidence from this work consequently continues to support earlier work by authors such as Jeffery (1979) or Lyneham (2000), that suggests some staff project an uncaring and dismissive approach towards service users they view as inappropriate attenders. Such seemingly uncaring attitudes and behaviours contravene the NMC code (2008) which emphasises that registered nursing staff must treat people kindly and considerately. It must be noted however, that no such experiences were observed during the collection of observational data.

In contrast, other experienced participants, were extremely reluctant to label and attribute the behaviour of service users presenting with complex clinical presentations, due to concerns not only for service user safety but regulator accountability. The dilemma this creates is mirrored when reviewing how ED nursing staff define

violence and aggression. Not only can it be suggested that staff are inconsistent when defining violence and aggression but also inconsistent in their approach to service user care delivery. Participants clearly acknowledged that colleagues assessed, planned, implemented and evaluated care delivery to service users differently, based on a variety of personal factors and care delivery would vary from shift to shift and staff member to staff member. The observational data collection component confirmed the varying approaches nursing staff adopted, when interacting with service users.

Nursing care delivery in the department appeared to have, on the surface, an overt level of consistency. Beneath the surface however, there appeared to be a murky, foggy, inconsistent nursing world characterised by autonomous nursing staff, providing inconsistent shift to shift care delivery, and service user assessment and management. The dilemma this creates relates to how such inconsistent nursing philosophies, relating to service user care delivery will lead not only to inconsistent care in the short term, but also to inconsistent role modelling, and role modelling consequences in the longer term. Subsequently the dilemma this work potentially identifies relates to the wider fabric of nursing, because this work suggests that ED nursing staff, participating in this research, had widely contrasting views relating to service delivery, at the heart of which lies the actual role of nursing staff in the ED. This world was not a secret, covert world to participants but a world participants freely discussed and commented upon.

7.3.2) Study aim two

Discussing the behaviours of emergency nursing staff in relation to formally reporting experiences of violence and aggression in the clinical area.

Data collected from the interview component of the study suggests that the current reporting process is not fit for purpose. All of the respondents agreed that the reporting process did not truly reflect the levels of conflict in the department between service users and staff. The observational component of the study also identified that conflict amongst service users occurred but was frequently not documented. The

incident forms themselves were also frequently poorly completed. This is important as the NMC code (2008) emphasises that registered nursing staff should keep clear and accurate records. The NMC code (2008) goes further by emphasising that registered nursing staff must inform someone in authority, if they experience problems that prevent them from working within, this code or other nationally agreed standards. They must report concerns in writing if problems in the environment of care are putting people at risk.

The data collected from the interview component of the study supports published work by authors such as Hislop and Melby (2003) or May and Grubbs (2002). Frequency of incidents, a lack of prioritisation and excessive workloads, poor post-incident response from the employing organisation and police, a lack of feedback following previous reporting, staff provocation and attribution of the aggressor`s behaviour all contribute to under-reporting.

Specifically in relation to new knowledge in this area a variety of issues were raised. Relating to the previous section, participants differed in their opinions relating to defining incidents as violent, and this would influence the reporting process. From the documentary analysis it became clear that violent incidents were frequently incidents that occurred in public, took place over a prolonged period of time and involved multiple staff members. One such incident was identified during the observational component of the study. Despite this, documentation was haphazard and sporadic, appearing to rest solely on the whim of individual staff to engage in the reporting process.

Incident form reporting, varied with staff using the form for a variety of reasons; not just to report incidents, but to criticise colleagues or the failure of equipment or environmental security measures. Not addressed furthermore, in the current ED literature, but raised in this study, was the phenomenon of service user/service user conflict. This was raised in the documentary analysis and interview components of the study, and observed, but it is not an area the current ED literature refers to. Such incidents are extremely concerning as there is potential for litigation when service users who perceive themselves to be victims of a crime, whilst on the hospital

premises, could commence litigation against the host organisation rather than the actual aggressor. These incidents furthermore, challenge the very nature of the hospital environment being considered a place of safety.

Participants identified the benefits of reporting incidents; to include enhanced working environments, occupational defence, target hardening, individual service user exclusion, and hot spot analysis, all factors that could enhance both service user and staff safety. The participants however, projected what can be described as a disempowered and apathetic attitude towards their occupational circumstances, inconsistent and incongruent with the attitude one might expect from members of a professional group.

Clearly the participants accepted that the current reporting process was not capturing the realities of clinical practice, purely in relation to the number of incidents experienced and formally reported. Experienced participants struggled to clearly explain the bureaucratic process through which the incident forms were processed, were largely unaware that incident forms were edited by administrators before being entered onto the hospital data base, and appeared resigned and accepting of the current situation.

This disempowered and apathetic attitude was also evident in a wider sense. For example, participants appeared accepting of their occupational circumstances. Concerns relating to the environmental infrastructure and general sense of a poor security infrastructure were articulated, but there was no sense of concerns being so real as for participants to be taking practical steps to address their occupational circumstances. Some participants believed enhanced security measures were required in the department studied and it was suggested that serious staff injury was inevitable at some point in the future.

It appeared that participants had little practical knowledge relating to the individual staff policy drivers working within the wider trust. Trust policy appeared to be an external policy, participants reacted to, which was not moulded, shaped or influenced by the majority of participants themselves. The forces discouraging reporting appeared to swamp and smother the forces encouraging reporting, and this perspective

appeared to be an overt, accepted situation across the participants contributing to the study, to the point where participants would openly laugh at the suggestion that the reporting process was credible. Even when some participants articulated that reporting had contributed to an improved security infrastructure, the perception that the employing organisation paid lip service to staff safety, and that the organisation was not really committed to enhancing staff safety remained.

7.3.3) Study aim three

Exploring situational factors at play relating to violent and aggressive experiences of ED nursing staff.

As identified in chapter 5 a discussion related to situational factors is presented below under the following headings:

- aggressor characteristics
- nursing staff characteristics
- situational/environmental context
- consequences

7.3.3.a) ***Aggressor characteristics***

In terms of considering the potential characteristics of service users involved in conflict with staff, only limited evidence suggested that individual service users were involved in multiple incidents. Incident form analysis identified two incidents (n=38), where service users had been previously known to the department and in two incidents the same service user was implicated twice. This can partly be explained as interviewees suggested that regular aggressors were excluded from the service, through a "*red card*" banning system. This creates a significant dilemma however, due to the legal and perceived ethical dilemma of with-holding treatment in life threatening situations. The general consensus from the interview component of the study was that a certain level of aggression from service users was a tolerable, occupational hazard. The X factor of not being able to label aggressors as violent or

medically ill, beyond reasonable doubt, and hence attribute behaviour, created a perception of a potentially unsolvable occupational dilemma.

Other characteristics of potential aggressors, identified in the literature received a greater level of support. This study supports the perspective that medical presentation, particularly symptoms of cognitive impairment, resulting in confusional states, psychiatric histories, alcohol and substance abuse and gang criminality all potentially contributed to conflict between staff and ED attenders. This supports the work of authors such as Knott et al (2005) and Crilly et al (2004). Although the ED literature emphasises that the most likely aggressor nursing staff may encounter will be a young male, with the exception of referring to gang criminality or confused elderly service users, neither gender or age of service users were specifically highlighted by interviewee participants as relevant to this work. As we shall see, participants emphasised both the behaviour of service users towards staff, and the behaviour of staff towards service users, as dominant variables along with the infrastructure of the department.

A variety of other factors that have received only minimal attention in the literature, have been raised in this work. The potentially stressful experiences of bereavement, or being the original victim of criminal assaults were raised as further potential precursors to staff/service user conflict. One can suggest that the pure nature of emergency care work, where staff encounter members of the general public, presenting with a variety of physical and psychological traumas, means that encountering hostility, as individuals struggle to cope with , for example, life changing or life threatening experiences, becomes inevitable. The practicalities moreover of delivering personal nursing care, do appear to increase the vulnerability of nursing staff to experiencing a range of conflict situations. The attitude towards one`s role as a nurse also appears important, as the incident form analysis suggested that staff appeared to place themselves in compromising and potentially dangerous situations, motivated by a primary desire to help others.

The complexity of the nature of conflict in the ED, between staff and service users can be elaborated upon when considering the length of time of incidents identified

during this study. The triangulated approach to data collection emphasised the public and prolonged nature of incidents as volatile; yet involving vulnerable service users with, for example, complex psychiatric histories; presenting in the department well enough physically to project aggressive or violent behaviour; yet were vulnerable to hurting themselves, others or vulnerable to both physical or psychological deterioration. In these situations staff frequently felt obliged to continue to interact with such service users, as ejecting them from the department could result in life threatening consequences. Consequently, some service users would remain in the department shouting, swearing and being disruptive.

This work suggests that equitable care across the spectrum of service user presentation was not being met, as service users presenting with psychiatric histories, for example, waited for prolonged periods of time for psychiatric assessment and management. Subsequently the responsibility for service disruption, caused by such individuals, cannot lie entirely at the feet of such individuals so as much with the service infrastructure whereby free, equitable care for all is called into question by this work. Toleration of such service users and situations importantly, appears to be identified in this work as seen in the unsophisticated tactic of ignoring such individuals which appeared to be a relatively common strategy. This clouds the very nature of attempts to separate and label original aggressors and original victims and casts a shadow of doubt over the delivery of a high quality and consistent service.

The role of the hospital location and the general characteristics of the service users accessing the service, were raised on multiple occasions. Interviewees raised the perception that social class influenced both the service users` approach to communicating with staff or indeed, engaging in conflict. The perception that aggressors brought their lifestyle, attitudes and behaviour into the ED environment was frequently commented upon. The observational component of the study also identified that a dominant situational factor related to the behaviour of service users, accessing the service.

At the micro level, an appreciation of such data is very important as healthcare staff. When leading the direction interpersonal communication with service users takes,

staff may have a potential advantage when anticipating the potential verbal threats of likely aggressors. A key component of conflict escalation is the temptation to engage in arguing with manipulative verbal abusers, whose abusive techniques are underpinned by a desire to extract a negative reaction from their victim. Not responding to hostility with hostility is a cornerstone of conflict resolution and subsequently predicting the potential line or direction of verbal abuse may prevent, for example, staff moving from reasonable limit-setting to essentially arguing due to feeling insulted.

The ED literature emphasises the importance of not confronting aggression with aggression (Lyneham 2000, Levin et al 1998), yet the interview component of this study suggests some staff actively engage in confrontations with service users (an approach other colleagues are aware of), and appear to be personally insulted when meeting behaviour in the workplace they find unacceptable. The Royal College of Psychiatrists Research Unit (1998) recommends making deliberately friendly overtures; not confronting; making a concession and showing concern as positive steps towards managing potentially violent service users. Data from this study however, suggests that participants were divided, depending on individual situations, whether to project a passive or macho approach to confrontations with service users. The personal safety of some participants appeared to run second to a desire to enforce compliance on certain service users, particularly service users viewed as inappropriate attenders. There seemed to be a blurring of the boundaries in relation to nursing staff policing the department themselves.

The role of waiting times will be considered later in the text, but interviewees also highlighted the perception that violent individuals were characterised as individuals who did not wait for a prolonged period prior to engaging in conflict with staff, but immediately demanded prompt treatment. The observational component of the study also identified that confrontational individuals appeared to arrive at the department door in a hyperactive state, rather than becoming increasingly frustrated as they waited for treatment. As discussed in the literature review, this supports the perspective in the literature that prolonged waiting times play only a limited role in explaining ED violence.

Addressed in the literature review by both Adib et al (2002) and Jenkins et al (1998) was the perception of service user attitude towards nursing staff. In this study this component received considerable attention when discussing the trigger factors at play, in explaining the development of conflict between staff and service users. The perception that nursing staff are viewed by some service users as obstructing or delaying the ultimate goal of medical care suggested that some service users see the organisation of ED care as a negative, not positive, experience. Subsequently conflict may be inevitable when, on the one hand caring nursing staff, striving to provide high quality care in the best interest of the service users, are dismissed, as medical opinion and treatment, not nursing processing through the department, is the dominant service user goal. Some service users simply did not value the nursing contribution to ED care and articulated this dissatisfaction with a variety of derogatory comments, or through a tactic of minimal compliance strategies that were clearly identified when conducting observations.

The work also addresses the darker side of human nature as this study identifies a variety of frightening and dangerous experiences for staff, encountering unpredictable and volatile service users who utilised routine hospital equipment as weapons and projected both verbal abuse and physical assault. In particular the interviewees raised concerns relating to increasing violence, emanating from gang criminality; as well as the issue of dissatisfied service users uniting to complain regarding service delivery. As noted earlier the former could not be confirmed during this study but the latter could.

As a social researcher, what really struck me as the data collection process progressed, was the sheer bravery and courage of nursing staff who were practising in extremely challenging circumstances and caring for potentially extremely frightening individuals. The insight of caring staff who projected an empathetic non-judgmental appreciation of the social circumstances of some service users must also be applauded. My perception, as an academic, who has examined general hospital conflict for a number of years, is that the sterile nature of the current ED literature, formatted within academic journals, does not communicate the physical and emotional traumas to which nursing staff are subjected, or the commitment to delivering high quality care many staff project.

7.3.3.b) Staff characteristics

Although the general impression from the literature suggests that inexperienced staff are most likely to be involved in service user/staff confrontations (Little 1999, Grenade and Macdonald 1995), this work found that the majority of incidents in the ED studied involved more senior staff.

Not only did the nursing hierarchy influence staff involvement but occupation also played a role. Both the incident form analysis and the data gathered from the interviews suggested that nursing staff were much more likely to be involved in confrontations with service users primarily because some nursing staff viewed themselves as departmental managers and limit-setters. The data collected, suggested that the medical staff focussed purely on the medical treatment and management of service users, whilst, in contrast, the nursing staff not only engaged in the proactive management of specific incidents but projected a defensive shield around the junior medical staff, shielding them from service user confrontations. It is important to emphasise that nursing staff would lead and become involved in situations; and were not always passive victims of indiscriminate violence. The decision of individual staff to proactively limit-set rather than purely react to conflict, as it developed, means that certain staff are more prone to being involved in confrontations with service users than others.

In particular, the attitude of some staff towards service users was raised by all the interviewees. Interviewees emphasised the potentially judgemental, negative, confrontational and rude behaviour of certain staff towards service users, resulting in poor communication between some staff and some service users. Such behaviour offers examples of the failure of some staff to adhere to the NMC code (2008). It can be argued that such behaviour has the potential to cause or inflame conflict between staff and service users and from a risk management perspective the NMC code (2008) states that registered nursing staff must act without delay if they believe a colleague or anyone else may be putting someone at risk.

Despite the NMC code (2008) stating that registered nursing staff must treat people kindly and considerately, interviewees implied that in specific situations staff would actively encourage and provoke confrontations with service users. This was largely related to staff either perceiving individual service user presentation as inappropriate or due to staff actually enjoying the nature of the confrontation. Inappropriate attendance was raised on a number of occasions with individuals presenting with trivial problems or in particular faking injury; and receiving a variety of negative responses from staff. Such attitudes, as already noted, have been addressed in earlier literature by authors such as Hislop and Melby (2003) and Luck et al (2007) and staff involved in such behaviour are clearly not adhering to the NMC code (2008).

Both role modelling and shift leadership were areas raised during these discussions with interviewees, emphasising the importance of positive, clear, high quality, senior nursing care that could be projected from more experienced to less experienced colleagues. It has been suggested that nursing is largely an apprentice process, and the modelling of senior staff plays a large part in moulding staff attitude and behaviour (Lee 2001). Whilst undergoing workplace socialisation nurses may come to adopt the norms, values and rules that characterise their collective working group (Reeve 2000). The data collected, related to negative staff attitudes, in some cases, gives cause for concern as negative role models may negatively influence the attitudes of nursing students or less experienced colleagues.

7.3.3.c) Situational/environmental characteristics

Both the incident form analysis and data collected, during the interview component of the study made reference to the ED environment in question. A number of incident forms completed by staff made reference to failings in the security infrastructure and environmental problems such as staff isolation and uncontrolled access. Poor corporate security was also clearly identified during the observational component of the study.

The increased throughput of service users was raised, but this was countered by the perception that generally the service infrastructure had improved over recent years. Gauging the workload level in the department was difficult as interviewees would comment on the busy nature of ED work. More experienced staff however, suggested that the nature of ED nursing had changed, but generally the working conditions had improved. Despite this, on several occasions I observed the waiting area, full to the point, where people could not find a seat and queued outside the department.

From a security perspective, the free access and ability of individuals to wander freely around the department is an important issue. Incident forms identified confrontations developing and moving from room to room across the ED; and interviewees also raised the problem of a lack of controlled access across the department. Interviewees also suggested that a limited level of fortification sent the wrong message to potential aggressors. The organisation could be viewed as open to criminal activity, as it lacked perimeter fencing, controlled access or control of movement within the specific department studied.

The actual departmental layout was also not ideal, as the geographical layout of the department resulted in staff working in triage, being isolated from colleagues. It is well recognised that one potential high risk situational factor for individuals for the experience of work related violence is working alone or in isolation from one`s colleagues (CFSMS 2004, NAO 2003).

One specific situational factor raised during this work is the role of waiting times and the development of staff/service user confrontations. Only a very small number of incident forms raised the issue of waiting times (3 n=38), which can be viewed as surprising when one considers the literature devotes considerable time to discussing this issue. Generally three broad areas were raised during this work. First, the general perception from interviewees was that violent individuals arrived in a hyperactive state, and in that respect waiting times played only a minimal role in the development of staff/service user confrontations. Interviewees did however, suggest that violent

service users, on arrival at the department, evaluated the number of individuals waiting and projected a confrontational persona in order to "*queue jump*". The observational component of the study, to a degree, supported this perspective.

Second, in more general terms, the perceived improved service infrastructure and faster processing of service users through the department, had reduced waiting times and consequently waiting times were perceived as not playing as much of a significant role in the development of confrontations as in the past. Experienced interviewees were divided, when assessing the levels of violence and aggression in the department studied. Some suggested that the mere presence of security staff, a service not in place early in their ED careers, indicated that violence and aggression was a more serious issue today. Others suggested that one needed to quantify the situation, for example suggesting violence and aggression emanating due to frustrating waiting times had reduced, but violence and aggression emanating and influenced by gang criminality and alcohol had increased.

Third, a further issue that was raised by a number of interviewees, was the perception that it was not necessarily the length of time service users waited for treatment but the lack of communication between service users and staff, that contributed to a feeling of frustration leading to confrontations. The observational component of this study did suggest that communication between staff and service users was an area of concern. One can suggest consequently, that initiatives designed to reduce and improve the waiting time experience for service users, would have a positive impact on the level of ED conflict departments may experience.

7.3.3.d) Consequences of experiencing workplace conflict

The consequences of experiencing workplace conflict are relevant to examining situational factors, as aggression can be both an antecedent and a consequence of experiencing workplace conflict. This work identified a number of issues relating to

the consequences of experiencing workplace conflict. For example, as already noted, this work identified the phenomenon of service user/service user confrontation, which could have significant legal consequences for departments required to provide a duty of care to service users. Interviewees also raised concerns relating to service users having to witness public confrontations between individuals and healthcare staff. The observational component in addition, identified the wide variety of both positive and negative experiences to which service users accessing the service could be exposed.

The work highlighted a number of potential organisational management techniques that could be applied post-incident; including cautioning or banning individuals from care, but this would obviously become problematic in situations of life threatening injury. Not addressed in the literature, but raised during this work, was the inconsistent approach of staff towards managing service user confrontations.

Finally, the negative impact for staff, exposed to persistent verbal abuse, for example, was raised by participants who suggested that individuals could become burnt out. Participants reflected on changes in their attitudes and behaviour towards service users, and their occupation, suggesting that staff became hardened and desensitised the longer they work in the ED setting.

7.4) Discussing this work within a professional context

I have chosen to place the following discussion and later the recommendations, within the broader concepts of professionalism and leadership; as these areas were optional courses I completed as part of the taught component of doctoral studies. From an educational perspective I have taken the position that the lack of published research, related to my chosen topic; identified through the literature review, particularly research conducted by clinical nursing staff; inconsistent and poor documentation of incidents; inconsistent management of incidents and care delivery; the dubious nature of aspects of practice revealed during the collection of interview data; challenging

working conditions; and the disempowered attitude some participants articulated, relating to their occupational circumstances, that were identified during this study, could all be viewed as potential educational issues. The higher education sector has a potentially, key role to play in relation to addressing ED violence experienced by nursing staff through positively addressing the findings of this study.

The professional status of nursing is often subjected to both internal and external debate as professionalism incorporates attitudes representing levels of identification with, and commitment too, a particular profession (Wynd 2003). The knowledge accessible to a particular assembly of people, the conduct that is expected from this group and the power and authority the group has over its training and/or education which takes place over a recognisable duration of time, along with state registration which permits entry to be prevented to others who do not correspond to the requirements, are attributes that collectively and commonly characterise professional status within the literature (Rutty 1998). Greenwood (1957) characterised the traits of a profession as requiring the possession of;

- a basis of systematic theory.
- authority recognised by the clientele.
- community sanction of this authority.
- a code of ethics.
- a professional culture sustained by professional associations.

Friedson (1970), viewed a profession as an occupation that has succeeded in controlling its own work and been granted legitimate autonomy, usually through the state ,while Johnston (1972), further suggests that professional bodies are defined by an ability to exercise power by members of the occupation itself.

A variety of authors have challenged the perception that nursing actually is a profession. Etzioni (1969) concluded that nursing is not a profession, because it lacks a scientific knowledge; base and is not independent and self governing. Toren (1972)

described members of the nursing profession as semi- professional; while more recently Fawcett (2003), described members of the nursing profession as being composed of little more than skilled trades people.

When considering the earlier criteria of traits of professional status, offered by Greenwood (1957), or in relation to individual nursing staff meeting published standards (NMC code 2008), in order to project professionalism; the data collected for this dissertation identifies a significant number of discrepancies. The data collected can be interpreted as evidence, that challenges the foundations relating to describing nursing as a profession; because this work identifies both multiple examples of participants failing to adhere to the NMC code (2008) and displaying attitudes and behaviours incongruent with the summary, in the literature, of positive traits of professional status.

In 1996, the 49th United Nations World Health Committee announced that the prevention of violence should be a leading priority for public health researchers and practitioners (Dahlberg and Krug 1996). Chappell and Di Martino (2006) emphasise that workplace violence requires comprehensive strategies and solutions, due to the complexity of the phenomenon of violence and aggression, yet the literature review clearly identifies that the quality and quantity of literature dedicated to an area one could consider as a fundamental emergency nursing requirement of personal safety is extremely limited. In particular, the number of original research papers written by clinical nursing staff is very small and is a concern as the NMC (2008) code emphasises that registered nursing staff should deliver care based on the best available evidence.

One characteristic trait of professional behaviour is the dissemination of increasingly sophisticated scientific research findings, through scholarly presentations and publications in research journals (Adams and Miller 2001). The emergency nursing literature however, does not possess a body of systematic theory or generalised knowledge researching ED violence and aggression; and furthermore the majority of

research papers are written by medical personnel. It must also be noted that none of the participants, referred specifically to policy documents, original research or concept papers examining violence in the ED, suggesting that their academic knowledge related to the subject matter was limited.

Historically, although the Briggs Report (1972) and the DoH (1989) *Strategy for Nursing,* emphasised the importance of research based nursing the DoH (2000b) concedes that nursing has a limited historical research tradition; and despite considerable progress in recent years, current arrangements fail to maximise the nursing contribution to research and development. The DoH (2000b) has emphasised that the two main barriers preventing the nursing profession from contributing fully to the research and development agenda; are capacity and capability: with too few nurse researchers and too few nurses in practice who are sufficiently research aware.

The limited number of authors writing in the field of ED violence, coupled with the stand alone, uncoordinated generation of research papers in this field, brings sharply into focus the DoH (2000b) comments that nursing research endeavour has tended towards one-off projects rather than programmes, limiting the potential to synthesise a comprehensive theoretical base. This can be supported, as Rafferty et al (2003) have noted that 73% of published research in nursing is unfunded and the literature review conducted for this study identified that only 9 pieces of research confirmed funding. It can be argued that the limited number of original research papers, which suggests violence and aggression management in the ED is not underpinned by research, purely due to the lack of research conducted in this field, is a symptom and example of a wider professional failing.

Professionalism is also viewed, within the literature, as containing a vocational component. For example, the care and compassion some participants projected when involved in this work supports this perspective. This work however, clearly challenges the perspective of authority recognised by the clientele and sanctioned by the community.

The ethical component of professional status can also be called into question, as the findings of this work suggest that some participants freely disclosed that they themselves were involved in, or were aware of, colleagues involved in a variety of extremely controversial practices. Data collected during this study raises concerns, for example, relating to specific incidents of poor practice, a lack of respect for individual dignity; suspicions of discriminatory practice and a lack of regard for equality and diversity; a lack of care and consideration; confrontational attitudes and provocation; poor risk management and poor documentation of experiences of events, all of which could be considered as contrary to the recently revised NMC (2008) *Code of conduct, performance and ethics for nurses and midwives.* If one accepts that individual nursing staff may justify their claims to professional status through adherence to the NMC code(2008), some of the data collected during this study calls into question whether participants themselves, or colleagues of whom they were aware, were meeting these regulatory standards.

This work also challenges the perspective that ED nursing can be characterised as an occupation, that has succeeded in controlling its own work and been granted legitimate autonomy (Friedson 1970). Wilkinson and Meirs (1999) have commented that the nursing profession`s location, in a centrally administered welfare system, exposes it to the vagaries of political will and economic change and this has a direct effect on the work nurses do, where and with whom they do it. For example, participants clearly placed a great deal of onus upon meeting government targets relating to waiting times; and the perception of being constantly busy and stretched suggests that individual staff, delivering nursing care, had little autonomy over their day to day responsibilities. The clinical task, of caring for service, users dominated the nursing day and this was reflected in the participants` frequent references to time management concerns.

The collected data also raises concerns, relating to the ability of nursing staff to make objective evaluations of service users who present with complex clinical conditions. The NMC code (2008) emphasises that nursing staff must recognise and work within the limits of their competence. A significant school of thought within the nursing profession however, is pushing for expanded roles and responsibilities even though, arguably, nurses are in no position to make clinical diagnoses, since their

undergraduate education does not prepare them for this (Scott 2002). Actually applying a diagnosis to an intoxicated individual, or an individual presenting with a mental health crisis, when a physical injury is also implicated, is a significant challenge requiring a significant level of education and training (for medical staff let alone nursing staff). On the one hand experienced participants acknowledged this perspective; but others appeared comfortable with dismissing some service users` presentations, as inappropriate, due to a perceived lack of seriousness. One can argue that such decision making requires a significant degree of competence and making such decisions, without an appropriate level of education, contravenes the NMC code (2008).

Lukes (1974) suggested that powerful individuals and groups are able to manipulate the wishes and desires of others, persuading them to accept things that may even be harmful to them. One could argue, that one such example, relates to the organisation of ED services whereby nursing staff position themselves, willingly, to manage conflict that could be interpreted as originating due to the organisation of ED medical services. Participants in this study had positioned themselves as a defensive buffer to the medical staff, managing confrontations and protecting the medical staff from potential aggressors. This can be interpreted as an example of one professional group sacrificing itself for another. My interpretation of this situation was twofold. First, a variety of measures could be taken to decrease waiting times in the department studied, one such option being to increase the number of experienced, suitably qualified medical personnel available to treat service users. The UK health system is one in which health or illness is overwhelmingly determined by the medical profession (Hewitt-Taylor 2004). It can be argued that the numbers and experience of medical staff in the department studied, ultimately influenced the quality of medical care delivered by the department and subsequently this impacted on the day to day experience of the nursing staff.

ED conflict, is subsequently not an issue that can be tackled purely at local level, but requires a complete analysis of national and local factors, that contribute to service delivery, because both medical and nursing provision are national issues with contracts between the nursing and medical profession being negotiated nationally with the DoH.

As noted earlier Greenwood (1957) suggested that the characteristic traits of a profession involved the possession of a professional culture sustained by professional associations. The professional association however, between the medical and nursing professions has been critiqued by a variety of authors. From its origins nursing was organized to mirror the domestic arrangements of the Victorian household, with predominantly female nurses functioning effectively as servants of the male doctors (Brook and Crouch 2004). There is no doubt that nursing is frequently portrayed as subordinate to other professions, particularly to medicine (Farrell 2001, Freshwater 2000, Manley 1997). Barriers hindering nursing development have been suggested, including medical dominance, the socialisation of nurses and a lack of educational opportunities for nursing staff (Chan 2002).

Farrell (2001) suggests that a predominantly female nursing workforce is prey to sexual stereotyping; and subsequently notes that nursing must face up to the dual oppressors of medicine and gender. Women account for almost 93% of nurses, midwives and health visitors in the United Kingdom (RCN 2002) yet are stereotyped as submissive, passive, lacking self confidence and being emotional, while men are seen as the decision makers (Thyer 2003). Davies (1995) suggests that nursing work is devalued because it is seen primarily as women's work and hence:

- few resources are devoted to its reorganisation and further development.
- the work remains under-analysed and poorly understood.
- changes arise as a by-product of other policy initiatives.
- nursing voices are accorded little legitimacy and respect in policy debates.

Relevant to this discussion are also the comments of Taormina and Law (2000) who suggest that nurses need a thorough understanding of the hospital environments in which they work. This study suggests that some participants knew little of the bureaucratic process involved in violent incident form collation; or how to proactively influence the working environment in which participants practiced. The NMC code (2008) emphasises that nursing staff must report concerns in writing ,if problems in the environment of care are putting people at risk; and also states that staff must inform someone in authority if they experience problems that prevent staff from working within the code. Data collected during this study however, identified that

incidents of physical violence and verbal abuse were frequently not reported in writing. Furthermore, the examples of poorly documented incident forms also contravene the NMC code (2008) guidelines on record keeping. These multiple examples of failures to adhere to the NMC code (2008) can be interpreted as calling into question the clinical professionalism of some of the participants.

Wilkinson and Meirs (1999) have stated that nursing is not a powerful profession as nurses do not work in isolation from other occupational and professional groups; many of whom are also competing for, or maintaining, professional status and the rewards that come with it. One can argue that the nursing profession`s lack of traits of professional status, outlined by Greenwood (1957) and the trappings and benefits this confers is contributing to a failure to address and guarantee, as far as possible, the personal safety of the nursing staff.

A major concern, is that the challenges to the nursing profession which I have highlighted above, supported through interpreting the data I have collected, may lead to nursing being viewed as an unattractive career choice and the Fitness for Practice (1999) report suggests that nurse recruitment may suffer from a competitive labour market and young people's increased career expectations.

Attracting and recruiting the best people into nursing is important; yet studies continue to suggest that nursing is an unattractive career option to many young people (NHS Careers 2006). Neilson and Lauder (2008) recently reported that in a study of high academic achieving school pupils, nursing was viewed in terms of a negative, low status career. A profession must be judged by the quality of the individuals who collectively make up that group and challenges that deter future, potential high quality recruits, must be addressed if the profession is to maintain, protect and enhance its status. One must be concerned additionally, that persistent experiences of verbal abuse or physical assault in the clinical area, may result in valuable and experienced nursing personnel abandoning nursing altogether.

Strauss and Corbin (1998) state that the grounded theory process produces a set of well developed concepts, related through statements of relationships, which together constitute an integrated framework that can be used to explain or predict phenomena.

As noted in the conclusion of the literature review in their original work Morgan and Steedman (1985) commented that neither the scale of the problem of ED violence nor the trend had been established; and nearly 2 decades later Winstanley and Whittington (2004) suggest that there seems to have been little progress towards actually explaining the prevalence of aggression in any health sector.

For the first statement of relationships I have taken the perspective that the hidden power broker and influencer in relation to promoting ED research which explore nursing staff experiences of violence and aggression, is the higher education sector. The current situation can be explained through the relationship between the higher education sector and clinical practice. The failure of the higher education sector to adequately prepare and equip future nurse researchers, partly explains the lack of research in this field. Unless there is organisational change within the higher education sector we will continue to be unable to understand, predict or explain the phenomenon of ED violence, as this field will not be adequately researched.

The second statement of relationships relates to the actual role of the nurse in clinical practice. As noted above, the data collected during this thesis challenge the perception that nursing is a profession. As nursing lacks the characteristic traits of genuine professional status, nursing suffers from a lack of role clarity because the nature of the specific role of nursing staff remains under-researched. Consequently ambiguity of role creates inconsistent care that manifests in the differing attitudes and behaviours of nursing staff towards defining, reporting and managing violence in the ED.

This also relates to the educational preparation of future nursing staff by the higher education sector, as data from this study suggests some staff are willing to work in a "*speciality*" riddled with inconsistency in terms of care delivery. One can argue that newly qualified nursing staff, equipped and facilitated with the tools to engage in research activities, may consider researching the actual role of the nurse in the ED. This could lead to clarification and consistency, relating to the role of the ED nurse, as the role of the ED nurse is researched and debated. This could have an impact on the approach nurses take towards ED violence.

The third statement of relationship, relates to the occupational circumstances within which ED nursing staff practise. Data collected, during both the interview, and observational components, of this study clearly identified that participants routinely struggled to meet their obligations in terms of caring for service users within the remit of the NMC code (2008). Research in the clinical area becomes a secondary priority to care delivery, in such circumstances, which creates a challenge for educationalists, attempting to promote and develop a research culture.

Cullum (1997) has commented on this issue, by concluding that the onus for keeping abreast of research developments has been firmly placed on individual nurses, despite the fact that nurses, whose critical appraisal skills may be less than adequate, may not find it possible to access research findings during the working day.

Fourth, the disempowered, apathetic attitude projected by some participants, in relation to how they viewed the amount of control they possessed over their occupational circumstances is also a cause for concern. The lack of perceived action of the host organisation and the police, viewed by some staff as groups characterised as not listening to the concerns of clinical staff, also challenges the notion of professional authority. One must question the legitimate, professional status of a group, year on year experiencing clear threats to their personal safety but not engaging in clear proactive steps to improve their working environment. Nothing, suggested to me, that the level of violence and verbal abuse, experienced by staff practising in the department, this year would not be repeated and experienced by staff in the future.

Consequently, violence and aggression will continue to be a characteristic, occupational hazard of ED nursing partly because nursing staff themselves are unwilling to project a confident and assertive approach towards ensuring their personal safety. One can argue that educational strategies in the higher education sector, that emphasise, enhancing the development of individual members of the nursing team in terms of projecting confidence and assertiveness, could have an impact relating to nurses improving their occupational circumstances.

In summary, the limited traits of professional status which nursing enjoys; the limited research tradition that is a characteristic of nursing; poor occupational circumstances; attitudes and behaviours and historical barriers relating to power; medical dominance and gender inequalities have created conditions whereby the role of the ED nurse and the ED nurses experiences and responses to ED violence and aggression are both poorly researched or understood. Subsequently nursing care suffers from ambiguity and inconsistency.

These multiple, complex dilemmas require multiple, complex solutions, but there are a number of positives one can also highlight. Throughout my academic journey, that has resulted in the completion of this thesis, I met numerous committed, caring, knowledgeable, high quality, nursing personnel for whom I have the utmost admiration. In 1972 Johnson commented, that the power of the nursing profession is exercised by providing a service mediated through employment; and this comment remains applicable today. As long ago as 1990 Salvage noted the sheer weight of nursing numbers; a uniquely predominant female workforce; the nursing profession`s key role in the smooth running of the service; and the key role of nurses within trust hierarchies as positive unique factors that were a potential untapped nursing power base. My own data collection experiences whilst completing this work emphasised that the ED studied could simply not function without the contribution of the nursing staff and the willingness of the nursing staff to commit to providing a high quality service.

Nurses make up the largest professional workforce in the UK NHS; account for more than one third of purchasing expenditure and nearly half the salary costs (Royal College of Nursing 2002). Nurses are a central resource in the NHS and are in a powerful position to improve the experience of patients, the quality of care and healthcare outcomes across a whole range of health services (Maben and Griffiths 2008). Nurses are also in a potentially powerful position to improve the educational opportunities and occupational circumstances for themselves and other nurses.

Subsequently, when placing this work firmly within the educational literature, I will go on, in the recommendations section (7.6), to propose that the higher education sector has a clear opportunity to lead on the promotion of nursing as a genuine

professional body and this leadership may result in improved levels of personal safety in the ED.

7.5) Summarising this work`s original contribution to new knowledge

This work has identified a number of areas, currently not addressed in the ED literature. The data relating to service users engaging in or experiencing conflict from other service users is an important security concern that has not been highlighted in the ED literature up to this point in time. Importantly, the phenomenon of service user/service user conflict was identified during the analysis of completed incident forms demonstrating the validity of adopting this approach.

In relation to research aim 1, in particular this work contributes towards understanding the complex, subjective judgements participants engage in, when demystifying situations characterised as violent or aggressive in the ED studied. The attitude of some participants towards service users viewed as inappropriate attenders, and the dilemma of caring for service users projecting unintentional aggression was particularly highlighted.

In relation to research aim 2, a much greater insight towards examining how nursing staff define and report incidents of violence has been offered. The work also discusses, in-depth, factors influencing the motivation of participants to report incidents. The study highlights the factors discouraging participants from reporting incidents in writing which has created a reporting process that is not fit for purpose. As noted earlier, all of the respondents agreed the reporting process did not truly reflect the levels of conflict in the department between service users and staff.

When reviewing the data, poor, inconsistent documentation was a major feature. Participants identified the benefits of reporting incidents to include enhanced working environments, occupational defence, target hardening, individual service user

exclusion, and hot spot analysis, all factors that could enhance both service user and staff safety.

The data collected however, demonstrated that some participants projected a disempowered and apathetic attitude towards their occupational circumstances. Limited knowledge of the reporting process; a failure of staff to proactively improve or influence their occupational circumstances; and a perception that completing incident forms was a futile exercise, in terms of invoking positive change, were all features of this work.

In relation to research aim 3, in terms of reviewing aggressor characteristics participants emphasised how stressful situations, such as bereavement or being original victims of criminal assault, contributed to the development of conflict. The demographic characteristics and attitudes of the population the department served was also emphasised as important variables. Furthermore, the role of the nurse in the ED in terms of policing, limit-setting or managing potentially hostile situations was also identified. The data collected also suggested that at times, participants were willing to place themselves in potentially dangerous situations from a risk management perspective a large number of avoidable personal safety issues, such as offering potential aggressors enhanced opportunities to compromise personal safety were identified. A specific example of this relates to staff carrying scissors or stethoscopes inappropriately.

This work suggests that enhancing the departmental infrastructure, reducing waiting times, for example, improves the service from a personal safety perspective but also emphasises that ED violence requires both internal and external departmental initiatives to improve staff safety. The perception that gang-related violence was increasing in the area surrounding the hospital, and this was impacting on the ED service is a real cause for concern particularly as this work suggests some participants had little confidence in the security infrastructure of the department studied. An insight of the negative attitudes towards nursing staff, projected by service users and

vice versa were areas that also received attention. In contrast to the literature, this work suggests that more, rather than less experienced staff were likely to be involved in conflict with service users.

The process of collecting and interpreting qualitative data within a grounded theory approach frequently results in the development of emergent themes. The data, collected with the original purpose of exploring the stated research aims also led to the emergence of 4 themes. These themes related to limited research, particularly by clinical nursing staff, in relation to the subject matter, inconsistent practice, challenging working conditions and a disempowered attitude of some participants in relation to their occupational circumstances. The identification and discussion of these themes can all be offered as examples of new knowledge, when applied to the ED setting.

In terms of explaining how the data collected relates to the theory offered I can suggest the following summary. First, preliminary discussions with ED staff identified that the 3 original aims of the research required researching. Second, the options of professionalism and leadership, taken and completed as part of the course assignments, became central to the development of the thesis as these options were intended to influence the direction the thesis took. Third, the critiquing of original research reports undertaken during the literature review further supported the choice of the 3 original research aims, but also identified the limited number of papers exploring ED violence, written by clinical nursing staff. Fourth, the analysis of incident forms written by nursing staff contributed to developing an understanding of all 3 original research aims but also identified the second emergent theme of inconsistent practice. Fifth, inconsistent practice was also a theme that developed during the process of conducting interviews and observations. Sixth, interviews and observations contributed to understanding the 3 original aims of the research, but also resulted in the development of the third and fourth emergent themes relating to challenging working conditions and a disempowered attitude of some participants in relation to their occupational circumstances. Therefore data collection and analysis addressed the 3 original research aims and the 4 emergent themes.

The uniqueness of the study and the development of this work`s original contribution to new knowledge was enhanced by approaching data collection and analysis within a grounded theory framework. This was also achieved by interpreting the data, within the broader concept of professionalism, sub-divided and conceptualised into examining the adherence of participants to the NMC code (2008) and through exploring the traits of professional status. Furthermore, this was also achieved through the recommendations outlined below which emphasise the potential for the higher education sector to demonstrate proactive leadership in relation to responding to ED violence. This approach was a conscious decision taken, influenced and underpinned by the course ethos of using course assignments as building blocks that contributed to the final completed thesis.

7.6) Recommendations

I have chosen to offer and justify my recommendations, prior to elaborating on the core, central categories because the core, central categories of professional maturity and identity are the end product of data collection and analysis grounded within the data and an intellectual debate. The problem of ED violence and aggression cannot be solved merely by examining the individual department and suggesting a variety of changes; as the issues raised in this thesis apply not only to managing ED violence and aggression, but to wider professional issues. Furthermore, any recommendations offered may have a variety of potential consequences and therefore recommendations are offered in bold with reference to potential consequences, offered as appropriate. The recommendations begin with addressing the emerging themes of the research and then address the original research aims.

Recommendation 1

The first recommendation is that the higher education sector moves towards a model whereby under-graduate degree programmes formally require the collection and analysis of original data by nursing students rather than literature critiquing.

This recommendation is designed to address the lack of original research, related to the subject matter, being conducted by clinical nursing staff in the ED that was identified, during the literature critiquing process. Fundamental to nurse education is the concept that nurse education must strive to develop the profession (Quinn 2000). The WHO (2002) emphasises that researching the causes of violence is a primary precursor towards the goal of violence prevention. When considering the lack of ED nursing staff engaged in researching ED violence, developing high quality researchers of the future is one component of a multi stranded potential solution.

Evidence-based practice forms a cornerstone of the NMC Code (2008), as good quality nursing is partly grounded in high quality evidence-based practice (Maben and Griffiths 2008). Evidence suggests that nurses, exposed to basic research training in their initial general nurse education, perceive fewer barriers to research utilisation compared to nurses without such training (Nilsson Kajermo et al 1998). Studies have also shown that research education promotes knowledge of and positive attitudes to research (Hundley et al 2000, Lacey 1996). The teaching of practitioners, to develop critical appraisal skills alongside awareness of research methods, is fundamental to this process (Richardson 2000). Therefore, one strategy to improve the quantity and quality of research papers exploring ED violence published by nursing staff is through the development of researchers of the future at under-graduate level.

In the United Kingdom there has been an era of intense academic evolution of nurse education, including the transfer of most formal nurse education to the university sector (Lorentzon 1997). Unfortunately, in the UK, higher education, under-graduate, degree programme nursing courses have moved away from formally requiring under-graduate nursing students to conduct original research that actually involves original data collection and analysis. Current under-graduate diploma nursing students are also not required to engage in formal research activities involving original data collection.

Nurse education is moving towards all graduate status and the move towards achieving an all graduate profession has been viewed as compelling because of the need for highly knowledgeable, skilled, autonomous registered practitioners to fulfil increasingly complex roles (Maben and Griffiths 2008). This move does offer an

opportunity to incorporate formal research driven, data collection assessments into under-graduate programmes.

Recommendation 2

The second recommendation is that along with the higher education sector, regulatory bodies and bodies representing clinical nursing staff should campaign for formal, ring-fenced research time written into the national contracts of nursing staff. Although the DoH (2000b) emphasised the dual research barriers limiting nursing research to be capacity and capability, data from this study demonstrates that the current occupational environment, within which clinical nursing staff function, is the primary factor stifling clinical nursing research. This is related purely to limited research opportunities.

Practitioners require nursing knowledge and an evidence-base for nursing interventions, to create and underpin improvements in nursing care for patients (Grocott et al 2005). Clinical nursing staff however, such as participants working in the department studied, are contracted to work within the ED and are expected to function as evidence-based practitioners but have no formal contractual research opportunities. A lack of research time partly explains the limited number of research papers published by clinical nursing staff but also potentially explains the wide variations in service delivery, inconsistent practice and attitudes towards the role of the ED nurse.

Participants frequently referred to excessive workloads, during the interview component of the study. Observations also identified situations were staff where under extreme pressure to meet their clinical responsibilities. One potential consequence of working in an environment, where the workload is excessive, has been offered by Fassel (1998) who suggests that a workaholic mentality may result in the employee, suffering from the sense that there is never enough time to do all that is needed, and consequently such individuals may feel they have fallen short . This can impact upon the confidence, self esteem and perceived levels of personal power of individual staff and may partly explain the disempowered attitudes, displayed by some participants in this study.

Maben and Griffiths (2008), note that the usual career route for nurses has not allowed them to combine practice and research. In relation to clinical practice, Parahoo (2000) refers to the lack of leadership, vision and role models within nursing management, who are actually seen as obstacles to the utilisation of research. This relates not only to implementing research findings but collecting research data. Retsas (2000), concluded that nurses have insufficient time to implement new ideas and read research, let alone conduct it and argues that these issues must be addressed from an organisational level. Clinical nursing staff therefore, are trapped within a workplace organisational structure and style, that does not primarily meet their needs as professionals; and creates organisational barriers that prevent the development of a genuine research culture (Thyer 2003). Maben and Griffiths (2008) have suggested that NHS commissioners and providers should ensure that adequate resources are provided, to support ongoing education and training, and career development to enable nurses to fulfil their future roles. Such resources should not be left to the whim of local managers working within acute care hospital trusts, but negotiated and confirmed at national level.

Recommendation 3

The third recommendation is that the higher education sector commits towards empowering and politicising the student body: the future members of the nursing profession, towards a more genuine goal of professional autonomy. In this context, professional autonomy relates to staff consistently demonstrating adherence to published standards such as the NMC code (2008) and through demonstrating the projection of traits of professional status. Throughout this work concerns related to the above have been identified and discussed on multiple occasions. The data collected during this research, identified that participants were concerned regarding their occupational circumstances, and their ability to fulfil their professional obligations. Time management and potential poor service delivery were raised on multiple occasions. Participants also frequently projected a disempowered attitude towards improving their occupational circumstances.

Recommendation 3 can be achieved through an educational leadership strategy; adopted by the higher education sector and designed to develop and equip future

nursing staff with a more astute and enlightened understanding of the political, economic, social, professional and historical factors that have created the current occupational climate. It can also be achieved by nurse education instilling the values of adhering to the NMC code (2008) and through instilling the values of adopting the traits of professional status, into under-graduate nurse education.

Nursing leaders, at all levels, need to acknowledge and understand the complex and ambiguous position that nursing continues to occupy in healthcare (Davies 2004).
There have been many changes that have reconfigured nursing in the UK, such as the shift to a university education; the increasing diversity of the nursing role; the introduction of support workers, role substitution; the advent of a general manager culture and the recent health reforms which focussed on access, productivity and finance (Maben and Griffiths 2008). Politically motivated changes have dominated the recent past. For example, the creation of NHS Trust status and the implementation of the internal market (Mohan 1995). Other changes include competitive tendering, clinical grading and the *Agenda for Change* pay structure. One can argue, that the potential consequences of many of the above changes have effectively made the nursing profession, fragmented, disunited and potentially more compliant and less able to resist future political change.

The enhancement of the NHS manager’s role in controlling costs; the reduction in the number of qualified nurses and the rise in the number of healthcare assistants can all be seen as part of an overall reduction in the power of the professions most closely associated with the NHS, i.e. Nurses and Doctors (Wilkinson and Miers 1998). Political ideology underpins healthcare delivery in the UK, and consequently developing a more politically astute nursing body is a perspective supported by authors such as Keighly (2004), Rodwell (1996) and Stilvers (1991), who stress that a key component of nursing development is for nurses to develop an increased political awareness and understanding of economic factors affecting nursing.

To meet this aspiration one potential strategy which higher education nursing leaders could adopt, is a transformational leadership approach. A generally accepted definition of transformational leading is that it is an approach that motivates followers

to perform to their full potential over time by influencing a change in perceptions and providing a sense of direction (Bass and Avolio 1994).

Transformational leaders, it is suggested, have a vision and long term strategy, they aim to share power and empower others; igniting followers with a shared vision (Hyett 2003, Thyer 2003). Interestingly the leader's role, in transforming, organisations is a recurring theme. Transformational leadership is commonly commended in the healthcare literature with Trofino (2000) emphasising that transformational leadership is best suited to team building and the development of teams. In this context the team can be viewed as higher education lecturers adopting a transformational approach and facilitating a team comprising of a potentially powerful nursing student body.

In contrast, transactional leaders are traditionally concerned with the day-to-day operation of organisations (Hyett 2003). In essence it implies a more traditional managerial style as transactional leadership is hierarchical with power retained by senior managers (Thyer 2003). Transactional leadership is predominantly found in bureaucratic organisations such as the NHS (Thyer 2003). The dilemma faced by nursing is that transformational leadership skills may be limited in practice by the transactional method of auditing, performance monitoring and centralised reporting (Firth-Cozens and Mowbray 2001).

One can argue that the dilemma facing many clinical nursing staff in the site researched, and hence perhaps the wider profession; as these staff frequently mentor nursing students who may adopt the attitudes of their role models; is that a characteristic leadership style utilised within the NHS in the UK is a transactional approach. This approach leans heavily towards the task of practically treating service users. It may also be argued that senior nursing managers are also immersed in a transactional paradigm through their requirements to operationalise targets set by the DoH, such as, for example, the four hour maximum wait in emergency care.

In the UK, the NHS management structure can be characterised as a pyramid structure of management, where one works for the person above him/her (Hyett 2003). Blanchard (1998) argues that nursing management in the past has a direct and control

style of management, rather than leading through establishing direction, aligning, motivating and inspiring people. Caine and Kenrick (1997) have noted that, historically, clinical nursing managers have failed to use their position and authority to facilitate evidence-based practice, because of other competing demands. Consequently higher education can influence the clinical environment and act as a change catalyst by leading nursing forward; moulding and shaping the clinical environment within which nursing staff practice, by developing the ability of future nursing staff to proactively shape and mould their occupational circumstances. This may be achieved through higher education sector lecturers adopting a transformational approach, designed to empower and politicise future nursing students who will develop into clinical, educational, research and managerial nurse experts and leaders.

Kleinman (2004) argues that concentrating on prospective (student nurses, for example) rather than current managers can help to address uncertainties about how to develop positive leadership characteristics. The educational preparation of student nurses`, who are the future of our profession, therefore is a vital strategy which we must, as nurse educationalists, get right. The challenge is for higher education to create a learning environment , where educationalists develop the ability to motivate others, inspire a shared vision, develop an ability to confidently challenge obstacles, develop an ability to create a fertile learning environment and emphasise the projection of positive role modelling (Tourangeau 2003).

Factors such as the lack of primary research and systematic reviews; the status of nursing as a profession in a multidisciplinary setting; and research training in nursing curricula must be addressed collectively by the nursing profession (Parahoo and McCaughan 2001). For nurse leaders (including those in the higher education sector) there is a need to put the economic and social welfare of their staff/students at the top of their agendas (Keighley 2004) and project a united front.

Nursing leaders need to be more active in the political arena to achieve change (Chan 2002, Kuokkanen and Leino-kilpi 2000), because nurses are engaged in an unremitting struggle to claim status and respect as a middle class profession within environments in which political, professional, historical and personal factors

continuously undermine this claim (Jewkes et al 1998). As Davies (2004) notes, the dilemma which the nursing profession faces, is a lack of power and influence on the health policy scene; and perhaps we need to start from the assumption that the nursing profession operates in a position of both structural and cultural disadvantage.

Kuokkanen and Leino-kilpi (2000) argue that nurses must be able to believe in their own power and ability to instigate change, even in an environment of limited resources, managers and leaders need to be creative in their approach to supporting and developing staff (Hyett 2003). The impact of nursing care on patient outcomes, for example, is generally not acknowledged in UK healthcare and therefore nursing remains totally undervalued (Scott 2003). Yet we must accept that it is nurses who need to lobby and agitate for change, we cannot rely on other healthcare stakeholders to do this.

This equally applies to the educational development of nursing students. Yoder-Wise (1999) describes leadership as the ability to create new systems and methods to accomplish a desired vision, and it is the challenge for today's nursing leaders in the higher education sector to set the agenda for the future. That agenda needs to emphasise that we need not only to call for evidence-based nursing but a healthcare system that supplies the tools, contractually, for nurses to actually conduct research and achieve genuine professionalism and evidence-based status. In this context there is a need for effective nursing leadership, not just management (Lewis 2000). The higher education sector has an opportunity to be at the forefront of this debate proactively leading, not simply reacting to policy.

A transformational approach could aim to promote a confident, dynamic nurse of the future, who is prepared to consider political agitation for improved working conditions that will allow and promote a genuine research culture, improved working conditions and improved service user care. Leading a politically aware nursing workforce is one way of achieving these goals; and generating interest in research, leadership, politics and power dynamics needs to be a fundamental goal of all those involved in educating nurses of the future. The nursing profession should engage in debate with other national stakeholders from a position of industrial strength, through

the educational empowerment of the individuals who collectively make up the profession.

In relation to the original aims of the research, the following recommendations are offered. Importantly, the discussion above is relevant to the following recommendations as these recommendations may only be achieved if the wider nursing profession adopts a proactive approach to improving the current situation.

Recommendation 4

A wider debate relating to clarifying occupational violence and aggression which ED nursing staff experience is required so that policies can be initiated to manage and reduce the potential for nursing staff to experience verbal abuse and both intentional and unintentional physical assaults. This requires adequate resources and should be researched as part of a wider national strategy, rather than being left to one off, small scale self funded projects, which are the dominant characteristics of the current literature.

Recommendation 5

At local level, the current incident reporting system examined, requires a thorough overhaul as the system, in its current format, is not fit for purpose.

Recommendation 6

A consistent response from employers and the police towards prosecuting offenders engaged in criminal activity in the ED is recommended. Failure to adopt such an approach may place the host organisation at risk of litigation by victims.
Recommendation 7

It is recommended that managers consider improved perimeter security and controlled access to both the corporate facility and the department. Concerns relating to increases in criminal activity and the overall poor level of corporate

security were identified during this study, and the potential for future security breaches and consequent litigation should not be underestimated.

Recommendation 8

A fundamental examination of the broader role of the ED nurse is also recommended. Within the department studied, clear inconsistencies between defining violence and aggression, reporting violence and aggression, managing violence and aggression and responding to the consequences of violence and aggression were identified. Management of violent service users, and indeed all service users, varied from shift to shift and staff member to staff member and this appeared to be acknowledged by the staff themselves; this situation requires a more consistent approach. This can also be addressed through a co-ordinated, national research strategy.

Recommendation 9

From a risk management perspective; developing an educational package for nursing staff working in the ED, based on the findings of this work, is an on-going project and recommendation. This will be developed in collaboration with departmental staff where the research was conducted. The publication and dissemination of the findings from this research study will form part of this process.

7.7) Presenting the core central categories

Strauss (1987) described the characteristics of core, central categories in terms of meeting the following criteria:

- the core, central category appears frequently in the data.
- the core, central category helps explain most of the variations in the data.
- the core, central category links easily with other categories.
- the core, central category has implications for a general or formal theory.

- the core, central category emerges from the data and consequently the theory is able to progress forward.
- the core, central category permits maximum variation in the analysis.

The two core, central categories I identify are embedded within the nature of professionalism and leadership. As noted above however, the lack of research, particularly published by clinical nursing staff, related to my chosen topic identified through the literature review, the inconsistent practice, challenging working conditions and the disempowered attitude some participants articulated relating to their occupational circumstances that were identified during this study, could all be viewed as educational issues. Defining, reporting and considering situational factors contributing to ED violence, can also be viewed as professional issues. Furthermore, participants themselves discussed their experiences and knowledge of interpersonal conflict with service users that could be viewed as giving examples of behaviour that contravened the NMC (2008) code.

These core, central categories are designed to explain the data collected and will be justified through a summary of the key issues identified during this study. In relation to the original research aims, findings suggest that ED nursing staff inconsistently define what constitutes a violent or aggressive incident due to a variety of subjective variables. ED nursing staff are inconsistent in their attitude and behaviour towards formally reporting incidents of violence and aggression, resulting in the questionable documentation of specific incidents. ED nursing staff are inconsistent in the assessment and management of violent and aggressive incidents. ED nursing staff, in addition, appear to accept challenging working conditions compromising personal safety, and a variety of situation factors contribute to ED violence; including inter-service user violence, an area not currently addressed in the ED literature. These findings, as noted above, can be interpreted as challenges to the notion that nursing enjoys the trappings of professional status.

7.7.1) Professional Maturity

The first central core category I have labelled through this work relates to professional maturity. I have interpreted the findings of this study to perhaps reflect wider symptoms of an immature profession. The nursing profession lacks a substantive research base, for example, in relation to clinical nursing staff conducting and publishing original research exploring violence and aggression in the ED. The data collected during this study also highlights examples of nursing staff not adhering to published codes of practice, partly due to excessive workloads. An excessive workload potentially reduces the capacity for nursing staff to engage in formal research activities and this limits the power base of the profession.

This perspective can explain the lack of research relating to ED violence and aggression and inconsistencies already highlighted relating to defining, formally reporting and managing violence and aggression in the ED. A more mature profession may address these issues by adopting a more robust research strategy that quantifies the variables contributing towards ED violence and offers practical recommendations that emphasise personal safety. At the moment, ED violence experienced by nursing staff is not addressed through the sound interpretation of research, simply due to a lack of research evidence.

The disempowered attitudes displayed by some participants, the acknowledgement of less than optimal working conditions and practices and the inconsistent approach to explaining or conceptualising occupational circumstances and practice suggest an immature professional group, which has yet to confidently take its place at a table currently occupied by stakeholders whose roles and goals ultimately impact upon the very nature of nursing. If one accepts that professional nursing staff partly demonstrate their professionalism through adherence to the NMC code (2008), the findings from this study raise cause for concern. One can argue that adhering to such regulatory standards may require participants to project a confident and single-minded determination, in the face of extremely difficult occupational circumstances. This

requires a mature approach in the clinical area towards one`s responsibilities. These responsibilities, promoted by higher education institutions, can be instilled during under-graduate nurse education.

The disrespect shown to participants by individual members of the general public, highlighted through this work, can also be explained by suggesting that some members of the general public are yet to grant members of the nursing profession authority and community sanction of this authority.

One could argue that professional immaturity also contributes to the perception, by some participants in this study, that their concerns relating to their occupational circumstances were not being addressed by employing power-brokers such as the host organisation senior managers. Finally, the inconsistencies relating to participants` management of violence and aggression, and the inconsistencies identified relating to the actual role of the ED nurse in the acute sector, could suggest that the profession has not matured to a point whereby a clear understanding of the environment within which ED nurses practise, or the role of the ED nurse in that environment, exists.

These issues can be addressed as the profession matures, develops, researches and defines its position within the healthcare setting and it is these areas where higher education has the potential to lead, through emphasising professionalism and creating a more fertile research culture. The research recommendations stated above, based on the study findings, are designed to contribute to and influence this process.

7.7.2) *Professional Identity*

A second, core central category I propose, relates to inconsistent nursing assessment, planning, implementing, managing, evaluating and documenting care when participants experience conflict situations. My interpretation is that the department studied was staffed by individuals with very differing perspectives relating to the role of the nurse, on a day to day basis, in the ED setting, and this impacted on the wider consistency of care delivered. I have labelled this as professional identity because the differing approaches to defining violence and aggression, formally reporting violence and aggression and interpreting the situational context of violence and aggression all appeared to be underpinned by the individual personal belief systems of participants.

Variations relating to how participants viewed the role of the ED nurse compromised the projection of a consistent professional identity by staff, as experienced role models in the department differed in their philosophical approaches to managing workplace conflict (or providing general care) and this will ultimately impact upon the less experienced nursing staff creating a self perpetuating dilemma. Examples of inconsistent professional identify were being played out in the department studied, as nursing staff struggled to deliver a consistent, high quality service in the face of extremely challenging occupational circumstances. One can suggest that empowered, politically astute, assertive and confident nursing staff may be reluctant to accept sub-optimal working conditions, particularly if this involves compromised personal safety. Such staff alternatively, may be more proactive in relation to changing such poor occupational circumstances if they exist. If the goal of higher education is the development of professional nursing staff, who consistently and rigorously adhere to the NMC code (2008) and project the traits of professional status then this work suggests that current educational strategies are not producing the end product.

Consequently, my goal as a nurse educator, must be to facilitate the development of a more professionally mature nursing body. A profession that projects a unified identity and is prepared to engage in political debate to improve the power of the nursing

profession and the occupational circumstances within which members practice. A profession adopting professional values may be much better equipped to proactively manage challenges to professional status, and challenges to personal safety in the ED.

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APPENDIX 1: Curriculum Vitae

International Conference Presentations (primary presenter)

Ferns, T., West., E. and Reeve, R. (2008). *Workplace violence and intentions to quit: Results from a survey of London nurses*. International Conference on Violence in the Health Sector Amsterdam October 2008.

Ferns, T and Meerabeau, E. (2008). *The reporting behaviours of student nurses who have experienced verbal abuse*. International Conference on Violence in the Health Sector Amsterdam October 2008.

Ferns, T and Meerabeau, E. (2007). *The exposure to verbal abuse of student nurses gaining placement experience*. Royal College of Nursing International Nursing Research Conference 2.11.2 May 1st 2007.

Research based Publications

Ferns, T and Meerabeau, E (2009) "Reporting behaviours of nursing students who have experienced verbal abuse" *Journal of Advanced Nursing* 65(12) 2678–2688.

Ferns, T and Meerabeau, L (2008). Verbal abuse experienced by student nurses. *Journal of Advanced Nursing,* 61 (4): 436-444.

Ferns, T and Chojnacka, I. (2005). Angels and swingers, matrons and sinners: nursing stereotypes. *British Journal of Nursing,* 14 (19): 1028-1032.

Ferns, T (2002). The nature and causes of violent incidents in intensive care settings. *Professional Nurse,* 18 (4): 207-210.

Concept papers

Cork, A and Ferns, T. (2008). Managing alcohol related aggression in the emergency department (Part 2). *International Emergency Nursing,* 16: 88-93.

Ferns, T and Cork, A. (2008). Managing alcohol related aggression in the emergency department (Part 1). *International Emergency Nursing,* 16: 43-47.

Ferns, T. (2007). Considering theories of aggression in an emergency department context. *Accident and Emergency Nursing,* 15: 193-200.

Ferns, T. (2007). Characteristics of people who assault nurses in clinical practice. *Nursing Standard,* 21 (50): 35-39.

Ferns, T. (2007). Factors that influence aggressive behaviour in acute care settings. *Nursing Standard,* 21 (33): 41-45.

Ferns, T. (2006). Violence, aggression and physical assault in healthcare settings. *Nursing Standard,* 21 (13): 42-46.

Ferns, T. (2006). Under-reporting of violent incidents against nursing staff. *Nursing Standard,* 20 (40): 41-44.

Ferns, T. (2005). Terminology, stereotypes and aggressive dynamics in the accident and emergency department. *Accident and Emergency Nursing,* 13: 238-246.

Ferns, T. (2005). Violence in the accident and emergency department-An international perspective. *Accident and Emergency Nursing,* 13: 180-185.

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Ferns, T. and Chojnacka, I. (2005). Reporting incidents of violence and aggression towards NHS staff. *Nursing Standard,* 18 (38): 51-56.

Rew, M. and Ferns, T. (2005). A balanced approach to dealing with violence and aggression at work. *British Journal of Nursing* 14 (4): 227-232.

APPENDIX 2: SUMMARY OF PAPERS PRESENTING QUANTITATIVE DATA.

Reference	Author Occupation	Date and County	Focus	Site	Time period examined	Instrument	Sample	Ethical approval	Results Statistical Analysis	Critique	Funding
Ochitill, H. N. and Kreiger, M. (1982). Violent behaviour among hospitalised medical and surgical patients. *Southern Medical Journal,* 75: 151-155.	1 Dr and one medical academic	USA 1982	Demographics of violent patients. Situational factors	Site specific general hospital (including the ED)	Data collected over a 4 year period	Analysis of hospital records/medical notes	29 incidents identified	Not discussed	15 incidents of physical assault 10 incidents of verbal abuse Emphasised the role of substance/alcohol abuse Identified increased length of hospital stay of violent patients Descriptive statistics	The study did not identify the parameters of the search in relation to defining violent behaviour	Not stated
Morgan, M. M. and Steedman, D. J. (1985). Violence in the accident and emergency department. *Health Bulletin,* 43 (6): 278-282.	1 Clinical nurse 1 Dr	UK 1985	Physical violence Weapons use Verbal abuse Characteristics of aggressors Client presentation/situational factors Characteristics of victims Reporting	Site specific ED	Prospective 6 month study	Analysis of violent incident proformas	102 incidents identified	Not discussed	49 incidents of verbal abuse 51 incidents of violence Emphasised role of alcohol/substance abuse Descriptive statistics	Based purely on incident forms which does not give a complete picture of clinical practice	Not stated

			practices Timing variables Police involvement Aggressor management								
Lavoie, F., Carter, G., Danzi, D. and Berg, R. (1988). Emergency department violence in United States teaching hospitals. *Annals of emergency Medicine*, 17 (11): 1227-33.	4 Drs 1 authors background not disclosed	USA 1988	Physical violence Weapons use Verbal abuse Aggressor management Litigation Security measures	170 teaching hospital ED`s	5 year retrospective study	Postal survey	170 ED medical directors Response rate 74.7%	Not discussed	Identified high levels of violence, weapons use, visible security measures and restraint of violent attenders in USA emergency departments. Discusses timing of incidents Descriptive statistics	Although focussing on medical staff the paper quantifies the seriousness of USA ED violence. The paper concedes that the reliability of the results are called into question as tallied responses are the subjective interpretations of doctors and have little objectivity. However a good unsophisticated paper utilising clear descriptive statistics.	Not stated
Mahoney, B. S. (1991). The extent, nature and response to victimization of emergency nurses in Pennsylvania. *Journal of Emergency*	Nurse academic	USA 1991	Victim demographics Situational factors Incident consequences Weapons utilisation	State wide study	Career experiences	Postal survey	2000 RN's invited to participate (n=1209, rr 60%)	Not discussed	97.7% of responders had experienced some type of victimisation during their careers Identified statistically significant relationships between sex and frequency of assaults, length of shifts and verbal	Despite a failure to address ethical approval this is a high quality paper due to the attention paid to instrument design, piloting and analysis	Not stated

Nursing, 17 (5): 282-94.									abuse, and hospital locality and victimization/weapons exposure. Identified victimisation influences career decision making Inferential statistics		
Keep, N. B. and Glibert, C. P. (1992). California nurses association informal survey of violence in California emergency departments. *Journal of Emergency Nursing,* 5 (9): 44-50.	1 clinical nurse, I nurse manager	USA California 1992	Quantifying numbers of incidents of violence Trigger factors Security measures	State wide survey	Not stated	Telephone survey	103 Nurse managers	Not discussed	89% of respondents reported acts of violence occurring between 1 and 5 times per month in individual departments Concerns regarding trigger factors such as psychiatric presentations, substance abuse and gang activity	The informal nature of this study detracts from the validity and reliability of findings Responses are the tallied opinions of nurse managers The study raises concerns that incidents of violence are played down by organisations but does not offer data to support this perspective	Not stated
Cembrowicz, S. P. and Shepherd, J. P. (1992). Violence in the accident and emergency	2 Drs	UK 1992	Physical violence Weapons use Characteristics of aggressors Characteristics of	Site specific ED	10 year retrospective study	Analysis of violent incident book and security records	407 incidents identified	Not discussed	407 incidents identified, demographics of aggressors, weapons use, categories of staff assaulted Descriptive statistics	The knowledge sought was not available justifying the purpose of the study and the paper justified the importance of the research. However, the discussion went far beyond	Not stated

department. *Medicine, Science, Law,* 32 (2): 118-122.			victims Client presentation/situational factors							analysing the study results and could have been more focussed	
Schneiden, V. and Marren-Bell, U. (1992). Violence in the A and E department. *Archives of Emergency Medicine,* 9: 330-338.	1 academic researcher. 1 ED nurse manager	UK 1992	Verbal abuse Physical assault	Site specific ED	Not stated	Questionnaire	(n=58, response rate 65%)	Not discussed	Large proportion of responders had experienced physical violence Descriptive statistics	A pilot for later work	Not stated
Ordog, G. J., Wasserberger, J., Ordog, C., Ackroyd, G. and Atluri, S. (1993). Violence and general security in the emergency department. *Academic Emergency Medicine,* 2 (2): 151-154.	3 Drs 2 authors qualifications not stated	USA 1993	Physical violence Weapons use Security measures	Site specific ED	14 year retrospective descriptive analysis	Emergency Department security records	115 incidents identified	States that Institutional Review Board Approval was not required	115 incidents of weapons- related violence with examples described Descriptive statistics	Conclusions and recommendations are based on the results of the study and are informative. However recommendations may not be relevant to an international audience	Not stated
Brayley, J., Lange, R.,	2 Drs 3	Australia 1994	Aggressor demographics	1 Teaching	Retrospective review of	Medical notes	282 incidents	Not discussed	Reported 282 violent incidents, identifies	The strength of this paper is the broadening	Not stated

Baggoley, C., Bond. M. and Harvey, P. (1994). The violence management team: An approach to aggressive behaviour in a general hospital. *The Medical Journal of Australia,* 161 (4): 254-258.	occupations not stated		Shift variables Aggressor management Client presentation/situational factors	Hospital including the ED	previous 44 months`	following attendance to violent incidents	identified		medical presentation of patients implicated and subsequent medical management Descriptive statistics	of the data analysis to describe patient consequences related to medical management	
Graydon, J., Kasta, W. and Khan, P. (1994). Verbal and physical abuse of nurses. *Canadian Journal of Nursing Administration,* 7 (4): 70-89.	2 Nursing Academics 1 Clinical Nurse Specialist	Canada 1994	Victim demographics Verbal abuse Physical violence Hospital location Aggressor characteristics Shift variables Educational preparation Aggressor management Psychological impact	3 hospitals, a large teaching hospital, a psychiatric hospital and a community hospital including the ED	Analysis of abuse over 5 previous working days	Postal survey	2344 nurses were invited to participate and 603 (25.7%) responded	Confirmed	199 (33%) of respondents experienced abuse in the previous 5 working days, abuse most frequently experienced in extended and emergency care areas. Inferential statistics	The results are not clearly presented as it is not possible to extract specific data related to emergency nurses. Sample size is small	Stated

			Reporting practices Client presentation/situational factors								
Schneiden, V. and Marren-Bell, U. (1995). Violence in the accident and emergency department. *Accident and Emergency Journal,* 3 (2): 74-78.	1 Academic Researcher 1ED Manager	UK 1995	Physical violence Shift variables Verbal abuse Timing variables Educational preparation Reporting practices	National study	Time frame not identified	Postal Survey	300 participants invited and 196 questionnaires were returned (response rate 65%)	Not discussed	Identified high levels of violence and verbal abuse, perceived associations between physical violence and medication, verbal violence and waiting times, verbal violence and night shifts and a lack of formal training and debriefing Descriptive statistics	Although focussing on emergency department nursing staff the supporting literature is over reliant on studies from the mental health setting. No time frame related to responses	Not stated
Ganzini, L., Edwards, P., Surkan, P. J. and Drummond, D. J. (1995). Characteristics of violent elderly in the emergency department. *International Journal of Geriatric Psychiatry,* 10 945-950.	4 Drs	USA 1995	Aggressor demographics Physical violence Aggressor management Verbal abuse Weapons use Client presentation/situational factors	1 urban veteran affairs medical centre including the ED	A 5 year retrospective study	Data extracted from Dangerous Behaviour Reports Medical Records	236 reports were reviewed cross referenced with medical notes	Not discussed	21 incidents of elderly patients being involved in 26 violent acts. Emphasises the variables of substance abuse and mental health issues. Emphasised a statistically significant greater risk of younger attenders committing acts of violence ($p < 0.0001$). Inferential statistics	Very clear objectives that could be realistically achieved	Stated

Whittington, R. Shuttleworth, S. and Hill, L. (1996). Violence to staff in a general hospital setting. *Journal of Advanced Nursing,* 24: 326-333.	1 Nursing Academic 1 Dr 1 Scientific Officer	UK 1996	Victim demographics Physical violence Verbal abuse Verbal threats Educational preparation Psychological consequences Client presentation/situational factors	1 general hospital in the north west of England including the ED	1 year retrospective study	Postal survey Interviews	905 staff members invited to participate of which 343 responded (38%) 101 staff randomly invited to participate in interviews of which 53 responded (52%)	Confirmed	10% of incidents of physical assault reported to occur in the emergency department Inferential statistics	Very low response rate from ED staff (n=7). Only paper to take a mixed method approach Examined from the perspective of Poyner and Warne`s Model of Workplace Violence	Not stated
Rose, M. (1997). A survey of violence towards nursing staff in one large Irish A and E department *.Journal of Emergency Nursing,* 23 (3): 214-219.	1 clinical nurse	Ireland 1997	Physical violence Psychological consequences Reporting practices Verbal abuse Police involvement Physical consequences Educational preparation	Site specific ED	Career experiences	Questionnaire	27 of 36 staff invited to participate (rr 75%)	Not discussed	60% of respondents reported being physically assaulted, 40% in the last 12 months`, 91% of respondents worried about being physically assaulted, identifies lack of formal reporting of incidents Descriptive statistics	A lack of clarity related to operationalised definitions of verbal abuse and physical assault. A small sample size	Not stated
Presley, D. (1998).	Not stated	USA 1998	Victim demographics	An undisclose	Not stated	Postal questionn	A convenien	Not discussed	10% of responders reported being	A small study presented as an abstract due to	Not stated

Emergency Staff perspectives on violence and safety in the emergency department. *Journal of Emergency Nursing,* 24 (5): 390.			Physical violence Reporting practices Educational preparation Staffing patterns Psychological consequences	d number of ED`s		aire originally developed by Poster and Ryan (1986)	ce sample of 101 emergency staff rr not stated		assaulted more than 10 times in their careers and 68% reported the most recent assault occurred in the previous 6 months` Descriptive statistics	word limitation	
Jenkins, M. G., Rocke, L. G., McNicholl, B. P. and Hughes, D. M. (1998). Violence and verbal abuse against staff in the A and E departments: a survey of consultants in the United Kingdom and Republic of Ireland. *Journal of Accident and Emergency Medicine,* 15 (4): 262-265.	4 researchers, 1 identified as a Dr	UK and Ireland 1998	Hospital location Security measures Physical violence Verbal abuse Reporting practices Aggressor characteristics Client presentation/situational Victim characteristics Psychological consequences Staffing levels	National study	1 year retrospective study	Postal questionnaire	310 ED consultants invited to participate resulting in a response rate of 273 (n=273, rr 88%)	Not discussed	The questionnaire generated a huge amount of data highlighting and implicating alcohol, waiting times, recreational drug usage and unrealistic patient expectations as contributing to violence. The paper identified a variety of staff injuries and variables in security measures Descriptive statistics	The study presents some interesting perceptions but is hampered by any evidence of a literature review.	Not stated

			Timing variables								
Zernike, W and Sharpe, P (1998). Patient aggression in a general hospital setting: Do nurses perceive it to be a problem? *International Journal of Nursing Practice,* 4 (2) 126-133.	1 Nurse researcher 1 nurse educator	Australia Brisbane 1998	Factors leading to the incident The nature of the incident Management and outcome of the incident Aggressor demographics	The study was conducted in a general hospital setting including the ED	Data collected over a six month time period	Prospective analysis of incident forms and staff interviews	68 completed incident forms	Not discussed	26 incidents identified as having the potential for the development of aggressive behaviour Identified a potential trigger factor related to changes in medical management Identified the majority of incidents reported at night or during evening shifts Identified a perception that aggression was inevitable in certain circumstances Identified physical assaults and verbal abuse Identified a variety of consequences for staff and aggressors Descriptive statistics	The paper fails to consider ethical approval and names the host organisation for data collection Instruments utilised for data collection are unclear as the study reports on the findings of incident form analysis but later indicates staff were interviewed The papers authors are not clear in relation to their opperationalised definitions A large amount of data was collected but only a limited discussion is offered The paper reports findings in an overly generisable style. There is no way of identifying how many incidents occurred in the ED or the specific nature of these incidents. Subsequently a critique of the paper was relevant but findings could not be integrated into the literature review except to note that ED violence was highlighted as a problematic issue	Not stated

										for the organisation conducting the study	
Fernandes, C, M, B, Bouthillette, F, Raboud, J, M, Bullock, L, Moore, C, F, Christenson, J, M, Grafstein, E, Rae, S, Ouellet, L, Gillrie, C and Way, M (1999) "Violence in the emergency department: a survey of health care workers" *Canadian Medical Association Journal* Nov 11 1-6	3 Drs 6 nursing staff 2 nursing academics	Canada, Vancouver 1999	Physical violence Verbal abuse Educational preparation Post- incident consequences	Site specific ED	1 year retrospective study	Questionnaire	Of 163 staff members approached 105 (65%) completed the survey	Confirmed	57% of sample reported being physically assaulted and 68% reported an increased frequency of violence over time Inferential statistics	No literature review offered, non responders not followed up	Stated
Cooke, M. W., Higgins, J. and Bridge, P. (2000). *A and E The Present State*.	3 Drs	England 2000	Security measures Violent incidents resulting in lost staff time	National study	1 year retrospective study	Questionnaire	137 (43% rr)	Not discussed	Departments experienced an average of one attack on staff in the last year which resulted in lost staff time (Total 63 attacks)	Did not consider psychological consequences or injuries not resulting in time off work	Not stated

Universities of Warwick and Birmingham: Emergency Medicine Research Group.									Descriptive statistics		
Erickson, L. and Williams-Evans, A. (2000). Attitudes of emergency nurses regarding patient assaults. *Journal of Emergency Nursing,* 26: 210-215.	1 staff nurse 1 nurse consultant	USA Mid West 2000	Hospital location Victim demographics Shift variables Physical violence Reporting practices Psychological consequences	2 site specific ED`s	Not stated	Retrospective questionnaire based upon Poster and Ryan (1998) Patient Physical assault questionnaire	ED RN`s, a convenience sample, response rate 98% (n=55)	Confirmed	82% of respondents had been assaulted in their careers, 56% assaulted in the previous year and 29% of incidents went unreported Inferential statistics	A high quality study utilising a previously validated questionnaire, a high response rate, clear objectives and informative discussion	Not stated
Lyneham, J. (2000). Violence in New South Wales emergency departments. *Australian Journal of Advanced Nursing,* 18 (2): 8-17.	nursing academic	Australia NSW 2000	Security measures Hospital location Physical violence Verbal abuse Location of incidents Psychological consequences	study of New South Wales members of the Emergency Nurses Association	Not stated	Retrospective questionnaire based on seven themes developed through semi - structured interviews	Interviewees identified through network sampling, questionnaire response (n=266), 11.9% of the total number of ED nurses	Confirmed	High levels of all manifestoes of violence, 92 incidents of weapons- related incidents, 53 incidents of opportunistic weapons use Inferential statistics	A good paper, a clear results section although utilising respondent demographics and inferential statistical analysis may have improved the results section. The paper would also have benefited from an improves response rate as the low response rate 11.9% of the total number of ED nursing staff in NSW could be an	Not stated

			Weapons use Aggressor demographics Security assistance Clinical presentation/situational factors Reporting practices Post- incident support Police involvement Educational training				in NSW			unrepresentative sample	
Lee, F. (2001). Violence in A and E: the role of training and self-efficacy. *Nursing Standard,* 15 (46): 33-41.	clinical psychologist	New Zealand 2001	Victim demographics Educational preparation Physical violence Verbal abuse Psychological consequences	2 site specific ED`s	Retrospective 3 month study	Questionnaire	130 staff invited to participate resulting in a 58% response rate (n=76)	Confirmed	Identified high levels of verbal abuse, only 4% had never experienced verbal violence High levels of physical violence (79%) Examined aggression management training identifying extremely low levels of training in managing verbal abuse (2 respondents)	Could have utilised a triangulated approach comparing self reporting questionnaires with formal incident forms	Not stated

									Inferential statistics		
Winstanley, S. and Whittington, R. (2002). Violence in a general hospital: comparison of assailant and other assault-related factors on accident and emergency and inpatient wards. *Acta Psychiatr Scand,* 106 (412): 144-147.	1 academic 1 nursing academic	North west England 2002	Aggressor demographics Clinical presentation/Situational factors Incident location Physical violence Verbal abuse Security presence Shift variables	7 inpatient wards and 1 ED	3 month prospective study	Semi-structured interviews	Semi-structured interviews (n=48)	Not discussed	69 incidents identified, identified the variable of unintentional assaults Inferential statistics	A large sample size, concise presentation of results and evidence of a contribution to new knowledge by elaborating on un intentional injury. However the paper is limited due to a relatively small discussion and failure to clarify which incidents specifically related to the ED	Not stated
Adib, S. M., Al-Shatti, A. K., Kamal, S. El-Gerges, N. and Al-Raqem, M. (2002). Violence against nurses in healthcare facilities in Kuwait. International Journal of	3 Drs 2 nurses but roles not stated	Kuwait 2002	Victim demographics Verbal abuse Physical violence Weapons use Physical consequences Aggressor characteristics Shift variables	National cross-sectional study	6 month retrospective study	A cross sectional questionnaire	5876 responses (84%) of registered nurses in Kuwait	Confirmed	48% of respondents had experienced verbal violence and 7% physical violence. Opportunistic weapons identified and patients most likely perpetrators Inferential statistics	A very high response rate and clear explanation of inferential statistics that underpin results is offered. Literature review offered was not comprehensive and the discussion speculative. ED respondent results were not separated from the wider study	Stated

Nursing Studies, *39 (4): 469-478*.			Clinical presentation/situational factors Reporting practices Security involvement								
Fernandes, C. M., Raboud, J. M., Christenson, J. M., Bouthilitte, F., Bullock, L. Ouellet, L. and Moore, C. F. (2002). The effect of an education program on violence in the emergency department. *Annals of Emergency Medicine,* 39: 47-55.	2 Drs 1 academic 4 nursing staff	Canada 2002	Physical violence Verbal abuse Educational preparation Victim demographics Psychological consequences Physical consequences Aggressor management Client presentation/situational factors Reporting practices Location of incident	Site specific ED	Not stated	Cross-sectional prospective survey	687 (84%) of 789 questionnaires completed	Confirmed	27% of staff reported some type of physical violence during shifts Inferential statistics	An interventional study examining the impact of an educational programme, a high quality paper but results inconclusive	Stated
May, D. D.	1 nurse	USA	Victim	Site	1 year	Survey	125 staff	Confirme	88% of respondents	Only a short period of	Not stated

and Grubbs, L. M. (2002). The extent, nature and precipitating factors of nurse assault among three groups of registered nurses in a regional medical centre. *Journal of Emergency Nursing,* 28 (1): 11-17.	practitioner 1 nursing academic	Florida 2002	demographics Verbal abuse Weapons use Physical violence Physical consequences Aggressor characteristics Clinical presentation/situational factors Reporting practices Educational preparation Aggressor management Psychological consequences Racial tension	specific ED, ITU and general floor	retrospective study		were invited to participate and the response rate was 86 (68.8%)	d	reported verbal assault and 74% physical assault. ED staff reported 100% experienced verbal assault and 82.1% physical assault Inferential statistics	time (2 weeks) for data collection which may have influenced the response rate	
Atawneh, F. A., Zahid, M. A., Al-Sahlawi, K. S., Shahid, A. A. and Al-Farrah, M. H. (2003).	5 Drs	Kuwait 2003	Physical violence Physical consequences Psychological consequences Aggressor	Site specific ED	1 year retrospective study	Questionnaire	81 of 86 staff identified responded (rr 94%)	Confirmed	70 respondents reported verbal insults or threats 13 physical violence Inferential statistics	Very high response rate would have benefited from publishing the 12 item-frequency weighted questionnaire	Not stated

Violence against nurses in hospitals: prevalence and effects. *British Journal of Nursing,* 12 (2):102-197.			demographics Educational preparation Police involvement Reporting practices								
Merfield, E. (2003). How secure are our emergency departments? *Emergency medicine,* 15: 468-474.	1 Dr	Australia 2000	Security measures	National study of directors of Australasian College of Emergency Medicine	Data collected over a 1 month snap shot period	Questionnaire	n=70 88% response rate	Not discussed	Identified erratic levels of security Inferential statistics	Published the questionnaire utilised and focussed the discussion on the research questions	Not stated
Hesketh, K. L., Duncan, S. M., Estabrooks, C. A., Reimer, M. A., Giovannetti, P. Hyndman, K. and Acorn, S. (2003). Workplace violence in Alberta and British	7 nursing academics	Canada Alberta and British Columbia 2003	Physical violence Verbal abuse Reporting practices Aggressor demographics Psychological consequences	Alberta wide study	Retrospective 5 previous shifts	Postal questionnaire	12, 332 nurses invited to participate, response 6526 (52.8%) Emergency staff response 671	Not discussed	21.9% of respondents experienced physical assault and 39.9% threats Inferential statistics	The paper offers a very good description of the utilised instrument and defined categories of violence enhancing the reliability of the instrument	Stated

Columbia hospitals. *Health Policy,* 63 (3): 311-321.											
Dickson, G. C. A., Price, L., Maclaren, W. M. and Stein, W. M. (2004). Perceptions of risk: a study of A and E nurses and NHS managers. *Journal of Health Organisation and Management* , 18 (5): 308-320.	1 academic 3 other roles not stated	Scotland Glasgow 2004	Risk of violence	5 Specific ED`s	Not stated	Questionnaire	270 nurses invited to participate , 110 responded (41%) 132 managers invited to participate and 42 responded (38%)	Not discussed	Higher perceptions of risk of violence were reported by nurses as opposed to managers Inferential statistics	The questionnaire was piloted and a clear presentation of results is offered. However comparing responses with hospital records of violent incidents may have enhanced the validity of the study	Stated
Crilly, J., Chaboyer, W. and Creedy, D. (2003). Violence towards emergency department nurses by patients. *Accident and*	2 nursing academics 1 clinical nurse	Australia New South Wales 2003	Victim demographics Physical violence Shift variables Verbal abuse Incident location Aggressor	2site specific ED`s	Data collected prospectively over a 5 month period	A descriptive, prospective longitudinal cohort design	108 nurses invited to participate , 71 responded (66%)	Confirmed	70% reported experiences of violence Inferential statistics	Well presented results section, reasonable response rate, and piloted questionnaire. However, a superficial literature review utilising mental health literature. The literature review fails to identify important themes	Not stated

Emergency Nursing, 12: 67-73.			management Timing variables Clinical presentation/situational factors Failure of aggressor to wait for treatment								
Winstanley, S. and Whittington, R. (2004. Aggression towards health care staff in a UK general hospital: variation among professions and departments. *Journal of Clinical Nursing,* 13 3-10.	2 nursing academics	North West England 2004	Victim demographics Physical violence Verbal abuse Aggressor demographics	1 Hospital wide study including the ED	1 year retrospective study	Questionnaire	1141 invitations to participate and 375 returned (response rate 33%) ED response 13	Confirmed	30.8% of ED respondents experienced physical assaults and 75% experienced verbal aggression Significantly more respondents from the ED experienced threatening behaviour from patients and visitors Inferential statistics	Defined physical assault, threatening behaviour and verbal abuse contributing to the reliability of the study but reported a very small ED specific sample (n=13)	Not stated
Ergun, S. F. and Karadakovan, A. (2005). Violence towards nursing staff in	2 nursing academics	Turkey Imzir 2005	Victim demographics Physical violence Verbal abuse Shift variables	4 site specific ED`s	career experiences	Questionnaire	92 nursing staff invited to participate and 66 responded (n=66, response	Confirmed	98.5% of responders reported verbal violence and 19.7% physical violence 83.%% of incidents went unreported Inferential statistics	Well presented results section that meets the research aims with good use of the literature in the discussion	Not stated

emergency departments in one Turkish city. *International Nursing Review,* 52: 154-160.			Reporting practices Educational training Psychological consequences Physical consequences				rate 72%)				
Knott, J. C., Bennett, D., Rawet, J. and Taylor, D. (2005). Epidemiology of unarmed threats in the emergency department. *Emergency Medicine Australasia,* 17: 351-358.	2 Drs 1 nurse researcher 1 clinical nurse	Australia Melbourne 2005	Aggressor demographics Clinical presentation/situational factors Shift variables Location of incident Timing variables Physical violence Physical consequences Verbal abuse Aggressor management Police involvement Security	Site specific ED	1 year prospective study	Analysis of hospital records based on "code grey" calls	Analysis of written records describing 151 incidents	Confirmed	Verbal or physical violence reported in 104 incidents Demographics of aggressors Inferential statistics	No literature review offered, no explanation, results offered difficult to appreciate due to presentation. Identified a competing interest in that 1 author is also journal section editor	Stated

			involvement								
Landy, H. (2005). Violence and aggression: how nurses perceive their own and colleagues` risk. *Emergency Nurse,* 13 (7): 12-15.	1clinical nurse	UK 2005	Victim demographics Verbal abuse Physical violence Risk of violence Reporting practices	Site specific ED, ITU and medical ward	Not stated	Questionnaire	75 staff invited to participate response rate 40 53% 13 ED staff responded	Not discussed	Results suggest violence is also prevalent in other areas than ED`s Inferential statistics	No abstract, no clear identification of aims Very small sample size which calls into question the validity of inferential statistics offered	Not stated
Ryan, D. and Maguire, J. (2006). Aggression and violence-a problem in Irish Accident and Emergency Departments? *Journal of Nursing Management*, 14: 106-115.	2 nursing academics	Ireland 2006	Victim demographics Physical violence Verbal abuse Educational preparation	2 site specific ED`s	4 week retrospective study	Questionnaire	80 staff invited to participate (response n=37, 46%)	Not discussed	80.5% reported threatening verbal aggression 38.9% sever violence Emphasised experiences of service users spitting Inferential statistics	Utilised and adapted a previously validated questionnaire, relatively short period for consideration (1 month). Small sample size	Not stated
Gates, D. M., Ross, C. S. and McQueen, L. (2006). Violence:	1 nursing academic 1 Dr 1 nurse	USA Cincinnati, Ohio 2006	Victim demographics Verbal abuse Physical violence	5 site hospital wide study including the ED	6 month retrospective study	Questionnaire	242 responders of approximately 600 workers	Confirmed	Reported 319 assaults by patients and 10 assaults by visitors. Identified 65% of assaults were not	The paper defines the study variables relating to definitions of violence adding to the reliability of the study. However presented results do not	Stated

Recognition, management and prevention Violence against emergency department workers. *The Journal of Emergency Medicine,* 31 (3): 331-337.			Reporting practice Client presentation/situational factors Staffing factors Educational preparation Security measures Psychological; consequences				invited. Of this group 95 (39.4%) were registered nurses		reported and 64% of respondents had not received any training over previous 12 months` Descriptive statistics	allow for in depth analysis of ED staff responses	
Erkol, H., Gokdogan, M. R., Erkol, Z. and Boz, B. (2007). Aggression and violence towards health care providers-a problem in Turkey? *Journal of Forensic and Legal Medicine*, 14: 423-428.	4 Drs	Turkey 2007	Victim demographics Verbal abuse Incident location Timing variables Clinical presentation/situational Physical violence Verbal abuse Reporting practices Security involvement	4 site specific ED`s	career experiences	Questionnaire	124 responders of which 44 (35.48%) were nurses/midwives.	Not discussed	87.1% of responders experienced aggressive behaviour 36.9% of incidents occurred in the ED waiting room and 11.9% of incidents in triage Descriptive statistics	The major dilemma with this study is the fact that nursing and midwifery staff are grouped together. Due to the large amount of demographic data collected inferential statistics could have been utilised.	Not stated

			Educational preparation								

APPENDIX 3: SUMMARY OF PAPERS PRESENTING QUALITATIVE DATA.

Reference	**Author Occupation**	**Date and County**	**Site**	**Methodology**	**Time**	**Instrument**	**Sample**	**Ethical Approval**	**Trustworthiness**	**Results**	**Critique**	**Funding**
Jeffery, R. (1979). Normal rubbish: deviant patients in casualty departments. *Sociology of Health and Illness*, 1 (1): 90-107.	Academic (School of Sociology)	UK 1979	3 ED`s	Not stated	Data collected over seven months`	Field work notes Tape recorded open ended interviews	17 junior doctors	Not discussed	Evidence of thick description Limited evidence of an audit trail Credibility enhanced through use of direct quotations Limited dependability Data triangulation Limited information related to periods of field work	Categorised emergency at attenders as “Good” or “Rubbish” in the opinion of the medical (and nursing) staff	Although focusing on doctors nursing staff are implicated and the strength of this paper lies in the intimate association between written quotations and observations offered and the development of an intellectual perspective	Not stated

Blank, C. A. and Mascitti-Mazur, J. E. (1991). Violence in Philadelphia emergency departments reflects national trends. *Journal of Emergency Nursing,* 17 (5): 316-321.	1 Trauma nurse coordinator (RN) 1 Researcher (RN)	USA 1991	7 ED`s	Not stated	Not stated	Informal telephone survey	7 ED nurse managers	Not discussed	Transferability limited due to lack of thick description Confirmability limited by lack of an audit trail Results not fed back to respondents Concerns relating to the richness of data identified through a telephone survey	Identified concerns relating to a lack of a comprehensive , holistic security policy, the presentation of attenders with traditional weapons and weapons customised for maximum impact and a perception that abusive behaviour was precipitated by lengthy waiting times, overcrowded waiting rooms, previous problematic ED encounters, patients perceptions of being ignored and a lack of social service support	The paper is informative but the "informal" nature, small sample size and over reliance on anecdotal evidence to develop the discussion effects the papers quality	Not stated
Akerstrom, M. (1997). Waiting-a source of hostile interaction in an	Academic (School of Sociology)	Sweden 1997	1 ED	Not stated	The fall of 1990 with a few follow up interviews in the	Semi-structured taped interviews Field observations	ED staff including various grades of nursing staff and receptioni	Not discussed	Single site raising questions related to transferability	Themed related to the processing of patients and conflict related to hostile patient and	The major shortcoming of this paper is the lack of attention to detail in relation to audit trails and reproducing the study	Not stated

emergency clinic. *Qualitative Health Research,* 7 (4): 504-520.					spring of 1995	2 researchers involved in data collection	sts. Exact number not stated		Limited evidence of a clear audit trail Data not fed back to respondents Data triangulation Limited information related to field observations	staff attitudes		
Levin, P. F., Hewitt, J. B. and Misner, S. T. (1998). Insights of nurses about assault in hospital based emergency departments. *Image-Journal of Nurse Scholarship,* 30 (3): 249-254.	2 nursing academics 1 Doctoral student	USA 1998	One large metropolitan area of the USA	An ecological, occupational health framework	Not stated	Focus groups	22 Registered Nurses divided into 4 focus groups	Not discussed	Evidence of thick description Poor audit trail Credibility enhanced by themes being fed back to clinical staff Focus groups added to the dependability of the study	14 themes emerged	An in depth review of the wider literature related to workplace violence. Use of a framework for analysis but a weak method section that fails to address ethical issue or participant recruitment clearly. Results tend to be presented rather than critiqued and explored and reference to the study limitations was superficial.	Not stated

Christensen, D. C. and Marshall, E. (1998). Nurses responses to acts of violence by patients in the emergency department. *Journal of Emergency Nursing,* October 24 (5):387.	Not Stated	USA 1998	2 ED`s	Not stated	Not stated	Semi-structured taped interview	9 nursing staff	External audit	Poor presentation of results no evidence of thick description Identifies an audit trail but further information not offered Results not fed back to respondents Poor audit trail related to decisions	Identified themes through content analysis, "Responding to the Act", "Changing practice", and "Looking Back"	A small study but did highlight areas for future study	Not stated
Catlette, M. (2005). A descriptive study of the perceptions of workplace violence and safety strategies of nurses working in Level 1 trauma centres. *Journal of Emergency Nursing,* 31 (6): 519-525.	1 nurse researcher	USA 2005	2 ED`s	Framed within patterns of knowing (ethical, empirical, intuition, aesthetics) (Carper 1978)	Not stated	Structured interviews	8 ED nursing staff	Confirme d	Evidence of thick description Data not fed back to respondents An audit of decisions is offered but it is limited	Identified 2 key themes related to inadequate safety measures and vulnerability	Good use of quotations to support the presentation of results and the subsequent discussion	Not stated
Luck, L.,	3 nursing	Australia	1 ED	Instrumental	Data	Participant	20 ED	Confirme	Evidence of	Identified 3	A triangulated approach	Not stated

Jackson, D. and Usher, K. (2007). Innocent or culpable? Meanings that emergency department nurses ascribe to individual acts of violence. *Journal of Clinical Nursing,*	academics	2007		Case study	collected over a 5 month period	observation Semi-structured interviews Informal field interviews Researcher journaling	RN`s	d	thick description Member checking confirming identified themes Clear audit of decisions Evidence of data triangulation Explanation of periods of observations offered	core themes relating to judgements regarding experiences Identified that of 16 violent incidents observed none were reported	contributed to the rigour of the study. Clear presentation of the research process	

APPENDIX 4: AGGRESSOR CLASSIFICATION

Type 1

The perpetrator has no legitimate relationship with the targeted organisation or its employees and enters the work environment to commit a criminal act. In the healthcare context this would be, for example, a car thief entering the facility to commit a crime.

Type 2

The aggressor has a legitimate relationship with the organisation and commits an act of aggression whilst being served by the organisation. This individual could be a patient, a service users relative, friend or visitor. The incident could be either intentional or unintentional. An example would be an intoxicated service user threatening staff. The key point is that this person believes they have a legitimate reason for being within the facility.

Type 3

The aggressor is a current or former employee (an insider) who targets a co-worker or supervisor for perceived wrong doing. In the healthcare context this includes nursing staff being involved I bullying or harassment or staff lacking respect for their employing organisation.

Type 4

The aggressor has an ongoing or previous legitimate relationship with an employee of the organisation. This group, could, for example, include employees or partners who are engaged in domestic violence.

APPENDIX 5: EXAMPLES OF PARTICIPANT INFORMATION SHEETS AND CONSENT FORMS.

Participant Information Sheet (A) (version 1)

Title of the study

Nursing staff experiences and responses to violence and aggression in the emergency department: a grounded theory study.

An invitation to participate in a research study

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish and please ask me if there is anything that is not clear or if you would like more information. Making an informed decision on participation is important so please take your time when deciding whether or not you wish to take part.

What is the purpose of the study?

Research literature suggests that internationally emergency nurses are concerned regarding levels of violence, aggression, intimidation and verbal abuse they experience at work. The wider aim of this study is to capture the realities of clinical practise and;

- To identify how emergency department nursing staff define violence and aggression in the clinical area.
- To explore situational factors that influence, encourage or minimise the development of violent and aggressive situations in the emergency department.
- To explore the behaviours of emergency nursing staff in relation to formally reporting experiences of violence and aggression in the clinical area.

Why have I been chosen?

All qualified nursing staff practising in the department are invited to participate.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. It is important that you understand that participation is entirely voluntary, you do not have to give a reason for not taking part and if you do agree to participate you may still withdraw at any time without giving a reason.

What will happen to me if I take part?

All qualified nursing staff agreeing to participate will be asked to complete the attached consent form supplying contact details. I am asking you to agree to being interviewed regarding your experiences of violence and aggression in the emergency department.

Interviews will take approximately one hour and will be tape recorded and transcribed by myself. The interviews will be conducted in private and will be arranged at a time and place convenient to you.

What do I have to do?

If you are willing to participate please complete the consent form and return to the researcher in the sealed, self addressed envelope. A box for collecting consent
forms has been placed in the staff coffee room.

What are the possible disadvantages and risks of taking part?

This study is of an extremely sensitive nature that involves participants being asked to reflect on experiences they may have found potentially frightening or stressful. This may cause anxiety prior, during or following the interview. A fundamental role of the researcher is to strive to protect participants from harm during the research process and so I am very happy to be contacted at any stage by staff who have or develop concerns as the study progresses. Participants may also wish to consider contacting services within the hospital such as the staff counselling service (020 8333 3149).

What are the possible benefits of taking part?

The views of emergency department nursing staff are very important and this research is a format for staff to raise issues that concern them or that they feel passionate about. In the short term discussions related to experiences of aggression may be therapeutic although there is a possibility that focusing on such events could have negative consequences. In the long term the conclusions and recommendations offered by this study could influence strategies designed to improve personal safety in the emergency department.

What happens when the research study stops?

Handling, storage and destruction of the data will be in compliance with the Data Protection Act 1998. All data will be anonymised and transcripts and data analysis procedures will be carried out and stored on a password protected computer. The data will be used in a research report but anonymised before being included in the report, so that nothing you say can be linked to you.

Will my taking part in the study be kept confidential?

All the information about your participation in this study will be kept confidential.

What if I am concerned with any aspect of the study or change my mind about taking part?

If you have any further questions or are unsure about anything related to this study please contact me, my contact details are:

Terry Ferns
University of Greenwich, School of Health and Social Care
Grey Building, Southwood Site, Avery Hill Rd, London

SE9 2UG

Tel 020 8331 8000 Ext 9985 E mail T.Ferns@gre.ac.uk

In addition you may withdraw from the research at any time without question.

Who is organising and funding the research?

The research is organised through the University of Greenwich.

What should I do next?

If you agree to participate please complete the consent and contact details form.

CONSENT FORM (A) Version 1

Title of Project: Nursing staff experiences and responses to violence and aggression in the emergency department: a grounded theory study.

Name of researcher: Terry Ferns

To be completed by the participant: (please circle)

I confirm that I have read the information sheet about this study YES/NO

I confirm that I have had an opportunity to ask questions and discuss this study YES/NO

I confirm that I understand that my participation is voluntary;
YES/NO

I confirm that I understand that I am free to withdraw from this study;

- At any time
  YES/NO

- Without giving a reason for withdrawing
  YES/NO

I understand that the information I will give will be kept confidential and all data will be anonymised;
YES/NO

I understand that direct quotations from interviews may be incorporated into the thesis but they will be anonymised; YES/NO

I agree to take part in the study; YES/NO

Signed Date

Name in block letters

Home address and telephone number

To be completed by the researcher:

Signed Date

Name in block letters

Participant Information Sheet (B) Version 1

Title of the study

Nursing staff experiences and responses to violence and aggression in the emergency department: a grounded theory study.

An invitation to participate in a research study

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish and please ask me if there is anything that is not clear or if you would like more information. Making an informed decision on participation is important so please take your time when deciding whether or not you wish to take part.

What is the purpose of the study?

Research literature suggests that internationally emergency nurses are concerned regarding levels of violence, aggression, intimidation and verbal abuse they experience at work. The wider aim of this study is to capture the realities of clinical practise and;

- To identify how emergency department nursing staff define violence and aggression in the clinical area.
- To explore situational factors that influence, encourage or minimise the development of violent and aggressive situations in the emergency department.
- To explore the behaviours of emergency nursing staff in relation to formally reporting experiences of violence and aggression in the clinical area.

Why have I been chosen?

All qualified nursing staff practising in the department are invited to participate.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. It is important that you understand that participation is entirely voluntary, you do not have to give a reason for not taking part and if you do agree to participate you may still withdraw at any time without giving a reason.

What will happen to me if I take part?

I am asking you to agree to being observed while working as an emergency department nurse. The focus of the study is the day to day behaviour of emergency nursing staff related to managing personal safety. The study does not revolve around making judgements regarding individual practise nor will observation occur during periods of intimate care delivery.

What do I have to do?

If you are willing to participate please complete the consent form and return to the researcher in the sealed, self addressed envelope. A box for collecting consent forms has been placed in the staff coffee room.

What are the other possible disadvantages and risks of taking part?

This study is of an extremely sensitive nature. This may cause anxiety prior, during or following the research process. It is potentially stressful consenting to being observed when practising as an emergency care nurse. A fundamental role of the researcher is to strive to protect participants from harm during the research process and so I am very happy to be contacted at any stage by staff who have or develop concerns as the study progresses. Participants may also wish to consider contacting services within the hospital such as the staff counselling service (020 8333 3149).

What are the possible benefits of taking part?

The views of emergency department nursing staff are very important and this research is a format for staff to raise issues that concern them or that they feel passionate about. The data collected from observing practise can be used as a format for promoting high quality nursing care and in the long term the conclusions and recommendations offered by this study could influence strategies designed to improve personal safety in the emergency department.

What happens when the research study stops?

Handling, storage and destruction of the data will be in compliance with the Data Protection Act 1998. All data will be anonymised and transcripts and data analysis procedures will be carried out and stored on a password protected computer. The data will be used in a research report but anonymised before being included in the report, so that nothing you say or do can be linked to you.

Will my taking part in the study be kept confidential?

All the information about your participation in this study will be kept confidential.

What if I am concerned with any aspect of the study or change my mind about taking part?

If you have any further questions or are unsure about anything related to this study please contact me, my contact details are:

Terry Ferns, University of Greenwich, School of Health and Social Care
Grey Building, Southwood Site, Avery Hill Rd, London, SE9 2UG

Tel 020 8331 8000 Ext 9985 E mail T.Ferns@gre.ac.uk

In addition you may withdraw from the research at any time without question

Who is organising and funding the research?

The research is organised through the University of Greenwich.

What should I do next?

If you agree to participate please complete the consent and contact details form.

CONSENT FORM (B) Version 1

Title of Project: Nursing staff experiences and responses to violence and aggression in the emergency department: a grounded theory study.

Name of researcher: Terry Ferns

To be completed by the participant: (please circle)

I confirm that I have read the information sheet about this study;
YES/NO

I confirm that I have had an opportunity to ask questions and discuss this study;
YES/NO

I confirm that I understand that my participation is voluntary;
YES/NO

I confirm that I understand that I am free to withdraw from this study;

- At any time
  YES/NO

- Without giving a reason for withdrawing
  YES/NO

I understand that the information I will give will be kept confidential and all data will be anonymised;
YES/NO

I agree to take part in the study; YES/NO

Signed Date

Name in block letters

Home address and telephone number

To be completed by the researcher:

Signed Date

Name in block letters

APPENDIX 6: A PUBLIC HEALTH AND SOCIAL SUMMARY OF THE HOSPITAL CATCHMENT AREA

Appendix 6 briefly summarises the key characteristics of the borough the ED site, chosen for this study, serves. In order to ensure confidentiality and anonymity the borough will be referred to as X (this strategy is also applied to the reference list).

Background

The characteristics of the hospital catchment area are important when considering issues related to emergency nursing staff experiences of violence because the hospital catchment area characteristics dictate the demographics of service users who access the service. Szuster, Schanbacher, and McCann (1990) comment that the demographic characteristics of those attending ED`s for reasons associated with alcohol and substance abuse were male sex, younger age, unemployment and higher levels of social deprivation while Plant, Plant and Thornton (2002) note that evidence from the Scottish Crime Survey indicates that victims of crime are more likely to live in rented accommodation as opposed to owner occupier housing, and residents living in high rise accommodation are most at risk of experiencing violent assault. Skogan (1990) found that the area in which people lived was a more significant indicator of the number of disorders they reported rather than any one personal characteristic and disorder was most common in areas with low neighbourhood stability, poverty and high ethnic minority populations.

The London Borough of X; a summary

The following summary related to the London Borough of X is taken from the following publications;

- London Borough of X Local Implementation Plan Chapter 1, Local Demographic, Social and Environmental Context.
- Select committee on Office of the Deputy Prime Minister: Housing, Planning, Local Government and the Regions. Memorandum by the London Borough of X (HOM 26).
- X Health Profile (2004) X Primary Care Trust.
- Crime in England and Wales 2001/2002 Home Office.

The London Borough of X is the third largest inner London borough and is situated in the south-east of London. According to the 2001 census, X has a population of 248,922. Super Output Areas have been devised in a constant way across the whole of England each with a population size of approximately 1,500 people. X is one of the capital`s least wealthy boroughs and despite improvements in recent years, fifty four (32.5%) of X`s Super Output Areas (SOA`s) were ranked within the 20% most deprived in England according to the Index of Multiple Deprivation (2004), three of those SOA`s were also in the worst 10%. Four of X`s wards have more than 80% of their SOA`s in the 20% most deprived category. The Index of Multiple Deprivation combines indicators across seven key domains;

- Income
- Employment
- Health Deprivation and Disability

- Barriers to Housing and Services
- Education, Skill and Training Deprivation
- Living Environment Deprivation
- Crime

Overall X was ranked as the fifty seventh most deprived local authority in England and when looking at the average score of each individual domain, X is the thirty eighth most deprived local authority in England. Overall 4 out of 10 of X children live in households in poverty. In 2004, X's unemployment rate is 6.1% compared with a national average of 3.1%. Approximately a quarter of the population of X aged between 16 and 74 years do not have qualifications.

X benefits from an ethnically and culturally diverse population. The black and minority ethnic (BME) population is greater in the borough (34%) than the London average (28.9%) and comprises 50% of all school pupils. Twenty four percent of X's population were born outside the United Kingdom.

X has a higher proportion of homes rented from the Local Authority (26%) and a lower proportion that are owner occupied (50%) than is the case nationally. Over a third (34%) of households with dependent children in X is headed by a lone parent, usually the mother. Twenty seven percent of households with dependent children in X have no adults working. Almost 20% of X residents are in unsuitable accommodation and at present approximately 17,000 homes do not meet the decent homes standard; the highest proportion of those people live in council housing.

Disadvantaged groups are over represented amongst users of the homeless services for X. Members of black and ethnic minority groups make up 73% of all applications to the Homeless Persons Unit. For many homeless applicants English is not a first language. Women are also particularly over represented, and many of this client group are sole carers of children or have been the victims of domestic violence. Over 86% of homeless households receive some kind of welfare benefit and poverty is a key factor within many households. Car ownership in X is less than the London average with a greater proportion of X residents having no access to a car as opposed to the London average.

X has the eighth highest rate of teenage pregnancy in England, which means one of the highest rates in Europe. The conception rates of 15-17 year olds are significantly above the national average-5.3 per thousand in the United Kingdom, 80 per thousand in X. In 2002 X ranked seventh in London for premature deaths from all causes. Life expectancy at birth in 2002 for X residents was in the lowest 10% in England for males and in the lowest 5% in England for females. There is a higher infant mortality and post-neonatal mortality rate than nationally which correlates strongly with deprivation. X has a higher percentage of low birth weight babies than the national average. X has higher than average premature mortality and morbidity particularly from coronary heart disease, cancers and respiratory illnesses. About 19% of deaths of X residents are due to smoking. The death rate due to smoking in people over 35 years of age is approximately 30% greater than London.

According to the Home Offices crime statistics for 2001, X has one of the lowest crime rates in inner London. Crime figures for X (2001/2002) (Home Office Research Development Statistics) are listed below (Table 4).

Table 4 Crime rates for borough X.

Offences	Total	Rate per 1,000 population	Average rate per 1000 population in England and Wales
Violence against the person	5,501	22.4	10.9
Sexual offences	389	1.6	0.7
Robbery Offences	1, 966	8.0	1.5
Burglary Offences	2,612	10.6	6.5
Theft of motor vehicle	2,161	8.8	5.0
Theft from car	2, 371	9.6	10.9

In relation to domestic violence in 2003/2004 there were 2,436 recorded domestic violence offences ranking X as tenth out of the London boroughs.

Mortality from alcohol related conditions is significantly higher in X than the national average with male mortality 50% higher and female mortality 20% higher. It is estimated that 30,000 X residents either binge drink or are chronic drinkers. X has the fourth highest level of substance misuse of the six boroughs in the South East London Sector — 5.7 people per 1,000 residents aged between 15 and 44 were in drug treatment programmes in 2001-2002 (National Drug Treatment Monitoring System).

X has significantly higher rates of mental illness than England and Wales and suicides contribute significantly to the number of premature deaths in the borough. The Mental Illness Needs Index 2000 (MINI 2K) score for X for schizophrenia and other psychoses is 1:55 (England is 1). This score indicates that X has comparatively greater mental health needs than other Primary Care areas within the country.

APPENDIX 7: EXAMPLE OF THE OBSERVATIONAL STRATEGY PACK UTILISED

Observational Strategy

Holloway and Wheeler (2002)

How many people are present in the setting or take part in the activities?
What are their characteristics and roles?
What is happening in the setting?
What are the actions and rules of behaviour?
What are the variations in the behaviours observed?
Where do interactions take place?
Where are people located in the physical space?
When do conversations and interactions take place?
What is the timing of the activities?
Why do people in the setting act the way they do?
Why are there variations in behaviour?

Polit and Hungler (2004)

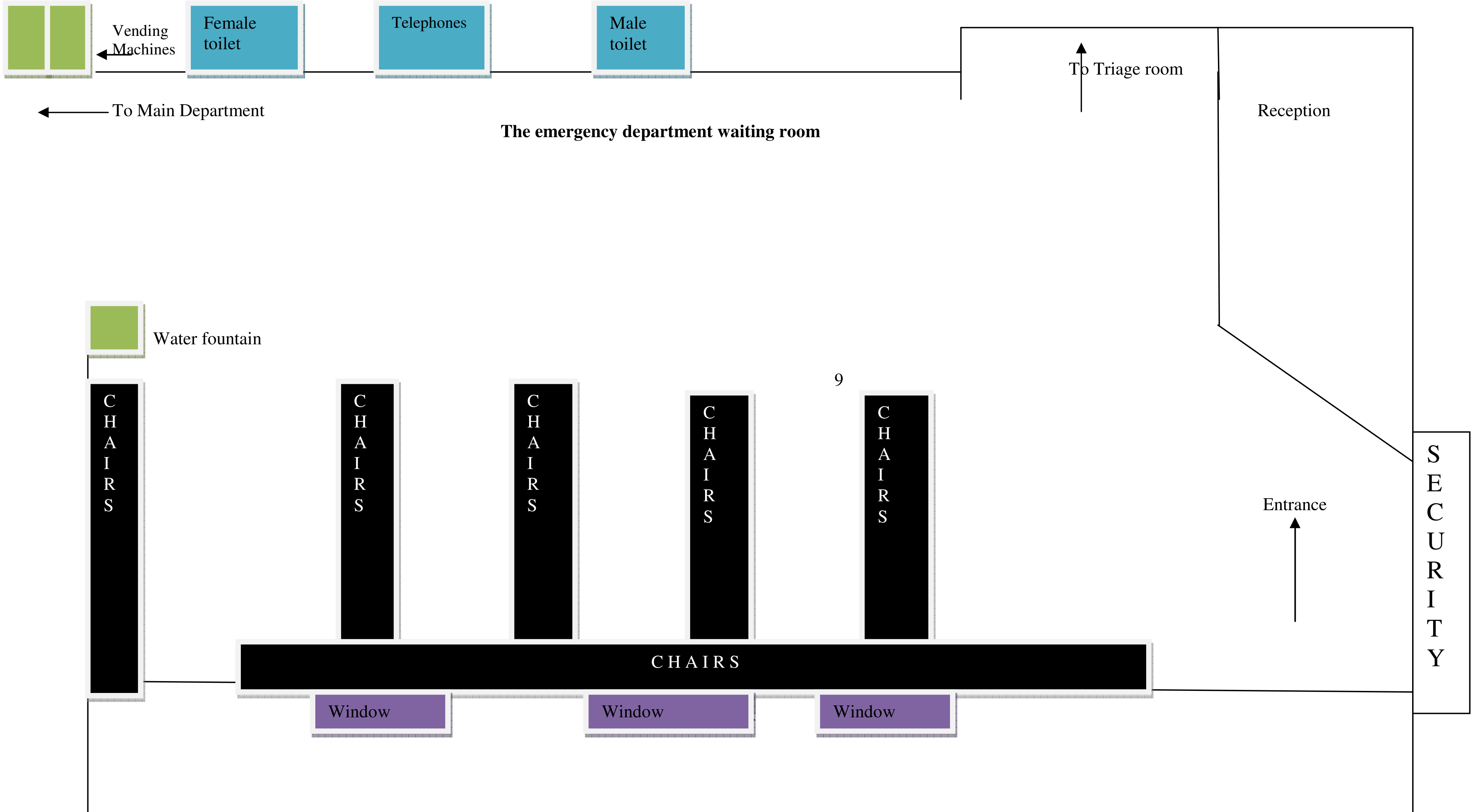
What are the main features of the physical setting?
What is the context within which human behaviour unfolds?
What types of behaviours and characteristics are promoted (or constrained) by the physical environment?
What are the characteristics of the people being observed?
How many people are there?
What are their roles?
Who is given free access to the setting-who "belongs?"
What brings these people together?
What is going on-what are the participants doing?
Is there a discernable progression of activities?
How do the participants interact with each other?
What methods do they use to communicate, and how frequently do they do so?
What type of affect is manifested during the interaction?
How are the participants interconnected to one another or to the activities underway?
When did the activity or event begin?
When in it scheduled to end?
How much time has elapsed?
Is the activity a recurring one and if so how regularly does it occur?
How typical of such activities is the one that is under observation?
Intangible factors What did not happen (especially if it ought to have happened?
Are the participants saying one thing verbally but communicating other messages non verbally
What types of things were disruptive to the activity or situation?

Observational notes

Objective descriptions of events and conversations: information such as time, place, activity and dialogue

Theoretical notes
Interpretive attempts to attach meanings to observation
Methodological notes
Instructions or reminders about how subsequent observations will be made
Personal notes
Comments regarding my own feelings

Observational Period	Time	Service users present	Service user behaviour	Words	Nurse Behaviour	Comments



Vending Machines
Female toilet
Telephones
Male toilet
To Triage room
Reception
To Main Department
The emergency department waiting room
Water fountain
CHAIRS
CHAIRS
CHAIRS
CHAIRS
CHAIRS
CHAIRS
Entrance
SECURITY
Window
Window
Window

Appendix 8: GLOSSARY OF RESEARCH TERMINOLOGIES AND SPECIALIST TERMS.

Abduction: is the process of inference, it is also used to mean just the generation of hypotheses to explain observations or conclusions.

Axial coding: axial coding involves relating the generated categories to their subcategories through the processes of induction (see below) and abduction (see above).

Bias: when a point of view prevents impartial judgment on issues relating to the subject of that point of view. Bias relates to factors, other than those investigated, which may influence the findings of a study.

Coding: the process of breaking up the data into segments to make sense of them.

Confirmability: a measure of the objectivity of the data, the extent to which data and interpretations reflect the phenomena of study.

Consent Form: a document explaining all relevant study information to assist the study volunteer in understanding the expectations and requirements of participation in a clinical trial. This document is presented to and signed by the study subject.

Constant comparison: the constant comparative method is a process whereby findings are verified and corrected on the basis of the data collected.

Credibility: a study has credible findings if they reflect the experience and perceptions of the participants. Those who read the report and any published articles must also view the findings as credible.

Deduction: deduction is the process of knowledge acquisition by the formulation of a theory or hypothesis and the collection of data thereafter in order to support or reject it.

Descriptive statistics: figures which summarize or describe a data set, without making any inferences or generalizations. All measures listed on this page are descriptive statistics. In contrast, there's inferential statistics, in which inferences are made about the data - such as using a sample to make estimate about a population.

Dependability: establishing dependability can be seen as a parallel process to that of confirming reliability in quantitative data. An audit trail of the research may assist in establishing dependability.

Dimensions: dimensions show the position of a property (see below) along a continuum or range.

Emergency department (ED): an **ED** is a healthcare treatment facility, specialising in acute care of patients who present without prior appointment, either by their own means or by ambulance. Due to the unplanned nature of patient attendance, the

department must provide initial treatment for a broad spectrum of potential illnesses and injuries, some of which may be life-threatening and require immediate attention. .

Emic perspective: gaining the insiders view.

Flip-flop technique: analysing data from multiple perspectives.

Forcing the data: attempting to force the data into a theory that does not fit.

Grounded theory: this term was coined by Glaser and Strauss (1967) to mean an inductive approach to research whereby hypotheses and theories emerge out of, or are "grounded" in, data.

Hot spot analysis: analysing data identifying trends or patterns. For example, identifying specific situations or trends resulting in workplace conflict.

Induction: this means that after a large number of observations have been made, it is possible to draw conclusions or theorise about particular phenomena.

Inferential Statistics: a branch of statistics that is concerned with the use of sample evidence and probability theory to make safe generalizations about the characteristics of a population. The two main aspects or sub-branches are interval estimation and hypothesis testing.

Informed consent: the process of learning the key facts about a clinical trial before deciding whether or not to participate. It is also a continuing process throughout the study to provide information for participants. To help someone decide whether or not to participate, the doctors and nurses involved in the trial explain the details of the study.

Interpretivism: it is the belief that people continuously make sense of the world around them and different people may have different interpretations of the same phenomena. Interpretivism, is a blanket term for a collection of approaches broadly called "qualitative" that share an opposition to the logical positivists` notion of studying humans as objects or particles.

Major injuries area: an area of the ED designed to care for service users presenting with major injuries.

Md: missing data.

Micro analysis: word by word, line by line and paragraph by paragraph analysis, a free flowing process involving examination and interpretation of the data producing both manifest and latent content.

Minor injuries area: an area of the ED designed to care for service users presenting with minor injuries.

Open coding: open coding aims to fragment or break down the data so that discrete concepts and categories can be identified and compared resulting in the development of properties and dimensions (see below).

Paradigm: beliefs and values which particular research communities share about the type of phenomena which can or cannot be research and the methodologies to be adopted.

Peer review: review of a clinical trial by experts chosen by the study sponsor. These experts review the trials for scientific merit, participant safety, and ethical considerations.

Phenomenology: a philosophical theory about the lived human experiences and the ways in which they express themselves.

Pilot study: a small preliminary study that allows the researcher to test the research method.

Positivism: an approach that emphasises the general laws, separating facts from values and often involves an empiricist commitment to naturalism and quantitative methods.

Properties: characteristics that are common to all the concepts in a category.

Purposive sampling: sample drawn from the population in a deliberate or targeted way according to the logic of the research. This involves making a judgement or relying on the judgement of others in selecting a sample. Researchers use their knowledge of potential participants to recruit them. The purpose of this type of sampling is to obtain as many perspectives of the phenomenon as possible.

Qualitative Data: data that provide or contain non-numeric information; they serve merely as labels or names for identifying special attributes of the unit of interest.

Quantitative Data: data that provide or contain information as to how much or how many; hence they are always numeric. A variable that assumes quantitative values is called a Quantitative variable. An example is the Salary or Experience (in years) of the employees.

Rapid assessment and treatment unit: an area of the ED for service users who require prolonged clinical observation, assessment and medical/nursing management.

Reflexivity: this is the continuous process of reflection by researchers of how their own values, perceptions, behaviours or presence and those of the respondents can affect the data they collect.

Reliability of an instrument: the consistency of a particular method in measuring or observing the same phenomenon.

Resuscitation room: the resuscitation room is an area of the ED where the most seriously ill patients will be cared for. It contains the equipment and staff required for dealing with life threatening illnesses and injuries.

Rigour: the accuracy and consistency of a research design that gives a measure of its quality.

Rr: response rate.

Sample Size (*n*): the number of individuals in a group under study.

Selective coding: this is achieved via a four stage method called the constant comparative method (see above) a process whereby findings are verified and corrected on the basis of the data collected.

Semi-structured interview: interview in which respondents are asked questions from a partly pre-determined list but are allowed flexibility in their answers.

Statistically Significant: the conclusion that the results of a study are not likely to be due to chance alone because the P-value derived from the statistical analysis is smaller than the critical alpha value (usually 0.05). No matter how small the P-value, the conclusion of statistical significance is valid only when opportunities for bias are minimal.

Survey: a research designed to obtain descriptive and correlational data from a large population usually by questionnaire, interview or even by observation.

Target hardening: adopting security techniques reducing the opportunity for criminal activity or increasing the opportunity for criminal activity to be identified.

Theoretical sampling: after interviewing an initial sample the grounded theorist will analyse the interviews for the data that emerge and start to create initial theories about the phenomenon of interest. This initial and ongoing analysis will lead the researcher to ask further questions around the area of interest and may lead to them recruiting further subjects to the study in order to help answer emerging questions or to further consolidate an emerging theory. This process is called theoretical sampling.

Theoretical saturation: the point at which no new insights are obtained, no new themes are identified, and no issues arise regarding a category of data.

Thick description: an analysis of the group culture, a view of its patterns of working, member relationships, meaning and functions.

Transferability: the extent to which the research findings can be transferred from one context to another by providing a “thick description” of the data, as well as identifying sampling and design details.

Triage: triage refers to an area where nursing staff grade service users by clinical need and urgency of care.

Triangulation: the use of two or more research approaches, data collection methods or analysis in one study.

Unstructured observation: a data collection method used where actions or events are observed and recorded without predetermined categories or checklists.

Validity of an instrument: the degree to which a measure accurately assesses the specific concept it is designed to measure.

Waiting room: An area where service users enter a queue for treatment.

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