RESILIENCE IN NURSING: THELIVED EXPERIENCES OFMENTALHEALTH AND CASUALTY NURSES WHO RETURN TO THE WORKPLACE AFTER BEING ASSAULTED BY PATIENTS AT GWERU PROVINCIAL HOSPITAL

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DEDICATION

I dedicate this accomplishment to my husband Benjamin Mambende, who believed in me, when in times I doubted myself.

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ABSTRACT

Nurses in the hospital setting are the frontline staff caring for patients. Despite the high incidents of violence directed at the mental health and casualty nurses while on duty, there is limited qualitative data that explores the lived experience of returning to the workplace after an assaultive incident. This phenomenological study sought to explore and analyze the phenomenon of registered nurses who are employed in high risk settings at Gweru provincial Hospital. The research questions considered the detailed descriptions of the lived experiences of the nurses when returning to the workplace after assaults. The theoretical framework of shame resilience was used as the participants continued to survive and thrive after the adverse assaultive events. Data was collected using in-depth interviews from purposeful sampling. Nine registered nurses working in the high risk areas of mental health and casualty departments provided detailed descriptions about the phenomena. Data management was an inductive iterative analysis completed and facilitated by the use of NVivo10 software program. The study found out that participants had a brief emotional response post assault mitigated by the community of nursing personnel from their immediate surroundings and felt that assault was "part of the job". Providing a true culture of safety would include enhancements to the internal community of bedside nursing practice. In addition research is needed interventions that can effectively enhance the internal community after assault by patients. This study contributes to positive social change by providing registered nurses, an oppressed group, a voice to mitigate negative consequences associated with assault in the hospital setting.

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction

Nurses in the hospital setting are the front line staff caring for patients. Their duties include helping, promoting, healing and alleviating the suffering of those in their care. The nursing code of ethics expects nurses to form and maintain professional relationships with patients, practice with compassion, and respect all patients regardless of their social, personal and health related status (ANA, 2010). However, contemporary research suggests that violence targeted at nurses is very prevalent especially in high risk settings of the health care sector such as the mental health department (Gerberich & Alexander, 2004). Frequently, negative effects of violence among nurses employed in these settings are reported (Findorff, McGorven & Sinclair, 2005). The usual response of health sector administrators worldwide is to avail victims with violence inhibition strategies as a way of minimizing risk. Despite these efforts, violence against nurses continues to escalate. Surprisingly, mental health nurses in the Casualty Department return to work after being assaulted by patients while on duty in the hospital setting. In resource constrained countries like Zimbabwe, research has not adequately explained the resiliency of mental health nurses in the Casualty Department. This information gap triggered the present study exploring resiliency among mental health nurses in the Casualty Department at Gweru Hospital.

1.2 Background

Aggression in the workplace is a topical issue the world over. The United States department of labor estimates that approximately 2 million workers are victims of violence every year (Dol,2010). Health care is one of the largest industries in the United States and nearly two- thirds of all non-fatal victims of violence are health care workers, placing them at a risk five times greater than the entire work force (NIOSH, 2013a).Amongst health care occupations, the nursing profession has the highest percentage of workplace viciousness (Harrell, 2011). A survey completed in 2012 in the United States, reported 42% episodes of workplace assault against nurses perpetrated by either patients or family members as compared to 11% episodes in 2011 (Duffin, 2013). Research has also shown that an estimated 80% of nurses do not feel safe in the workplace (Peek-Asa et al., 2009). As of 2008 the overall prevalence rate of injuries from assault

on mental health nurses and casualty department nurses in the United States was 20.4% for every 10 000 workers (NIOSH, 2013b). On the African continent, a study conducted by Gerberich, Church and McGovern (2004) with Ethiopian nurses revealed 68% violence prevalence rate among nurses in psychiatric inpatient departments. According to this study, nurses who worked in psychiatric inpatient departments were 4 times more likely to experience workplace violence than those who did not work in such settings.The most common types of abuse that nurses experienced were swearing, loud aggressive tone of voice, scolding and insults.

Workplace hostility has a serious impact on the healthcare and wellbeing of nurses (Findorff et al., 2005).For example, nurses who experience workplace violence may present with fatigue, irritability, lack of concentration, unhappiness, depressive sensation, depersonalization, shame and emotional exhaustion (Findorff, McGovern & Sinclair, 2005; Siebert, 2005). Contemporary research suggests that the impact of workplace violence on healthcare and nurses' well-being is worsened by work overload, role conflicts, lack of time, lack of self-care, poor job related interpersonal relationships, feeling powerless to provide quality care, struggling with competing demands, deaths, conflict with doctors, peers and supervisors and inadequate emotional preparation for traumatic and difficult episodes(Gates, Gillespie & Succop, 2011a).it has also been established that work place bullying affects nurses' sense of wellbeing, their job satisfaction and instils in them a propensity to leave (Chihambakwe et al., 2005; Whinstanley & Whittington, 2002).

While on professional attachment at Gweru Provincial Hospital the present researcher observed that mental health and casualty nurses returned to workplace and appeared to maintain a healthy and stable psychological functioning after assaultive incidents. Therefore the study sought to explore the nurses' ability to cope well with workplace violence, sustain good health and energy when under constant pressure; bounce back easily from set-backs and overcome adversities.

1.3 Statement of the Problem

Violence against nurses is an internationally recognized global phenomenon whose prevalence is worsening annually (Tamra, 2002).The National Occupational Safety and Health a subsidiary of the Occupational Safety and Health Administration (NIOSH) expects research to identify violence prevalence rates, risk factors for violence and effective violence prevention

interventions (NIOSH, 2004). Available literature show that research focus has mainly been on the effectiveness of workplace violence intervention programming (i.e., the training and techniques utilized) (Wassel, 2009).So far, over 100 articles have been published on workplace violence against nurses (Spector, Zhou & Che, 2013). However, there is limited literature that address lived experiences the experience of resilience for nurses returning to workplace after an assault from the perspective of the victims and the strategies that nurses use to maintain resiliency after an assault. Research therefore needs to uncover the meaning and the essence of resilience for nurses who return to the mental health casualty departments after being assaulted by their patients (Wolf, Delao & Perhats, 2014).

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1.4 Purpose of the Study

The purpose of this qualitative, phenomenological research study was to gather an in-depth understanding of the lived experiences of resilience on returning to work as a mental health nurse and a registered general nurse, employed in a high risk area, after being assaulted by a patient while on duty in the hospital setting. Using the lens of an oppressed group, the focus was on the experience of returning to the same contextual space in which a traumatic event was experienced. The high risk setting utilized in this study was the in-patient psychiatric and the Casualty department at GPH. The study has provided significant insight into the experience by nurses of workplace violence and returning to work place as a registered general nurse after being assaulted by a patient. The phenomenological approach was applied as it is concerned with the experience from the perspective of the individual (Maustakas, 1994). The lived experiences can never be grasped in its immediate manifestation, but only through reflection which provides a contextual essence of the totality of the experience (Van Manen, 1990). Through interpretation of the lived experiences, the researcher was able to provide reflective interpretation and meaning to the experience of workplace violence for nurses employed in high risk settings.

Findings from this study add to the body of knowledge and address the gap in the research relative to managing workplace violence after a shameful, traumatic physical assault of nursing personnel. This study provides a voice for the nurses after the negative work experience of assault.

1.5 Research Questions

RQ1 – What are the positive experiences of mental health and casualty nurses when returning to the work place after a shameful assaultive incident Gweru provincial hospital?

RQ2 – What are the negative experiences of mental health and casualty nurses when returning to the work place after a shameful assaultive incident at Gweru provincial hospital?

RQ3 –What are the strategies that can be used by the mental health and casualty nurses to deal with the effects of workplace assault at Gweru provincial hospital?

RQ4 – How have the assaultive incidents affected nursing practice of mental health nurses and casualty nurses at Gweru Provincial Hospital?

1.6 Significance of the Study

The results of this study can have a significant impact on the lives of nurses working in high risk areas of healthcare. Also the results of this study will provide the health care industry with meaningful insight to the post assault needs of nurses. Identifying the experience as a resiliency concept can assist organizations in their ability to develop resilient nursing employees and provide a venue for healthy adoption to traumatic events. Opening a dialogue surrounding the experience of returning to work after an assault can promote social change through empowerment of nurses and their patients.

The impact and scope of violence in healthcare is clearly demonstrated. Nurses have an unequal position in the hierarchy of the health care team (Greenfield, 1999). Evidence will suggest that the more unequal the society the greater the risk for violence (Williams and Donelly, 2014). It is important to determine what can be done in the aftermath of violence to negate effects if possible. Survivors of assault in the workplace have been provided a voice in this complex issue. The idea was that a collective voice increases a sense of confidence to nurses who have returned to the work place after assault. Providing a voice articulates the experience, moves towards a collective identity and is a beginning step in making social change (Crossley and Crossley, 2001).

A phenomenological approach to workplace violence is transformational as the true life experiences will ignite a movement within the health care hierarchy to promote positive social change. The experience provided a meaningful venue to empower nurses who have been identified as an oppressed group. Violence as a dimension of oppression gains legitimacy if tolerated and unchallenged (Dubrosky, 2013). Placing the victim in the framework of violence diminishes the exploitation of nurses by the institutions at which they are employed.

1.7 Assumptions

1. The assumption that the participants will be openly sharing their actual experience and describe any experience that may have occurred.
2. When analyzing a phenomenon, researchers try to determine the themes, the experiential structures that make up the experience (Van Manen, 1990). As a researcher, one assumes that the underlying experience is similar in nature between all participants so that the information can be synthesized and themes can be drawn to provide a broad understanding.
3. If it is determined that there is potential for adverse reactions to discussing what happened after the assault, the participant will be immediately provided an EAP and excluded from the study.
4. The most significant assumption is that mental health and casualty nurses in the study have gained mastery over the assault experience by returning to workplace and by so doing they have developed some sense of resiliency. Nurses that return to work resuming professional duties and meeting job performance expectations should not be actively experiencing potentially harmful antecedence of the event and should be able to articulate the experience upon returning to workplace.

1.8 Delimitations

The scope of this research was to develop an in-depth understanding of the experiences of nurses who have been assaulted while on duty in the mental health and Casualty department at Gweru Provincial Hospital setting. Although there is a significant amount of outcomes research related

to violent events in healthcare, there has yet to be an examination of the experience upon return to work that can ultimately lessen the impact of the adverse event for the professional nurse. The literature has characterized registered general nurse as demonstrating oppressed group behavior (Greenfield, 1999). Prior evidence suggest that violence in nursing has its origins in the context of being excluded from the power structures that are dominant in today's healthcare organizations (Dubrosky, 2013). The population and environment were significant to this study. To identify resiliency in mental health and Casualty nursing, the participants had to experience a violence episode and return current organizational structure, not once but twice. The workplace environment was also crucial to this study. The workplace environments were selected because they offer an Employee Assistance Programs (EAP). The findings from this study will be transferable to any healthcare setting meeting the same study criteria that employee registered general nurses and is supported by the government medical programs.

1.9 Limitations

There are several potential limitations in utilizing a phenomenological approach for this study. As a sale researcher, completing all interviews and analyzing data alone increases a potential threat to credibility. The second limitation to the study is the setting. The design setting was in one urban hospital organization that meets inclusion criteria for workplace safety and adheres to the voluntary guidelines set forth by occupational safety and health administration (2004). This allows for generalizability to other similar health care institutions. The limitation of trustworthiness in data must be addressed when completing a phenomenological study. The researcher expected truthfulness in data. The first was selecting participants within the organization for the study that had no relationship with the researcher at all. There were several safeguards implemented to assure truthfulness. The second was assuring confidentiality and informing participants prior to the study of the strategies set fourth that would maintain their confidentiality. The sample size is also a potential limitation in qualitative studies. In order to address this potential limitation the researcher conducted the interviews until data saturation was met.

1.10 Definition of Terms

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

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

Resiliency: Resilience refer to the process of adopting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress (Green, 2002).

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

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

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

1.11 Chapter Summary

Violence directed towards nurses is a significant issue in health care. Although there is a significant body of literature that describe the incidence, interventions to prevent violence and the impact that violence has on both nursing and healthcare organizations, there is little evidence that allows nurses describe the experience of bouncing back and returning to the workplace after a shameful incident of assault. The following study provided a deeper understanding of mental health and casualty nurses experience of resilience through traumatic, shameful incidents of assault in the workplace.

Chapter 2 will offer evidence of the extent and influence that assault has on nurses and organizations. The perceptions and concepts of the theoretical framework of positive adaption

known as shame resilience theory are examined. Supportive evidence and its application to nursing and violence in healthcare will produce logical connections.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The purpose of this study was to develop an in-depth understanding of the experience of resilience on returning to work as a mental health or casualty nurse after a shameful assault by a patient while on duty in the same high risk hospital setting. This chapter reviews the current literature on the prevalence of assault towards mental health nurses and casualty nurses, associated risks, the impact on nurses' organizations and practice. The professional practice of nurses has been described as demonstrating oppressed group behavior (Dubrosky, 2013; MathesonBobay, 2007).Recognizing that the return to workplace setting in which an assault accurs for an oppressed group of individuals has challenges. Nurses feel very shameful and helpless after being assaulted by patients whom they are trying to help. A theoretical framework of Shame resilience theory and the notion of positive outcomes despite adversity were examined. Identification of factors that can accentuate positive outcomes despite adversity is vital for nursing practice and quality patient care.Consequencies of workplace violence such as stress and nursing burnout, effects of violence on nurses retention, the position of nursing in health care as well as the strategies used by nurses to cope with workplace assault were major aspects that were looked at. Some key words used to access literature included nursing and violence ,nursing and assault ,shame resilience in nursing, oppression and nursing ,Workplace violence and interventions, hardiness and nursing, workplace violence in health care. Only relevant studies were sought and identified. The literature reviewed hundreds of articles with a majority of studies based on international research findings. All sources were related to resilience in nursing factors and violence in health care.

The first section will review prevalence incidence and associated risk factors related to violence directed towards mental health and casualty department nurses. The second section discusses the effects that violence has on nurses individually including associated risk factors. The direct construct of the impact of workplace violence on practice will be explored. The impact workplace assault has on both organization and nursing practice will be identified. The third section will review the theoretical framework of Shame resilience, constructs that assist in

defining resilience as positive outcomes when faced with adversity will be identified for relational themes in resiliency on returning to workplace after the adverse shameful event such as assault (Gillespie,Chaboyer and Wallis, 2007).An in depth understanding of the experience of overcoming shame and returning to work is imperative for future practice. Ultimately, knowing resilience or positive outcomes of resilience can assist mental health nurses and casualty nurses in overcoming shame and adversity, benefits not only the nurses individually but also organizations and their patients which can result in significant positive social change.

2.2 Workplace Aggression in Nursing

Hostility in the healthcare industry is well recognized and remains a serious concern for health care providers in the United States. The Beaureu of Labor and Statistics (BLS) that healthcare workers were victims of approximately 11,370 assaults in 2010 which was a 13% increase over the number reported in 2009 and 19% of which occurred in nursing (Nationaal Institute of Occupational Safety and Health) (NIOSH),2012).Nurses are at the highest risk of violence in the workplace (Harell , 2011).Among all health care workers, nurses have the highest rate of violent victimization with over 300 000 reported incidents of violence reported in the United States (Harell,2011).The numbers only account for reported workplace violence and the actual number of violence in nursing maybe considerably higher. The number of incidents of assault may be 80% higher because research suggests that individuals in the healthcare area underestimate the incidence of violence they experience while on duty(Findoff,McGovern,Wall,Gerberich &Alexander,2004).

The prevalence of workplace violence presents a concerning picture. There are several reported forms of aggression. The NIOSH (1996) provides a range of definitions for workplace violence that includes but is not limited to physical assault, threatening behavior, or verbal abuse occurring in the work setting.(NIOSH,1996).A large study conducted by Hader (2008) conducted that 80% of nurses surveyed from the United States ,Afghanistan, Taiwan and Saudi Arabia had experienced violence within the wok setting. The study noted that 25,8% experienced physical violence with 92,8% of respondents being female; the number is consistent with the national percentages of registered general nurses (Hader 2008).Out of the reported episodes of violence 53,2% were committed by patients towards nurses (Hader, 2008)The consistent prevalence of workplace violence demonstrates the threat that nurses face. According to Hader (2008) 73% of nurses experienced some form of violence occasionally, 17% reported violence often 1,7

described workplace violence as always being experienced. The evidence clearly identifies that exposure to violence in health care is common with half of all workers reporting exposure (Findorff, McGovern, Wall & Geberich, 2005;Winstaley &Whittington, 2004). The prevalence of the magnitude of incidents of workplace violence is clearly presented through ought the literature.

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

The causation of underreporting workplace violence is abundant and dynamic. Evidence suggests that nurses consider aggression and violence as part of their job (Findorff et al., 2004).In a survey of casualty nurses, 76%,stated their decision to report a violent incidence on whether or not the patient was perceived as being responsible for their actions.(Ericksons & Williams Evans,2000) The determination of causation of assault then falls on the nurse who self-determines if the assault was warranted. Research has indicated that during the aftermath of violence at workplace nurses self-perceptions surrounding the incidence include shame, blame,punishment.fear,poor morale, vigilance and distrust of the organization (Kindy,Peterson&Parkhurst,2005).This evidence provides insight into some possible causes of non-reporting of workplace violence by nursing professionals.

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

Workplace violence in nursing is a complex phenomenon. There are several types of reported workplace violence. The definition of workplace violence by the National Occupational Safety and Health Administration (OSHA) under the US Department of lab our is “any physical assault, threatening behavior or verbal abuse occurring ion a work setting” (OSHA, 2004 p4). Work-place violence is further defined as physical, sexual or verbal (Copeland, 2007 p2). NIOSH (2006) has documented that definitions of workplace violence are not consistent among government agencies, employee, workers and other interested parties. In order to maintain clarity of the definition of violence in the workplace, only physical violence will be the focus of further discussion throughout the study.

There are also certain areas of the healthcare industry that are notorious for increased risk of violence towards nurses. The compelling research for this study considered the highest risk areas in nursing. The typology of the wrongdoer will be a customer / client patient that becomes violent while being under care of the registered general nurse at Gweru Provincial Hospital. A focused exploration of current research has identified physical assault, in casualty rooms and psychiatric inpatient hospital settings with the perpetrator being their patient as a high risk environment.

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

Psychiatric settings are considered a high risk area for physical aggression and workplace violence. One study indicated that 76% of nurses reported physical assault and 186% experienced serious physical aggression (Nijmen, Bewers, Qud & Jansen, 2005). Often nurses

experience more than one episode of physical assault in the workplace. In the mental healthcare setting, one study found that 62% of clinical staff were assaulted at least once with 28% reported being assaulted in the 6 months prior to the study (Coldwell, 1992). Another study determined that 34% of clinical staff was physically and again less than 50% reported the incident (Privitera et al., 2005). One research study established that 94% of mental health nurses had been assaulted at least once in their carriers with 54% testifying that they have been assaulted 10 times (Poster &Ryan, 1994). Further investigation has indicated that eight out of ten nurses experienced some form of physical violence in the past 12 months. (O' Connell et al., 2000). These findings represent physical attack only, threatening, intimidating or verbal to physical aggression.

Vulnerability to physical assaults in mental health units is mainly due to mental disorders of the patients (Johnson, 2004& Quintal, 2002). Exploration has indicated that 90% agents of physical violence are patients (Gerberich et al., 2004). A constant finding throughout the literature is that patients with a diagnosed mental illness including Schizophrenia, mania, psychosis and certain types of brain syndromes including dementias, substance abuse and personality disorders have a direct connection with hostility (Johnson, 2004; Quintal, 2002)

Progressive psychiatric symptoms such as hallucinations and delusions accounted for 20% of assaults (Nolen et al., 2003). Comorbid medical conditions and social factors of patients seeking mental health services including inadequate pain management, gang violence, autoimmune deficiency syndrome, pancreatitis or tuberculosis have also been attributed to increased acts of violence. (Carney, Love&Morrison, 2003). The most at risk populations for displaying violence and aggression towards mental health nurses have been identified as male (75%) with a mean age of 39, carrying a diagnosis of Schizophrenia (100%), with a history of violence (93%) and substance abuse (56%) (Flannery, Irvine &Peck, 1999). Patient correlated aspects in the mental health setting are uncontrollable variables that nurses are exposed in the nature of their work duty.

Mental health settings inherently place nurses at risk for workplace violence. Mental health inpatient hospital settings for psychiatric patients provide a structured, supportive environment. The inpatient psychiatric units have restrictions that often infringe on the patients personal freedoms, such as locked doors, and no smoking areas which are universal patient safety

guidelines. The unit environment process including the structure, level of stimulation, patient autonomy and safety provisions can influence the incidence of violence (Hamrin, Lennace &Olsen, 2009). The enforcement of unit rules, denial of privileges and involuntary commitment for treatment has positively correlated with aggression in the mental health setting (Flannery, 2005; Johnson, 2004). The structure of the environment has an impact on the success of aggression in the impatient psychiatric setting.

The casualty department is also considered a high risk area of assault. Exposure to physical aggression in casualty departments has been reported to be as high as 67%. (Lennaco et al., 2013). In a study by Crilly et al. (2004)79% of nurses in the casualty department experienced workplace violence by patients that were believed to be under the influence of alcohol (57%) or mentally ill (40%). A study examining conflict in one casualty department established that 50% of the incidences were direct physical assault between staff and patient with 16% involving medical equipment used as opportunistic weapons such as canes, crutches, tables or chairs (Ferns, 2012).

The nature of the patient population and environment of casualty departments are similar in scope to psychiatric units with some describable differences. Environmental risk factors in a casualty department includes working directly with potentially dangerous patients, poor security uncontrolled movement by the public, delays in service, crowding and an overall uncomfortable setting. (Taylor & Rew, 2010). The first point of contact with the patient and the service provider that determines the wait time process in an emergency room is known as the triage (Lavoi et al.,1998).It was identified that 78% of vicious incidents happened within one hour of triage to casualty department (Lavoi et al., 1988).

Those accustomed with the casualty departments know that wait time is an inherent problem and the method of triage is an accepted practice in the emergency departments. Other essential risks in a casualty department include ease and accessibility from the public, 24 hour access, alleged environmental chaos, augmented stimulation and a high stress environment (Howerton, Child& Mentes, 2010). All known risk factors are identified but remain salient in casualty departments.

There is acknowledgement in the literature, that certain risk factors in relation to staff themselves, pose a risk for violence against nursing personal. Certain nursing staff appearances

such as age, places a nurse at an increased risk for aggression (Estryn – Behar et al., 2008). In the mental health setting, male nurses are more likely to be assaulted, but other studies have reported that female dominated profession (Howerton, Child& Mentos, 2010). The likelihood that experience and training has some impact on decreasing violence has also been implied in the research. (Johnson, 2004). This only may prove that resiliency is formed with experience, however limited research on this subject has been identified. Additional personal well-known risk factor that relates to nursing is increased contact with patients. Evidence has shown that nurses' interpersonal communication and attitude towards working with a particular population is a potential risk factor.

A hostile confrontational staff member or those who are fearful has been linked to an increased risk or violence (Quintal, 2002). The nature of nursing duties, together with lifting of patients, holding patients, inadequate staffing and increased patient capacity is reported to be connected to violet behavior (Lawoko, Sources, year; Nolan, 2000; Ozlung, 2006). The combination of risk factors including the nurse, the environment, the patient, variable definitions of violence and under reporting make workplace violence a complex incident.

The risk and the propensity of under reporting makes workplace violence a substantial matter for nurses employed in the high risk areas such as the mental health departments and the casualty departments. The evidence in prevalence lacks uniformity due to self-selected reporting and centralized of occurrences .Exposure to potentially violent perpetrators may be unavoidable by these nurses. Although significant attention has been brought to the prevalence and preventive strategies, the fact remains that mental health nurses and casualty department nurses are at substantial risk of physical violence in the workplace. The need to further explore the consequences of violence in the workplace towards nurses requires further investigation to fully understand the impact that aggression has on nurses and the profession.

2.3 Consequences of Workplace Agression towards Nurses

The consequences of workplace violence are multi-factorial impacting the individual nurse the organization and the profession. The effect of physical injury is self- explanatory causing mostly minor injuries (Coldwell, 1992). However, from 1997 to 2009 there were 130 documented workplace homicides in the healthcare and the social assistance industry (NIOSH, 2012).

Indication suggests that physical assault is the strongest analyst for the use of sick time, on average 3, 7 days as compared to the average use of time by nursing personnel (Nijman et al., 2005). Physical hurt alone has an obvious impact on health, however the psychological effect can be equally as overwhelming.

The psychological impact that workplace violence has on the individual nurse has been well examined in the literature. One study that examined psychiatric nurses' post assault in the workplace discovered that 17% met criteria for Post-Traumatic stress Disorder (PTSD) immediately after the assault and after 6 months 10% met the criteria for Post-Traumatic Stress Disorder (PTSD). Seventy eight percent of workers exposed to work related violence experienced at least one adverse symptom that included shame, anger, irritation, sadness or depression (Findorff, McGovern &Sinclair, 2005). O' Connell et al. (2000) found that the most frequent emotional responses to violence in the workplace included shame, frustration, and anger. Fear, burnout, stress and emotional hurt. Long term stress and trauma after assault can have a cumulative effect leading a nurse to experience symptoms including apathy, flashbacks, crying spells, intrusive thoughts and nightmares (Phillips, 2007). This emotional response also has an effect on low self-esteem, diminished productivity and increased mistakes. (Ozge, 2003). This if not well managed can lead to a compromise in job related duties and performance in care.

Mental health and casualty nurses who are exposed to violence in health care may compromise their ability to care for patients appropriately. Exposure to aggression can endorse fear of future episodes that enhance somatic symptoms and cause intent to leave an organization in which the violent episode took place (Rogers &Kelloway, 1997). One study reported that 12, 4% of nurses working in environments with the potential for violence had caused fear that perpetuated mental and physical distress and 6.4% reported a decrease in productivity in practice. (Budd, Avery &Lawless, 1996). The predisposition for workplace violence can impact patient care by limiting a nurse's ability to practice.

Limitations on practicing nurses can not only affect patients, but the health care organization. The communication and coherence between colleagues in the health care setting is instrumental in caring for patients. Hospital employees who have been exposed to violence in the workplace have reported more stress reactions and a weaker sense of coherence with colleagues as opposed

to non-exposed employees. (Hugh &Mickkelsen, 2005). The literature also has identified that exposure to workplace aggression causes decreased job satisfaction, decreased satisfaction with family support known as nursing "burnout". (Nijman et al., 2005; Inoque et al., 2006, Maguire &and Ryan, 2007). Burnout has been associated with high work demand with low levels of resources to cope that increases emotional exhaustion (Winstanely &Whittingham, 2002). These individual stress reactions have a significant impact on organization.

An individual's response to workplace violence can have far reaching effects on care and perception of their hospital organization. Reactions to aggression in the workplace included sick leave (20%) of staff and the use of alcohol or drugs (20%) by employees after an incident (O' Cornell et al., 2000) for patients. Compounded with the emotional strain workplace violence can negatively affect an organization.

It has been estimated that 80% of nurses do not feel safe at work (peek – Asa et al., 2009). The lack of institutional support and sense of abandonment particularly surrounding inadequate staffing levels, unfulfilled promises of workplace safety, ignored concerns, insufficient education, lack of support by peers and administrators can lead to nursing dissatisfaction (Gacki – Smith et al., 2009). Even in Organizations that provide EAP for violence exposure, research has found that most employees did not receive the resources (Caldwell, 1992). The confirmation further exemplifies the significance of a culture of safety and support in high risk environments. Hospital organizations are integrally impacted by workplace violence. The cost of institutional violence within an organization can be dramatic. Malingering, productivity and frustration with the working environment are loses that are not easily accounted for when reviewing the impact on an organization. Research by the international labor organization reported that the cost of violence and stress in the workplace represent 10 – 3.5% of the gross domestic product over a range of countries (Water et al., 2005). The effect on individual employees overall well-being that include mental and physical health, job satisfaction and morale are closely tied to organizations productivity and overall cost (Hatch- Maillette &Scalora, 2002). The organizational level may also experience legal liability cost, employee turnover and resource allocation to hiring and retaining employees (Hatch - Maillete& Scalora, 2002). Sustaining qualified personnel is a significant financial issue for the occupation of nursing.

Casualty department nurses reported that they were unable to work in the casualty department after a violent incident (Howerton, Child &Mentos, 2010). The occurrence of workplace violence continues to be an issue that impacts individuals, organizations and the profession of nursing.There is clear and compelling evidence that workplace violence in health care has numerous effects. Twenty years of inquiry has specified that this is not only a health care problem but a social concern. In light of the many challenges that healthcare is currently experiencing, workplace viciousness should be considered priority. As a public concern a preventative framework of Resilience has been instituted. The effectiveness of preventative strategies continues to be another challenge in mitigating workplace violence.

2.4 Preventive Strategies to Workplace Violence

Evidence clearly demonstrates the risks and consequences associated with workplace violence in health care amongst nurses. The impact that work place violence has on individuals and organizations is substantial. In view of the effect, governmental agencies and accrediting bodies have endorsed recommendations and rules to conduct the workplace violence issue.

In spite of the consequence of workplace violence in health care, the United States government has been slow to respond. At present, there is little legislation that is enacted to specifically protect nurses. In many it is not a felony to assault a nurse as a health care provider, however this is changing at a low pace. There are no federal laws that require workplace violence prevention as a mandatory requirement for organizations. The Occupational safety and Health Act of 1970 mandated that employers have a general duty to provide their employees a workplace free from recognized hazards likely to cause death or serious harm. (National Advisory Council on Nursing Education and Practice, 2007). The guidelines that have been issued include preventative strategies for health care organizations (OSHA, 2011) enacted enforcement procedures for inspecting agencies that have workplace violence incidence in order to review incidents and provide a generalized enforcement of the policies and procedures that they have been recommended (OSHA, 2011). The occupational Safety and Health Administration recommended strategies include; management commitment, employee involvement in violence prevention, worksite analysis, hazard prevention and control safety and health training along with record keeping (OSHA, 2004). Although slow in response, the regulation has been moving consecutively forward in addressing violence in the workplace.

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

Healthcare organizations have in turn applied recommendations for strategies in protecting workplace violence. The cultural shift is to support a safe workplace, with little empirical evidence on the most effective strategies to address workplace aggression. Most organizations have policies that include preventive strategies. However, there is little evidence that addresses the best strategies in decreasing the incidents of workplace violence.

The US Department of Labor and OSHA have utilized a conceptual Framework model, known as the Haddon matrix, on an injury prevention epidemiological perspective method. The Haddon matrix has been designed to include the essence of transition awareness between relationships, between man and his environment, human ecology and man's relationship with certain potentially or actually hazardous physical attributes of environment (Haddon, 1999). The Haddon Matrix is comprised of three distinct phases, the pre-event phase, event phase and post event phase (Gates et al., 2011b). The application of the Haddon Matrix for violence prevention includes the host as the healthcare worker, the vehicle as the injury vector, the agent as the patient and the environment that includes physical and social structures in the health care setting (Gates et al., 2011b). The event phase aims at instructing personal or prevention measure to minimize assault and prevent injuries including training workers in protective strategies (Runyan, Zakocs & Zwerling, 2006). Utilizing a primary, secondary and tertiary model the Haddon Matrix is able to encompass the experience of workplace violence. In the aftermath of a

violent incident one study demonstrated a consistent theme. After assault in the workplace evidence suggest that administrative support, development and enforcement of policies, procedures and resources must be provided to nurses (Gates et al., 2011b). Although most employees are aware of supportive mechanisms in place such as EAP, they do not use the service following an episode of assault in the workplace (Findorff, McGovern &Sinclair, 2005). The conceptual framework has been applied in several health organizations, however there has been mixed results of effectiveness due to variations in stakeholders.

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

Workplace violence prevention programs have shown to be a consistent component of organizational approaches to managing violence against nurses. However, workplace violence prevention programs have not shown to be effective consistently across all health care organizations (Ferrell &Cubit, 2005). The basic evidence is the continued prevalence of reported violence in the work against nurses.However, workplace hostility prevention programs have not shown to be effective consistently across all health care organizations (Ferrell &Cubit, 2005). The basic evidence is the continued prevalence of reported violence in the workplace against nurses. One significant issue is that there is no consistency with programs. Some organizations focus on the identification of aggressive factors, verbal aggression while others focus on identification of characteristics of aggression. (Peek – Asa et al., 2009 p 171). It is virtually impossible to examine the effectiveness of aggression management programs in health care as there is no standardized curriculum or intervention that has proven effectiveness across the institutions.

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

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

The scale of the management of hostility in the workplace as outlined by the Haddon Matrix includes the event and post event stages. Administration and management are crucial during these phases. Research has found that the most safety initiatives are patient centred instead of employee centred (Kawalenk et al., 2012). Organizational administration needs to commit to promoting a culture of safety. One such commitment would include adequate staffing ratios. Bowers et al (2007) found a significant relationship between lack of adequate staff and incidence of agression. Administration needs to continue to support and follow policy and guidelines.

Action plans for improvement can be developed by gathering the best evidence and engaging all stakeholders to reduce violence in the hospital setting.

Workplace aggression in health care towards nurses is a complex issue. This literature review has demonstrated that assault in the workplace is not only prevalent but has a significant impact on nurses as individuals and professionals. Although some strides have been made from a legislative, policy and organizational standpoint there remains a pervasive and lingering effect on nurses as evidenced by the existing problem. The culture of safety within an organization is inherent in the [policies created. Nurses who have the most frequent victims should be at the centre of all workplace violence initiatives.

2.5 Stress and Nursing Burnout

A mixed methods study by Gillespie and Melby (2003) examined nursing in mental health and casualty departments, focusing on its effect on patient and its impact on life outside of workplace. A total of 56 surveys were distributed with each area receiving half, 30 were returned for a response rate of 60%. Measurement for nursing burnout was conducted using the 22 item Maslach Burnout Inventory (1996). Results showed that emotional exhaustion was exhibited by nurses feeling exhausted when waking (P-O.039), yet able to create a relaxed environment for their patients (P-O.030). No significant difference was found between the two settings in regard to emotional exhaustion, depersonalization, or personal accomplishment. However, the mental health and casualty department nurses identified more moderate levels of emotional exhaustion, when compared to those in the acute medic area. A recommendation, of this study would be to further explore how one deals with emotional exhaustion. Small sample size and lack of time allocated for the participants to complete the surveys were identified as limitations.

For the qualitative portion of the study three randomly selected nurses participated in one focus group. Within the focus questions were asked pertaining to the effects of stress and burnout on the individual's lives outside of the workplace. The focus groups identified the following themes related to the impact of burnt, exhaustion, insomnia, increased alcohol. Nicotine abuse, irritability and decreased opportunities for debriefing of situations. A potential limitation of the qualitative portion of this study was the use of only one focus group with three participants (Gillespie & Melby, 2003). Future implications for practice are the need to prioritize specific

interventions to proactively prevent, which carries out undesirable psychological and physical effects as well as to reduce turnover.

2.6 Nurse Preservation

A Canadian study by Sourdif (2004) examined reasons for nurses' intention to continue in their current workplace. A convenience sample of 108 nurses (49%) response rate) answered questions de rived from the Nurses' intent to stay. Questionnaires (Taunton et al, 1997). Job satisfaction (M = 87.77, SD = 17,20 ad supervisor satisfaction (M = 100.83, SD = 14.67 accounted for 25% of the overall intent to stay score. Descriptive statistics showed that intent to stay was least affected by organizational commitment (M = 34.32, SD = 6.96) and work group cohesion (M =- 30.56, SD = 5.28). Correlation showed that all variables were significantly related with the strongest relationship being between satisfaction at work and administration (r = 0.667;p<0.01). Intent to stay was related to satisfaction at work (r = 0.667, p = 0.222) and satisfaction with administration (r = 0.602, p = 0.016). The results of this study add to the body of research identifying factors that lead to nursing retention by enhancing an organization's ability to predict nurse turnover intentions. The researchers recommended development of protocol aimed at the nurses' violent to stay characteristics with subsequent interventional studies.

In Florida, Nedd (2006) examined the relationship between nurses intent to stay in their job with perceived nurse empowerment. Five hundred nurses were surveyed via mail (response rate 12%). Ninety three percent of the participants were female and had an average of 20 years of professional nursing experience. Four different scales were utilized: the job activities scale (Laschinger, Kutscher & Sabiston, 1993). The Organizational relationship scale (Laschinger, Sabiston & Kutzsher, 1993), the Conditions of work Effectiveness Questionnaire (Chandler, 1987) and The Intent to stay scale (Kim, Price, Mueller & Watson, 1996). Intent to stay within the workplace positively correlated with all of the nurse empowerment variables in this study. Formal power (r = 0.43),p<0,01), informal power (r=0.31, p<0.01), overall work empowerment (r=0.52, p <0.01), Opportunity subscale (r =0.48 < 0.01), and the resource subscale (r = 0.45, p < 0.0). There was no significant relationship between intent to stay and any of the demographic variables.

2.7 The Situation of Nursing in Healthcare

Nurses play a crucial role in health care. Nursing is defined as the safety, support and optimization of health and abilities, prevention of illness, and injury, mitigation of suffering through the diagnosis and treatment of human response and advocacy in the core of individuals, families, communities and populations. (ANA, 2014a). This places nurses in the forefront of human suffering and a mainstay in the healthcare population. A change in the safety of health care is dependent on the response of the nursing workforce. However, nursing is wrought with many negative social characteristics that identify them as an oppressed work group (Dubrosky, 2013).

An examination of the current state of the profession is needed in order to fully demonstrate the need for empowerment and social change.

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

Nurses offer the service of health care. This service is considerably driven by financial determinants. The services provided to consumers or patients are strained by many variables. The most significant concern of these is the cost of health services. The structural issue includes increasing cost of health care as well as the lack of ability to pay for the totality of services

demanded by the public has presented an unequal supply and demand. The consumer driven profession is demanding the highest quality of care and nurses are not available to meet the demand.

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

Subjugated group behaviors are highly correlated with the response to aggression in workplace. Violence is considered a social justice issue of oppression because it is directed at members of a group simply because they are members of that group (Dubrosky, 2013). Hostility gains further legitimacy within a group when it is tolerated. Research has indicated that nurses are undecided about violence, particularly the notion of zero tolerance, suggesting that a degree of violence be, if not acceptable, is tolerable (Lovell &Skellern, 2013). A dominant culture that allows other groups to maintain control and not challenge the existing status quo, perpetuates oppression. Nursing remains exploited in regards to workplace assault and remains powerless in the current health care formation,

Hopelessness is a major indicator of oppressed groups. Powerlessness is exemplified in workplace aggression as the lack of decision making with narrow capacity to make changes in regards to major decisions that are made by regulations and administrators, based on what is best for the health care organization rather than what's best for the nursing employee (Dubrosky, 2013). Nursing leaders have a propensity to promote the agendas of healthcare institutions and

administrations rather than promoting the agenda for employees (Roberts, Demarco & Griffin, 2009). Throughout the evidence, there was little research regarding the nurses' voice in workplace violence, outside of prevalence. Giving nurses a voice assists in empowerment and provides a forum of respect that allows nurses to be part of the decision making process and can promote social change (Roberts, Demarco & Griffin, 2009).

Nurses are at the front position of experiencing hostility in the workplace. There are many variables that place nurses in harm's way as potential targets inherent in the profession. Nurses are the frontline care providers for patients that may be angry, afraid, in pain or anxious. It is a nursing response to provide care. Nurses tend to be more tolerant of inappropriate behavior and often put the needs of others above their own (Phillips, 2007). It is nurses that often give painful treatments such as insertion of intravenous catheters or wound dressing changes. The nurse is also the individual that places individuals in isolation, prohibits smoking and sets limits on patients that can lead to patient frustration and resentment. Knowing that these indices prevail as part of the job it is apparent that the nursing response to violence has become in a sense acceptable.

There are a number of suggested strategies that address oppressed categorical behaviors. The first is to understand the cycle of oppression in order to alter the silence and inaction (Roberts, DeMarco & Griffin, 2009). The implication of workplace violence needs to come to the forefront of the profession and health care institutions. Organizations have focused on the patient with the expectation of nursing staff to tolerate violent behavior (Gates et al., 2011b). There is need for nurses to share their voice on the experience of returning to work after an assault.

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

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

2.8 Resiliency in Nursing

An in depth appreciation of the strategies that nurses use to uphold and enhance emotional wellbeing in response to workplace violence may assist in positive adaptation. Nurses need to benefit from the strengths and resources when faced with the significant interminable challenge of workplace violence.

In an interpretive phenomenological analysis, Ablett and Jones (2007) interviewed palliative care nurses working in hospice settings to describe their experiences related to resiliency. As part of this study, resilience was thought to connect not from strain avoidance but through dealing with the stress at the exact time in which it was identified. Themes that surfaced from the resiliency data were: active choices to work in palliative care field, past personal experiences influence the current events, personal attitudes towards care giving and life. Awareness of own spirituality, personal attitudes towards work, aspects of job satisfaction and stressors, ways of coping and personal / professional issues and identified boundaries. Suggestions from the study indicated that nurses' active reflection on work events may assist with positive emotional outcomes after caring for the terminally ill patients and their families. Debriefing and active coping would contribute to the nurses' resiliency capabilities. Edward (2005) studied the resilience of mental health workers using a phenomenological design. In this study, resilience is defined as the ability of the individual to bounce back from adversity, persevere through difficult times and return to a state of internal equilibrium or a state of healthy being"(Edwards,2005 p.142). The researchers interviewed a select group of six mental health workers; five were female and four were nurses, one was a physician and one was an allied health professional. Analysis of the findings was performed using Colaizzi's (1978b) seven step approach. Resiliency themes that emerged from this study were: importance of non-work support, professional development, insight into work performed, creativity, flexibility and humor

integrated into workplace; faith and morality, experience and expertise, supportive workplace and keeping work life separate from home life.

Overall, the most resilient nurses were those who had access to and utilized the resources to overcome adversity. These results speak to the importance of health care organizations to facilitate the development of resiliency in nursing since it can positively impact satisfaction and nurse retention.

An exploratory, correlational study examined the relationship between job satisfaction and resiliency in the field of mental health. Matos et al. (2010) sampled psychiatric nurses from five inpatients units. Thirty-five nurses completed the Resilience Scale (Wagnild & Young, 1993) and the index of Work Satisfaction Scale (Stamps, 1997; Zangaro & Soeken, 2005) for a response rate of 76%. Cronbach's alpha coefficients were 0.97 for the Resilience Scale was and 0.92 for the index of Work satisfaction. A positive correction was found between resiliency and job satisfaction ($r=O.33$; $p < 0.05$). Participants were asked which components affected their satisfaction at work. The variables that impacted the nurses' satisfaction were; pay (66%), scheduling (59%), work environment (56%), co-workers relationship with the supervisor (47%) and physicians (38%). Analysis found out that resilience accounted for 10 percent of overall job satisfaction and 20 percent satisfaction with professional status. One suggestion for further research was to examine each of the elements of resiliency to inform the relationship between resiliency and job satisfaction.

Gillespie, Chaboyer, Wallis and Grimbeek (2007) performed a correlational cross-sectional study to examine the relationship between resiliency, experience, educational level, length of employment, age, coping, hope, self-efficacy, control, collaboration and competence through a statistical resilience model. Out of 2860 Australian registered nurses, random sample of 1,430 nurses were mailed a survey (54% response rate). Seven different scales, were utilized; the Perceived Competence Scale (Chao et al., 1994), the collaboration with Medical staff and the Cohesion Among Nurses Scale (Adams et al., 1995), the managing Stressful Situations Scale (Cronquist et al., 2001), the General self-Efficiency Scale (Schwarzer & Jerusalem, 1995), the Adult Dispositional Hope scale (Synder, 2000), the ways of coping Scale (Lazarus & Folkman, 1984) and the Connor – Davidson Resilience Scale (2003). Using a multiple regression model,

resilience was best explained by the combined variables of hope (beta = O.344, $p < 0.001$, r = 067), coping (beta = 0.176, $P < 0.001$, r 0.53), self-efficacy (beta = 0.264, $P < 0.001$, r = 0.63), Control (beta = 0,159, $P < 0.001$, r = 0.47) and competence (beta = 0.101, $P < 0.001$, r =0.38). Replicating this study with other nursing specialties would add to the understanding of the impact of resiliency in nursing. Supplemental validation of the revised resilience model would lead to developing interventions surrounding promoting resilience. Resiliency programs could become part of orientation and ongoing retention effects.

Larrabee et al. (2010) conducted a non-experimental predictive study in South Africa that investigated the relationship of resiliency with stress at work, empowerment, satisfaction and intent to stay through statistical testing of the Stress Resiliency Model. Nurse participants were chosen randomly from five major hospitals with two of the hospitals having a school of nursing affiliation. The sample set included 464 nurses (response rate 55%). Five seales were utilized in the questionnaire. Price and Mueller's two intent - to - stay items (1981), the Work Quality Index (Whitley & Putzier, 1994). Hinshaw and Atwood's Job stress Scale (1985), Spretzer's Psychological Empowerment questionnaire (1995) and the K. W Thomas and Tymon's Stress Resiliency Profile (1994). Overall, the nurses surveyed were unsure regarding their intent to stay ($r=25$, $P < 0.001$). Satisfaction ($M = 4.41$, $SD = 95$, $p < 0.$ 0.05). Empowerment ($M = 5.33$) $SD = 0.84$, $p < 0.05$) Stress level ($M = 8.91$, $SD = 25.79$) $p < 0.05$) and resiliency ($M = 7.8$, $SD = 21.60$, $P < 0.05$) all displayed above average results. This study also validated the Stress Resiliency Model for all paths ($df = 220$ $p < 0.50$ except intent to stay ($= -1.65$, $p < 0.05$). One recommendation was to develop training programs to further validate the model within different areas of nursing practice.

2.9 Theoretical Framework

2.9.1 Shame Resilience Theory

The Theoretical framework that was used for this study is called shame resiliency theory. Resiliency is characterized by good outcomes in spite of a threat to adaptation or development (Masten, 2001). Resiliency is the act of bouncing back or resisting to crack under pressure (Seligman, 2001) .According to the American Psychological Association, resiliency is the

process of adopting well in the face of adversity, trauma, tragedy, threats or even significant sources of risk.

Brene Brown developed the Shame Resilience Theory (SRT). According to Brown, (2006) SRT is an intensely painful or experience of believing we are flowed and undeserving of acceptance and belonging. She also says that nursing as a women dominated profession, women often experience shame after being assaulted by patients in the workplace. Shame is not a fleeting emotion. It is powerful and can negatively affect mental health. Studies of shame have been linked to violence, assault, depression, addiction and overall low self- esteem (Brown, 2006).

After every incident of violence and assault by patients at work, shame creates feeling of fear, blame and disconnection among nurses. When experiencing shame along with the situations mentioned above, it can cause mental health and casualty nurses to isolate themselves from friends, community or workplace. Common triggers of shame according to Brown (2006) are sexuality, professional identity mental health and surviving trauma.

The principal idea behind shame resiliency theory is studying the way people avoid feeling confined, weak and alone when they feel shameful. The goal of linking Brown's theory of resilience to workplace assault in nursing is to help nurses understand that they do belong. Resiliency against shame helps the mental health and casualty department nurses who feel shameful after assault by patients to feel empathy, connection, power and freedom (Brown, 2006).

Shame resiliency theory is primarily made up of four steps which are recognizing the personal vulnerability that led to feelings of shame, knowing the outside factors that led to the opinion of shame, connecting with others to receive and offer empathy as well as discussing and deconstructing the feelings of shame themselves (Brown,2006). These steps emphasize how vital it is to know that shame needs to be recognized and understood before it can be defeated. Much of SRT research says that unchecked feelings of shame among assaulted nurses can be harmful to mental health.

To overcome shame after incidents of assault at work during practice, mental health and casualty nurses should practice empathy. Empathy is powerful, it is the feeling that one understands and share another person's experiences and emotions. Practicing empathy can help these nurses to develop resiliency on returning to work after an assault and can assist them in building connection while shame can isolate (Brown, 2006).

The resiliency framework identifies risk as a base predictor of high probability of undesirable outcomes. The framework corresponds with the subject of violence in the workplace against nurses. Vulnerability is considered an individual's personal constructs of coping behaviors that impact the quality of adaptation (Masten, 2001). Constructs that assist in defining resilience include self –efficacy attributes, hope and coping (Gillespie, Chaboyer &Wallis, 2007). The previous evidence presented in this chapter would suggest that the prevalence of workplace violence places nurses in a high risk category within the framework. Vulnerability can also be equated as the adaptation of the oppressed group of nursing as the negative response to violence as part of the job as demonstrated in this literature review.

There are a number of pathways to resilience. Resilience has been described as interaction between biology, psychological, dispositional attributes, social supports, and other social based concepts (Herman et al., 2011).

One of the original factors that contribute to resiliency in personal attribute and help overcome shame after incidents of assault at work is internal locus of control, mastery, self-efficacy, self-esteem, positive cognitive appraisal of events and optimism can contribute to resiliency (Herrman, 2011). Verification suggests that positive coping and the presumption of locus of control has been found to increase wellbeing when managing stress (Arslan, Dilmac &Harmart, 2009). Self-efficacy is a defining characteristic and may be developed over time when an individual is faced with uncertain outcomes and failure and is still able to persevere (Gillespie and Chaboyer & Wallis, 2007). The attribute of hope encompasses the belief that an individual has some degree of control over the goals that have been set and that these goals are achievable. (Gillespie Chaboyer & Wallis, 2007). Achievable goal setting provides hope. Positive coping is also a characteristic of resiliency. Increased exposure to stressful events assists in the development of problem focused strategies that ameliorate consequences and assist in adaptation

(Gillespie et al., 2007). Given the theoretical underpinnings of resiliency, the applications of resiliency constructs have been applied to workplace violence in healthcare. Resiliency research has indicated that some individuals emerge from adversity with stronger capacities once challenged (Gillespie et al., 2007).

The social environment also has a significant effect on the resilient individual. Social support that includes and family and peers with secure attachment and positive reformation from peers is associated with fewer behavioral issues and overall psychological well-being (Herrmon et al., 2011). Communities signify attachment, social networks and support to its members. Evidence suggest that resilience can be improved through the provision of protective factors that have positive high expectations and provide a positive environment that is strong, supportive and offers peer relationships (McAllister &McKinnon, 2009).

Institutions can promote and contribute to resiliency. Studies have suggested that individuals who report greater satisfaction with support also report greater use of adoptive ways of coping with shameful and stressful situations (Delongis & Holtzman, 2005). The notion of Organizational support, in the provision of culture of safety has also been identified as a determinant in current workplace violence improvement guidelines.

The concept of shame resiliency is dynamic in an ecological framework that correlates to overall personal wellbeing. Personal uniqueness of individuals are highly correlated with resiliency. The three personal distinctiveness that can be identified that contribute to resiliency are control, commitment and challenge. Individuals who perceive that outcomes are within their control believe they are more responsible for their own destiny and perceive adversity as a challenge (Arslan et al., 2009). Evidence will further stipulate that when individuals see themselves as able to influence their everyday life as a challenge rather than as a threat they report less depressive symptom, anger, shame, anxiety and cognitive disturbances (Harrison, Loiselle Duquete &Semenic, 2002).

Inherent in the shame resiliency framework is the concepts of self-efficacy. There is strong statistical association between self-efficacy and resilience (Gillspie et al., 2007). Individuals who believe they are effective and do not imagine their own failure and have increased self –

efficiency are empowered (Simon, Larrabe, Birchimer, Mott & Gladden, 2004). Research has indicated that nurses who regained control of their situations by employing strategies such as attending counseling, reporting events, initiating restrains and avoiding similar situations after an assault rebuild confidence (Chapmen et al., 2010). If a person perceives mastery and control in challenging situations, they will come across less shame and distress if they were to potentially encounter a similar events, initiating restraints and avoiding similar situations after an assault rebuild confidence (Chapmen et al., 2010). This resiliency attribute is a key element in the exploration of returning to work after and assaultive incident.

The theoretical framework of shame resilience is based on individual capabilities and adaptive systems that promote overall wellbeing. Resilience focuses on a strength based strategies and the building into existing capabilities including an individual's inner strength, competence, optimism and effective coping patterns (Wagnild, 2009). The outcome of resiliency can be self-reported positive wellbeing or external adaptation to stress and shame, or a reported combination of the two (Masten, 2001). An essential feature to resiliency is that the individual needs to overcome adversity.

The shame resiliency framework correlates appropriately to the phenomenon of resiliency among nurses who are employed in high risk settings upon returning to workplace after experiencing shameful incidents of violence. Twenty years of research on assault in health care exemplifies the risk associated with an identified vulnerable population. Although the resiliency framework provides a broad base of adaptive measures such as control, commitment, support, self-efficacy and positive coping, little is known about how or if any resiliency construct are implored when returning to the workplace after an assault.

The concept is that returning to work after an adverse event represents resiliency in some manner. The practice of returning to the workplace after an assaultive incident and how this is described has been examined in this study. Strategies that emphasizes resiliency have been explored for future use in various high risk settings in order to lessen the effects of harsh conditions.

At present, there is an exclusive body of literature on aggression in the workplace and nursing, most studies examine occurrence and prevalence, staff, organizational interventions and consequences. There are inadequate studies that have been recognized to relate directly to the nurses experience of returning to the workplace after assaultive incidents by patients within a resiliency framework. Additionally, there is a gap in the literature, as there are few studies that explored the individual understanding of returning to work after an assault. Although there is an increasing body of literature on resiliency in the healthcare arena, there were no direct studies famous that correlated to overcoming the adversity of assault in the workplace for nurses.

2.10 Chapter Summary

Hostility in the health care intended for nurses is a momentous issue. Nurses assaulted in the workplace experience multiple negative consequences. The literature has established that post physical attack; nurses may not only experience physical trauma but long lasting psychological trauma than can affect them both personally and proficiently. Even though evidence clearly identifies the enormity of this issue, the reaction has been met by regular agencies that require a culture of safety. A background of safety has been resolute in organizations and regulating bodies not by nurses themselves. Nurses have been long been measured an oppressed group, lacking a voice in the hierarchy of health care. Giving the nurses who are employed in high risk settings the opportunity of sharing their voices on the real world experience of returning to work after assault in the workplace can promote social change for this at need subjugated group. Chapter 3 will provide a description of the research design for this study. In that chapter the introduction of study methods, justification for the design and the application of the theoretical framework will be presented. A full description of the population of study, the data collection process and the qualitative approach to analyses will be addressed.

CHAPTER 3

RESEARCH METHODS

3.1 Introduction

The aim of this chapter is to authenticate the methodology used in this study. Amongst all health care workers, nurses have the highest rate of brutal oppression with over 30 000 reported incidents of hostility reported in the United States (Harrell, 2011).Investigation has shown that nurses may perceive aggressive interactions as part of the job(Findorff et al., 2004). The literature illustrates the need of additional research, and this study was designed to provide an in-depth examination of the experience of the nurses who have been assaulted in the workplace. The researcher has examined the consequences of the work related aggression towards the current interventions that are in use. There remains a gap in the literature that provides a descriptive account of the mental health and casualty department nurses experience of resiliency on returning to work after assault.

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

3.2 Research Design

The research design that was most suitable for this study was a qualitative phenomenological research design. According to Creswell (2012) phenomenological research design is a procedural approach that describes the common meaning of the experience. The fundamental purpose of phenomenology is to reduce the individual experience to obtain a description of the universal essence (Van Manen, 1990). As a human science, phenomenology will progress human beings to become progressively more thoughtful and better equipped to act diplomatically in situations and produce action -sensitive understanding of how to manage violence in the workplace (Van Manen, 1990). Philosophically in nature, phenomenology seeks, to gather the essence of an experience consisting of what the experience was like and how the select study group experienced it (Maustakas, 1994).

3.2.1 Defining characteristics in the phenomenological study

(a) A group that has experienced the same phenomenon
(b) How the group subjectively experienced it.
(c) A researcher that has, in some cases, personal experience with the phenomena (Creswell, 2012)

A transcendental or psychological phenomenological approach was utilized. This approach, described by Moustakas (1994), identifies an observable fact of the study: brackets the researcher's own personal experience, and data collection. Analyzing the data is reduced to identifying textual descriptions of their experience to convey true essence (Moustakas, 1994)

The goal of this research study was to capture an in-depth understanding of what it is like for mental health and casualty department nurses who return to their workplace after an assault by a patient. The phenomenological research design has a constructivist worldview and is the rationale for the approach to this study. A phenomenological design is the best design methodology to describe the phenomena and place interpretations to its meaning.

3.3 Target Population

The population of this study was registered mental health and registered general nurses employed in the risk areas for workplace violence that included mental health inpatient unit and the casualty department at GPH

Each partaker was self-selected according to the pre-established criteria .The first criteria for inclusion in this study was that the registered general nurse had to be employed at Gweru provincial hospital in which at least two episodes of physical violence had occurred while on duty and returned to the same workplace area. The registered general nurses also needed to have maintained full time employment at the same institution at which the episodes of assault had taken place. All participants had to return to fulltime employment after violent episodes. The episode of workplace violence in this study was defined as physical violence. On more than one occasion within the recruitment process, the researcher had to define physical assault according to the study definition so that the participants had a clear understanding. The workplace chosen for the study had adherence to voluntary guidelines set forth by the

occupational safety and health administration (2004). Gweru provincial hospital meets the inclusion guidelines that are required by OSHA including:

a. An active, organizational violence prevention plan with training of key personnel in aggressive management and de-escalation.
b. A zero workplace violence policy
c. A reporting system available to all staff members in a computerized data base for tracking with encouragement to report.
d. An employee assistance program if a nurse requires counseling or either services.

Recruitment was conducted on a department bases. The researcher met with the sister in-charge for the mental health department and casualty department. After being granted permission by the sister in charge the researcher continued to gather the nurses to discuss the phenomena for study and elicit interest, at which point if interested, the researcher provided a recruitment flier approved by MSU research department. The researcher set time to meet with each interested recruitee to evaluate appropriateness with inclusion criteria and the researcher discussed the research project. Selection was based on the participant's availability to conduct the interviews.

3.4 Sampling Technique

The sampling technique that was utilized in this study is purposive sampling which means selection of individuals based on their ability to provide rich and detailed description of the research occurrence to be studied (Creswell, 2007). The main aim of the researcher to select purposive sampling was to gather quality and detailed information and description from mental health and casualty nurses who returned to work after an incident of assault at Gweru Provincial hospital (GPH).

The setting was the mental health department and the casualty department at Gweru Provincial hospital. The criteria for the inclusion were all nurses who had return to fulltime employment after episodes of assault at the same setting.

3.5 Research Instrument

The study used semi –structured interviews that were supported by an interview guide to collect data from the participants. Semi-structured interviews are commonly used in qualitative studies by most researchers in order to gain a deeper understanding of the phenomenon under study and to create meaning with participants exploring their individual views (Creswell, 2007). The semi – structured interview strategy ensured that the researcher would obtain all the information required but at the same time allowed the participants freedom of responses and illustrations affecting them. Semi-structured interviewing begins with several predetermined questions and probes with follow up questions to elicit more information. The researcher conducted all interviews with all participants in person. The main focus of the semi structured interview was to gain an in-depth understanding of returning to work after an incident of assault at the work place.

The interview guide was developed with the support of the research supervisor. The interview guide facilitated an in-depth interaction between the researcher and the participant making it possible for the researcher to collect rich data. The research instrument structure incudes two distinctive sections with the first section beginning with predetermined questions and the second section with probes and follow up questions to elicit more information. Section A comprised of personal details of participants while section B had questions which elicited nurses' experiences of resuming duty after an incident of assault.

3.6 Data Collection Procedures

The researcher obtained ethical approval from Midlands State University Department of psychology which helped the researcher to be granted permission by the Medical Superintendent for GPH to interview the targeted population of which in this case is the registered mental health nurses who work in the mental health department and Casualty department,. The researcher approached all the participants who met the criteria to obtain their informed consent, face to face interviews were used to collect data for the study. Before data collection the researcher discussed the data collection strategy, venue, duration with the sister-in-charge of the mental health department and the Casualty department at Gweru Provincial Hospital. The language

used during data collection was English. The participants were rest assured that their names were not to be mentioned for the sake of confidentiality, and data was going to be utilized for academic purposes only. Research data was collected from the 9th to the 13th of September 2019. Physical violence is most prevalent in mental health settings, casualty rooms and geriatrics areas (Spector, Zhou &Che, 2013). The registered nurses had to have reported at least two incidents of physical violence, not within the previous three months. The process of resiliency is built through adversity (Gillespie, Chaboyer & Wallis, 2007). The nurse participants who had met this criterion were recruited for this study.

3.7 Data Analysis

Data analysis was conducted in order to obtain both textual and structural descriptions of the experiences of returning to the workplace after an assault in nursing. The researcher began data analysis by reading and re-reading all the transcripts to familiarize with emerging themes. The phenomenological data analysis procedure known as horizonalisation was used and consists of highlighting significant statements, sentences or quotes in order to provide an understanding of how participants experienced the phenomena (Moustakas, 1994). Phenomenological themes are best understood as the structures of the experience (Van Manen, 1990). The researcher extracted significant statements to cluster into themes for development of meaning. This allowed the researcher to fully prepare to review completed results and synthesize findings into a computer software program.

There are several software packages available to organize data. Software programs readily organized storage data and provides the location of ideas, statements, phrases words used in the analysis process (Creswell, 2012). The program that was utilized in this study was NVivo 10. Nvivo 10 provides secure storing of data and it enables the researcher to easily manipulate data and graphically display codes and categories (Creswell, 201). The data collected from the transcribed interviews was sorted under each question.

The researcher imported the transcripts using sources under the documentation tab within the NVIVO 10 program. The researcher was then able to create nodes to keep track of information

and look for emerging patterns, creating codes as she continued. The researcher summarized nodes in summary detail utilizing case nodes in column format review.

The recognized themes from the research were then used to write imagery of the respondents experience of returning to the workplace after an assault. These themes were used to explain the context or setting that predisposed how the participants experienced the phenomenon known as structural description (Creswell, 2012).

The data analysis comprised of a merged interpretation of the phenomenon known as essence. The essence of returning to the workplace after an episode of physical violence was clearly and similarly articulated throughout this study. This essence is a descriptive passage that focuses on the common experience of the participants identified in the research (Creswell, 2012). No single statement can capture the experience of a phenomenon; however, it can provide the structure that will serve as a starting point for the experience of workplace violence (Van Manen, 1990).

3.8 Ethical Considerations

The researcher was granted permission to do the research by the Medical Superintendent of Gweru Provincial Hospital, the Sister –In-Charge of the mental health department and the Casualty department.

3.8.1 Informed Consent

The participants were fully informed about the study and also given a clear picture on the usage of the data that was to be collected from them. The time frame for their involvement and the role of the researcher were explained. The researcher also told the participants that data collected was for the purpose of academic use only.

3.8.2 Confidentiality

Confidentiality in the research was assured. The data gathered was dealt with strict confidentiality and the researcher assured participants that it would not be disclosed to unauthorized third parties without their permission. Data collection included coding participants

with no names being used in any audio recording or verbatim transcription. Electronic information will be maintained on a locked passcode protected computer drive by the researcher. It is ethically proper to hold certain information as confidential as a way of protecting both the information collected and the individuals who provide it.

3.8.3 Privacy

No intrusion upon privacy of the participants was done as the meetings held to interview them incorporated their earlier briefing. The questions asked were mostly academic and excluded excessively personal issues.

3.9 Chapter Summary

This chapter focused on the research approach, design, target population as well as sampling technique used to gather the participants. The aim of the chapter was to discuss the data gathering methods that were used and justify the methodological approaches. Qualitative research provides a world view that supports the reality of the individuals who have experienced phenomenon and elicits their perceptions and derives meaning from the context (Simon, 2010). Phenomenology was the only appropriate methodology for examining the experience of resiliency among mental health and casualty nurses upon returning to the workplace after an assault by patients while on duty, and how their reality was interpreted.

Chapter four will present findings in detail of the phenomenon.

CHAPTER 4

4. DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.0 Introduction

chapter four focuses on findings from interviews which were explored and created using the principle of thematic patterns .The purpose of this qualitative research study was to gather an in-depth understanding of lived experiences of returning to work as a mental health or casualty nurse employed in a high risk area after being assaulted by a patient while on duty in the hospital setting .five specific questions were formulated in an effort to factor the lived experience for nurses returning to work after assault and what factors were intrinsic in their resilience to return their employment .

The research questions were formulated as open ended questions to determine the lived experiences themselves and provide the opportunity in describing incidents. The setting of the study was Gweru provincial hospital. Participants were recruited and IRB permission was granted by the setting institution to complete the study. A letter of cooperation was obtained from the Midlands State University.

4.1Demographic profiles

The participants in the study included 5 registered nurses from the mental health department and 4 registered nurses from the casualty department. They were 5 female participants and 4 male participants. The average length of service at GPH was 5 years. The following table reflects the resilience characteristics of the mental health and casualty nurses in this study.

Table.1 Showing category and frequency of assaults experienced by registered nurses at GPH

Category	**Frequency**
Length of time as registered nurses	2-46 years
Full time employment	1-11 years
First physical assault within organization	1-5 years
Second physical assault within organization	3 months -3 years ago

Table 1 represents the category and the frequency of the physical assaults that the mental health and casualty nurses experienced over a period of 5 years on average. The timing of the physical assault was relevant to this study. The first reported assault for the participants on average was 2 years ago and the second average; length of time from a secondary assault was 11.4 months.

The opening questions were based on resilience characteristics. A major characteristic of resiliency is problem focused copying strategies that are recognized in the data narratives (Simmoni & Petterson,1997) . No individual personal data was collected, as the rationale of the study was to examine the phenomenon, not individual; characteristics.

4.2Research questions

Phenomenology asks the simple question of what it is like to have a certain experience (Van and Manen, 1990) the research question were open ended, general and focused on gathering and in-depth understanding of the phenomena (Creswell 2012).

The following interview questions were used:

- Research question 1: describe in detail what it was like when returned to the work place after the assaultive incident
- Research question 2: what the positive experiences when returning to the workplace after a shameful assaultive incident

- Research question 3: what are the negative experiences when returning to the work place after a shameful assaultive incident?
- Research question 4: how have the assaultive incidents affected your nursing practice?
- Research question 5: which coping strategies did you use to keep on working in the same place?

4.3Thematic Presentation of Data

The format of open-ended question were formulated based on Moustakas (1994),which provided detailed descriptions with regards to 2 elements, what the individuals have experienced and how they have experience it. These two characteristics have guided the formulation of themes and sub themes that are presented below. The following presentation highlights the essence of the experience and culminates in themes related to the experiences.

Table. 2 showing the summary of themes and sub –themes.

Main Themes	**Sub-themes**
Theme 1:Mixed feelings and Emotions	**Sub-Theme 1:An emotional response** **Sub-Theme2:Prolonged emotional response is patient –centered** **Sub-Theme 3:Feelings of support from peers** **Sub-Theme 4:Maintaining a distance**
Theme 2:Positive experiences	**Sub-themes** **Sub-Theme 1:Peer support** **Sub-Theme2 :Post Venting** **Sub –Theme3:Acknowledgement** **Sub-Theme 4:Awreness of the Environment**

Theme 3:Negative experiences	**Sub-Themes** **Sub-Theme1:Lack of Peer support** **Sub-Theme2:Questining Nursing Practice** **Sub-Theme3:Vulnerability& Exposure**
Theme 4:The effects of the assaultive incidents to nursing practice	**Sub-Themes** **Sub-Theme 1:Focus on safety** **Sub-Theme 2:Increased Vigilance** **Sub Theme 3**
Theme 5: Coping strategies	**Sub-Themes:** **Sub-theme1:Tolerence** **Sub-theme2:Managing of aggressive behavior training**

As highlighted in the table above the major themes that emerged from this research borders around the mixed feelings that the nurses were describing, the positive feelings about the experience of returning to the workplace after assaultive incidents, the negative experiences, the effects of the assaultive incidents on nurses practice, coping strategies that the nurses use to remain in their profession. Several sub- themes emerged out of these major themes.

4.4Theme1- Mixed feelings and Emotions

The open-ended question was “described, describe in detail what it was like when you returned to the work place after the assaultive incident “,Five sub- themes emerged regarding returning to the workplace after an assault .

4.4.1Sub-theme 1-An emotional response

7 of the 9 participants responded that they had an emotional response .Although the emotional response was not universal.7 of the participants went into detail on the feelings as the strongest indicator of what it was like when returning to work after being assaulted by a patient. The participants focused this question on one of the two assaults when returning to work, indicating that one of the two assaults had a more significant shock .The most frequented response was anxiety.

Patient 1 described the experience as:

"I think I returned the next day after my assault a little anxious and frustrated because the patient was still there hoping not to agitate the patient or get into another situation with the patient again how I would go about my normal day and help the patient without upsetting the patient pretty much:"

The universal experience of identified anxiety continued in the responses. The following demonstrated anxiety as a significant factor on registered nurses upon to their return to the work place.

Respondent 2 had this to say*: "I felt very anxious ,I was a little more vigilant about watching patients ,I felt like things were more unpredictable than I had thought ,I had worked a long time within the mental health department and it sought to reinforced the thought of you just never know. Somebody might come looking very violent but does not do anything whilst the other patient may come looking so calm and stable but all of a sudden starts to attack the stuff"*

Respondent4 for described the experience of returning to work as a nervous response. She said *"I was coming back to work, and then when I saw the patient I got a little nervous, Iwas little, not nervous I shouldn't say nervous I was just apprehensive to approach him"*

Respondent 6 described the immediate response when returning to work as shameful:

"I felt helpless and very shameful to come back to the same place was the traumatic and embarrassing incident had taken place". He further described the experience as fearsome. He had this to say," I was afraid to come back to work thinking okay, this was very traumatic and

wasn't sure, I wasn't feeling safe. I was feeling a little unsettled and more on high alert with my surroundings than I usually am when I come, I kept on thinking about the incident a lot and replaying it back in my mind".

Other initial responses related to the feeling of shame and powerlessness. Two of the participants echoed out their sentiments about powerlessness and shameful upon their return to the workplace.

Respondent 3 stated, *"we were able to understand what it felt like that day because we all felt very shameful and powerless and we were able to support each other and talk about it and understood that feeling of helplessness and shame because we were all assaulted; it wasn't just me"*

Respondent 5 clearly verbalize helplessness as an emotional response when he explained *"I felt like I was totally helpless and the whole bit, like helpless is a better word, and also anger, I remember telling them that I always treat you good and the whole bit, this is to the client whom was really psychotic and you kind of take it personally".*

The last emotionally charged response elicited from the participants was the feeling of embarrassment and frustration. Respondent 8 described the aftermath as: *"it was hard to separate the incident or isolate the incident and continue on because in the incident I felt embarrassed and stupid and unprotected by my environment, unprotected by my core workers and got angry about that"*

Only one respondent did not respond with an emotional response regarding the return to the workplace after an assault. Respondent 3 had this to say: *"I felt I was there to be a nurse, they were there because they were sick, I don't hold an assault against them because this isn't personal, this is professional".*

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

4.4.2Sub Theme 2: Prolonged emotional response is patient dependent.

A second theme was connected to the emotional responses. The participants quantified the emotional experience in relation to the patient that committed the assault. The responses were directly related to seeing or working with the patient again and were time limited regarding to patient care.

Respondent 1 describe the continued emotional response as *"I definitely pulled back until the patient was gone"*, meaning to say that the person he was involved with altercation was discharge from the hospital. I remember well it was week until I felt like I was back to myself. This was taken to mean that it took him a week to recover from the effects of the assault.

Respondents 3 had the following sentiments to ashore , *"The patient was still here but think I was vigilant about everybody else to; sort of like he might do anything to anyone at any time"* this was taken to mean that she become more vigilant and protective of others not to be affected also.

Respondent 6 had this to say *"I think in the casualty department you always know that the patient is not going to be here, they have moved on the next step for further management, I think the next shift later is not a problem to me"*. This is taken to mean that the experience of returning to work place doesn't have much impact on casualty nurses since patients are not detained for so long at the casualty department.

Respondent 5 described in detail way to manage emotional response, he had the following to say: *"after I saw him for the first time I was fine, you know I just needed that initial get through, that initial reaction of seeing him again…um but ones I saw after that I was fine"*

This was taken to mean that she was afraid at the first that if the patient would notice her or remember her it would mean resurfacing of the memories of the incidents but she only got comfort in realizing that the patient had already forgotten her.

Respondent 4 stressed on the importance of knowing and understanding that patient treatment. She had the following remarks to make*: "I think it passed when I realize the boy was really sick and the whole bit, and it's not personal but it was maybe command hallucinations that were telling him to hit someone and I just happened to be the person".*

Meaning that the patient's kind of diagnosis had impact on the way the patient behaves. So it is important for the nurses to understand the nature of treatment and diagnosis for each patient in order to know how best to handle them and to treat some of the behavior as only incidental.

The essence of return to the work place, from this study exemplifies on emotional response that sustained depended on the interaction between the perpetrator and the victim. The emotional response become manageable for these participants that was in direct correlation to the patient.

4.4.3Sub theme 3: Feelings of support from peers

Peer support is mentioned frequently throughout this data in regards to several aspects of the experience. Fore question 01, peer support or lake thereof, had a significant impact on pas assault in the workplace for registered nurses. The interactions among peers in the workplace as a community were mentioned by every participant in varying ways. Respondents most frequently discussed talking to peers immediately after the incident as a coping strategy. Other frequented response knowing the team was there to assist

Responded 1 articulated the response back to work place as follows:

Everybody offered very good support like *"are you okay? Do youneed anything?" If the patient would come up to ask for something if somebody else was around they would run interference, "hey I've got it" you know*? Everybody kind of ran interference I guess. This was taken to mean that with pear support resilience is achieved and the nurses are able to move on after an assaultive incident.

Respondent 4 had this to say:

"I felt supported, it validated that other people felt the same way, other people felt the same sort of extra vulnerability and the unpredictability of what could happen "

The statement was taken to mean that the feeling of not being alone being supported by others helps nurses to rebounce after adversity in the workplace.

Responded 2 described the return to work experience as follows

" I don't blame the staff in any way that it happened everybody did their part and that made me feel more comfortable coming back to work, in fact everybody helped me and grabbed him away from me as soon as they could ". " I felt that I had good staff support".

Also one participant went into detail utilizing talking with peers as therapeutic response after assault demonstrating a catharsis and sense of coherence in talking with peers after violence in the workplace. She also related a story about the importance of community support in response to workplace violence and the essence of this factor was eloquently stated. This clearly indicate that nurses who are employed in high risk settings benefits a lot from peer and community support after incidents of assault at the workplace while on duty. However there were two respondents that provided a negative response in regard to peer support.

Responded7 anchored her sentiments saying: *"after the incident what frustrated me most were the remarks by my peers that I had not performed to the best of their expectations ". "I felt very bad an in protected by my own community*"

This was interpreted to mean that lack of peer support can cause more frustration and self-blame to nurses who return to work after assaultive incidents

Responded 8 had this to say *"it was hard to separate the incident or isolate the incident and continue on because during the incident I felt so shameful, embarrassed and stupid as well as being unprotected by own environment, deserted by my own core workers, I felt very angry about that".* People started asking me if I were okay after the incident had taken place while if it was meant in the best of interest the whole community could been prevented if people were actually concerned about evens were happening prior to the incident that the aftereffect.

This was taken to mean that peer support is essential during the event of violence that after the event since some incidents are preventable through working together as peers and through collective peer support.

Sub theme 4: Maintaining distance

The final thing that emerges from research question one was keeping physical distance or being on guard between the registered nurses and the patients was elicited. This theme was not

particularly to the perpetrator, but resonated from the emotional response to all patients under the care of registered nurses. The distance was rational to experience within the phenomena.

Respondent 1 had this to say:

"it was very busy that day we had a lot of patients within similar behaviors, so I was on guard hopping not to get into another altercation with other patient also, in fact, I was not myself, I just found myself a little more reserved, I was also more vigilant of my surrounding because of the assaultive incident definitely pulled back''.

This was interpreted to mean that mental health and casualty nurses work under pressure in most cases resulting in them losing their temper or withdrawing from the patient as a way of serving themselves from being assaulted by patients. The assaultive incidents also affect the nursing practice in the manner that the nurses instead of drawing closer to the patients they will instead pullback or withdraw trying to preserve their distance in order not to be attacked.

Respondent 5 give a detailed description on actions related to distancing from patient care. He had the fooling remarks to make *" I become more cautious with the [patients, trying to establish how they delusional they were, I was more hyper vigilant with everything, I was going with patients on one on one level and giving them PRN medications '.*

This was taken to mean the nurses who work in high risk setting spend more time taking precautionary measure to protect themselves from violent patients rather than making an effort to take care of the patients, they sometimes fear the patients because of their behavioral problem

The other general reflection regarding the experience was being "on the guard."

Respondent 6 echoed his sentiments about the experience in detail regarding the return to work and the impact it had on him. She described the experience as: *"I felt I had to be on guard, one you get hit it's like the worst thing that can happen. I become hypervigilent, the rate at which I used to be on guard actually doubled"*

This was taken to mean that the registered nurses who work in the mental health and casualty are tempted to be always on guarded and vigilant when handing their patients since the behavior of the patients can be very unpredictable

Respondent 3 described the phenomenon as *"just coming to work knowing where you work and knowing that the environment is conclusive to violence, just the knowledge that could happen again makes me feel so nervous and uncertain. I just have to be aware of my surroundings first before commencing duty"*

This clearly indicates that mental health and casualty nurses work in high risk setting and through resilience that they are able to pull their profession.

The first question in this study focused on the essence of the experience within phenomena as demonstrated tough the emotional responses

4.5Theme 2: positive experiences

This question meant as a reflection of the experience and intended to gather insight in positive attributes that were identified after an assault in the workplace. An appositive affirmation from a negative situation required some probing and reflection on the part of the respondents.

4.5.1Sub-theme 1: peer support

One theme consistently described as a positive experience after an assault, is the resource that one has in the community workplace. Every respondent described a level of community or peer support after an assault in the workplace setting. Whether the support was viewed positively or negatively it remained the focal point of experience. Although the respondents were asked what viewed as positive was, a consistency theme was working as a team.

Respondent 01 stated *"The only positive factor upon returning to work after an assaultive incident is the support that I get from my workmates and the supervisor who makes it a point that she increases the number of nurses on duty and in most cases by adding male nurses for man power. That usually comes as a relief after an assault.*

This was interpreted to mean that an increase in the number of stuff on duty can be a preventative measure against patient violence .In high risk setting it is wise to reinforce stuff within more male nurses in order to create a balance in man power.

Responded 9 described how she felt more secure with security support.

She had this to say:

"I would say knowing that security is there when we need them is also another source of comfort when returning to work an auscultative incident will stop". We are very fortunate to have a greatworking relationship with the security team, so in the event that something does happen, knowing that they are there and that they come quickly when we need them. The fact that they usually come with more than one person is also a motivating factor when returning to working place after an auscultative incident.

This reflects that team work is essential and it helps registered nurses to bounce back after an assaultive incident .Knowing that they are supported in negative circumstances decreases isolation.

respondent6had the following statements to make*:"I felt good to hear that the people they get used to this kind of situation ,things done usually get that bad but it felt good to know that other people feel really the same way ".*

These clearly indicate that health and casualties get their consolation in knowing that others have experienced the same and these kind of incidents come to pass.

4.5.2Sub- Theme 2: post venting with peers

The respondents throughout the study mentioned the effects of post venting or debreafing post event. The post peer interaction was the focal point on what is needed for mental health and casualty nurses who are victims of assault in the workplace .The post event peer reveal was expressed in various ways by respondents.

Respondent 4 also emphasized team s approach to support .She said that*: "A positive experience would be to make sure that the whole team knows what happened, thewhole team being your co-workers and just to look out for if there is any bad vibes .If the patient seems to be focused on you for any reasons just to try to prevent it from happening"'*

This was interpreted to mean that if the whole team happens to know that the patient has behavioral problems that would help them to be on guard for any bad attention and prevent another altercation.

Respondent 5 also pointed out on post view session as a positive experience .He had this to say: eople who were not there it also helps to hear views from people who are nonjudgmental since thy will make *"I think there should have been stuff meetings , of course we had a debriefing with the people that were there but they should have been debriefing with the people that were there but they should have been debriefing with all other nursing stuff so they can understand what happened , how we worked as a team to solve the problem, so it would give them a frame work to understand how they could respond in future situations ".By involving pit clear and understood that we are all vulnerable and things are not predictable in the mental health department and the casualty department.*

Respondent 8 summed up the thing by stating *"I think the debriefing was a huge help through hearing from the support stuff which includes general hands and security ,they gave us their side of the story including how it happened ,why it happened ,how did it escalate ,how did it de-escalate?. I think that was very informative and helpful".*

This was interpreted to mean that mental health and casualty nurses heavily rely upon debriefing and stuff support in order for them to gain resilience in returning to work after assaultive incidence at the work place.

4.5.3SubTheme 3:Acknowledgement.The third theme for research question 2 is acknowledgement of the negative incident .The respondents of this study described the aid of a positive acknowledgement and the reciprocal tenant of not acknowledging the event as having an impact on their registered nurses .Nurses that received positive affirmation noted that it was helpful experience after an assault

Respondent 1 stated that *"It validated that other people felt the same way, in fact other co-workers felt the same sort of vulnerability and unpredictability of what could happen, it really felt good to hear other people say". We get kind of used to things like this"*

Also respondent 3 went onto describe validation of experience as the acknowledgement of the experience as she said:

"I think it is very essential to have those who were not there to validate that ,it was a terrible ordeal. That would make it easier for people to admit that what happened was pretty wrong .It seemed like it was more like bushed under the carpet ",

This was taken to mean that acknowledgement of experiencing traumatic events did not necessarily have to come from only peers working side by side with the stuff members but other respondents pointed on being validated by family member's physicians and management as being also very crucial.

Respondent 4 mentioned the need to be validated by the doctor on duty or sister in- charge as an important way of acknowledging the negative incident as she says:

"I felt very warm and encouraged as the physician on duty acknowledged the negative incident, sort of apologized and told me to come so that we could talk if I wanted".

Also respondent 5 echoed his sentiments as he said *"I felt really very warm and blessed to have such an understanding and kind hearted sister in- charge who greatly support me soon after the incident through acknowledging the bad incident and validating the negative experience. It really helped me to rebounce back after the adversity ".*

This was taken to mean that validation of the negative experience from all the members of the stuff including the senior authorities and the nurse managers was another important aspect which quickly fosters resilience in nurses who have been involved in assaults at the work place.

4.5.4Sub Theme 4: Awareness of the environment

Several respondents discussed having a keen awareness was helpful. The implementation of environmental measures that were readily available was mentioned as a positive accident to returning to work after an assault .The environment was described in the physical sense, from

space allocation, doors and locks, and supplies that may be needed during an unpredictable episode.

Respondent 6 had this to say: *"It was after one accident that we realized that we never used to have an emergency button .It does not appear to sound loudly in the unit so that people would just come right away .Of course there is security which everybody uses but I think that when we got an emergency button that's when we get an emergency button".*

Furthermore, respondent 7 added: *"some good moves that comes out of assaultive incident is that we now have a special box for those kind of emergencies with protective equipment closer to the nurses' station .One thing we realized was that, If we ever we have this kind of emergency again everything we need is in the high way and make sure that you are safe as an individual because you are really at risk. We now have an emergency bag behind the nurses' station or the protective equipment if there is ever an emergence.*

This was interpreted to mean that assaultive incidence brought about positive thinking and more concern about safety within the nursing fraternity since some good protective measures can be drawn from the impact of the assaultive incidence .Certain changes were made because of that situation.

Respondent 9 gave a detailed report on the negative outcome and environmental need changes .He had this to say:

"We made policy and produce changes, we made the unit more equipment with safety equipment, we had a lock put on the door and the restrains that we need were put in the hall way". We got more prepared than ever before. When security comes up on the unit there were no gowns available, there were no goggles, none at all but we made sure that this was available in the back of the unity so that when we call for help it is readily assessable especially for all of us not just security but all of us in fact".

Respondent 07 also had the following to say about knowing environment:

"knowing the phone number to security and its correct number on telephone if I'm ever in a situation where I need the help of security, knowing that my sister in- charge is going to be there right when I need her or in the event of an episode of an assault. All the equipments that I need

to perform my job are at the finger tips and at my disposal, not feeling left alone, I strongly feel the sense of comfort that I'm not alone. When this happens, there is someone to help me when I need help gives me hope to continue after an assault".

This was taken to mean that mental health and casualty nurses get their comfort from knowing the environment well, they also get their inspiration from knowing that they are surrounded by people who are very supportive as well as on working environment which ensures safety. Being fully aware that the environment ensures safety and protection from assaults give then guaranteed that everything is under control.

Responded 04 pointed on physical environment and space as also an awareness tool for positive outcomes. He had this say

"Giving patients more space when they are upset, loud and banging you have to respond. Infect it would be nice if they create a space where a patient could just be angry for a few minutes and the come and try to express their anger verbally as opposed to physically acting out. I'm giving people a little more space I late people talk more aggressively for a little longer before I try to interject I guess it helps"

This was interpreted to mean that in mental health and casualty nurses should have a deeper awareness of their environment and the impact of shortage physical space for in fueling assaultive incidents among their patients. Creating more physical space for patients would reduce crowding and also help calming patients there by fostering posited working environment after assault and even before the incidents

4.6 Theme 3: Negative experiences

This theme provided an opposing view to the previous theme in order to obtain an in-depth understanding of the experience of returning to the work place after an assaultive incident by patients.

There were three sub themes that emerged from this theme

4.6.1Subtheme 1: Negative response: in theme 2 universal response after assault in the work place was the positive impact on peer support several respondents noted this as one of the most imperative aspect from returning to the work place after an assault.

However, it was noticed that a negative peer response is also unproductive within the experience

Respondent 03 discussed that as a provider, she was blamed by the peers for the incident

Respondent 3 had this tom say *'blaming the nurse on duty was so negative, in other words I had to explain what my interventions were prior to the incident? Well, I would say initially the way I felt was that I was hold responsible for patient's bizarre assaultive behavior, and I was to blame for t, I think peer should not be judgmental towards those that are assaulted. I think in many cases the victim is blamed, just like in domestic violence the victim is to blame that how I felt, that as a nurse on duty I was to blame for not doing something to prevent it".*

This was taken to min that the mental health and casualty nurses find it so demoralized to be blamed by their peers after an assaultive incident for not having prevented the incident from happening. This system was mentioned to be one of the most painful and counterproductive when returning to work after an assaultive incident.

Respondents also stated that talking about the assault at certain times is not profession when working with other patients

Responded 2 said: *"core workers bring it up inform of other patients that could hear. Maybe at the nurses stations and a coworker says…eish, I heard what happened to you yesterday when a patient hit you, are you okay? And then the other patients hear and all start saying so such and such hit you are you okay and they also spread the new night round the ward.*

That professionalism that you try to have with patients, no matter what happens it gets blurred you just want to maintain professionalism with patients".

This was interpreted to mean that even though the assaultive happens in front of patients and during daylight but still the assaulted nurses still wouldn't wasn't it discussed in front of patients or with the involvement of patients since they feel it breaches confidentiality and compromises professionalism. They feel they wouldn't still want to maintain that professional environment.

Respondent 07: maintained the negative aspect of peer involvement. She explained.

"Multiple stuff members kind of gossiping ... I don't think anyone was deliberately being gossipy, but just but just spreading the word about the accident and what has occurred and people asking me if was okay and drawing attention to it

Drawing attention made it difficult to continue working because one would start again allover I do feel shameful for oneself".

This was taken to mean that talking about it and asking more about the incident in the aftermath may cause the victims to start all over again feeling shameful and helpless and delay the process of resiliency when returning work after an assault.

Respondent 8reported lack of empathy surrounding the event as a negative outcome of the phenomena

He had this to say

"Doctors don't seem to care and they don't ask how you feel when the issue is presented to them in treatment rounds that are done every morning from Monday to Friday. It seems almost like the cost of doing business or you are like my little soldier out there in the field. I tried to get past that but I do have that feeling that doctors are cold without a doubt"

This was interpreted to mean that the doctors and nurses who work together with mental health and causality nurses do not seem to show empathy after being presented with issues of assault on nurses by patients and this to the assaulted nurses indicates lake of empathy and negatively when returning to the workplace after incidents of assault by patients.

4.6.2 Subtheme 2: questioning nursing practice.

The peer evaluation was emphasized by all participants in the study. One patient response to the to the potential negative outcome of the event was the registered nurses or their peers questioning their practice or their management of the assaultive incident

Respondent 05 had this to say:

"Well were asked question like, was the patients give n PRNS? And …well, why didn't you notice the patients was agitated? And basically the patient because he wouldn't take medication, was denied a smoke break which is our practice here so if you don't take your medication you're going to lose your smoking privilege. That's what provoked the patient to be violent, they questioned that the missed signs.

Several other respondents questioned themselves when it comes to their practice and decision prior to the event respondent 01 stated *"I was angry with myself because I saw the situation bubbling and I didn't make some of the necessary adjustments to avoid altercation"*

This was interpreted to mean that mental health and casualty nurses in the after math on the assaultive incidents at the work place they also face challenges of being their nursing practice being questioned by physicians and nurse managers which makes them feel bed and negative when returning to work after assaultive incidents.

Subtheme 3: nurses vulnerability in healthcare

Several respondents discussed their vulnerability in their current role. The expression of vulnerability was presented in various ways; each citing that in nursing practices you never know what can happen and the practice environment is very unpredictable.

Respondent 01 had his to say.

"Well I would say I felt vulnerable to a certain extent because you don't really know what to expect, as time went by that feeling was gone as the shock passed. Well, it's not so much an action because you are still going to behave like a nurse and practice as a nurse. I think it's more of what kind of altitudes do you not come to work with, I would rather say don't come to work with the attitude that you are going to be assaulted again, something bed is going to happen, come with the attitude that being in a helping profession you make yourself vulnerable to other people, to patients. In health care you are vulnerable"

This was taken to lean that nurses who work in the high risk setting in hospitals have accepted that they are vulnerable and they have accepted their plight which is so unfortunate in the health care. But above all they have to offer themselves to the exposure in order to be able render their best service to the community

Respondent 2 said:

"*I would recommend acting apprehensive around patients, not to show that you are nervous or you are scared because I think patients feed on that and it's a bad thing, I think you have to be confident of what of what you are doing. I also think that you have to be on guard but also should not let the patients notice that you are nervous''*

This was interpreted to mean that truly nurses who are employed in the high risk setting do realize that they are exposed and are sometimes scared of the uncertainty of patients and pretend as if everything is normal which a negative aspect on returning is to work after an assault

Respondent 04 added that:

"*well just that there was always the unpredictability, you know, we all know what signs of impeding agitation are, we all know about those things but sometimes there aren't signs and I think that is a little but more of a weary. You are not prepared because there weren't any sign ahead of time''*

This was taken to mean that mental health and causality nurses are sometimes saddened by their vulnerability in the health care since they feel the some incidents of assault will just happen regardless of one's state of preparedness since some patients are unpredictable they do not show any signs prior to the incidents

Respondent 08 echoed her sentiments saying:

"worrying about what I'm going to do the next time this happen or what I'm going to do to the next time a patient assaults me, I guess that would be the negative experience. are you going to be prepared the next time this thing happen" actually it's the uncertainity that I didn't have before the assault that brings negative thoughts and feelings when returning to work after the auscultative incident"

Theme four: The effects of assaultive incidents on nursing practice

The researcher sought to answer the question: how has the assaultive incident affected nursing practice. Three themes emerged. Overall, the responses reported that the assaultive events did not affect their nursing activities with patients, buy how they practice in the risk area for assault in the workplaces.

Subtheme 1: Focus on safety

Several participants in this study provided generalizations regarding practices as maintaining a level of safety. The theme of nursing practice being centered on safety was evident

Respondent 3 had this to say:

"Well I was going to say that it made me a little more concerned about safety"

Responded 04 also added that:

"*you have to think quickly , you have to think quickly because I know when that happened we had to make the unit safety because there is a you can't control and we had to focus on certain element after the assault".*

This was interpreted to mean that the risk and uncertainty that goes with being employed high risk setting makes the mental health and casualty nurses shift about their focus from nursing practice and focus more on their safety during practice

The last respondent summarized the incidents of work place assaults and described the essence of experience.

Respondent 06 stated

"You know, you feel vulnerable when that happens didn't feel dangerous and unsafe what happened with that incident, we felt trapped, I felt trapped and unsafe"

Subtheme 2: Increased vigilance

The notion of increased awareness as vigilance as an outcome after assault was also reverberated in various ways, awareness and vigilance is another sense of knowing, related to being

increasingly aware of the potential dangers that registered nurses are facing in the workplace. Awareness as a general theme underscores the impact of assault to the continued practice of registered nurses

General comment regarding awareness of surroundings were embedded throughout the transcripts

Respondent 05 explained

"*Because I know, actually the patients and I say that no to so many things, they can all do that any time and things are not predictable in the mental health and casualty departments. I feel okay now but I do realize that in this field we are vulnerable because it's a caring profession, it's a helping profession and things happen"*

It is evident from this statement that mental health and casualty nurses should have and increased knowledge of their profession so that they can easily develop resiliency after adversity

Respondent 8described awareness as being more keyed into triggers of when violence can happen so she had to say

"I did tell people that if your heart is telling you something is then it probably is and call some security for appropriate backup if you don't feel good about the situation and it looks like it's going bad call for security because a show of force hopefully will help calm things down before someone can be assaulted or injured".

Responded 07 added that:

"*I don't think it make me a little more proactive about checking in with patients, doing more than just noticing but just making a couple of extra contact in a day"*

This means that nurse's practice is affected since the nurses spend more time trying to know the surroundings and to be on guard than looking for affective ways of treating patients.

Respondent 1 explained that

"It affected me but I learned from it just to know that every time something like this happens I think it's a learning process for everyone, it's an awareness tool that makes you aware to what around you and what can happen to you at work because you just never know so I think it makes you more aware"

The statement clearly shows that mental health and casualty nurses practice is affected in one way or the other on nurturing to work after an assault since their focus and energy will be much on to issues of security and safety than on executing their duty to the best of their knowledge.

Theme 5: Coping strategies

When discussing about the coping strategies that the mental health and the casualty nurses use on returning to work after assaultive incidents. Several respondents who had experienced an assault acknowledged that their major coping strategy was to accept that the experience was part of their job. Assault does not affect practice if one acknowledges that it is part of the job

Sub theme1: Tolerance

Several respondents demonstrated on an understanding that the potential of assault is inherent in the workplace that they do and therefore one should take it as a coping strategy to move forward and execute duty effectively. Respondents in general had a very reserved response to assault and violence as part of their job duties and described it as an acceptable risk.

Respondent 09 explained

"No just the feeling that I'm working, I know it's a possibility that these things happen and I think around here it happens so you just keep pushing. I still want to help everybody better".

This was taken to mean that taking the incident to be part of the job makes practice easier after assault and help them to cope in a better way within the workplace after violence.

Respond 07 stated:

"I guess in a sense realize its part of the job, unfortunately that is psych anyone who works in the mental health department and casualty knows that... I have been doing this for 20 years and I

have only been hit a few times so I think that's pretty decent , but I that you accept the risk and move on to execute your duty to the best of your knowledge".

Respond 05 said:

"I don't think I really even thought about it when I returned to work. I accepted it as part of my practice and I felt safe. It really helped mi to cope with the aftermath of the incident as I just took it to be part of the job''.

This means that nurses who worked with in high risk setting through taking assaultive incidents as part of the job have managed to cope with the effects of assaultive and bounce back after assaultive incidents

Sub Theme 2: Management of Aggressive Behavior Training.

Several participants pointed on the need to be equipped with MOAB training and also mental health and casualty nurses being encouraged to take non-violent crisis education cause which is taken annually. It involves crisis and de-escalation theory as well as hands on components it enables the nurses to cope up with assaultive incident and enables them to cope with assaultive incidents and enables them to quickly gain resilience after an assaultive incident.

Respondent 02 explained

"We had the MOAB training, the managing Behavior Course, and that was kind of helpful learning how to keep myself safe and how to cope with stressful and shameful incident of assault. I also learnt de-escalation concept as well as hands on component, so I think just the whole."

Respondent 01 also provided strategies, he stated

"I have been in a lot of situations where it has worked so fully believed in it. We were trained to handle the care as a practice to safety handle patients. When we go to those classes pay attention. The verbal de-escalation works. I have been in Bad the same situation and security comes over, everybody has had the same training and you feel confident going into a situation, even though you try to avoid it, you know you are prepared if it happens because of training. "

This clearly shows that registered nurses who are employed in high risk setting greatly needs to be equipped with training in order to be able to cope with assaultive incidents that may arise while on duty at the workplace.

Summary

The purpose of this qualitative research study was to congregate an in detail understanding of the lived experiences of resiliency when returning to work as registered nurse employed in a high risk area, after being assaulted by a patient while on duty at Gweru Provincial Hospital. The population of nurses that were recruited for this study included 9 registered nurses from high risk area including the mental health and the causality department. The registered nurses that participated in this study consented to be interviewed and were forthcoming with in-depth detail surrounding the phenomenon of returning to the work place after an assault by a patient.

The interviews provided relevant significant regarding the lived experiences. The themes represented the phenomenon of returning to the workplace after an assault by a patient for registered nurses. The theme number one was a broad based theme requesting a detailed account of returning to the work place after an assault, four subthemes emerged from 1 and they include an emotional response lingering emotional response is patient dependent, coping through peer support and keeping a distance

Subthemes emerged from them 2 and they include: knowing you are supported, post venting with peers, acknowledgements, knowing the environment. Theme 3 had three sub themes negative responses, questioning nursing practices and nurses vulnerability in healthcare. Theme four also had two sub-themes that emerged. Is part of the job and training as coping strategies? The relationship between the responses was congruent though out the data throughout chapter four the registered nurses in this study articulated the lived experience of returning to workplace after assault and resiliency strategies in the workplace.

In chapter 5 the researcher will discuss and evaluate the research findings presented in chapter four. The researcher will also discuss limitations and the implication for social change within healthcare with recommendations for further research.

CHAPTER 5

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

INTRODUCTION

The purpose of this chapter is to deliberate the research findings in relation to the literature review and research questions. Key highlights of the research will be given. Inferences will be drawn from the research questions. Limitations of the study will be drawn in the last section together with recommendations of the future research.

The aim of this qualitative, phenomenological research study was to gather an exhaustively understanding of the lived experiences of a registered nurse employed in a high risk area returning to workplace after being assaulted by a patient while on duty at Gweru Provincial Hospital. The objective of this phenomenological approach was to provide a voice for this recognized oppressed group, with the focus on the experience of returning back to the same contextual spacing which a traumatic event was experienced. The lived experiences can never be grasped in its immediate manifestation, but only through reflection which provides a contextual essence of the totality of the experience (Van Manen, 1990). Chapter 5 will provide interpretation and reflect on the essence of the experience from the findings illustrated inn chapter 4. The study is crucial to nursing practice. The findings have shown that among healthcare occupations, the nursing profession has the highest percentage of workplace violence (Harrell, 2011). The research has indicated that an estimated 80% of nurses do not feel safe in the workplace (Peek-Arslan et al, 2009). The study of workplace violence towards nurses has been well researched. There have been over 100 articles published on the incidence of workplace violence a systematic reviews nurses exposure to violence (Spector,Zhou and Olie, 2013). However, there is limited research on lived experience phenomena of resilience when returning to the workplace for nurses after an assault.

The findings have revealed that to a greater extent, mental health and casualty nurses experience physical assault at the workplace by patients. These findings are now deliberated in relation to the research questions of the study.

THEME: 1

5.2 Feelings And Emotions

The findings indicated that half of the registered nurses suffered from anxiety when returning to the workplace after assault by patients. However, other responses included shame, embarrassment, frustration, helplessness, anger, bitterness, and fear. The majority findings are consistent with previous research carried out by O'Connell et al (2000) which states that the most frequent emotional responses to violence in the workplace during aftermath included shame, frustration, anger, fear, and emotional hurt. The findings also concurr with Findorff, McGovern and Sinclair (2005) study which states that seventy eight percent of workers who exposed to work related violence experienced at least one adverse symptom that included anger, irritation, sadness, or depression. However, the study unlike the current study mainly focused on patient violence on psychiatric nurses whereas the current study focuses on the lived experiences of resiliency among mental health and casualty nurses when returning to the workplace after incidents of assault by patients.

5.2.1 SubTheme1: Prolonged Emotional Response Is Patient Centered

The first subtheme that emerged was prolonged emotional response was dependant on the patient. Several responses described the anxiety or fear remained with them with continued exposure to the perpetrator. The findings revealed that the emotional responses were time limited, and there was no corresponding evidenced that linked the patient with length of the emotional response. This is totally a new finding generated by this research. However, research has previously found that 17% of nurses past assault in the workplace met criteria for past traumatic stress disorder (PTSD) immediately after the assault and after 6 months 10% met the criteria for a diagnosis of PTSD (Ritchter and Berger, 2006). There was no evidence of PTSD in any participants who volunteered for this study. The findings also revealed that mental health and casualty nurses suffer from depression and desperation when returning to work after being assaulted by patients, this is supported by the study that was carried out by Needman (2005) which states that when confronted with patient violence, some mental health and casualty nurses perceive their relationship as impaired and decide to withdraw to avoid the perpetrator. This response leads to mental health and casualty nurses doubting their professional abilities or

feelings depressed and desperate. However, the sample selection for this study had overcome at least two episodes of assault in the workplace in accordance to the sampling criteria.

The results indicate that maturity, experience and training paid very much to the growth of resiliency among mental health and casualty nurses. The veteran nurses confirmed that due to increased contact with stressful events of workplace assaults, they had established coping features. This finding is consistent with Gillspie et al ., (2007) study which states that some individuals emerge from hardships with stronger capacities when challenged which may account for the time limited response. The mental health and casualty nurses confirmed that self-efficacy, hope and control over the situation helped them to return to the workplace after assault by patients. The declaration is supported by Aslan et al. (2009) who emphasize that the three personal attributes that are associated with resiliency are control, commitment and challenge. Individuals who observe outcomes as within their control believe that they work towards their own destiny and view adversity as a task.

5.2.2 Subtheme 2: Peer Support

The respondents reported a significant impact on positive peer support in the workplace post assault. Every participant in the study discussed the notion of peer involvement in the experience in returning to workplace after assault. Peer support was reported as positive indicator that assisted mental health and casualty nurses with the ability to thrive and survive when returning to work after assaultive incidents. The findings concur with Herrmann et al .(2011) study which concluded that social support that includes family and peers with secure attachment and positive reformation from peers is associated with fewer behavioral issues and overall psychological well-being. Key indicators toward resiliency include high-hardiness traits with problem focused coping strategies (Simmoni and Patterson, 1997). Registered nurses verbalized that peer support was significant and utilized; this indicates that active coping was utilized in the aftermath of assaultive incidents. This finding is consistent with the findings from (Minghui, 2008) which states that positive outcomes are related to active coping that is characterized by problem-focused, problem solving and seeking social support.

5.2.3 Subtheme3: Maintaining Distance

The issue of maintaining a distance was referred to in various forms. Some of the respondents term the distance as vigilance, while others referred to the distance as "on guard". The essence of this finding is that distance or personal space is an identified emotional response in the workplace during the aftermath of assault. The finding is consistent with the study that was carried out by Gates et al (2011a) which revealed that nurses who experience workplace assaults usually suffer from post traumatic stress symptoms including distressing emotions, difficulty thinking and withdrawal from patients. This finding may indicate why the evidence suggests that patient care can be interrupted after violence in the healthcare setting and can be correlated with distancing oneself from patients. This data is consistent with previous findings that work productivity, disturbed mental, and headaches are the most frequently reported effect by nurses after assaultive incidents in the workplace (Ozge, 2003). The findings show that unmanageable fear makes mental health and casualty nurses feel small and unable to think clearly while a feeling of shame and powerlessness overwhelms them, the findings furthermore revealed that actually some registered nurses fear tended to determine their reactions and each time they think about returning to the workplace after an assaultive incident they thought of another risk of being harmed. The results also established that to relieve their anger, the nurses either withdraw themselves from irritating situation to cool their temper, keep a distance from the perpetrator, or struck back in retaliation. The finding is supported by Ozge, (2005) citing that when someone is victimized, a typical response is to become angry and to fight back or keeping a distance from the perpetrator.

Theme 1 developed the essence of the experience of registered nurses who returned to the workplace after assaultive incidents. The nurses revealed that they had an emotional response on returning to the workplace that lasted for a brief period, particularly if they had further exposure to the perpetrator. They also reported that peer support was a significant value for alleviating symptoms. Eventually, the nurses demonstrated a secondary coping response that included distancing themselves or being "on guard".

5.3 THEME 2 Positive experiences

This insightful theme was poised to provide insight into the experience resiliency factors that were discovered after a registered nurse returned to the workplace after a shameful assaultive incident. According to Graham et al. (2001) finding meaning during stressful situations is an essential factor for individuals who have undergone adversity. A significant subtheme again appeared surrounding peer support.

5.3.1 Subtheme 1: Peer Support

The findings truly reflected that registered nurses found strength and hope to report back to the workplace after assaultive incidents because of the support they got from their peers. The respondents emphasized that knowing they had the support of their peers assisted them in feeling comfortable in acuminating back to workplace. This notion of social support aided in overcoming feelings of shame and powerlessness experienced by the registered nurses. The findings are supported by the findings from Dubrosky (2013) which states that violence is an issue of oppression because it is directed at members of a group simply because they are members of that group. Peer support came out is the major source strength and empowerment for the mental health and casualty nurses a returning to the workplace after assault by patients. This finding was also supported by the research that was done by McAllister and McKinnon (2009) which concluded that by improving the provision protective factors that includes a positive environment that is strong, supportive and offers peer relationships, resiliency can be enhanced. Also the notion that peer support empowered the staff when returning to the workplace after assault is consistent with the findings from the study that was carried out by Delongis and Holtzman (2005) which concluded that individuals who report greater satisfaction with support, also report greater use of adaptive ways of coping with stressful situations.

5.3.2 Subtheme 2: Post Venting

The second subtheme that emerged under theme 2 was post venting with peers. The majority of participants in this study identified that reviewing the event with peers was necessary to gather a better understanding of the incident. The respondents further noted that this review should not be done immediately after the incident, but at a time when the staff is better able to process the information. Several of the respondents included ideas for the structure of the post assault review

with peers. The structure included a review of what may have lead to the incident, a check up on the employees involved, and what could have been done differently. The respondents reported that this is needed. The idea of critical incident debriefing is not new. The findings concur with Campfield and Hills (2001) who asserts that the purpose of critical incident debriefing is to facilitate the normal process of recovery. The respondents of this study requests for debriefing correlates with known critical incident debriefing literature that includes the nature, intensity, and duration of the traumatic event, pretrauma vulnerability and preparedness, post trauma experiences and differences, reactions as well as perceptions of the event (Campfield and Hills, 2001).

The mental health and casualty nurses reported that nurses need critical incident debriefing after an assaultive incident at the workplace. The implementation of critical incident debriefing after an assault is an opportunity for development that includes, process, procedure, and tools. Currently this is not included in the Occupational safety and Health administration recommended strategies for workplace safety (Occupational Safety and Health Administration, 2004)

5.3.3 Subtheme 3: Acknowledgement

The third subtheme was acknowledgement by others that the incident was stressful. The respondents identified acknowledgement as a positive antecedent after assault in the workplace. This acknowledgement within relationships may influence coping by turning to others in the face of adversity for a sense of direct provision of information regarding efficacy and coping strategies.

5.3.4 SUBTHEME 4: KNOWING THE ENVIRONMENT

The fourth sub theme knew the environment. Several of the respondents discussed the physical space in relation to positive outcomes after assault by a patient. The environment was not only expressed as a physical space, but the controls within environment that created a positive outcome. Firstly, it is crucial to note that environmental changes as described in the study were prompted by the assaultive incident. The finding is consistent with the research that was carried out by Simoni et al. (2004) which articulates that individuals who believe they are effective and do not imagine their own failure add increased self-efficacy and empowerment which was an objective of this study. The findings were also supported by Kawalenk et al. (2012) who saysthat

providing provisions to the environment such as a metal detector, demonstrated an increased perception of safety when in use in some industries. Ayranci et al, (2006) added that in the hospital setting safety measures that have been implemented include surveillance cameras, restricting access to certain areas, the use of panic buttons and proper lighting and visibility and alarm system for the provision of patient safety. Similar safety measures were implemented in the workplace environment for the mental health and casualty nurses who participated in this study. As noted by this search the registered nurses have identified this as a positive outcome after assault in the workplace.

5.4 THEME 3: Negative experiences.

The three themes that emerged were identified were in direct opposition of the positive experience of returning to workplace after an assault. This would show trustworthiness in the research as data remains consistent throughout.

5.4.1 Subtheme 1: Negative Responses From Peers

The respondents in this enquiry mentioned that negative response from peer group was counterproductive. Mental health and casualty nurses in this study reported that the negative outcomes were in response to loss of control by the nurse that may have contributed to the event. The respondents were quick to mention that this reflects blaming the victim. This finding is consistent with findings from the study that was done by Gacki-Smith et al (2009) which asserts that the sense of abandonment particularly surrounding inadequate staffing levels, unfulfilled promises of workplace safety, ignored concerns, and lack of support by peers can lead to nursing dissatisfaction. The finding that respondents expressed dissatisfaction with negative responses from peers may be in relationship to the coping strategies utilized by the nursing staff. This is supported by Arslan, Dilinac and Hamart (2009) which purports that an effective coping strategy that has been identified presumes that locus of control increases well-being when managing stress. The implication in negative responses by peers assumes the loss of control over stressful event; therefore it is viewed as a poor outcome

5.4.2 Subtheme 2: Questioning Nursing Practice

A negative response was the nurse were questioned regarding the management of the patient either by themselves or a peer. Interestingly, before this finding the same respondents stated that they felt the need for review of the incident with their peers as imperative after an assault and noted this in theme 2 as positive. This reflection may indicate that there is a need for nurses to believe in their individual capability to manage patients. This finding is supported by the study that was carried out by Avey et al (2010) which asserts that the belief in one's capabilities to mobilize cognitive resources assists the individual in cause of action to successfully execute a specific task within a given context and be reflective of perceived self-efficacy.

5.4.3 Subtheme3: Nurses vulnerability in Health Care.

This was an interesting finding and directly correlates with nursing as an identified oppressed group. This finding is consistent with the research done by Gates et al. (2011b) which articulates that it has been the expectation of nursing staff to tolerate violent behavior. The finding concurs with the study carried out by Roberts, Dermarco and Griffin, (2009) which states that nurse have long been placed in subordinate roles with a lack of power and control within hospital based system. So vulnerability within the workplace directly correlates with an oppressed group and the respondents of this study recognized the notion.

5.5 THEME 4: The effects of the assaultive incidents to nursing practice?

This theme did not elicit any significant data regarding practice; however the focus of the respondents in this study was identified by their own personal developmental changes after the assault relational to the practice setting.

5.5.1 Subtheme 1: FOCUS ON SAFETY

The respondents of this study reported that concerns about maintaining safety were enhanced after the assaultive incidents in the workplace. The safety strategies identified in this research study were objective in nature with some netinga re-enforced focus on education. Antidotal evidence has suggested that education has limited impact on assault rates. The finding is supported by research that was done by Kowalenk et al (2012) which purports that it has indicated that preventive programs increase knowledge and confidence to deal with aggressive or

assaultive patients. However, Oestrom and Van Mierlo (2005) supports educational programs that included recognition of aggression, interaction with the aggressive individual and the skills and techniques to prevent potentially threatening events from occurring demonstrated improvement on individuals' insight into aggression as well as increasing the ability to cope with adverse situations. This response by the participants of the study may be correlated with gaining mastery and an effective coping mechanism.

5.5.2 Subtheme 2: Increased Awareness

This generalized theme resounded that their workplace is considered at risk for violence. The respondents identified the unpredictable nature of the work environment in which they practice. This finding is consistent with the study that was carried out by Johnson (2004) which reveals that patients with diagnosable mental illness that includes schizophrenia, mania, psychosis and certain types of brain disorders have a direct correlation with violence. The finding was also supported by findings from Howerton, Child and Mentes (2010) which asserts that the casualty department also has inherent risks towards aggression. This is due to ease and accessibility from public, 24 hour access, perceived environment chaos, and increased stimulation, as well as high stressful environment pose a risk for increased violence. Interestingly to note is that this notion of awareness was mentioned under the theme, how has this incident affected your nursing practice? However, the risk associated with this work setting has been well documented so the interpretation would include limited awareness of the setting before the assaultive incident.

5.6 THEME 5: Coping Strategies

The respondents of this study had clearly acknowledged that working with patients pose a risk of safety. The findings indicated that the registered nurses used tolerance as a coping strategy when returning to the workplace after an assault. The participants revealed that they considered violence to be part of their job and that was their major coping strategy when returning to the workplace after assaultive incidents. These findings are consistent with Findorff et al (2004) who suggests that nurses consider violence and aggression as part of their job. The narrative data clearly shows that respondents of this study had tolerance for workplace violence as their major coping mechanism when returning to the workplace after incidence of violence. The finding is supported by Whittington (2002) who asserts that tolerance is considered an attitudinal

dimension that is defined as an expressed awareness and endorses positive evaluations. Findings also show that most of the participants had developed resiliency as a major copying strategy when returning to workplace after an assaultive incident. The findings were e supported by Mansten (2001) who asserts that resiliency is characterized by good outcome in spite of serious threat to adaptation or development.

5.6.2 Subthemes 2: Managing Aggressive Behavior Training (MOABT)

Several participants of this study revealed that they use the knowledge that they got from MOAB training that they receive annually. The findings indicate that mental health and casualty nurses are highly trained on how to manage violence and keep themselves safe in the face of adversity. This is supported by Gillespie et al (2007) who asserted that unlike general nurses mental health and casualty nurses where thoroughly trained and prepared to meet patient violence.

5.7 Theoretical Framework and Implications

The most powerful outcome of this study is the direct application of the theoretical framework of shame resiliency identified throughout this study.

Resiliency is the act of bouncing back or resisting cracking under pressure (Seligman, 2001). According to the American Psychological Association, resiliency is the process of adopting well in the face of adversity, trauma, and tragedy threats even significant sources of risk. Resiliency is characterized by good outcomes in spite of a serious threat to adaptation on development (Masten, 2001).

Shame resiliency theory is an intensely painful experience of believing we are flowed and undeserving of acceptance and belonging. The major aim of linking shame resiliency theory to the field of nursing is that nursing as women dominated profession nurses often experience shame and helplessness when returning to workplace after being assaulted by patients while on duty at the workplace. Findings from respondents revealed that the participants of this study after being assaulted suffered from shame and anxiety mainly which powerfully and negatively affected their mental health when returning to work after an assaultive incident. This is supported by Brown (2006) who asserts that shame is not a fleeting emotion but it is powerful and can negatively affect mental health.

The findings also reveal that after every incident of violence and assault at the workplace, shame creates feelings of fear, blame and disconnection among mental health and casualty nurses. This finding is consistent with Dubrosky (2013) who says that registered general nurse's exhibit oppressed group behavior.

The principal idea behind shame resiliency theory is studying the way people avoid feeling confined, weak and alone when they feel shameful. The main purpose of linking Brown's theory of resiliency to workplace assault in nursing is to help the mental health and casualty nurses understand that they do belong. The findings revealed that several participants were able to return to the work place because they had developed resiliency against shame. The findings are consistent with Brown (2006) which articulates that resiliency against shame helps registered nurses who feel shameful after assaults by patients to feel empathy, connection, power and freedom.

The sample selection for this study was based on resilient features including remaining in the workplace after at least two episodes of assault while on the duty. The sample exemplified a population that meets the criteria for an at risk population. The application of resiliency as a notion in returning to the workplace after incents of violence has clear implications for further development.

The findings of this study were consistent with the theoretical model of resiliency. Most significantly was the continued reverberation of peer support as an effective strategy post assault in the workplace. This is consistent with the findings from the study that was carried out by DeLongis and Holtz man (2005) which purports those social relationships may influence coping by turning to others in the face of adversity for a sense of direct provision of information regarding self-efficacy and coping strategies. Shame resiliency research suggests that individuals, who report greater satisfaction with support, also report greater use of adaptive ways of coping with stressful situations and this was also correlated in the findings.

Another correlation with resiliency framework in this study was the role of self-efficacy and a sense of coherence. The mental health and casualty nurses in this study reported both positive and negative peer responses were incoherent in returning to the workplace environment after an

assault. This finding is supported by Wagnild (2009) who asserts that resiliency attributes have been measured through the example of self-efficacy, self-esteem, and sense of coherence.

Another characteristic inherent in resiliency that was found in this research study was the question of one's practice and frequented requests for critical incident debriefing with peers. This finding is supported by Avey et al (2010) which states that resiliency has demonstrated that belief in one's capabilities to mobilize cognitive resources assists the individual in a course of action to successfully execute a specific task within a given context. The finding also corresponds with research that has indicated that cognitively adapting to experiences is enhanced with strategies such as finding meaning, gaining mastery and enhancing self through social comparisons (Chapman et al, 2010). The mental health and casualty nurses in this study demonstrated an active coping approach when it came to adversity. The coping strategies implored by the respondents included seeking support , tolerance, using experience obtained from training as well as problem focused strategies to create a change in the environment. The finding is supported by Simmoni and Patterson (1997) who suggests that the single significant characteristic that encompasses resiliency is in the coping approach that includes high-hardiness traits with problem-focused coping strategies.

The application of resiliency was well demonstrated in this study. The process of resiliency is activated through adversity and the introduction of interventions that reduce the difficult situation (Gillspie et al, 2007). There has been limited application of resiliency when returning to the workplace after assault in nursing. The respondents in this study identified resiliency correlates that assisted them in overcoming adversity when returning to the workplace after assaultive incidents. Although resiliency correlates and risk groups have been clearly described in the literature, there remains a lack of understanding of the integration of resiliency into practice.

5.8 LIMITATIONS

The major limitation to this study was an urban, teaching hospital within a healthcare network. This facility has resources that may not be available to other organizations with similar structures. The setting had both casualty and a mental health department. Some organizations do not have both specialties within n the same campus location. The sample size is also a limitation

to the quality and credibility of qualitative research findings. However, when saturation was reached as per the data an additional two interviews were conducted to assure accuracy of information. The other limitation was related to the population chosen to participate in this study. The study design recruited nurses who were physically assaulted, at least twice, not within the previous three months and returned to the workplace. The findings show that there was a level of intensity and severity related to the physical assault. Lastly, truthfulness in the data is correlated with the interview responses. All attempts were made to assure an atmosphere of open honest communication during the interview.

5.9 RECOMMENDATIONS

The evidence from this study represents a powerful message from registered nurses who have been assaulted by a patient while o duty in the hospital setting. This research study presents the voice of mental health and casualty nurses after an incident in the workplace, and primarily that voice needs to be heard. The evidence presented several themes that were consistent across participants. The themes included, an emotional response that lasts for a brief period that is dependent on the interaction with the perpetrator, keeping one's distance, awareness. Acknowledgement, knowing one's environment, sensing safety, questioning practice, feeling vulnerable and coping strategies. The study described the essence of the phenomena which is a linguistic construction and description that structures the lived experience (Van Manen, 1990). The essence within the phenomena of this study was based on feelings and coping. The registered nurses told their story of living through a traumatic event at work. These feelings and essence were not quantitative, but even more powerful as feelings can be transformational.

The first recommendation builds on the purpose on the purpose of this study, to provide voice for an oppressed group. Robert's et al (2009) asserts that in order to understand the cycle of oppression, one must first alter the silence and inaction. The registered nurses have provided an understanding of the phenomena. The researcher will be presenting this information to the Gweru Provincial Hospital and the Midlands State University. The information that will be Gweru Provincial Hospital is for the nursing staff and leadership. However, the researchers do not believe it's enough. The researcher further recommends presentation of findings for local, regional and national conferences. She intends to make definitive plans to disseminate

information by writing their stories in a journal article. The goal is to break the silence of inaction.

This study correlated with resiliency concepts that help in overcoming adversity in registered nurses. The researcher believe there I a further need to examine a more inflexible or rigid sample of registered nurses. A corroborating sample of nurses who left nursing practice after a critical incident or assault is suggested. This understanding assists in the full development of antecedents that a registered nurse may experience after an assault.

The examination of the level of assault can also be more fully developed. This study did not define severity or intensity of assault. A follow up study that examines nurses that left the workplace with a high intensity critical assault injury may provide even more insight into the phenomena. A similar methodology could be applied, with extreme caution to do no harm. Implementing a resiliency scale before participation or having an extended period of time between the critical event and the interview would be also another recommendation.

There is certainly opportunity to develop mere insight on the role of peer support in the workplace, particularly after a critical incident or assault. Social relationships may influence coping by turning to others in the face of adversity for a sense of direct provision of information regarding efficacy and coping strategies (Delongis and Holtzman, 2005). The evidence from this research study presented several venues for further research on peer cultures for nurses in the hospital settings. Organizations need to recognize the need for peer support.

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

The application of shame resiliency as a theoretical framework demonstrates considerable promise in the workplace setting after adversity for employees. Resilience focuses on a strength based strategies and the building onto existing capabilities including an individual's inner strengths, competence, optimism and effective coping patterns (Wagnild, 2009). The resiliency strategies identified need to be fostered. Resiliency can be supported when it is learner, centered

has positive and high expectations in the environment and provides a strong social, supportive community (McAllister and McKinnon, 2009).

5.10 Implications for social Change

Results of this study can have positive impacts on registered nurses personally and professionally. The registered nurses in this study provide the story of the lived experiences of returning to the workplace after being assaulted by a patient. Their words were powerful expressions of feelings and essence of the incident that is transformational in the way we think the experience is like providing a voice articulates one's experience, moves towards a collective identity and is a beginning step for social change

5.11 CONCLUSION

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

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Appendices

Appendix A: Interview guide questionnaire

PRIMARY QUESTION	EXAMPLE OF PROBES
Describe in detail what it was like when you returned to workplace after the assaultive incident?	i. Probe for information regarding their individual views pertaining to the experience of returning to work after an assaultive incident, responsibilities, work experience, how they felt resuming duty after being assaulted by patients while on duty. What exactly was their view of the context of work place?
"What are the positive experiences when returning to the workplace after an assaultive incident?	Probe for information regarding what encouraged them to return to the workplace after such shameful and distressing incident. Which are their pull factors on returning to the workplace after incidents of assault.
"What are the negative experiences when returning to the workplace after an assaultive incident"?	Ask for information regarding their negative experiences on returning to workplace after an assaultive incident. Which are the push factors on returning to the workplace after an assaultive incident.

How have the assaultive incidents affected nursing practice?	i. What were the immediate impacts? ii. What were the longer term impacts? iii. What are the different impacts of verbal violence versus physical violence? iv. What impact did it have on carrying out your role as an RMN after the incident? Probe: Compare these to other incidences participant has described.
Which coping strategies did you use to keep on working in the same place after the assaultive incident	i. What personal factors influence your response to assaultive incidents? ii. Probe for hospital policies, guidelines, unit forms, individuals training and strategies.
	.

Appendix B: Approval letter

All correspondence should be addressed to:
"The Medical Superintendent"

Telephone: +263542-221302-6
Fax: 223192

MINISTRY OF HEALTH AND CHILD CARE
GWERU PROVINCIAL HOSPITAL
P.O.BOX 135
GWERU
ZIMBABWE

ZIMBABWE

Web:**gweruprovincialhospital.org**

Email:**gweruprovincialhospital@gmail.com**

Reference:

03 October 2019

Dear Sheila Mambende

RE: RESILIENCE IN NURSING: THE LIVED EXPERIENCES OF MENTAL HEALTH AND CASUALTY NURSES WHO RETURN TO WORK AFTER INCIDENTS OF ASSAULT BY PATIENTS AT THE WORKPLACE.

Thank you for your application to conduct research at Gweru Provincial Hospital. I am glad to advise you that your application for the research study **Resilience in Nursing: The lived experiences of Metal Health and Casualty Nurses who return to work after incidents of assault by patients at the work place,** has been approved.

This approval is premised on the study proposal that was submitted. Should you decide to vary your study in any way, you should provide the new material for approval.

You are reminded to seek approval from the Medical Research Council of Zimbabwe before conducting your study.

You are advised to avail the results of your study to the hospital through the Medical Superintendent.

Yours sincerely

DR F.J.MASHINGAIDZE
MEDICAL SUPERINTENDENT

GWERU PROVINCIAL HOSPITAL
MEDICAL SUPERINTENDENT
03 OCT 2019
P.O. BOX 135, GWERU
ZIMBABWE

Appendix C-Audit Sheet

MIDLANDS STATE UNIVERSITY

SUPERVISOR- STUDENT AUDIT SHEET

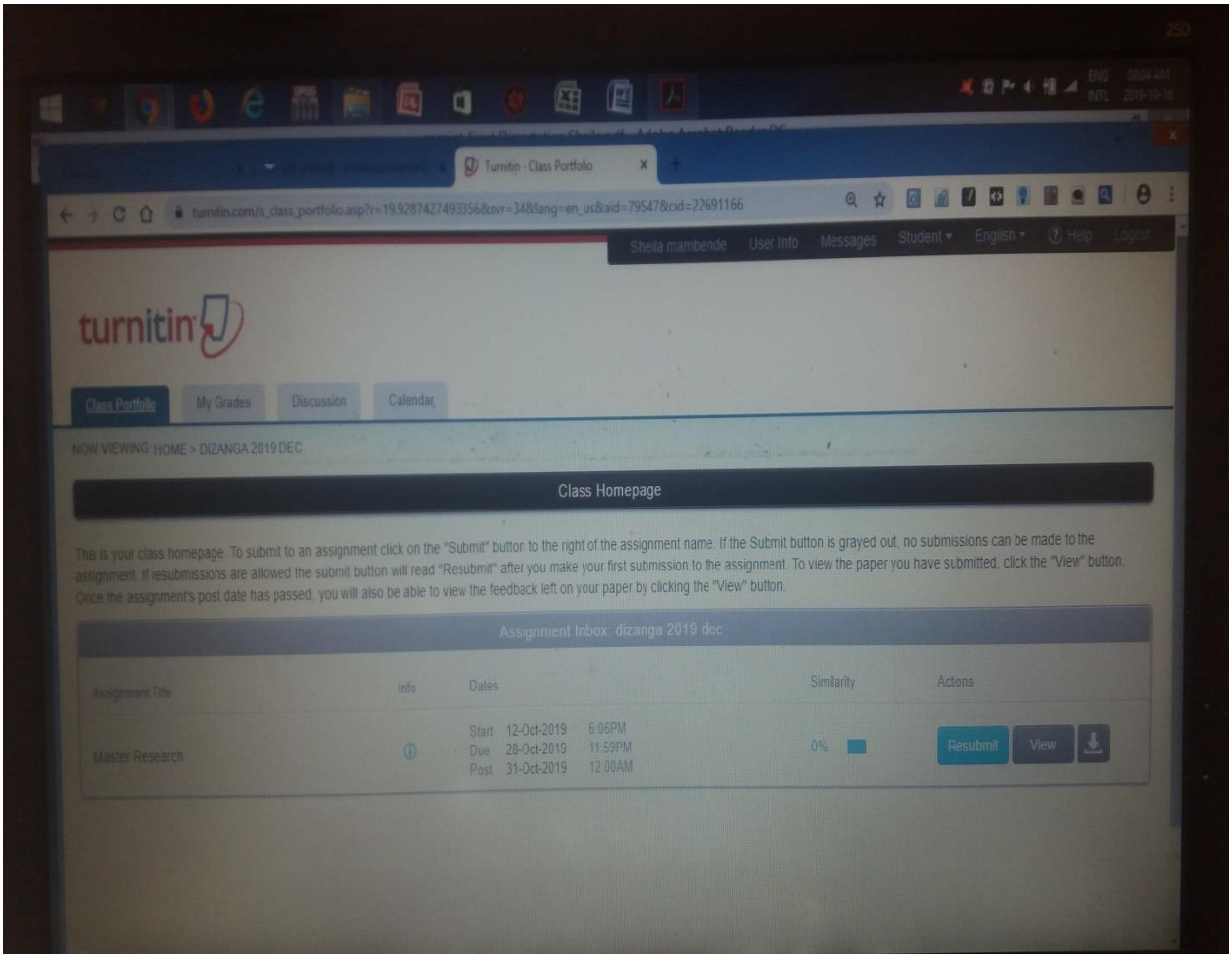
DATE	TOPIC DISCUSSED	COMMENT	STUDENT'S SIGNATURE	SUPERVISOR'S SIGNATURE
26/05/2019	Topic Approval			L Mavunganidze
09/06/2019	Proposal			L Mavunganidze
23/06/2019	Proposal Approval			L Mavunganidze
02/07/2019	Chapter 1			L Mavunganidze
07/07/2019	Chapter 2			L Mavunganidze
12/07/2019	Chapter 3			L Mavunganidze
27/07/2019	Aproval of instrument			L Mavunganidze
14-18/08/2019	Data collection			L Mavunganidze
20/09/2019	Chapter 4			L Mavunganidze
20/09/2019	Chapter 5			L Mavunganidze
09/10/2019	Final draft			L Mavunganidze

STUDENT'S SIGNATURE ……..

L Mavunganidze

SUPERVISOR'S SIGNATURE.. ……

Appendix D: Turnitin



Appendix E: Marking Guide

MIDLANDS STATE UNIVERSITY

FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF PSYCHOLOGY

A GUIDE FOR WEIGHTING A DISSERTATION

NAME OF STUDENT.....REG NO.....

	ITEM	POSSIBLE SCORE	ACTUAL SCORE	COMMENTS
A	RESEARCH TOPIC AND ABSTRACT: Clear and concise	5		
B	PRELIMINARY PAGES Title page, approval form, release form, dedication, acknowledgement, appendices, table of contents	5		
C	AUDIT SHEET Clearly shown on the audit sheet	5		
D	CHAPTER 1 Background, statement if the problem, significance of the study, research questions, hypothesis, assumptions, purpose of the study, delimitations, limitations, definition of terms	10		
E	CHAPTER 2 Address major issues and concepts of the study. Findings from previous work, relevancy of literature to the study Identify knowledge gap, subtopics	15		
F	CHAPTER 3 Appropriateness of approach, design, target population, population sample, research tools, data collection procedures, presentation and analysis	15		
G	CHAPTER 4 Findings presented in a logical manner, tabular data properly summarized and not repeated in the text	15		
H	CHAPTER 5 **Discussion (10)** Must be a presentation of generalizations shown by results: how results and interpretations agree with existing and published literature, relates theory to practical implications **Conclusions (5)** Ability to use findings to draw conclusions **Recommendations (5)**	20		
I	Overall presentation of dissertation	5		
J	References	5		
	Total	100		

MARKER.....SIGNATURE.....DATE.....

MODERATOR.....SIGNATURE.....DATE.....