NORTHEASTERN ONTARIO NURSES' PERCEPTIONS OF VIOLENCE IN ACUTE CARE SETTINGS

by

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Abstract

The incidence of workplace violence (WPV) is increasing and has become a worldwide concern. This is particularly true among medical workers, especially nurses, who are at a high risk of exposure, as they are the first and closest contact with patients. The Ontario Council of Hospital Unions and the Ontario division of the Canadian Union of Public Employees conducted a survey in Northeastern Ontario in 2019 and found that 96% of personal support workers and registered practical nurses experienced physical violence while working. This was 8% higher than the provincial average. This study explores Northeastern Ontario nurses' perceptions of violence in an acute-care setting through two research questions: What are Northeastern Ontario nurses' perceptions of violence and challenges to preventing violence? What improvements or changes are needed to reduce or prevent WPV? This study uses Sally Thorne's (2016) interpretive description qualitative methodology guided by the Haddon matrix conceptual framework of WPV. Registered nurses (n = 14) participated in one of three virtual focus groups from three patient care units. The overarching theme, nurses surviving violence in acute-care settings, is supported by three key themes: nurses' different perceptions and levels of threshold of violence, nurses in jeopardy, and changes needed to the status quo. The findings indicate that violence against nurses occurs daily and should never be justified. Education, training, and supports involving hospital staff, the local police department, the community, and the public are crucial to preventing WPV.

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Table of Contents

List of Tables

List of Figures

List of Appendices

Chapter 1: Introduction to Thesis

1.0 Introduction

Workplace violence (WPV) is growing and has become a serious concern in workplaces around the world. It is a significant cause of workplace inequality, discrimination, and conflict and, therefore, is considered to be a human rights issue (International Labour Office [ILO], International Council of Nurses [ICN], World Health Organization [WHO], and Public Services International [PSI], 2002; Registered Nurses Association of Ontario [RNAO], 2019).

The World Medical Association (2020) describes violence against healthcare workers as an international crisis that affects healthcare delivery. Characterized as a significant occupational hazard globally, WPV has dire consequences for healthcare delivery and affects healthcare providers' mental and physical wellbeing (Nowrouzi-Kia et al., 2019). Nurses are assaulted at greater levels than other healthcare workers, followed by nursing assistants and physicians (Ferri et al., 2016). As a result, WPV has generated much concern among nurses because of their close interaction with patients.

1.1 Background Information

The nursing profession in Canada is self-regulated, and registered nurses are bound by an ethical code that guides nursing practice as they care for patients (Canadian Nurses Association [CNA], 2017). The code provides an ethical framework for nurses to advocate for high-quality work environments and has two parts: The first part focuses on nursing values and ethical obligations that guide nursing practice. The seven values are "providing safe, compassionate, competent, and ethical care; promoting health and wellbeing; promoting and respecting informed decision-making; honoring dignity; maintaining privacy and confidentiality; promoting justice; and being accountable" (CNA, 2017, p. 3).

The second part of the code focuses on the actions that nurses can take to combat social injustice. For example, regarding the first value mentioned above, of providing safe, compassionate, competent, and ethical care, the Canadian Nurses Association (2017) states:

> Nurses work toward preventing and minimizing all forms of violence by anticipating and assessing the risk of violent situations and by collaborating with others to establish preventive measures. When violence cannot be anticipated or prevented, nurses take action to minimize risk and to protect others and themselves. (p. 9)

Nurses care for everyone, including those seen as victims of violence or abusers; therefore, measures are expected to be taken to ensure a safe work environment in which adequate care is provided to all patients, irrespective of their health situations. Moreover, employers and nurses must advocate for safe and ethical nursing practices, such as high-quality practice settings (CNA, 2017; RNAO, 2019).

Ontario has experienced a shortage of nurses, which leads to a reduction in the availability and quality of care for patients (Ontario Nurses Association [ONA], 2016). In fact, Scheffler and Arnold (2018) predict a shortage of nurses in Canada of up to 117,600 by 2030. The Canadian Federation of Nurses Union surveyed nurses in 2019, and 83% of the respondents said they believed that the amount of healthcare staff was insufficient to cope with patients' needs (Canadian Federation of Nurses Union [CFNU], 2022). To further elaborate on the issue of the nursing shortage, the union highlighted in 2022 the following contributory factors: violence, workloads, inadequate support staff, stress, and burnout. Violence is a significant problem, and improving working conditions and ensuring nurse retention require addressing violence in the healthcare industry (CFNU, 2022).

1.2 Definition and Types of Workplace Violence

According to the Occupational Health and Safety Act, WPV is described as exercising or attempting to exercise physical force by a person against a worker in a workplace or as an act that can be seen as a threat to the worker (Government of Ontario, 2020). The Canadian Nurses Association views WPV as physical and psychological violence, sexual harassment, and financial violence. Physical violence involves using physical force toward a worker and includes homicide, kicking, rape, biting, punching, spitting, and attacking with any weapon (CNA, 2019; Canadian Union of Public Employees [CUPE], 2018). Psychological violence involves harassment, such as intimidation, bullying, threats, shouting, and verbal abuse (CNA, 2019; CUPE, 2018). Sexual harassment includes repeated unwanted sexual behavior and suggestions that may harm the victim. Financial violence includes actions that prevent an individual's progress or promotion, thereby having a financial impact (CNA, 2019). Both physical and psychological violence are interrelated, as they can cause physical injuries and mental, sexual, emotional, and psychological harm (CUPE, 2018).

The Canadian Nurses Association (2019) also identifies horizontal and vertical violence. Horizontal violence indicates violence among fellow workers of the same level, and vertical violence is related to hierarchy or seniority and could involve management. Violence in the workplace can also comprise cyberbullying and domestic abuse (CFNU, 2018).

Four types of violence are recognized, with Types I and II recognized more frequently in healthcare settings (Public Services Health and Safety Association [PSHSA], 2016). Table 1 describes the four types of violence defined by the relationships and situations of each type of WPV.

Table 1: ***Definition of Four Types of Violence***

Four types of violence recognized under the Occupational Health and Safety Act (OHSA):	
Type I or the External Perpetrator	where the violent person has no relationship to the worker or the workplace
Type II or the Client/Customer	where the violent person is a client at the workplace who becomes violent toward a worker or another client
Type III or Employment-Related	where the violent person is a worker or has/had some type of job-related involvement with the workplace
Type IV or Domestic Violence	where the violent person has a personal relationship with an employee or client

(Occupational Health and Safety Act, 1990 as cited in Public Services Health & Safety Association, 2016, p. 2)

1.3 Common Occurrences and Types of Workplace Violence Experienced by Healthcare Professionals

The results of several studies indicate that incidences of WPV occur most often in emergency departments, psychiatric departments, drug and alcohol clinics, ambulance services, and remote healthcare centers (Brophy et al., 2018; Copeland & Henry, 2017; Ferri et al., 2016; Mento et al., 2020; Nowrouzi-Kia et al., 2019; Ramacciati et al., 2019; Vento et al., 2020). When examining the types of WPV, Type II violence has been reported in greater numbers by healthcare professionals and is identified as the most common form of violence in healthcare settings (Brophy et al., 2018; Ferri et al., 2016; Mento et al., 2020), although some studies also note the ubiquity of Type I violence (Ramacciati et al., 2019). Verbal abuse in terms of Type I and Type II was the primary form of violence experienced by participants of various studies (Copeland & Henry, 2017; Ferri et al., 2016; Ramacciati et al., 2019). Furthermore, patients and their relatives perpetrated more verbal and physical violence than other forms of violence (Ali-Ali et al., 2016;

Jakobsson et al., 2020; Margavi et al., 2020; Ridenour et al., 2017; Wu et al., 2019; Yoo et al., 2018).

1.4 Incidence of Workplace Violence in Northeastern Ontario

The healthcare system in Ontario employs 11.7% of the province's workforce, which is significant compared to other segments. In 2017, violence against nurses in hospitals caused 56% of lost-time injuries (Government of Ontario, 2017), and in 2018, Ontario's Workplace Safety and Insurance Board reported that 13% of lost-time injuries that year occurred as a result of WPV (Government of Ontario, 2019). The Canadian Federation of Nurses Unions also noted in 2017 that WPV accounted for 10% of lost-time injuries in hospitals and resulted in a loss of $23.8 million. In addition, WPV has led to increased absenteeism for nurses (9%) compared to employees in other sectors of the economy (5.7%; RNAO, 2019).

To further examine lost-time injuries due to WPV, the Ontario Council of Hospital Unions and the Ontario division of the Canadian Union of Public Employees surveyed northeastern Ontario in 2019, noting that 96% of personal support workers and registered practical experienced physical violence on the job. This is 8% higher than the provincial average. The Canadian Union of Public Employees (2019) further notes that 62% of personal support workers and 60% of registered practical nurses experienced sexual assaults at work.

More recently, in July 2022, the Ontario Council of Hospital Unions and the Canadian Union of Public Employees conducted a poll of staff members at Health Sciences North, a northern Ontario hospital. The union reports that, in Ontario, "The Canadian Union of Public Employees represents 50,000 hospital staff working at 120 sites of 65 hospital corporations. At Health Sciences North, the Canadian Union of Public Employees represents over 1,200 front-line staff"

(Ontario Council of Hospital Unions, 2022, para, 12). This number represents approximately 2.4% of Ontario's hospital employees.

The survey included 27% registered practical nurses; 33% personal support workers, healthcare aides, porters, paramedical staff, and rehabilitation care assistants; and 40% administrative, maintenance, housekeeping, and dietary workers. The survey results demonstrated increased physical and sexual violence against hospital workers (Ontario Council of Hospital Unions/ Canadian Union of Public Employees, May 2022). Sixty-five percent of the staff reported witnessing more violent incidents (36%) or slightly more violent incidents (29%) since the start of the COVID-19 pandemic, and 55% reported experiencing much more violence (31%) or slightly more (24%) in the same time frame. Seventy-four percent of staff reported feeling anxious at work (Ontario Council of Hospital Unions, 2022).

1.5 Consequences of Workplace Violence

Violence can have various consequences for hospital staff members and their families, friends, and patients (Bahadir-Yilmaz & Kurşun, 2020; Brophy et al., 2018; Jakobsson et al., 2020), including burnout, patient dissatisfaction, and diminished patient safety (Berlanda et al., 2019). Brophy et al. (2018) classified the personal impacts of violence on the healthcare worker as physical, psychological, mental, financial, and emotional, as mentioned in Section 1.2, Definition and Types of Workplace Violence (p. 3). These types of violence can also result in life-threatening injuries and death (Vento et al., 2020).

The physical consequences include bodily injuries such as bites, scratches, and body aches. Psychological and mental consequences include posttraumatic stress disorder, burnout, irritability, fatigue and sleep disturbances, hypervigilance, and anxiety (Brophy et al., 2018; Lanctot & Guay, 2014). Financial consequences can be uncompensated lost time and

absenteeism that eventually lead to economic losses. Emotional consequences include anger, sadness, fear, disgust, surprise, frustration, humiliation, vulnerability, and embarrassment. Finally, professional and organizational consequences include nurses quitting the profession, taking increased sick time, reducing their commitment, losing interest in work, and experiencing poor interpersonal relationships with colleagues (Brophy et al., 2018; Lanctot & Guay, 2014; Mento et al., 2020).

1.6 Potential Factors Contributing to Violence Against Nurses

1.6.1 Gender-Based Violence

Gender differences may explain why violence against nurses has been viewed as justified, because nursing is primarily a female profession (Brinkman, 2021). The International Labour Organization (2021) defines gender-based violence as violence toward people because of their gender or violence that affects one particular gender more than another. Biological and social gender differences place nurses at risk of becoming oppressed more often than other healthcare workers (Dubrosky, 2013). In healthcare, workplace violence has been perceived to be a justifiable and expected action; in other words, it has been judged to be a normal social behavior between the aggressor and the aggressed, not simply based on an outcome, such as a delay in service (Yagil & Dayan, 2019). In certain situations, people have tended to justify the violence that nurses experience; for example, poor communication increases tension between patients and family members (Quan et al., 2019). Yagil and Dayan (2019) mentioned two aspects of communication that could affect a nurse's role: providing adequate information and demonstrating care. Another situation in which nurses might justify the violence they experience is when a patient exhibits physical or mental problems.

1.6.2 Oppression

Dubrosky (2013) used Young's five aspects of oppression to analyze the oppression that nurses experience. These include exploitation, marginalization, powerlessness, cultural imperialism, and violence. First, nurses may have experienced exploitation by administrators and management officials due to the limits placed on their scope of practice; this can affect the nurses financially, physically, and psychologically. Second, some nurses may see themselves as marginalized in a medical community in which they are considered to experience a form of disseminative wrong with little power to effect change. As for the third aspect, powerlessness, nurses can be seen as having little or no control over how, when, and where to work, which could limit their capacity to influence decisions made by administrators and managers. Unequal power relationships such as these can contribute to violence against nurses (Al-Qadi, 2021). Fourth, nurses have voiced displeasure about what they call the cultural imperialism of a profession such as healthcare that is dominated by physicians. Finally, intraprofessional violence and violence perpetrated by patients and their family members contribute to nurses lacking the power to influence their situation (Young, 1990, as cited in Dubrosky, 2013).

1.6.3 Lack of Reporting of Incidences

Many instances of WPV are not reported, which poses a barrier to stopping this problem. The main reason for nonreporting is that most healthcare staff say they view violence as inevitable and a part of their job (Ashton et al., 2018; Brophy et al., 2018; Copeland & Henry, 2017; Ferri et al., 2016; Pierce, 2015; Vento et al., 2020). Other reasons for nonreporting include a lack of visible injury, cumbersome reporting systems, a lack of peer and managerial support, fear of reprisal or being blamed for the incident, and the sense that no action would be taken

(Kosny et al., 2018; Pierce, 2015). Another factor cited was that post incident support was not readily available for staff (Brophy et al., 2018; Shea et al., 2018).

1.7 Preventing Workplace Violence

Several factors have contributed to the ongoing problem of WPV involving nurses. Preventing WPV and creating a safe and healthy work environment require the involvement of multiple stakeholders, including the entire healthcare organization, the employer, the employee, policymakers, provincial and federal governments, unions, and the public. The Registered Nurses Association of Ontario Best Practice Guidelines (2019) provided 15 evidence-based recommendations for preventing WPV. These recommendations were divided into three broad categories—methods and tools, organizational procedures and policies, and training and educational strategies—that are designed to guide a multi-intervention and multidisciplinary organizational strategy for preventing WPV.

Healthcare workers should receive ongoing education on coping strategies as well as information about supervisory and staffing support to tackle WPV. The development of an evidence-based instrument is a useful method of implementing organizational interventions such as these (Ghosh et al., 2019; Public Services Health & Safety Association, 2017a; RNAO, 2019). According to Yagil and Dayan (2019), the adoption of zero-tolerance policies and mandatory reporting is critical to prevent WPV. Furthermore, continuous public awareness and organizational policies are required to solve the problem (Yagil & Dayan, 2019).

1.7.1 Violence Assessment Tools

Ghosh et al. (2019) discussed 16 tools used to prevent violence in various care settings. One tool, known as STAMP/EDAR—which stands for staring, tone/volume of voice, anxiety, mumbling, and pacing / emotions, disease process, assertive/nonassertive, resources—is

designed for use in the emergency department (ED). Two tools are targeted for general acute-care settings: the Violence Risk Assessment Tool (M55) and the Aggressive Behavior Risk Assessment Tool (ABRAT). Thirteen tools are prioritized for psychiatric settings, four of which seek to identify violence within three to six months: the Psychopathy Checklist–Revised (PCL–R)/screening version (PCL-SV); the Historical, Clinical, and Risk Management Tool (HCR-20); the Violence Risk Appraisal Guide (VRAG); and the Short-Term Assessment of Risk and Treatability (START). Seven are intended to identify violence between two and six weeks: the Brockville Risk Checklist (BRC), the Inter RAI Risk of Harm to Others Clinical Assessment Protocol (RHO-CAP), the Imminent Risk Rating Scale (IRRS), the Preliminary Scheme 33 (PS33), the Risk of Violence Assessment (ROVA), the Classification of Violence Risk (COVR), and the Fordham Risk Screening Tool (FRST)]. Two are designed to identify violence within 24 hours: the Brøset Violence Checklist (BVC) and the Dynamic Appraisal of Situational Aggression (DASA). The Violence Assessment Tool or VAT (Appendix A) was created based on a literature review that also compared components of the VAT with other checklists, such as the BVC and the DASA, to help determine potential risks of violence in patients in acute-care settings (Ogloff & Daffern, 2006; Public Services Health & Safety Association, 2017a; Woods & Almvik, 2002;).

The Ministry of Labour and the Ministry of Health and Long-Term Care collaborated with the Public Services Health and Safety Association to develop tools to address WPV through the Violence, Aggression, and Responsive Behavior project (Ministry of Labour & Ministry of Health and Long-Term Care, 2017). Project leaders recommended that the VAT be completed at first contact with the patient to assess the patient's risk indicators and observed behaviors, calculate the overall risk from the patient or client, and assess other contributing factors and

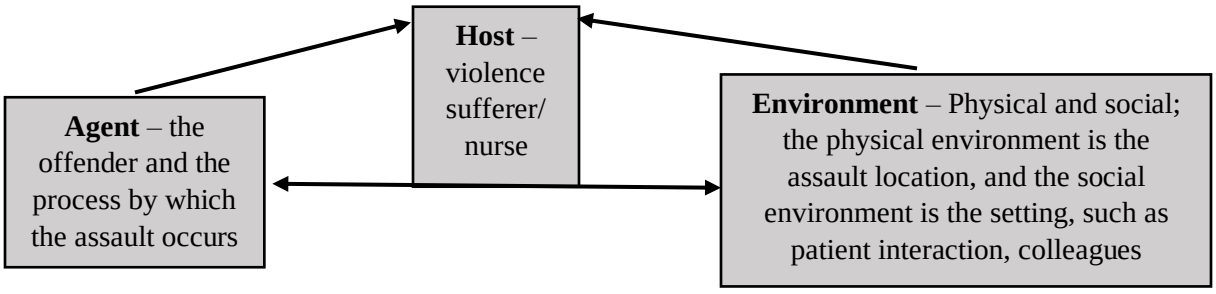
potential de-escalation techniques (Public Services Health & Safety Association, 2017a; Public Services Health & Safety Association, 2017b).

Additionally, the Ministry of Labour, Training, and Skills Development and the Ministry of Health and Long-Term Care recommend that the VAT be used in healthcare settings to reduce WPV. Overall, 77% of hospitals in Ontario reported knowing about the toolkits, 67% reported using them, and 89% of those who used them reported improved processes and planning measures (Public Services Health & Safety Association, 2019a).

1.8 The Haddon Matrix Conceptual Framework

The Haddon matrix conceptual framework, which is commonly used to recognize strategies to reduce injuries but is also now employed in WPV prevention research (as cited in McPhaul & Lipscomb, 2004), was selected for this thesis. The framework highlights the three public health domains of host, agent, and environment of disease (Figure 1, p. 11) in epidemiology as they relate to primary, secondary, and tertiary injury factors (McPhaul & Lipscomb, 2004).

Figure 1: ***The Haddon Matrix Conceptual Framework and the Three Public Health Domains***



(McPhaul & Lipscomb, 2004, p. 3)

When this is applied to WPV, the host is the sufferer of violence, which would be the nurse in this case. The agent or vehicle is both the offender and the process by which the assault

occurs. The environment is divided into the physical environment and the social environment. The physical environment is the assault location, which could be the home, street, or hospital ward, and the social environment is the social setting, such as tending to patients, interacting with colleagues, or meeting with supervisors. This framework has been used to assess factors relating to these three domains (host, agent, and environment) before the assault, during the assault, and after the assault (McPhaul & Lipscomb, 2004), as outlined in Table 2, p. 13. For example, before the violent assault, host or employee factors that could prevent violence include education and training, available procedures, and policies; agent or offender factors include appropriate communication and minimization of anxiety; and environmental factors include manager education, security, and police availability.

The Haddon matrix framework outlines prevention strategies and focuses on exploring nurses' perceptions of violence in acute-care settings while working in high-risk areas with patients, patients' families, and colleagues. The framework also guides organizational policies and the evolution of preventive measures. The framework suits this situation, serving as a skeleton on which to build the prevention of WPV among nurses, who are the focus of the study, and it outlines various approaches to contain WPV. However, only a comprehensive and multidisciplinary approach can ensure the effectiveness of WPV prevention.

Table 2: ***Haddon Matrix Application of the Framework to Prevent Violence in an Emergency Department***

	Host (employee) factors	Agent/vehicle (offenders-patient/visitor factors)	Physical/social environmental factors
Before assault	• Education and training • Policy and procedures • Preventing aggressive behavior • De-escalation and conflict resolution • Managing aggression	• Communicate to patients and visitors the policy that violence will not be tolerated and provide information about potential consequences of violent behavior • Minimize anxiety for waiting patients and visitors by communicating with them every 30 minutes	• Develop and communicate policy to employees and management that violence is never acceptable • Develop and implement violence policies and procedures • Provide education for managers, communicate education and response policies to security and police, and monitor access to emergency department • Develop mechanism to alert staff when patients and visitors with a history of violence visit the ED again. • Quiet environment and areas. Special area for aggressive individuals or safe room for criminals. • Enforce visitor policies (i.e., number of visitors)
During assault	• Education and training • Nonviolent crisis intervention	• Isolate perpetrator from others	• Implement security/police plan • Implement procedures for dealing with violent event • Create procedure for investigating physical threats
After assault	• Critical incident debriefing • Mandatory reporting of all physical assaults and physical threats	• Report to security/police • Collect patient's/visitor's name to alert staff upon return visit	• Create procedure for reviewing violent event

(Gates et al., 2011, p. 33)

1.9 Summary

Violence in the workplace is a growing concern among medical workers, especially nurses. As the first and closest contact person with patients, nurses are at a high risk of exposure to violence (RNAO, 2019). Violence in the workplace occurs most commonly in EDs, psychiatric departments, drug and alcohol clinics, ambulances, and remote healthcare centers. Type II violence, which is patient-related violence, has been reported most frequently (Brophy et al., 2018; Copeland & Henry, 2017; Ferri et al., 2016; Mento et al., 2020; Nowrouzi-Kia et al., 2019; Ramacciati et al., 2019; Vento et al., 2020) and is on the rise. Its physical, psychological, mental, emotional, financial, professional, and organizational effects harm the entire healthcare system as a result of increased lost-time injuries (Government of Ontario, 2017; RNAO, 2019).

Several factors have been identified as increasing the likelihood of nurses experiencing WPV. These include the fact that nurses are predominantly female (Brinkman, 2021), are seen as oppressed (Young, 1990, as cited in Dubrosky, 2013), and tend to fail to report instances of violence. The majority of healthcare workers, including nurses, consider violence to be an unavoidable and essential aspect of their work (Ashton et al., 2018; Brophy et al., 2018; Copeland & Henry, 2017; Ferri et al., 2016; Pierce, 2015; Vento et al., 2020), which has been a deterrent to reporting it. This propensity to allow WPV go unreported makes it challenging to tackle the problem.

The International Labour Organization (2021) has called for measures to prevent all forms of violence in the workplace. This includes various processes and policies such as laws, regulations, and prevention strategies. No one should experience WPV or aggression, and healthcare environments should be safe. Therefore, prevention strategies should be enforced, including multi-interventional and organizational efforts to ward off or manage WPV (Yagil &

Dayan, 2019). This qualitative research aims to explore Northeastern Ontario nurses' perceptions of violence and to provide suggestions to address the problem. In addition, the insights derived from this research can be used to help improve the workplace environment in acute-care settings.

Chapter 2: Review of Literature

2.0 Introduction to Literature Review

Chapter 1 highlights the critical need to address WPV experienced by nurses. Using a narrative review, Chapter 2 identifies and reviews current and relevant knowledge related to WPV involving nurses who work in Northeastern Ontario, including contributing factors; personal, professional, and organizational consequences; and prevention strategies to reduce WPV. A narrative review is formal or nonsystematic (Gregory & Denniss, 2018) and is a type of literature review that summarizes previous studies, identifying areas that require further research. The Critical Appraisal Skills Programme (CASP) checklist for qualitative research is used to appraise the studies included in this review (CASP, 2018). The checklist comprises tools for various studies, including systematic reviews, qualitative research articles, randomized controlled trials, cohort studies, and diagnostic studies. The qualitative checklist includes 10 questions divided into three sections: Section A addresses the validity of the study results, Section B examines the results, and Section C checks the local usefulness of the result (CASP, 2018).

This narrative review examines the literature on preventing WPV in healthcare settings. A narrative review encompasses a broad scope, as it addresses one or more research questions. The OMNI, PubMed, Scholars Portal, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and ProQuest databases were used to identify articles using search terms such as workplace and violence, WPV and hospitals, nurses' perception of WPV, violence assessment tool and perception, nurses and violence, healthcare workers and violence, violence assessment tools, violence assessment tool and implementation. violence assessment tool and effectiveness, and violence and psychiatric nurses. OMNI is a search tool that combines resources from 16

Ontario universities (Library and Archives, n.d), while PubMed provides research for biomedical and life sciences (PubMed, 2021). Scholars Portal was established in 2002 as a research database for Ontario universities to assess journals and other data (Scholars Portal, 2021). The Cumulative Index to Nursing and Allied Health Literature provides access to full-text journals and is a useful source for nursing and allied health (EBSCO, 2020). All studies selected for this review captured the three components of the Haddon matrix framework that guided this study: host, the nurse or healthcare staff member; agent, the perpetrator of violence; and the environment.

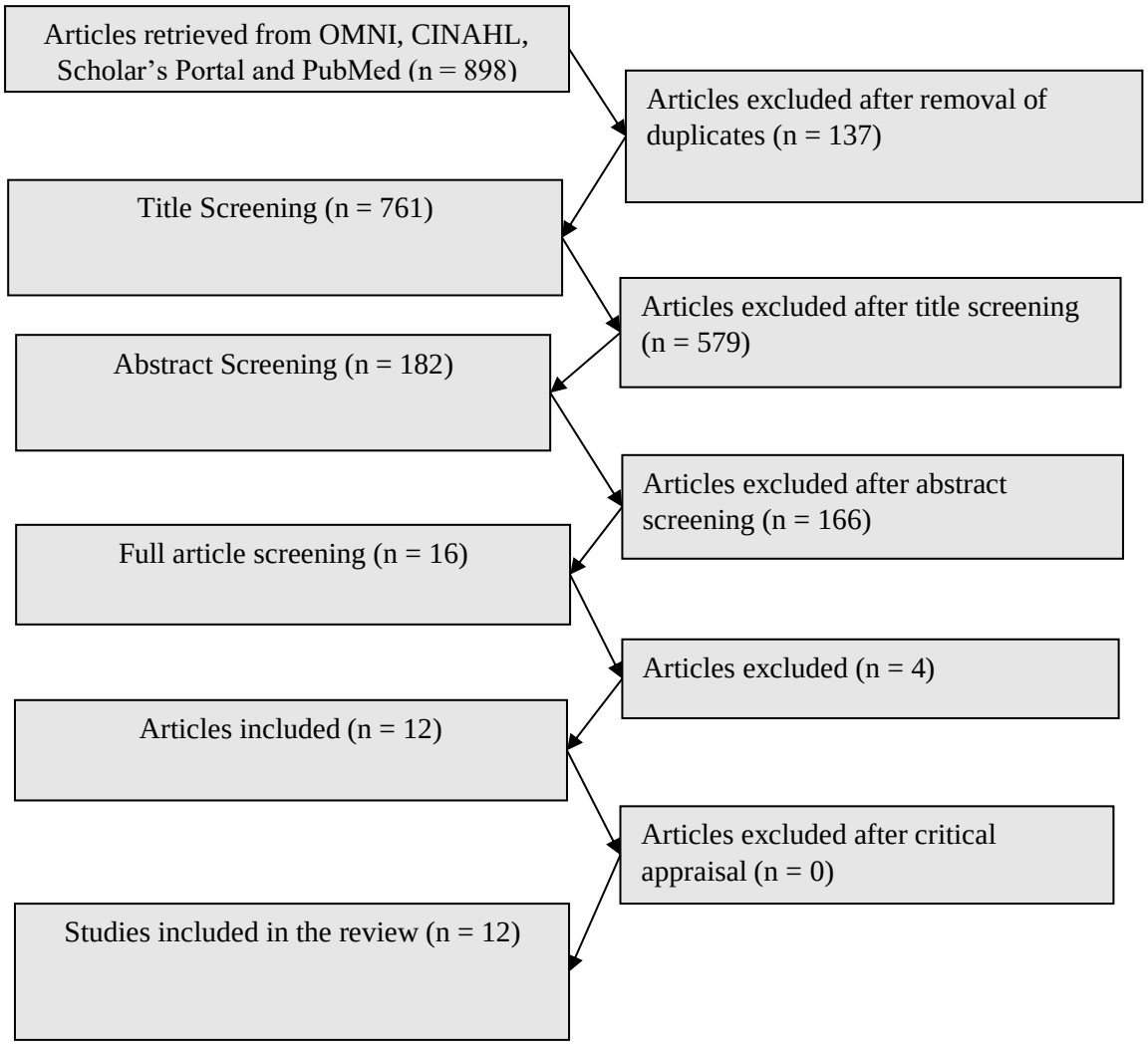
2.1 Inclusion and Exclusion Criteria

Articles were reviewed if WPV prevention among nurses in acute-care settings was evaluated. The following criteria were used to include articles for this review: (1) peer-reviewed, (2) published between 2016 and 2022, (3) published in the English language, and (4) directly assessed WPV in nurses and provided or suggested prevention strategies. Other reviewed papers—such as scoping, systematic, and integrative reviews—were also included. Articles published in languages other than English were excluded.

2.2 Search Outcome

The initial results yielded 898 articles published between 2016 and 2022. Upon further insepection, 579 articles were excluded following the review of titles, and 13 articles were excluded for being duplicates. That left 182 abstracts to be reviewed, and exclusions were made if the article did not satisfy the above-mentioned inclusion criteria. Sixteen articles emerged from this process, and four studies were excluded because their focus was not on nurses (Cowman et al. 2017; Jakobsson et al. 2020; Wu et al., 2019; Zhao et al., 2016). The references of these 12 articles were screened for relevance to this review, and no additional qualifying articles were found. The process used to arrive at the final articles is depicted in Figure 2.

Figure 2: ***Diagram of Article Selection Process***



2.3 Critical Appraisal and Level of Evidence

The articles were critically appraised using the Critical Appraisal Skills Program (CASP) checklists to assess the relevance of the research, result validity, and trustworthiness of the results (CASP, 2018).

The highest level of evidence, Level I, is from systematic reviews or meta-analyses of randomized control trials (RCTs) and is regarded as the most substantial level of evidence (Melnyk & Fineout-Overholt, 2019). Additional levels are Level II, a single RCT; Level III, a

non-RCT or quasi-experimental study; Level IV, cohort, case-control, or cross-sectional studies; Level V, systematic reviews or metasynthesis of qualitative studies; Level VI, a single qualitative or descriptive study; and Level VII, expert opinions of authorities (Melnyk & Fineout-Overholt, 2019). Using this standard of categorization (McNair & Lewis, 2012; Melnyk & Fineout-Overholt, 2019), two articles provided Level I evidence (Mento et al., 2020; Nowrouzi et al., 2019), one was Level III (Lamont & Brunero, 2018), four were Level IV (Berry et al., 2017; Havaei et al., 2019; Ramacciati et al., 2018; Ridenour et al., 2017), one was Level V (Ghosh et al., 2019), and four were Level VI (Brophy et al., 2018; Burkoski et al., 2019; Cabilan et al., 2020; Dafny & Beccaria, 2020). Table 3 provides a summary of the 12 studies included in this review, stating the authors, their countries, their research aims, study designs, settings, levels of evidence, and the themes captured in the review.

Table 3: ***Literature review summary***

	Authors	Country	Study Aim	Study Design	Sample and Setting	Literature Review Themes			Level of Evidence
						Personal, professional, and organizational consequences of WPV	**Workplace violence assessment tools**	**Prevention strategies for workplace violence**	
1.	Berry et al. (2017)	Canada	To test the utility of the Aggressive Behavior Risk Assessment Tool (ABRAT) and the Aggressive Behavior Scale (ABS) to predict violence	Retrospective cohort study	316 long-term-care residents		•		IV
2.	Brophy et al., (2018)	Canada	To explore staff experiences and ideas of WPV	Collaborative descriptive qualitative	54 Ontario Council of Hospital Unions (OCHU) staff: RPNs, PSWs, dietary, housekeeping, and other healthcare staff	•			VI
3.	Burkoski et al. (2019)	Canada	To explore the experiences of nurses using a technology-based violence prevention intervention	Interpretive study design	12 nurses from Humber River Hospital			•	VI
4.	Cabilan et al. (2020)	Australia	To understand the components of an occupational violence risk assessment tool	Participatory action research	15 ED nurses		•		VI
5.	Dafny and Beccaria (2020)	Australia	To explore nurses' perceptions of patients' and visitors' use of physical and verbal force	Exploratory qualitative design	23 registered nurses: 6 emergency nurses, 6 intensive care	•			VI

	Authors	Country	Study Aim	Study Design	Sample and Setting	Literature Review Themes			Level of Evidence
						Personal, professional, and organizational consequences of WPV	Workplace violence assessment tools	Prevention strategies for workplace violence	
					nurses, and 11 psychiatry nurses				
6.	Ghosh et al. (2019)	Australia	To examine risk assessment tools to predict patient violence in general acute-care hospitals	Integrative review	41 studies		•		V
7.	Havaei, et al. (2019)	Italy	To identify strategies used by nurses to prevent violence and collect their perceptions of workplace safety	Exploratory correlational study	771 medical-surgical units nurses and 189 nurses from mental health			•	IV
8.	Lamont and Brunero (2018)	Australia	To assess the effects of a violence training program in an acute-care hospital setting	Quasi-experimental	78 nurses from EDs, neurosciences, aged care, community services, respiratory and infectious diseases, and spinal services who completed both pretest and posttest evaluations			•	III
9.	Mento et al. (2020)	Italy	The impact of exposure to WPV among healthcare professionals and to improve knowledge about its consequences	Systematic review	27 studies	•			I

	Authors	Country	Study Aim	Study Design	Sample and Setting	Literature Review Themes			Level of Evidence
						Personal, professional, and organizational consequences of WPV	Workplace violence assessment tools	Prevention strategies for workplace violence	
10.	Nowrouzi-Kia et al. (2019	Canada	To identify antecedent factors and impacts of the various types of WPV	Systematic review	13 studies	•			I
11.	Ramacciati et al. (2019)	Italy	To analyze the characteristics of violence toward nurses	Cross-sectional study	1,100 ED nurses	•			IV
12.	Ridenour et al. (2017)	USA	To examine nurses' knowledge and experiences of violence prevention in healthcare facilities and to identify the training methods	Quantitative survey	309 nurses at hospitals and nursing homes			•	IV

2.4 Personal, Professional, and Organizational Consequences of Workplace Violence

Five studies reviewed in this section reveal the contributing factors to WPV and the personal, professional, and organizational consequences of various types of WPV among nurses. Two of the studies qre qualitative, one of which studied Type II violence (Brophy et al., 2018) and the other both Type I and Type II violence (Dafny & Beccaria, 2020); one is quantitative and studied Type I and II violence (Ramacciati et al., 2019); and two are systematic reviews (Mento et al., 2020; Nowrouzi-Kia et al., 2019). In addition, one studied Type II and III violence (Nowrouzi-Kia et al., 2019), and another (Mento et al., 2020) studied Type II violence. The types of violence, as described in Table 1 (pg. 4), include Type I, where the violent person is the patient's relative or visitor; Type II, where the violent person is the patient; Type III, where the violent person is a colleague; and Type IV, where the violent person has a personal relationship with an employee.

Two studies are Canadian (Brophy et al., 2018; Nowrouzi-Kia et al., 2019), two are Italian (Mento et al., 2020; Ramacciati et al., 2019), and one is Australian (Dafny & Beccaria, 2020). The literature in this section reveals the various consequences of WPV, such as clinical, environmental, organizational, social, economic, and personal. Additionally, the studies demonstrate how nurses express dissatisfaction in their jobs due to WPV, their perceptions of violence that is seen as part of the job, and the normalization of violence in the society.

A collaborative, descriptive, qualitative study (Brophy et al., 2018) was conducted among 54 Ontario Council of Hospital Unions staff members in Ontario (41 females and 13 males), focusing on their experiences and their perceptions of violence against healthcare staff. Thirteen focus groups were used to interview the purposive sample of 27 RPNs, six PSWs, nine administrative staff members, five cleaners and housekeepers, three dietary staff members, two

personal care assistants, one physiotherapist, and one maintenance staff using semistructured questions. These groups ranged from two to seven participants, and additional recruitment was made available through an open invitation. The purposive sample represented 16 facilities in Ontario. Brophy et al. (2018) explored Type II violence, the most common type of WPV in the healthcare setting. Data were analyzed using a qualitative software program. Five categories of findings outlined by the United States Occupational Safety and Health Administration were used to code the risk factors: clinical, environmental, organizational, social, and economic.

Three additional findings were identified: personal effects of violence, such as physical, psychological, mental, financial, and emotional (Brophy et al., 2018); barriers faced, such as lack of cooperation and support from management, rigorous reporting process, fear of publicly speaking about violence, and fear of job loss; and solutions, which the authors classified as primary, secondary, and tertiary. These solutions included increased staffing, enhanced security, personal alarms, building design changes, zero-tolerance policies, simplified reporting, and enhanced managerial support. Finally, the limitations of this study included the noninclusion of physicians and registered nurses, the small number of participants representing the province, and the fact that remote northern communities were not represented (Brophy et al., 2018).

A cross-sectional survey (Ramacciati et al., 2019) that explored Type II violence toward 1,100 ED nurses working in hospitals in Italy was conducted in 2016 using the National Survey Questionnaire titled “Violence Towards Nurses of First Aid” (QuIN16VIPs). The variables studied were all related to Type II and Type I violence, including verbal and physical violence and verbal and physical aggression. Seventy-six percent of respondents experienced verbal violence, 15.5% experienced both verbal and physical violence, and only 8.5% experienced neither. Most perpetrators were patients’ relatives and caregivers (85.3%), followed by patients

(75%), and visitors (18.6%). Participants could select more than one option regarding the perpetrators. Fifty-seven percent referred to the lack of institutional policies for reporting violent episodes. There was no difference in the nurses' experiences of violence based on gender and educational status. Fewer violence cases were reported in smaller EDs with fewer than 25,000 visits annually. A low response rate was a limitation of the study, meaning that the results were not generalizable. Furthermore, the authors reported recall bias (Ramacciati et al., 2019).

A 2019 systematic review of 13 studies by Nowrouzi-Kia and colleagues in Sudbury and Toronto investigated the antecedent factors involved in various types of WPV against nurses. The Critical Appraisal Skills Programme (CASP) and the Cochrane Collaboration's risk of bias assessment tools were used to assess the quality of the studies, which included five American studies (Canton et al., 2009; Chipps & McRury, 2012; Skarbek et al., 2015; Gacki-Smith et al., 2009; and Simons, 2008), two Canadian studies (Chionere et al., 2014, and Hesketh et al., 2003), and one study each from Turkey (Kaya et al., 2016), Slovenia (Kvas & Seljak, 2015), Israel (Kitaneh & Hamdan, 2012), Norway (Morken et al., 2015), New Zealand (Baby et al., (2014), and South Korea (Park et al., 2015). The methods used in the various studies were mainly quantitative (cross-sectional) but also included qualitative focus group interviews and individual telephone interviews. Six studies examined Type II violence, two focused on Type III violence, and five concentrated on both types of violence (Nowrouzi-Kia et al., 2019).

Nowrouzi-Kia et al. (2019) concluded that WPV caused nurses to experience job dissatisfaction. Participants identified several factors that led to Type II violence, including patients with mental health problems, alcohol and drug use, a history of stress and aggression, and a feeling of powerlessness. Additionally noted were system factors such as workload, a stressful work environment, lack of WPV awareness and security, and staffing limitations. For

example, evening shift nurses (4 p.m. to midnight) working during the most vulnerable hours of the day experienced more violence than those who worked the day shift. Nowrouzi-Kia et al. (2019) revealed the need for evidence-based interventions and the implementation of strategies to support nurses. A strength of the study was that it was conducted by Canadian researchers in various nations, thus offering a comprehensive sociocultural understanding.

Another systematic review of 27 studies between 2014 and 2019 was conducted by Italian researchers Mento et al. (2020) to examine the impact of exposure to WPV among healthcare professionals. They used the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines. Mento and colleagues included studies that examined most healthcare workers, including physicians, nurses, healthcare support workers, pharmacists, medical rescue workers, mental health workers, technical and support staff, managers, and educators. The studies were conducted in varying locations around the world, such as China (Peng et al., 2018; Sun, Gao, et al., 2017; Sun, Zhang, et al., 2017; Jia Tian & Li Du, 2017; Liang et al., 2015 and Li et al., 2019), Turkey (Bayram et al., 2017), Taiwan (Wu et al., 2015), Bahrain (Rafeea et al., 2017), Nigeria (Seun-Fadipe et al., 2017), Pakistan (Farah et al., 2018), Australia (Shea et al., 2017), Italy (Ramacciati et al., 2019), Germany (Vorderwulbecke et al., 2015), Iran (Babanataj et al., 2019), and New Zealand(Baby et al., 2019). Unfortunately, the location of 10 of the studies was not reported. Mento et al. (2020) revealed that most violent incidents occurred in emergency and psychiatric departments.

Occurrences of WPV are usually followed by some negative consequences for healthcare workers, such as anxiety, anger, depression, guilt, and reduced quality of life (Mento et al., 2020). Violent incidents often occurred after medical malpractice or when treatment outcomes

did not meet the patient's expectations. Type II violence was the most common form of WPV and was typically reported as verbal abuse or threats (Mento et al., 2020).

Mento et al. (2020) concluded that effective prevention strategies for any healthcare organization should include appropriate education for all healthcare workers and the provision of training programs to identify early signs of violent behavior exhibited by patients and visitors, to avoid escalation of these behaviors. Furthermore, the authors recommended the instruction of verbal and physical prevention skills, diversion and de-escalation techniques, and patient management protocols (Mento et al., 2020).

An exploratory qualitative study was conducted among 23 registered nurses (17 females and six males), which included six ED nurses, six intensive care unit nurses, and 11 psychiatric department nurses at a Queensland regional public hospital in Australia (Dafny & Beccaria, 2020). Three semistructured focus group interview sessions were conducted following recruitment of the participants, and the study aimed to explore nurses' perceptions of Type I and Type II violence. Data were analyzed using qualitative methods, including preparing the data for themes, subthemes, and eventual findings (Creswell 2013, as cited in Dafny & Beccaria 2020).

Five emerging themes focused on the nature of WPV, perceptions of WPV, incidents of violence and the roles played by gender, the specific job involved, and the process for reporting violence (Dafny & Beccaria, 2020). Patients were more frequently involved in physical violence, while verbal violence was more common among patients' relatives and friends. Nurses coped more with unintentional violence, incidents experienced by patients with mental health issues, than intentional violence involving sane patients. Dafny and Beccaria (2020) found that gaps in reporting violence was an issue for the following reasons: nothing would be done about it, lack

of time due to busy work schedules, and fear that the blame would be placed on the nurses for the violent occurrence.

Additionally, nurses in this study stated they believe there is a lack of general awareness of WPV in society, as the nurses could not discuss violent issues with friends and family for fear that it was seen as part of the job. Moreover, nurses believed their gender contributed to violence: Some patients saw female nurses as either doctors or nurses and male nurses as doctors, and patients assaulted female staff more frequently, suggesting the vulnerability of this population. Finally, the research limitations included the use of only one facility and only three settings in that facility (Dafny & Beccaria, 2020).

2.5 Summary of Personal, Professional, and Organizational Consequences of Workplace Violence

A common issue identified in the literature review was that both Types I and II WPV were frequent occurrences in emergency and psychiatry departments (Brophy et al., 2018; Dafny & Beccaria, 2020; Ramacciati et al., 2019; Mento et al., 2020; Nowrouzi et al., 2019) and intensive care units (Dafny & Beccaria, 2020). Some other issues identified in the literature included underreporting of violent incidents; lack of a policy for reporting (Brophy et al., 2018; Dafny & Beccaria, 2020; Ramacciati et al., 2019); a perception that violence is unavoidable, expected, and part of the job (Brophy et al., 2018; Dafny & Beccaria, 2020; Mento et al., 2020); and nurses' dissatisfaction in their roles (Brophy et al., 2018; Nowrouzi-Kia et al., 2019). Patient factors that led to WPV were dissatisfaction with treatment outcomes (Mento et al., 2020), mental health problems, alcohol and drug use, a history of stress and aggression, and a feeling of powerlessness (Nowrouzi-Kia et al., 2019). Consequences of violence for healthcare workers were identified as anxiety, anger, depression, and guilt, with other adverse outcomes for

wellbeing and quality of life (Mento et al., 2020; Nowrouzi et al., 2019; Brophy et al., 2018). This section also categorized the studies under the types of violence.

2.6 Workplace Violence Assessment Tools

This section explores the assessment of WPV tools in three studies: Berry et al. (2017), Cabilan et al. (2020), and Ghosh et al. (2019). The use of tools to prevent violence can be viewed as "before the event" for both the host and the agent, and these include strategies to help prevent WPV. The findings revealed the need for an easy-to-use tool to predict violence. Two of the studies were conducted in Australia (Caliban et al., 2020, a participatory action research, and Ghosh et al., 2019, an integrative review) and one in Canada (Berry et al., 2017, a retrospective cohort study). The studies in this section did not capture the types of violence.

A 2019 integrative review of 41 studies between 2000 and 2018 conducted by Ghosh and colleagues in Australia investigated risk assessment tools used to predict patient violence in general acute care. The review was guided by five stages of an integrative review and the PICOS framework (population, intervention, comparator, outcome, and study design). Ghosh et al. (2019) reported that 16 tools were found in the 41 studies examined in the review. One tool, the STAMP/EDAR (staring, tone/volume of voice, anxiety, mumbling, and pacing) / (emotions, disease process, assertive/nonassertive, resources), was used in the ED. Two tools were used in general acute-care settings: the Violence Risk Assessment Tool (M55) and the Aggressive Behavior Risk Assessment Tool (ABRAT). Thirteen tools were used in psychiatric settings, four of which are used to identify violence within three to six months: the Psychopathy Checklist-revised (PCL-R)/screening version (PCL-SV); the Historical, Clinical, Risk Management (HCR-20); the Violence Risk Appraisal Guide (VRAG); and the Short-Term Assessment of Risk and Treatability (START). Seven tools that seek to identify violence between two and six weeks are

the Brockville Risk Checklist (BRC), the Inter RAI Risk of Harm to Others Clinical Assessment Protocol (RHO-CAP), the Imminent Risk Rating Scale (IRRS), the Preliminary Scheme 33 (PS33), the Risk of Violence Assessment (ROVA), the Classification of Violence Risk (COVR), and the Fordham Risk Screening Tool (FRST). Two that aim to identify violence within 24 hours are the Brøset Violence Checklist (BVC) and the Dynamic Appraisal of Situational Aggression (DASA). The Historical, Clinical, Risk Management; Brøset Violence Checklist; and Dynamic Appraisal of Situational Aggression were cited most frequently in the literature (Ghosh et al., 2019). A summary of the tools listed is indicated in Table 4 below.

Ghosh et al. (2019) discovered that no easy and evidence-based tool was available to help predict violence in acute-care settings. The tools were cumbersome and time-consuming, and the scoring process was lengthy. The Brøset Violence Checklist and the Dynamic Appraisal of Situational Aggression instrument used in psychiatric settings were discovered as potential instruments in other general acute-care settings; however, they required enhanced testing to assess their reliability and validity. The need for a tool that is easy to use with no prior special knowledge was recommended. One of the strengths is that the study results come from various countries and locations, increasing sociocultural understanding (Ghosh et al., 2019).

Table 4: ***Summary of Violence Assessment Tools***

Violence Assessment Tools in Psychiatric Settings			Violence Assessment Tools in ED	Violence Assessment Tools in General Acute Care
Tools that identified violence with 3- to 6-month follow-up	**Tools that assessed violence between 2 and 6 weeks**	**Tools that predicted violence within 24 hours**		
Psychopathy checklist-revised (PCL-R)/screening version (PCL-SV) (Hare 2003; Dolan & Doyle, 2000; McDermott et al., 2008; Vitacco et al., 2009)	Brockville Risk Checklist (BRC), (Chagigiorgis et al., 2013)	*****Brøset violence checklist (BVC) (Almvik et al.,2000; Clarke et al.,2010; Hvidhjelm et al., 2014; Ogloff & Daffern 2006; Rechenmacher et al., 2014; Woods et al. 2008; Yao et al. 2014; Abderhalden et al., 2006; Almvik et al. 2007; Chu et al. 2013)	STAMP/EDAR (staring, tone/volume of voice, anxiety, mumbling, and pacing) / (emotions, disease process, assertive/nonassertive, resources) (Luck et al., 2007 and Chapman et al., 2009)	Violence Risk Assessment Tool (M55) (Kling et al., 2006; Ideker et al., 2011)
*****Historical, Clinical, Risk Management (HCR-20) (Webster et al.,1997; Arbach-Lucioni et al., 2011, Dolan & Blattner 2010; Langton et al. 2009; O'Shea et al., 2014; Gunenc et al., 2015; and Teo et al., 2012)	InterRAI Risk of Harm to Others Clinical Assessment Protocol (RHO-CAP), (Neufeld et al., 2012)	*Dynamic Appraisal of Situational Aggression (DASA) (Chu et al., 2013; Griffith et al., 2013; Lantta et al., 2016; Ogloff & Daffern 2006; Vojt et al., 2010).		Aggressive Behavior Risk Assessment Tool (ABRAT) (Kim et al., 2012)
Violence Risk Appraisal Guide (VRAG) (Harris et al., 1993; Cooke et al., 1999; Doyle et al., 2002; and Snowden et al., 2009)	Imminent Risk Rating Scale (IRRS) (Starzomski and Wilson 2015)			

Violence Assessment Tools in Psychiatric Settings			Violence Assessment Tools in ED	Violence Assessment Tools in General Acute Care
Tools that identified violence with 3- to 6-month follow-up	**Tools that assessed violence between 2 and 6 weeks**	**Tools that predicted violence within 24 hours**		
Short-Term Assessment of Risk and Treatability (START) (Webster et al., 2006; Nonstad et al., 2010; O'Shea et al., 2016 Wilson et al., 2013)	Preliminary Scheme 33 (PS33), (Bjørkly and Moger 2007; Hartvig et al.,2011; Eriksen et al., 2016)			
	Risk of Violence Assessment (ROVA) (Lynch and Noel (2010)			
	Classification of Violence Risk (COVR) (McDermott et al. 2011)			
	Fordham Risk Screening Tool (FRST) (Rosenfeld et al., 2017; Rosenfeld et al., 2017; Rotter & Rosenfeld 2018)			

*Denotes the tools that were cited frequently in the review by Ghosh et al., 2019

Cabilan et al. (2020) conducted a Participatory Action Research study in Queensland, Australia, to develop a violence risk assessment tool for ED nurses using the Consolidated Criteria for Reporting Qualitative Research guidelines. The study consisted of three focus groups and eight interviews with 15 participants. The interview questions used were codeveloped with the management of the ED. Data were transcribed in Microsoft Excel and thematically analyzed using Braun and Clarke's technique. Six broad themes were identified: risk assessment, risk communication, clinical implications of a risk assessment tool, tool attributes, implementation challenges, and unintended consequences. Caliban et al. (2020) suggested that implementing an occupational violence risk assessment tool would benefit the Queensland emergency department. The tool was designed to trigger an alert system linked to management strategies, allowing users to objectively assess occupational violence risk factors. The authors also noted the need for proper staff communication and training on occupational violence. The use of only one Queensland ED and the selection of only experienced nurses as participants were identified as study limitations (Cabilan et al., 2020). This study identified a significant need for developing a violence risk assessment tool to use at the facility.

A retrospective cohort study (Berry et al., 2017) was conducted to test the utility of the Aggressive Behavior Risk Assessment Tool (ABRAT) and the Aggressive Behavior Scale (ABS) to predict violent and aggressive incidents among new and existing residents of two long-term care facilities in Alberta, Canada. The Aggressive Behavior Scale is part of a larger Resident Assessment Instrument-Minimum Data Set system (RAI-MDS). The instruments used in this study were the Resident Assessment Instrument-Minimum Data Set system 2.0 and the Aggressive Behavior Risk Assessment Tool. The former included the Aggressive Behavior Scale, Cognitive Performance Scale, Depression Rating Scale, and demographics and was used

to track aggressive behaviors, cognitive impairment, mood patterns, and demographics. This was completed at the time of admission, quarterly or annually, and when a resident's condition changed. Berry et al. (2017) used the Aggressive Behavior Risk Assessment Tool to assess the following in "yes" or "no" responses: agitation, anxiety, confusion/cognition, shouting, physical aggression, mania, threatening, staring, mumbling, and threatening to leave.

Berry et al. (2017) found that 27 (8.5%) of the 316 residents exhibited at least one incidence of violence. The range of risk scoring for the Aggressive Behavior Risk Assessment Tool is between 0 and 2, with 0 being low-risk, 1 medium-risk, and 2 high-risk. The Aggressive Behavior Scale for behaviours is 0 for none, 1–2 for moderate, 3–5 for severe, and 6 or more for very severe. All 27 violent residents had moderate to severe cognitive function, while about 44.4% had major depressive disorders. Most of the residents with aggressive incidents (93.6%) had a high-risk Aggressive Behavior Risk Assessment Tool score of 2 or more, and 33.3% displayed severe aggressive behavior on the Aggressive Behavior Scale. With the Aggressive Behavior Risk Assessment Tool, almost all aggressive residents were identified correctly. The sensitivity and specificity for the Aggressive Behavior Risk Assessment Tool were 96.3% and 65.4%, respectively (Berry et al., 2017).

The Aggressive Behavior Scale was less helpful in predicting future violent episodes than the Aggressive Behavior Risk Assessment Tool. Berry et al. (2017) concluded that developing a useful predictive tool for identifying residents with a risk of aggressive behavior was an essential first step for managing WPV among healthcare staff. Limitations of the study included the fact that the nature of aggression was not assessed, and the use of only two facilities limited the generalizability of this study (Berry et al., 2017).

2.7 Summary of Workplace Violence Assessment Tools

Various tools have been used to prevent WPV in healthcare settings, including the Brøset Violence Checklist and Dynamic Appraisal of Situational Aggression (Ghosh et al., 2019). However, tools that were less cumbersome and less time-consuming were recommended, and the need for a violence assessment tool that would predict violence was suggested (Cabilan et al., 2020; Berry et al., 2017).

2.8 Prevention Strategies of Workplace Violence

This section reviews four studies on the prevention of WPV: Burkoski et al. (2019), an interpretive study design conducted in Canada; Havaei et al. (2019), an exploratory correlational study conducted in Canada; Lamont and Brunero (2018), a quasi-experimental study conducted in Australia; and Ridenour et al. (2017), a quantitative study conducted in the United States. The studies examined nurses' experiences with violence prevention and training interventions, which were captured under the host and environment domain of the Haddon matrix framework. Prevention and training interventions fall under "before the assault," "during the assault," and "after assault" (Table 2, p. 10). The studies in this section did not capture the types of violence.

An interpretive, descriptive qualitative study was conducted among 11 nurses (females and males) at Humber River Hospital in Ontario, Canada, to explore their experiences using a technology-based violence prevention intervention (Burkoski et al., 2019). Three nurses participated in individual interviews, while eight joined a semi structured focus group. Data were analyzed using content analysis that identified three themes: reassurance of safety, an increase in proactive measures, and limitations of technology (Burkoski et al., 2019).

Burkoski et al. (2019) discovered that the VAT, compared to the Brøset Violence Checklist and Dynamic Appraisal of Situational Aggression, was a more appropriate tool to

prevent violence. Humber River Hospital implemented an electronic flagging system that included symbols in the patients' charts, digital signage next to the doors of the patients' rooms, and a personal safety response system (PSRS). The authors concluded that real-time, easy-to-use tools are beneficial for reducing violence. However, the generalizability of the findings was limited due to the small sample size and the use of only one facility (Burkoski et al., 2019).

Havaei et al. (2019) conducted an exploratory, correlational study using secondary data from a nursing survey between 2017 and 2018. The aim was to identify strategies used by nurses to prevent violence and to understand their perceptions of workplace safety in medical–surgical and mental health units in British Columbia, Canada. The sample for this study included 771 nurses from medical–surgical units and 189 nurses from mental health units. Participants comprised registered nurses, licensed practical nurses, and RPNs. Among the strategies identified to prevent violence were nurses' intervention, availability of "code white" drills (an emergency response code for a violent patient) and responses to these drills, code white incident reviews, behavioral care plans, fixed alarms in the workplace, personal alarms, and WPV prevention training (Havaei et al., 2019).

Findings indicated that approximately 30% of medical–surgical units and 53% of mental health units had trained code white responders. Most of the participants acknowledged that employers listened to their suggestions about the prevention of violence. Most also had accessible fixed alarms on their units (61.4% of medical–surgical nurses and 75.8% of mental health nurses), and most had received violence prevention training (96% of medical–surgical nurses and 97.9% of mental health nurses). However, approximately 77.6% of medical–surgical nurses and 78.8% of mental health nurses said they felt safe in their workplace only sometimes or not all. The researchers concluded there is a need for a more rigorous analysis of violence and

evidence-based WPV prevention strategies. Limitations of this study included the use of secondary data and, therefore, limited targeted information (Havaei et al., 2019).

A quantitative survey was conducted among nurses in New Jersey to examine their knowledge of and experience with violence prevention in healthcare facilities and to identify the training methods used (Ridenour et al., 2017). A survey instrument developed by the researchers was mailed to 2,000 registered nurses and 2,000 licensed practical nurses who were randomly sampled from the New Jersey Division of Consumer Affairs Board of Nursing; a 22.5% response rate resulted in a sample of 309 nurses who worked in hospitals and nursing homes. Participants included 203 registered nurses, 97 licensed practical nurses, and nine whose jobs were unknown. Ridenour et al. (2017) noted that most participants were female (90%). The participants reported experiencing verbal abuse (57.8%), threats (52.3%), and physical assaults (38.3%) from patients (Type II) and family members (Type I). In addition, the participants experienced bullying (30.1%), verbal abuse (25.7%), and threats (19.8%) from coworkers (Type III). Approximately 78.7% of registered nurses received training in violence prevention compared to only 56.2% of licensed practical nurses. Some possible reasons for this discrepancy included a higher turnover rate, a lower employee status, and more night shifts worked by licensed practical nurses. Participants who worked at hospitals were more likely to be trained than their counterparts in nursing homes. New Jersey regulations require healthcare facilities such as nursing homes and hospitals to have policies for assessing, preventing, and reporting violence; committee review and violence assessments of incidents; postincident care; and training for violent events (Ridenour et al., 2017). Therefore, the researchers strongly recommended training for nurses.

In 2018, Lamont and Brunero conducted a quasi-experimental pretest/posttest study at a tertiary hospital in Australia to assess the effects of a violence-training program in an acute-care setting. A total of 104 eligible nurses participated from emergency departments, neurosciences, aged care, community services, respiratory and infectious diseases, and spinal services. Most participants (*n* = 78; 75%) attended the pretest and posttest workshop evaluations, and the majority of these participants were female (*n* = 56; 72%). Eleven workshops took place from March to December 2017 and addressed three goals: (1) developing a violence assessment and management plan, (2) using de-escalation techniques during violent incidents, and (3) using breakaways when attending to violent persons (Lamont & Brunero, 2018).

Lamont and Brunero (2018) used the following instruments: (1) Continuing Professional Development (CPD) reaction questionnaire, a 12-item scale that evaluated five items—intention, social influence, beliefs about capabilities, moral norms, and beliefs about consequences; and (2) the Confidence in Coping with Patient Aggression Instrument, which assessed participants' confidence in managing physical and verbal violence. The researchers reported a statistically significant relationship between the three goals of the workshop and most of the items listed on the instruments. The use of breakaways, such as pulling away and self-defense techniques, in a work setting to cope with physically aggressive behaviors such as bites and strangulation elicited the most response. Participants confirmed that instruction in these techniques strengthened their confidence in managing violence (Lamont & Brunero, 2018).

The researchers stated that WPV training represents a suitable means for managing violent behaviors and increasing confidence levels in WPV management. They concluded that, to successfully manage violence, there is the need for effective response, reporting systems, training and education, audits and reviews, and dedicated WPV roles. A limitation of this study

was that it was conducted in only one hospital and, as a consequence, its results may not be generalizable to all hospitals (Lamont & Brunero, 2018).

2.9 Summary of Prevention Strategies of Workplace Violence

Havaei et al. (2019) emphasized the need for evidence-based prevention strategies addressing WPV, recommending tools that nurses can use despite their busy schedules and that are easy to use without prior specialized training or expertise (Burkoski et al., 2019). Prevention strategies mentioned in the literature review included electronic flagging systems, personal safety response systems, personal and fixed alarm systems, and training (Burkoski et al., 2019; Lamont & Brunero, 2018; Ridenour et al., 2017). Training of staff had a positive impact on the knowledge and attitude of nurses regarding violence prevention (Lamont & Brunero, 2018), and yearly training was recommended to ensure that staff members were always prepared (Ridenour et al., 2017).

2.10 Rationale for the Study of Nurse Perceptions of the Utilization of the Violence Assessment Tool in Northeastern Ontario

The literature reviewed included studies from Canada (Berry et al., 2017; Brophy et al., 2018; Burkoski et al., 2019; Nowrouzi-Kia et al., 2019), the United States (Ridenour et al., 2017), Italy (Havaei et al., 2019; Mento et al., 2020; Ramacciati et al., 2019;), and Australia (Cabilan et al., 2020; Dafny & Beccaria, 2020; Ghosh et al., 2019; and Lamont & Brunero 2018). The review of the literature revealed that Types I and II WPV were a frequent concern in EDs and psychiatry units (Brophy et al., 2018; Copeland & Henry, 2017; Ferri et al., 2016; Mento et al., 2020; Nowrouzi-Kia et al., 2019; Ramacciati et al., 2019).

Common contributing factors associated with violence toward healthcare workers identified in the literature included the lack of a policy for reporting violence (Brophy et al.,

2018; Ramacciati et al., 2019;), and a perception that violence is unavoidable, expected, and part of the job (Brophy et al., 2018; Mento et al., 2020). Additionally, patient factors that often resulted in WPV were identified as dissatisfaction with treatment outcomes (Mento et al., 2020), mental health problems, alcohol and drug use, a history of stress and aggression, and feelings of powerlessness (Ferri et al., 2016; Nowrouzi-Kia et al., 2019).

Consequences for the healthcare providers included job dissatisfaction, anxiety, anger, depression, guilt, and reduced quality of life (Brophy et al., 2018; Dafny & Beccaria, 2020; Mento et al., 2020; Nowrouzi-Kia et al., 2019). Furthermore, the personal impacts of violence on healthcare workers were physical, psychological, mental, financial, and emotional (Brophy et al., 2018).

Suggestions for prevention included evidence-based intervention (Havaei et al., 2019; Nowrouzi-Kia et al., 2019), education and training programs (Brophy et al., 2018; Lamont & Brunero, 2019; Mento et al., 2020; Ridenour et al., 2017), diversion and de-escalation strategies (Mento et al., 2020), zero-tolerance policies (Brophy et al., 2018), and simplified reporting systems (Brophy et al., 2018; Ramacciati et al., 2019).

Limitations included the noninclusion of small, remote, northern communities (Brophy et al., 2018), reporting and recall bias (Berry et al., 2017; Ramacciati et al., 2019; Ridenour et al., 2017), the use of one facility (Burkoski et al., 2019; Cabilan et al., 2020; Copeland & Henry, 2017; Dafny & Beccaria, 2020; Ferri et al., 2016; Lamont & Brunero, 2018), the use of two facilities (Berry et al., 2017), the use of only three hospital units (Dafny & Beccaria, 2020), a small sample size (Brophy et al., 2018; Burkoski et al., 2019), and a sample composed only of experienced nurses (Cabilan et al., 2020). Other limitations included low response rates

(Ramacciati et al., 2019), the noninclusion of physicians and registered nurses (Brophy et al., 2018), and the use of secondary data, which limited targeted information (Havaei et al., 2019).

The literature review found no studies related to the WPV of nurses working in Northeastern Ontario, thus presenting a knowledge gap. Therefore, the research questions guiding this study are as follows: (1) What are Northeastern Ontario nurses' perceptions of violence? (2) What are the perceived barriers, challenges, or improvements needed to reduce or prevent violence against nurses in an acute-care setting? The results of this study address some of the gaps in knowledge about violence toward nurses working in this geographic area.

Chapter 3: Methodology

3.0 Introduction

This study was part of a larger mixed-method study titled Assessing the Reliability and Validity of the Public Services Health and Safety Association (PSHSA) Acute Care Violence Assessment Tool (VAT). The primary aim of the larger study was to assess the reliability and validity of the Violence Assessment Tool in determining the potential risk of violence that may guide decision-makers regarding the utilization and effectiveness of the tool. The research questions for the larger quantitative phase of the mixed-method study were: (1) What are Northeastern Ontario nurses' perceptions of the VAT in assessing the potential risk of violence in acute-care settings? (2) What are the gaps, challenges, or improvements needed for the VAT? The study involved two phases: The first was quantitative and involved a retrospective review of VAT assessments from patients' charts in the health records department and incident reports from the Occupational Health and Safety Department. This thesis concentrates on nurses' perceptions of violence in the workplace that is the focus of the second qualitative phase of the larger study.

3.1 Research Aim

This study aimed to explore Northeastern Ontario nurses' experiences and perceptions of violence and their suggestions for preventing violence in an acute-care setting.

3.2 Research Questions

(1) What are Northeastern Ontario nurses' perceptions of violence and perceived challenges related to reducing or preventing incidences of violence in an acute-care setting?

(2) What improvements or changes are needed to reduce or prevent workplace violence?

3.3 Research Design

Interpretive description developed by Thorne was the research methodology that guided this study (Thorne, 2016). Interpretive description is a qualitative study design that accesses the research question, identifies what is known and unknown, and provides the concept and context of the eventual findings. According to Thorne (2016), qualitative research is used when there is a requirement to acquire a superior and justifiable comprehension of existing knowledge. Qualitative research aims to acquire verifiable information through observation or experience of a phenomenon for which measurement is ineffective or misleading. Interpretive description goes beyond just the description of a phenomenon and provides an understanding of the emerging relationships, patterns, and associations. The research questions guiding this study require a description of a phenomenon—violence against nurses. The phenomenon of WPV has been studied broadly in health research but is still on the rise. The researcher and the nurse participants share a reality, and the knowledge from the resulting themes can be applied in clinical settings to effect a change (Thorne, 2016). Interpretive description also captures the subjective experience of individuals (Thompson Burdine et al., 2020; Thorne, 2016) and uses an analytical and inductive approach to understanding human health and disease. This technique is suitable for creating knowledge in applied sciences such as nursing research (Teodoro et al., 2018).

Interpretive description is grounded on already existing knowledge of qualitative research. In her book, Thorne provides an understanding of interpretive description as a method that indicates a logical rationale in its process: “When researchers reference their methodology as interpretive description, they are telling us something significant about their theoretical and epistemological positioning in entering into the study, and they are committing to an auditable logic in alignment with that positioning” (Thorne, 2016, p. 38). Epistemology is the nature of

knowledge; qualitative research is the cocreation of knowledge between the researcher and the participants' lived relationships and experiences. For qualitative researchers, every process that has been undertaken—including developing the research questions, devising the data collection methods, and choosing the techniques—involves a systematic method to achieve a finding. Interpretive description is congruent with qualitative research, ensuring a systematic approach to cocreate knowledge based on what is known. Therefore, interpretive descriptive design was used to achieve a deeper understanding, detailed description, and interaction with Northeastern Ontario nurses to understand their perceptions of WPV and suggestions for prevention.

A limitation of qualitative research is that it is considered less rigorous than other research strategies because the researcher is the instrument for the entire data process. Another criticism of qualitative research is that findings are not generalizable; nevertheless, although they are targeted to a specific sample, they can be transferred to similar situations (Denny & Weckesser, 2018). Finally, a limitation seen with interpretive description is its ability to determine the level of interpretation consistent with the method and the phenomenon studied (Hunt, 2009).

3.4 Ethical Consideration

Ethical review and approval for this study were obtained from the Research Ethics Board at Laurentian University (Appendix B) and from the ethics review board of the hospital included in the study in October 2020. Due to the delays in participant recruitment and data collection, which resulted from the impacts of COVID-19, this research study was prolonged. Consequently, ethics approval was renewed by the Laurentian University ethics board (Appendix C) and the hospital included in this study in October 2021. Due to the sensitive nature of the research and with an understanding that participants might be uncomfortable, participants were provided with the toll-free number of the Employee and Family Assistance Program (EFAP) at

the hospital to call if they experienced emotional distress or discomfort during the data collection process. This was indicated in the recruitment script and information package (Appendix D and F). For questions or concerns about the research, participants were also provided with the sample hospital Research Ethics Board Chair contact and the contact of the Research Ethics Officer at the Laurentian University Research Office (705-675-1151 ext. 3213 or 2436; toll-free at 1-800-461-4030; or email: ethics@laurentian.ca). Before the session began, participants were given permission to avoid answering any questions that made them uncomfortable.

3.5 Setting

This research was conducted at one acute-care hospital in Northeastern Ontario, a land area of 273,580.09 square kilometers with a total population of approximately 557,220 (Government of Canada, 2022). Northeastern Ontario is culturally diverse; 23% of the residents are Francophones and 11% are aboriginals, First Nation, or Métis. The North East Local Health Integration Network (NELHIN) administers the Northeastern Ontario public health system. NELHIN (2016) notes that "the NELHIN covers 44% of Ontario's land mass but is home to only 4% of the province's population" (pp. 9-10). The NELHIN geography is divided into five hub planning areas: Algoma, Cochrane, James Bay and Hudson Bay Coast, Sudbury–Manitoulin–Parry Sound, and Nipissing–Temiskaming. An estimated 60% of the population lives in Greater Sudbury, Sault Ste. Marie, North Bay, and Timmins (NELHIN, 2016).

3.6 Sample

According to Thorne (2016), there is no fixed rule for determining the appropriate sample size for interpretive description; it is up to the researcher to identify an appropriate stopping point. Interpretive description can be conducted on any sample size, but the best choice is to have a sample size consistent with answering the research questions to provide meaningful data. A

sample of 16–24 participants, six to eight from each unit (medical, mental health, and ED), was expected to participate. Ultimately, 14 participants from across all three units were chosen to provide an understanding of nurses' perceptions of violence (Thorne, 2016; Vasileiou et al., 2018). The sample was deemed sufficient to answer the research questions.

Data saturation is not a criterion of interpretive description. Instead, its focus depends on the interpretation and justification the researcher provides to explain the data (Thompson Burdine et al., 2020; Thorne, 2016). With health-related research, there is always new variation and diversity. Therefore, it is a good idea to accept and listen to as many viewpoints as possible, as long as the research demonstrates appropriate knowledge of what it is meant to study (Thorne, 2016).

The inclusion criteria for the study were all registered nurses who worked full time, part time, and casually in the medical unit, adult mental health unit, and emergency department (N = 138). There were 40 registered nurses in the medical unit, 30 in the mental health unit, and 68 in the emergency department. These units were purposively selected based on the support from literature as the three units that are most likely to experience violence. Purposive, convenience, and snowball sampling strategies were used to recruit registered nurses who worked in the three nursing practice areas to participate in one of three virtual focus groups. Purposive sampling involves recruiting specific individuals and, thus, allows for participant recruitment that provides information-rich data based on the participants' experiences (Thorne, 2016). Three nurses who worked part time at the hospital site were hired as research assistants for the project, and they recruited nurses working in the three units using the recruitment script (Appendix D). Convenience and snowball sampling techniques were used to augment the number of participants due to the low response for the focus groups. In addition, convenience sampling created a solid

basis for description, as the nurses closest at hand would be excellent sources to discuss the research (Thorne, 2016). Snowball sampling is a method whereby a study participant recruits another person to become a participant, and the group grows like a snowball (Krichherr & Charles, 2018). Therefore, the three sampling strategies yielded the number of participants required for the focus groups.

3.7 Recruitment of Participants

Recruitment posters (Appendix E) were available in the hospital units to advertise the study. Thirty-one nurses indicated their interest in participating, but only 14 actually did so. Potential nurse participants who expressed interest received an information package and a letter of consent via email (Appendix F). The letter included the research title, the names of the researchers, the funders, the contact number of the Employee and Family Assistance Program (EFAP) at the hospital site, the contact number of the sample hospital research ethics board chair, and the contact number of the Laurentian University research office. In addition, the letter provided brief background about the research, the aim of the study, the potential benefits (such as providing helpful information to reduce WPV), the potential risks (such as stressful or uncomfortable discussions regarding violence), information about confidentiality, and details about voluntary participation. The research assistant provided the nurse participants with the research team members' email addresses and phone numbers, which also were included in the information package and in the informed consent document. Free and informed consent was obtained from the participants via email before data collection commenced. Participants who consented were contacted via their preferred means of contact (emails, text messages, or phone calls). The participants decided on the date and time for the focus group via a blind Doodle poll to ensure their privacy.

3.8 Method of Data Collection

Focus group interviews were used to collect data from the participating nurses. This method allowed participants to share their experiences, thoughts, and perceptions about WPV. Focus groups are a strategic way of conducting group interviews about a shared belief and experience, and they work best if they are small, usually involving only six to eight participants (Thorne, 2016). Interpretive description supports this qualitative data collection method, as a method that provides a useful form of interpretation of the data is advised. One of the research team members, Dr. Renee Berquist, cofacilitated the sessions. A disadvantage of focus groups is that information that some participants may consider private and sensitive and that might be essential data may not be shared during the session. However, to address this, participants were given the contact numbers for support at the sample hospital and Laurentian University, as stated on pp. 45-46. In addition, emphasis was placed on the study's benefit for reducing violence in acute-care settings.

The nurses participated in one of three focus groups, which were conducted over four months, from July 26, 2021, to October 25, 2021. They were held at a location convenient for participants via the online Zoom platform to enable social distancing, following the COVID-19 requirements. Laurentian University's secure Zoom platform was used, and the sessions were recorded on Zoom and also on a digital audio recorder as a backup. Before the focus group discussion, participants received an information package and informed consent form (Appendix F), a demographic questionnaire (Appendix G), and a $20 digital Tim Horton gift card in appreciation for any inconvenience. Northern College, the workplace of one of the research term members, funded the gift cards.

The focus group interviews were conducted using the prepared semistructured questions to guide the discussion among the nurses (Appendix G). The questions were developed based on the literature review and discussions with my supervisor and committee members. They ranged from general to specific and in the order of relative importance to the issues in the research agenda. As outlined in the consent form (Appendix F), all participants agreed to protect the privacy of their fellow participants. Each session lasted 90 minutes to two hours.

The sessions started with an introduction of the facilitators and the participants. The nurses were asked again for their consent to participate in the research study. Nurses were then given five minutes to complete the demographic questionnaire (Appendix H) if they had not already done so. The demographic questionnaire included their qualifications, age range, job status, years of working experience, highest level of education, and experiences of physical and psychological violence. Nurses were given the definitions of physical and psychological violence as indicated in the demographic questionnaire (Appendix H), taken from the International Labour Office (ILO), International Council of Nurses (ICN), World Health Organization (WHO), and Public Services International (PSI) Joint Program on WPV in the health sector. Physical violence is "the use of physical force against another person or group that results in physical, sexual, or psychological harm. It includes, among others, beating, kicking, slapping, stabbing, shooting, pushing, biting, and pinching" (ILO, ICN, WHO, PSI, 2002, pg. 3). Psychological violence is defined as "the intentional use of power, including the threat of physical force, against another person or group, that can result in harm to physical, mental, spiritual, moral, or social development. It includes verbal abuse, bullying/mobbing, harassment, and threats" (ILO, ICN, WHO, PSI, 2002, p. 4).

To begin the conversation about violence, nurses viewed four educational videos about violent incidents. The Center for Research in Occupational Safety and Health and the Public Services Health and Safety Association funded the videos, and a media service in Sudbury, Northeastern Ontario, produced them. Actors simulated two cases from the emergency department, one from a mental health unit, and one from a medical unit, demonstrating behaviors of potential risks of violence in ascending severity for the nurses to assess and score using the VAT. The first case scenario involved Gladys, an 86-year-old female admitted to a medical unit with a history of dementia. The second featured Mike, a 45-year-old male brought into the emergency department by the police after he threatened a family member with a knife and smelled of alcohol. The third focused on Brayden, a 22-year-old male brought into the emergency department via emergency medical services and police after a friend alerted authorities to his bizarre behaviors. The fourth case involved Jim, a 30-year-old male patient brought by police in handcuffs to the emergency department and who was assessed in the mental health unit. As part of the larger mixed method, study participants scored the VAT instrument for observed behaviors from the videos (Appendix A). Data collected and analyzed for the larger study are not included in this thesis.

3.9 Data Analysis

Braun and Clarke's six steps for thematic analysis were used to guide the data analysis process of this research (Braun & Clarke, 2006). Thorne's interpretive description of qualitative data analysis involves entering the field, constructing the data, identifying patterns, and transforming the patterns into written and disseminated findings (Thorne, 2016). However, Thorne's method is not prescriptive in conducting qualitative analysis and does not provide a stepwise approach. Therefore, Braun and Clarke identified these steps by producing specific

examples and providing a straightforward guide to qualitative data analysis processes for better systematic guidance. Furthermore, an interpretive description aims at organizing and presenting findings so that the researcher can explore factors beyond the obvious. The core parts of conceptualizing the research findings include organizing the data into words and then grouping them to note similarities and differences within the data (Thorne, 2016). These are well captured in Braun and Clarke's steps.

Participants were assigned a code that was nonidentifying to ensure confidentiality (registered nurse 1 or RN1, RN2, RN3 ...). Data were analyzed for patterns and relationships to produce a broader understanding and meaning of the findings using an inductive approach.

The process of thematic analysis began by familiarizing oneself with the data and being situated in the data with an open mind, keeping records while doing so. The data analysis process began by manually transcribing the data from the three focus groups using transcription conventions of participants' audio and video data outlined by Kuckartz and Radiker (2019; see Appendix J). Focus group interview sessions were transcribed into Microsoft Word documents, which enabled me to immerse myself in the data. The recordings were then reviewed and compared with the transcripts for accuracy three times each. Before transcription, each of the entire video recordings was watched repeatedly to further understand the data. I then began transcribing while watching the videos.

The second step of Braun and Clarke's thematic data analysis involved the generation of initial codes. After the data were transcribed, the transcripts were printed, and I began coding by identifying patterns among pieces of data. I underlined, highlighted, and made notes of essential responses and discussions, including notes of vital descriptive labels for each quotation. The original transcript and the transcripts with notes were sent to my supervisor and a member of my

committee for review. Then, I compiled an initial table for each transcript with the following headings: participant excerpts, key descriptive labels from the excerpts, potential codes, and other thoughts. After this, a codebook was created, organizing codes into patterns and grouping them into themes and subthemes. Included in the codebook were definitions of the codes and excerpts that accompany the codes. This was reviewed by my supervisor, Dr. Judith Horrigan. Finally, similar codes were grouped and reorganized into themes. An example of one theme, nurses in jeopardy, included similar codes and definitions grouped under it. For example, one of the codes was violence on the rise; nurses said they have noticed an increase in violence and must live with it constantly. Some types of violence have decreased, such as Type III, while other types are increasing. Another example was the justification of violence, with abnormal and fearful behavior becoming acceptable in the workplace, and still another was the fear of working, as nurses constantly experience violence.

The third step involved searching for themes. Through coding, patterns were identified and sorted into groups; for example, data grouped and coded with the descriptive label "violence" were identified from nurses' accounts. Some key in situ words and phrases such as "increase in violence," "normalization of violence," "past violence experiences," and "navigating violence" initially facilitated the grouping and sorting of some of the data. This facilitated the creation of themes and subthemes. The fourth step of reviewing the themes was done repeatedly. These themes captured the importance of the data as they relate to the research question and provided meaning within the data set.

I proceeded to the fifth step by defining and naming the themes. The identification of themes was broadly based on identifying similarities and differences. An example was seen in the recurring pattern "of support," which was identified through nurses' articulation of the

variety of supports and resources that were available or lacking to facilitate their survival. These included “lack of managerial support,” “lack of police support,” “unhelpful security,” “support from colleagues,” and “extra support needed.” These patterns were named “organizational support,” which resulted in the naming of the key theme, “nurses surviving violence in acute-care settings,” which is further elaborated upon in Chapter 4. The final stage of thematic analysis involved producing a descriptive report that answered the research questions (Braun & Clarke, 2006).

3.10 Rigor

It is essential to ensure rigor or trustworthiness in qualitative research. For the findings to be credible, the research question should be justified, and the data should be interpreted to reflect the problem. Many ways to assess rigor exist in qualitative research, including credibility, confirmability, meaning context, recurrent patterning, saturation, and transferability (Leininger, 1994, as cited in Thorne, 2016). Others are credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985, as cited in Thorne, 2016). Thorne (2016) suggests ensuring evaluative criteria for interpretive description studies; these criteria include epistemological integrity, representative credibility, analytic logic, and interpretive authority.

Epistemological integrity demonstrates how the knowledge was created between the researcher and the research participants. This involves all of the systematic steps followed from the research questions, data collection methods, and data analysis to arrive at the findings.

Representative credibility demonstrates that the research claims are consistent with the sampled phenomenon. For example, the sample of nurses working in three units (adult mental health, medical, and emergency department) was consistent with the high violence rates.

Analytic logic refers to the reasoning that the interpretation of the data is actually what the research claims. Therefore, the data analysis and interpretation process were appropriately documented and communicated in the significant findings, using a systematic approach for qualitative research by identifying the problem and answering the research questions. The steps taken during the data collection, analysis, and decision-making process were documented and dated to provide an audit trail. In addition, the initial generation of themes from participant excerpts was documented and frequently reviewed by three research team members until the final themes were generated (Thorne et al., 2004; Thorne, 2016).

Interpretive authority ensures that the researcher provide some assurance that the research findings and reports are factual and trustworthy (Thorne, 2016). The sample, the qualitative research method used, and the interpretations were guided by a systematic approach to understanding the shared reality between the researcher and the research participants.

Beyond evaluation, interpretive description research examines the following to add to the credibility of the research process. The first consideration is moral defensibility, and a rationale for conducting the research process and the purpose of the knowledge sought should be provided. This study focuses on nurses' perceptions of violence, the challenges involved, and improvements needed to reduce and prevent violence. Considering the impacts that WPV has on healthcare workers and the health system, the findings would lead to better outcomes for both nurses and patients. This research is beneficial to nursing and health care. Second, disciplinary relevance explains the relevance of a particular study to its discipline. This research study has relevance in understanding the rising increase of WPV in health care and the constant need to address it. Third is a pragmatic obligation; this ensures that the findings extend beyond theoretical considerations and should be practical. Fourth is contextual awareness, which ensures

that the reader comprehensively assesses and understands the research findings. The final consideration is probable truth. As much as research attempts to proffer some truth, no set standards exist to measure it (Thorne, 2016). To ensure this criterion, this research critically answered the research questions and provided a rationale for the study and its implications. Finally, to ensure transferability, the context of this research study can be transferred to similar situations or participants.

3.11 Reflexivity

Reflexivity describes where I stand as a researcher; it allows me to understand my role and acknowledge my involvement with research (Thorne, 2016). It enables "abandonment of former self to take on a new challenge of becoming an instrument of credible and meaningful research" (Thorne, 2016, p. 118). While working at a hospital in Nigeria, West Africa, from 2014 to 2016, I experienced violence as a young intern. My interest in violence prevention was sparked by this exposure to life in a developing country, where violence prevention schemes were not readily accessible. Since I have experienced WPV, the knowledge gained through this research helped improve my understanding of nurses' perceptions of using the VAT to reduce violence.

My knowledge and interpretation of the nurses' perceptions were further complemented by my professional experience working as a physician at a hospital and my interactions with nurses. Violence is a sensitive issue, and I was mindful of this fact while interviewing the participants to ensure that their identities remained anonymous. I was also aware of the potential psychological effects this may have on me. As the researcher, I was conscious of my knowledge and experiences and ensured that the voices of the participants were a priority. Additionally, I was aware of reflexivity and its potential influence on this study. In response, I maintained a

handwritten journal of notes that included thoughts, statements, concerns, fears, feelings, and ideas I had experienced during and after the interview sessions (Thorne, 2016; Teodoro et al., 2020). An example was my notes about fears, as nurses shared their experiences with violence and its prevention. This journal allowed me to mitigate any assumptions that I may unintentionally introduce into the results of the research (Teodoro et al., 2020; Thorne, 2016).

3.12 Summary of Methods

In summary, the primary purpose of my research study was to explore nurses' perceptions of violence and their suggestions for preventing it in an acute-care setting. The processes used for developing the research questions, entering the field, selecting the sample, recruiting participants, collecting and analyzing data, and identifying the inductive processes used for interpretation were compatible with methods guiding interpretive description research (Teodoro et al., 2018). In addition, Braun and Clarke's (2006) six steps of data analysis guided this study's analytical process, specifically enabling a logical and systematic methodology for the interpretation.

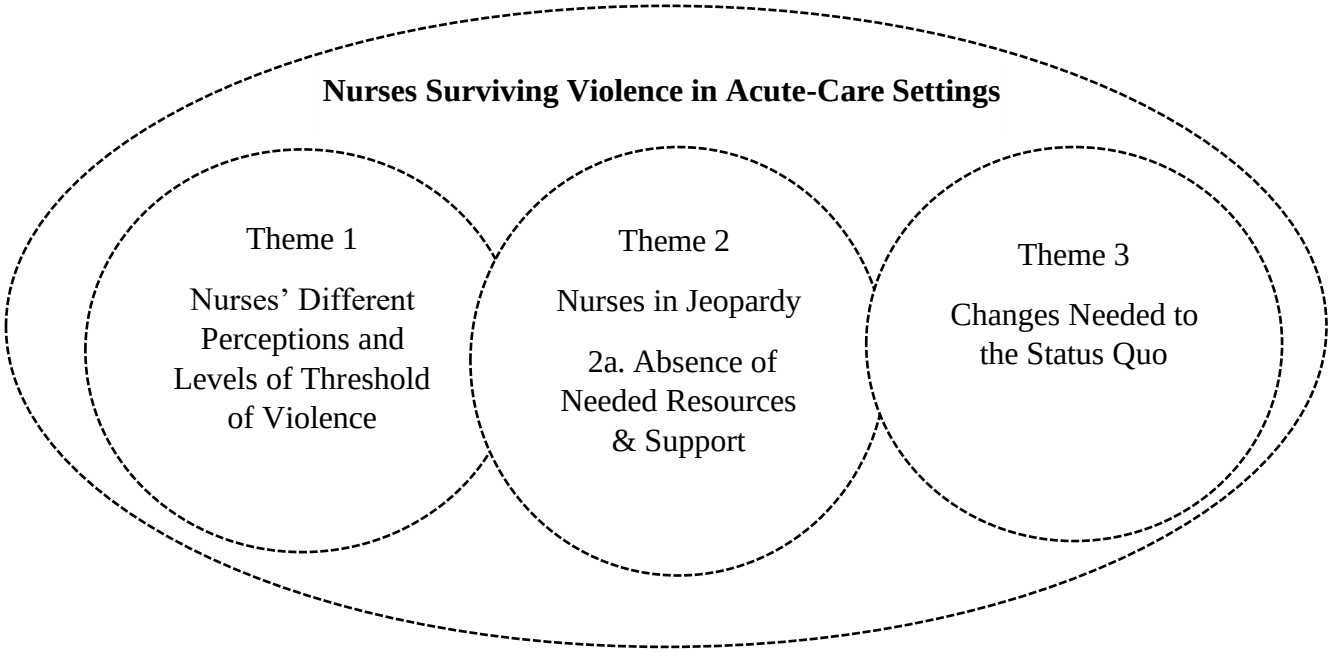
Chapter 4

4.0 Introduction to Results

This chapter presents the findings from the focus group interviews, a summary of the demographic characteristics of the 14 participants, and the themes and subthemes. Sally Thorne's (2016) interpretive description methodology guided this study to answer the following research questions: (1) What are Northeastern Ontario nurses' perceptions of violence and perceived challenges related to reducing or preventing incidences of violence in an acute-care setting? (2) What improvements or changes are needed to reduce or prevent workplace violence?

Data were collected through three focus group interview sessions. Thematic analysis was guided by Braun and Clarke's six-step process of analysis. As depicted in Figure 3, the overarching theme from the analysis of the three focus group interviews is *nurses surviving violence in an acute-care setting*. This theme is supported by three further themes: *nurses' perceptions and levels of threshold of violence*, *nurses in jeopardy* with *absence of needed resources and supports* as a subtheme, and *changes needed to the status quo*. Together, these themes provide an understanding of Northeastern Ontario nurses' perceptions of violence while working in acute-care settings. The dashed shape instead of a solid line encompassing each theme denotes the interconnectedness and overlap of the findings.

Figure 3: ***Nurses Surviving Violence in Acute-Care Settings***



4.1 Demographic Results

4.1.1 Characteristics of Participants

A total of 138 registered nurses were working in the sample hospital's mental health, medical, and emergency units. Overall, 31 registered nurses initially indicated an interest in participating in this research study, but only 14 actually joined one of three focus groups conducted between July 26 and October 25, 2021.

Results from the demographic questionnaire found that the majority of nurses (71%) worked in the ED and identified as female. Participants' ages ranged from 20 to 60 years, with the majority (57.1%) between 30 and 40 years old. All of the nurses worked full time and indicated that their highest level of education was a baccalaureate degree in nursing. Years in practice as an RN ranged from one year to more than 25 years, with the majority (57.1%) having more than 10 years of experience. Years of working at the hospital and in their particular unit

ranged from one to 25 years, with the majority (78.6%) having held their positions for more than five years.

4.1.2 Responses to Nurses' Experiences of Physical and Psychological Violence

As previously stated, nurses were given the definitions of physical and psychological violence and the classification of the different types of violence. Then, they were asked about their experiences of physical and psychological violence and their experiences with the four types of violence. Regarding physical violence, most nurses (57.1%) experienced Types I and II, and a few (35.7%) reported experiencing only Type II. Significantly, very few (7.1%) reported experiencing only Type I physical violence. Regarding their experiences with psychological violence, most nurses (64.3%) experienced Types I and II, with very few participants (7.1%) reporting experiencing only Type I and the same percentage (7.1%) reporting experiencing only Type II. None of the participants reported experiencing only Type III or IV physical and psychological violence.

4.2 Qualitative Results

4.2.1 Overarching Theme: Nurses Surviving Violence in Acute-Care Settings

This section presents findings based on the shared experiences of WPV among nurse participants and their perceptions of violence. *Nurses surviving violence in acute-care settings* is the overarching theme supported by three themes and one subtheme that describe nurses' perceptions of WPV. The first theme, *nurses' different perceptions and levels of threshold of violence,* describes some nursing factors that affect their perception of a violent situation, the experiences of violence, and the reason for the lack of reporting. The second theme, *nurses in jeopardy*, describes nurses' concerns about the rise in violence, the ways in which violence has been justified, and the fear they experience at the workplace. A subtheme, *the absence of needed*

resources and support, describes nurses' perceptions of a lack of adequate support to address violence at work from the management, hospital security, and the local police department. Conversely, nurses reported receiving support from their colleagues and coworkers. The third theme, *changes needed to the status quo,* describes nurses' perceptions of support needed to reduce the risk of violence, and they also provided suggestions for ways to prevent incidences of violence in the workplace that would benefit nurses.

4.2.2 Theme 1: Nurses' Perceptions and Levels of Threshold of Violence

This theme examined the nurses' perceptions regarding violence. The nurses shared that their interpretation of a situation as violent could be affected by having no tolerance for violence. Some nurses described having varying thresholds that influenced their perceptions and experiences of considering a situation potentially violent. One participant said, "If someone says 'I have a knife on me,' but they're not using that in a way that is aggressive, then I don't see it as being a weapon at the time" (RN 2). Other nurses reported having a lower threshold, with one respondent saying, "I am a very caring person, and I try to, like, I see that those patients are confused, and I try to help them" (RN6). While some interviewees assessed the incident according to the actual violent activity, another said:

> So, on a scale from being spit on to being punched like that, I find throwing more actively physical with your limbs to be more threatening. That is higher. I have a lower threshold for that, as opposed to, like, spitting, because the consequences of getting spit on, at least in my mind, are not as bad as being hit. (RN2)

Nurses' higher or lower threshold levels were discussed in relation to their working experiences. One nurse said, "I have been nursing for a year and two months. I only graduated last year. I have never been spat at or spit on before, so I think that changes my answer and

interpretation as well" (RN1). Conversely, some nurses with more experience said they never underestimate anyone and are always on guard, adding that even elderly or female patients can be violent. One nurse stated:

> So just, I guess my experience, previous to working in the hospital, also working in long-term care for four years at a local long-term care facility. And I've had all kinds of different experiences with that geriatric population as well. I never put it past anybody. (RN2)

Nurses reported that they are often seen as being the cause of the violent incident, adding that administrators would ask them what they could have done differently to avert the situation. One nurse said, "I think less victim-blaming would be nice. And it gets put back to if something happens. Well, what could you have done differently? That would not have happened" (RN14).

While nurses said they understood the importance of reporting a violent incident, some said they reported only serious violent incidents, as the following excerpt indicates: "Well, I find (I) probably report them less. Yeah, we would just save the reporting for the really big ones because (for) the minor ones or the lesser ones, we know nothing is really going to come of it" (RN11).

4.2.3 Theme 2: Nurses in Jeopardy

This theme describes the hazardous nature of the workplace for nurses and examines how they navigate violent situations; it is supported by a subtheme: *absence of needed resources and support.* The theme also addresses nurses' concerns about the lack of support they receive. Nurses stated that violence from patients and visitors (Types I and II) has escalated over the years in comparison to Type III.

> You mentioned earlier the example of the surgeon throwing a tool at you, and it is interesting, that would be, I guess, Number IV or Number III. And I have experienced

> that. But, I'll say that is one type of violence that's decreasing in my experience, as opposed to the other types, which are increasing. (RN11)

Some possible reasons for this increase were the growth in substance abuse locally, the COVID-19 pandemic, the nature of the department, and the nursing role of the staff involved. One of the nurses said:

> So, when you are trying to think about an overcrowded emergency department where the rooms are small, there is a lot of competing priorities for the real estate and the department equipment in the hallways as opposed to a big, wide-open room with a ton of space. Just the practice setting, I think, ups the risk. (RN 5)

Nurses say they live in jeopardy as violence is seen as becoming a normalized behavior. The patients see it as acceptable to yell at a nurse when they have waited too long. One nurse said,

> Yes. The more the behavior is normalized, such as the screaming, the more that it continues because we've seen it on a shift. If somebody starts screaming in triage, they all start screaming. It just seems to make it okay. (RN11)

One nurse described an incident that was one of the most frightening situations she has seen, with no improvement:

> Well, [names of nurses], there was probably one of the most epic, violent, scariest moments of our career. We all encountered it at the same time, and there was a big debrief about it. I think we are all a little tainted by it. Then nothing changed. (RN12)

Nurses said they had to find a way to cope with violence to enable them to work effectively.

Subtheme 2a: Absence of Needed Resources and Supports

Nurses spoke about the kind of support they receive from their workplace and highlighted their concern about the lack of managerial support. One nurse stated, "Management never backs up the nurses. They are always on the patients' or family side, and they get away with it and get what they want" (RN14). The nurses further explained the lack of support they receive from the local police: "The scenario that involves [names of nurses], the police, I guess, said (in) my calls to 911, I did not convey enough panic. So, the blame was, like, put on me" (RN8). The interviewees shared that the police would bring patients in pairs and hand them over to one nurse, which created a fearful situation for the nurses.

Additionally, the nurses demonstrated concern about the lack of adequate help from hospital security officers, stating that security personnel are often not actively involved in the management of violent patients and are usually uninterested or lack knowledge about how to tend to them. One nurse said,

> I do find security exceptionally unhelpful. They do not keep me safe whatsoever. They are not hospital employees. They are subcontracted through an external company, and they have zero hands-on (involvement) unless I personally tell them to go hands-on. So hopefully, if I'm getting choked, someone else will, on my behalf, say, "please put your hands on the patient." (RN10)

Nurses acknowledged that they receive more reliable and useful support from their colleagues rather than from the police or hospital security. One nurse said,

> I was going to say I would trust my coworkers, like the nurses and the physicians and even some of the aides we have in the department, over the security guards any day. I know my team would have my back over the security guards 100%. (RN 14)

The nurses described the type of additional support they would need, especially in the ED. In addition to the crisis workers who do not assume care for the patients, they suggested the constant presence of a psychiatric attendant: “Yeah, like a 24-hour psych attendant or something would be nice” (RN14).

4.2.4 Theme 3: Changes Needed to the Status Quo

During the interviews, nurses provided examples of how they managed violent situations, which included distraction and redirection techniques, gentle persuasion strategies, listening to the patients, and exhibiting concern. One medical unit nurse offered an example: “In school, we had to take this. I think it is called gentle persuasion techniques. So, I think just learning those skills and learning how to de-escalate, like, a potentially violent situation” (RN6).

Beyond that, however, nurses provided suggestions for violence prevention, such as interdisciplinary action, an improved flagging system, communication, a higher standard of care, and the benefit of using a violence assessment tool. One of the nurses said, “I also think nobody wants to take any responsibility for trying to manage the violence that it is just kind of the nurse’s responsibility. There is no interdisciplinary responsibility” (RN11).

The nurses expressed the importance of flagging potential violence upon a patient’s presentation to the ED, especially in triage. They expressed the importance of knowing a patient’s status to prepare them for a violent incident, should it occur. One of the respondents also stated:

> This would be way more helpful if the flag comes up when we’re in triage with the patient. For us, that does not happen until later. So, when I’m triaging somebody, it’d be great if I swipe their health card, and it would bring up their violence flag. However, it does not. It does

> not come up until later once they have passed the triage setting. So, I feel like that is a bit of a failure for us. (RN3)

A lack of appropriate communication was cited an issue in this workplace. When patients are transferred between departments, their risk-of-violence status can be missed or unknown at times. One of the respondent nurses said, "I have had patients that I have experienced care for that have been on the floor for a few days with a history of violence, and we still are unaware, and that sometimes is just a loss in translation" (RN1).

Some nurses stated that they have used a violence assessment form to determine a patient's risk of violence; however, with a busy workload, especially in the emergency department, managing or identifying WPV might be difficult, and the time necessary to use a violence assessment tool may not be feasible. Another nurse said,

> I am not sure of the best way to implement something. I do not have the answer, but it is hard if you are going to start being, like, here is this two-page tool you've got to fill out on this person now, too, on top of everything else. (RN14)

Other nurses mentioned the need for educational awareness about the violence assessment tool. Some had never seen or used it, adding that its use in preventing violence in healthcare settings is beneficial.

4.3 Summary of Results

This chapter described the findings of the research questions. The overarching theme was found to be *nurses surviving violence in acute-care settings*. This is supported by three key themes: *nurses' different perceptions and levels of threshold of violence*; *nurses in jeopardy*, with *the absence of needed resources and supports* as a subtheme; and *changes needed to the status quo.*

Nurses who were interviewed revealed their perceptions of having to survive violence in their workplace, experiencing fear and jeopardy at work. They also described an increase in the normalization of this unhealthy behavior while sharing experiences and strategies for coping with violence in the workplace. Nurses highlighted the inadequacy of managerial support, help from the local police department, and assistance from hospital security personnel, and they further acknowledged the support they receive from their colleagues while indicating the types of additional help that they would appreciate. Finally, nurses offered some recommendations for management, such as improving flagging systems, enhancing communication between departments, and restructuring nurses' schedules and workloads to enable appropriate management of violence.

Chapter 5

5.0 Introduction to Discussion

This study explored Northeastern Ontario nurses' perceptions of violence and their suggestions for preventing it in acute-care settings. The following discussion of the findings is structured on the overarching and supporting key emerging themes, as Figure 3 (p. 58) outlines. The two research questions that guided the research are: (1) What are Northeastern Ontario nurses' perceptions of violence and perceived challenges related to reducing or preventing incidences of violence in an acute-care setting? (2) What improvements or changes are needed to reduce or prevent workplace violence?

5.1 Nurses Surviving Violence in Acute-Care Settings

The overarching theme that answered the research questions, nurses surviving violence in acute-care settings, is supported by three key themes and a subtheme: *nurses' different perceptions and levels of threshold of violence*; *nurses in jeopardy* with *absence of needed resources and supports* as a subtheme; and *changes needed to the status quo.*

The first research question is linked to the first and second themes and subtheme, while the second research question is linked to the third theme. Recommendations for nurses and decision-makers, along with the study limitations and conclusion of this thesis, are included in this chapter.

5.2 Nurses' Different Perceptions and Levels of Threshold of Violence

This section explored the perceptions of nurses regarding violence. Among the factors that influenced nurses' interpretation of a situation as violent were having zero tolerance for violence, seeing varying levels of the threshold of violence, and having different levels of experience. Nurses' different perceptions of higher or lower thresholds for violence were related

to their work experiences: Some nurses said they never underestimated anyone; even elderly patients could be violent. Similarly, Dafny and Beccaria (2019) found that nurses in their study could tolerate unintentional violence in patients with dementia or delirium rather than intentional violence. A few nurses in this study had different perceptions of the severity of physical violence; for example, being physical, such as punching, meant a more difficult situation than violent acts such as spitting. Al-Qadi (2020) found that some nurses viewed punching and spitting as severe forms of violence. In this study, younger nurses with little experience had a higher threshold for violence. Contrarily, Al-Qadi (2020) found that repeated exposure to violence by older, more experienced nurses increased their threshold for verbal violence until they began regarding it as routine.

Nurses in this study were found to report only severe cases of violence, despite the availability of policies and procedures for reporting. Several other studies have found underreporting violence to be an issue (Brophy et al., 2018; Dafny & Beccaria, 2020; Ramacciati et al., 2019). For example, a previous study by Ramacciati et al. (2019) found that the lack of measures such as reporting procedures indicated that organizations were not prioritizing effective methods of addressing violence. Ramacciati et al. (2019) also noted that 57% of nurses reported a lack of institutional policy for reporting and preventing violence.

The reasons for not reporting violent incidents provided by participants in this study included the perception that nothing would be done about their statement as well as the rigorous reporting process. A reason for nonreporting seen in other studies was that healthcare staff saw violence as inevitable and a part of their job (Ashton et al., 2018; Brophy et al., 2018; Copeland & Henry, 2017; Ferri et al., 2016; Pierce, 2015; Vento et al., 2020). Furthermore, nurses who decided to report violence were concerned that they would be accused of causing the situation

and be further victimized, as the blame would be placed on them. Similar findings were reported in a study by Dafny and Beccaria (2020) and Kosny et al. (2018), in which participants said they feared reprisal from management.

Similarly, Dafny and Beccaria (2020) found that participants cited heavy workloads for needing more time to complete a report. Factors such as a busy schedule, a stressful work environment, and staffing limitations were reported to have contributed to violence. Improving these working conditions could address WPV and lead to nurse retention (CFNU, 2022; Nowrouzi-Kia et al., 2019).

5.3 Nurses in Jeopardy

This section explored the fear, the noticeable increase of violence, the consequences, and the justification of violence experienced by nurses. Nurses expressed concern about the fear of working due to WPV, which they described as “most epic, scariest, and nothing changed” (RN14). Furthermore, they said violence is increasing and expressed concern that it is becoming normalized. Similarly, researchers have found that violence has become a regular and unfavorable experience for nurses who simply decide to live with it (Al-Qadi, 2020; Brophy et al., 2018; Dafny & Beccaria, 2020; Ramacciati et al., 2019).

Nurses, other healthcare staff, and their leaders have determined that the more violent a society becomes, the more there is a tendency for violence in the workplace (Zuzelo, 2020). Nurses in this study expressed fear related to WPV and said they have experienced emotional and professional consequences. Similarly, physical, psychological, emotional, financial, and professional impacts have been reported in previous studies (Brophy et al., 2018; Dafny & Beccaria; Lanctot & Guay, 2014; Mento et al., 2020; Yagil & Dayan, 2019). The toll on the

emotional and physical wellbeing of nurses who must cope with violence is not always evident, but painful memories and invisible scars can appear (Al-Qadi, 2021).

It is apparent from the detailed stories provided by the participants in this study that there has been a rise in violence involving patients' families and friends (Type I) and patients themselves (Type II) when compared to violence from colleagues (Type III) and domestic violence (Type IV). Similar findings regarding the rise in Type I and Type II violence have been reported in some studies (Brophy et al., 2018; Dafny & Beccaria, 2020; Ramacciati et al., 2019). Only a few violent incidents against nurses involving coworkers such as doctors and other nurses were reported, compared to the number of instances of Type I and II WPV (Dafny & Beccaria, 2020). Ramacciati et al. (2019) reported that 76% of participants had experienced a rise in Type I and Type II physical violence. The frequency and severity of WPV found in this study are consistent with those discovered in other studies (Brophy et al., 2018; Dafny & Beccaria, 2020; Mento et al., 2020; Nowrouzi-Kia et al., 2019; Ramacciati et al., 2019). Type I and II WPV were frequent concerns in emergency and psychiatry departments of these study types.

The nurses in this study were predominantly female, reflecting the gender makeup of the nursing profession in general (Brinkman, 2021). The gender differences between men and women place nurses at risk of oppression and violence (Dubrosky, 2013). Although gender differences might explain why female nurses experience more violence, there should be no justification for violence toward nurses (RNAO, 2019; Yagil and Dayan (2019). Violence anytime or anyplace is never acceptable.

In some situations, patients and family members have justified the violence that nurses experience, citing poor communication as a factor (Quan et al., 2019; Yagil & Dayan, 2019). Yagil and Dayan (2019) examined the influence of the two mechanisms that justified violent

attacks on nurses: One relates to the agent (violent offender) and the other to the host (the nurse). The findings from Yagil and Dayan (2019) suggest that the patient in pain and distress may stimulate sympathy toward the violent offender and recommend providing adequate information and showing care to the offender.

5.3.1 Absence of Needed Resources and Supports

The nurses in this study perceived themselves as the primary caregivers for violent patients, which increased their exposure to violence, and they mentioned that if they receive support, it comes from their colleagues. The findings emphasized the need for collaborative action involving nurses and other healthcare staff, management staff, hospital security, the police, local community agencies, and the public to prevent violence against nurses. Nurses clearly expressed the type of additional support they need, especially in the ED.

The nurses in this study perceived that they were often left to manage violence independently, and they echoed the need for a collaborative effort involving various stakeholders to address violent incidents. Moreover, the nurses clearly stated the need for more managerial support and assistance from the local police department. Similar findings were also reported by Kosny et al. (2018), Pierce (2015), and Blando et al. (2014) about the lack of managerial support. On the contrary, Havaei et al. (2019) reported that most study participants acknowledged that employers listened to their suggestions about preventing violence. Nurses in this study said they also felt that hospital security personnel, though present, could have been more helpful. Similar findings were reported in a study by Blando et al. (2014), in which participants expressed concern about the lack of social services, managerial accountability, and law enforcement assistance when caring for mentally ill patients.

5.4 Changes Needed to the Status Quo

Throughout the interviews, nurses offered suggestions and recommendations regarding changing the status quo to prevent the risk of violent incidences. Suggestions included an improved flagging system, better communication, and clear care standards for managing violent incidents. For example, the need for a flag indicating potential violence when a patient's chart is pulled was mentioned in this study. A similar finding was also reported at Humber River Hospital by Burkoski and colleagues (2019), where the facility implemented an electronic flagging system that included symbols and digital signage to indicate the potential for violence. Nurses said they were concerned about the need for more patient communication between departments.

The current interventions and training available to prevent WPV against nurses are falling short of resolving this developing issue (Al-Qadi, 2020). In support of this, a study by Lamont and Brunero (2018) recommended the implementation of an effective response system, adequate reporting process, training and education, audit and review, and dedicated WPV roles among staff. In this study, nurses stated that they wanted more support from management during violent incidents but believed that such help would not be forthcoming. The ED nurses strongly recommended the constant presence of a psychiatric attendant to ensure safety at work 24 hours a day.

Some nurses in this study said they believe education and training in the use of an evidence-based tool are required to assess the risk of violence. This is supported by studies conducted by several researchers (Burkoski et al., 2019; Lamont & Brunero, 2018; Ridenour et al., 2017; Ridenour et al., 2017). However, some participants said that adding another assessment to nurses' busy schedules is not viewed realistic.

Nurses in this study shared strategies to manage aggressive patients and de-escalate potentially violent situations such as working in groups, applying distraction and redirection techniques, exhibiting concern, listening, and using gentle persuasion techniques. Similar findings were reported in the systematic review conducted by Mento et al. (2020), suggesting that nurses should learn patient management protocols, diversion, de-escalation techniques, and verbal and physical prevention skills to work safely and survive violent events. Similar strategies were reported in a study by Havaei and colleagues in 2019 and included nurse interventions, the availability of code white drills (emergency responses for a violent patient), code white incident reviews, behavioral care plans, fixed alarms in the workplace, personal alarms, and WPV prevention training. Furthermore, Lamont and Brunero (2018) encouraged WPV training workshops for nurses, including a strategic violence assessment plan, de-escalation techniques, and breakaway strategies.

5.4.1 Recommendations for Organizations

The Canadian Ministry of Labour, Training, and Skills Development and the Ministry of Health and Long-Term Care recommend that the VAT be used in healthcare settings to reduce WPV. Most centers that used this tool have reported improved processes and planning measures (Public Services Health & Safety Association, 2019a). A method of implementing organizational interventions is developing an evidence-based instrument (Ghosh et al., 2019; Public Services Health & Safety Association, 2017a; RNAO, 2019). For example, the VAT could be a potential tool, but this means adding another assessment to the nurses' workload.

To foster a secure work environment and ensure their support, nurses want their managers and administrators to provide more help in responding to violence and to promptly address incidents when they occur (Al-Qadi, 2020; Al-Qadi, 2021; Ramacciati et al., 2019). Management

could also advocate for employee training and reference materials (Ross et al., 2019). In addition, employers could develop and implement policies that ensure proper staffing and supervisory support for nurses, as staffing shortages have been demonstrated to exacerbate the situation (CFNU, 2022; Scheffler & Arnold, 2018). These include zero-tolerance policies regarding violence; protection for employees, including eliminating barriers and fears about reporting; eliminating impartiality between the aggressor and the nurse; and ensuring proper investigations of the situation (Dafny & Beccaria, 2020; Kosny et al., 2018; Ross et al., 2019).

5.4.2 Recommendations for Nurses

This research demonstrates a need for education and training of healthcare staff. Employers need to ensure that all employees are aware of their rights and responsibilities regarding WPV. Such training could be interactive to sensitize all staff members, particularly managers who have greater responsibility. There is no small or big violence; all forms of violence should be discouraged. Nurses should not remain silent, as doing so means consenting to violence. Instead, they should be encouraged to document it, report it, and seek support (Al-Qadi, 2020; Ross et al., 2019).

5.5 Application of the Haddon Matrix Conceptual Framework

As stated in Chapter 1, the Haddon matrix conceptual framework on violence and violence prevention strategies was used to assess factors relating to three time instances: before the assault, during the assault, and after the assault (McPhaul & Lipscomb, 2004). According to the framework (Figure 1, p. 11; Table 2, p. 13), the prevention of WPV involves a combination of the three domains—host, agent, and environment—which are linked to primary, secondary, and tertiary prevention. During this study, the findings suggest that prevention strategies for WPV are linked to all three framework components.

Similarities were noted before, during, and after the assaults for the three domains. Similarities before the incident included education and training in policy and procedures, de-escalation and conflict resolution, effective communication strategies, mindfulness of the departmental space, and designation of a particular area for aggressive patients. Similarities during the incident included the availability of ongoing intervention and an internal support system, implementation of procedures for managing violence, and the ongoing involvement of security personnel and the police. Similarities after the assault included mandatory reporting of all incidents, notification of the police, and a review of violent events.

To augment this framework, specific factors found before the assault in this research included a demonstration of care and concern for patients and family members, constant vigilance and awareness of intoxicated patients and other conditions that can trigger violence, assurances of appropriate workloads for nurses, and warnings to indicate the potential for violence. In addition, an emphasis was made regarding support from coworkers during an assault and less victim blaming after an assault.

5.6 Study Limitations

As with any research, challenges were identified in this study. First, the use of only one Northeastern Ontario hospital was a limitation; however, the findings of this study may be transferrable to other hospitals and acute-care settings (Holloway & Galvin, 2017). This research focused on only three high-risk departments for WPV at the sample hospital (ED, mental health unit, and medical department). Although the literature identified these areas as high-risk situations for violence (Brophy et al., 2018; Copeland & Henry, 2017; Ferri et al., 2016; Ramacciati et al., 2019; Nowrouzi-Kia et al., 2019; Mento et al., 2020), it is not known whether including additional units may have provided similar or different results.

Sample bias may be considered a limitation, as a combination of sampling strategies was used to recruit participants, including purposive, convenience, and snowball. Selection bias relates to the process of inclusion criteria of the participants. This study included nurses who worked full time, part time, and casually in three care units (Smith & Noble, 2014; Thorne, 2016). The participants were purposively selected based on their knowledge of and experience with violence and their ability to answer the research questions (Thorne, 2016).

5.7 Conclusion

This study examined nurses' perceptions of violence and suggestions for preventing it in acute-care settings. Nurses must ensure a safe work environment to provide adequate patient care, and employers and nurses must advocate for safe and ethical nursing practices (Al-Qadi, 2021). Unfortunately, the supply of nurses in Ontario falls short of the number needed to ensure full staffing levels, and the Canadian Federation of Nurses Union has highlighted WPV, heavy workloads, inadequate support staff, stress, and burnout as factors that contribute to the shortage (CFNU, 2022; CNA, 2017; ONA, 2016; RNAO, 2019).

Violence against nurses is still occurring daily; it is not justifiable, it is unacceptable, and it should never be tolerated. Although violence in healthcare settings is often considered inevitable, this should not be the case. Nurses and other healthcare staff should not be constantly subjected to this unhealthy behavior. Managing violence while simultaneously caring for patients requires adequate support, resources, and strategies. Adopting zero-tolerance policies and mandatory reporting is critical to prevent WPV. Furthermore, there is a need for continuous public awareness and organizational policies to solve the problem.

5.8 Recommendations for Future Research

A more extensive study of these issues could be conducted, including more nurses to make the findings more transferrable. In addition, future research could explore other strategies beyond the use of violence assessment tools that could help with violence prevention. Some of these strategies could include enhanced education; focused action involving hospital staff, the local police department, the community, and the public; violence de-escalation techniques; and violence flagging systems. This would strengthen the healthcare system as it moves forward.

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Appendices

Appendix A: Acute Care Violence Assessment Tool

☒ **Initial Assessment** ☐ **Reassessment**

Section A: Risk Indicators

Read the list of behaviours below and identify behaviours that will require specific care interventions. A score of 1 is applied for past occurrence of any of the History of Violence behaviours; and additional scores of 1 are applied for each observed behavior. Add the scores — **the maximum is 12**.

HISTORY OF VIOLENCE: **Score 1 for past occurrence of any of the following:**	**SCORE**
Exercising physical force, in any setting, towards any person including a caregiver that caused or could have caused injury Attempting to exercise physical force, in any setting, towards any person including a caregiver that could cause injury Statement or behaviours that could reasonably be interpreted as threatening to exercise physical force, in any setting, against any person including a caregiver that could cause injury	Click here to enter text.
OBSERVED BEHAVIORS: **Score 1 for each of the observed behaviour categories below.**	**SCORE**
Confused (Disoriented – e.g., unware of time, place, or person)	Click here to enter text.
Irritable (Easily annoyed or angered; Unable to tolerate the presence of others; Unwilling to follow instructions)	Click here to enter text.
Boisterous (Overtly loud or noisy – e.g., slamming doors, shouting etc.)	Click here to enter text.
Verbal Threats (Raises voice in an intimidating or threatening way; Shouts angrily, insulting others or swearing; Makes aggressive sounds)	Click here to enter text.
Physical Threats (Raises arms / legs in an aggressive or agitated way; Makes a fist; Takes an aggressive stance; Moves / lunges forcefully towards others)	Click here to enter text.
Attacking Objects (Throws objects; Bangs or breaks windows; Kicks object; Smashes furniture)	Click here to enter text.
Agitate/Impulsive (Unable to remain composed; Quick to overreact to real and imagined disappointments; Troubled, nervous, restless or upset; Spontaneous, hasty, or emotional)	Click here to enter text.
Paranoid / suspicious (Unreasonably or obsessively anxious; Overly suspicious or mistrustful – e.g., belief of being spied on or someone conspiring to hurt them)	Click here to enter text.
Substance intoxication / withdrawal (Intoxicated or in withdrawal from alcohol or drugs)	Click here to enter text.
Socially inappropriate / disruptive behaviour (Makes disruptive noises; Screams; Engages in self-abusive acts, sexual behaviour or inappropriate behaviour – e.g., hoarding, smearing feces / food, etc.)	Click here to enter text.
Body Language (Torso shield – arms / objects acting as a barrier; Puffed up chest – territorial dominance; Deep breathing / panting; Arm dominance – arms spread, behind head, on hips; Eyes – pupil dilation / constriction, rapid blinking, gazing; Lips – compression, sneering, blushing / blanching)	Click here to enter text.
TOTAL SCORE	Click here to enter text.

Patient's Risk Rating: ☐ Low (0) ☐ Moderate (1-3) ☐ High (4-5) ☐ Very High (6+)

Completed By (Name/ Designation) Click here to enter text._____ **Date:** Click here to enter text.

Section B: Overall Risk Rating

Apply the total behaviour score to the Risk Rating Scale to determine whether the patient's risk level is low, moderate, high or very high. Each level provides cues for further action to consider. If moderate or high / very high risk is determined, complete Section C to identify factors that may trigger or escalate violent, aggressive, or responsive behaviour and ensure the care plan includes measures to avoid or reduce risk behaviours identified.

Overall Score	Actions to take
Low **Score of 0**	Continue to monitor and remain alert for any potential increase in risk Communicate any change in behaviours, that may put others at risk to the unit manager / supervisor Ensure communication devices / processes are in place (e.g., phone, personal safety alarm, check-in protocol and / or global positioning tracking system)
Moderate **Score of 1-3**	Apply flag alert Promptly notify manager / supervisor so they can inform relevant staff and coordinate appropriate patient placement, unit staffing, and workflow Alert security and request assistance as needed. Ensure to inform security of risk management plan Scan environment for potential risks and remove if possible Ensure section c is completed and initiate the violence prevention care planning process– care plan should address known triggers, behaviours and include safety measures appropriate for the situation for both patients and workers Use effective therapeutic communication (e.g., maintain a calm, reassuring demeanor, remain non-judgmental and empathetic, and provide person-centered care) Be prepared to apply behaviour management and self-protection teachings according to organizational policy/ procedures that are appropriate for the situation – training programs provided may include GPA, Montessori, SMG, P.I.E.C.E.S, U-First, Stay Safe MORB training, self-defense Ensure communication devices / processes are in place (e.g., phone, personal safety alarm, check-in protocol and / or global positioning tracking system) Communicate any change in behaviours, that may put others at risk to the unit manager / supervisor Inform client of vat results, when safe to do so other Other:_____
High **Score of 4-5** **OR** **Very High** **Score of 6+**	Apply flag alert Promptly notify manager / supervisor so they can ensure relevant staff are on high alert and prepared to respond Alert security and request security assistance as needed. Ensure to inform security of risk management plan Scan environment for potential risks and remove if possible Ensure section c is completed and initiate the violence prevention care planning process – care plan should address known triggers, behaviours and include safety measures appropriate for the situation for both patients and workers Use effective therapeutic communication (e.g., maintain a calm, reassuring demeanor, remain non-judgmental and empathetic, and provide person-centered care Be prepared to apply behaviour management and self-protection teaching appropriate for the situation in accordance to organizational policy / procedures – training programs provided may include GPA, Montessori, SMG, P.I.E.C.E.S, U-First, Stay Safe, MORB training, self-defense Initiate applicable referrals Ensure communication devices / processes are in place (e.g. Phone, personal safety alarm, check-in protocol and / or global positioning tracking system) Communicate any change in behaviours, that may put others at risk, to the unit manager / supervisor so they can coordinate appropriate patient placement, unit staffing, and workflow Call 911 / initiate code white response as necessary Inform client of vat results, when safe to do so Other: _____

Section C: Contributing Factors

Physical, psychological, environmental, and activity triggers can lead to or escalate violent, aggressive or responsive behaviours. Documenting known triggers and behaviours and asking your patient or substitute decision maker (SDM) to help identify them can help you manage them more effectively and safely. Use the information collected and the intervention resources listed on p.2 and p.11 to develop an individualized violence prevention care plan and a safety plan to protect workers at risk.

QUESTION FOR CLIENT:	CONSIDERATIONS – Select any that Apply			
	PHYSICAL	**PSYCHOLOGIAL**	**ENVIRONMENTAL**	**ACTIVITY**
To help us provide the best care possible, please describe if there is anything during your stay that could cause you to become agitated, upset or angry e.g., I am agitated when…	☐ hunger ☐ pain ☐ infection ☐ new medication ☐other Click here to enter text._____	☐fear ☐ uncertainty ☐feeling neglected ☐ loss of control ☐ being told to calm down ☐ being lectured ☐other Click here to enter text._____	☐ noise ☐ lighting ☐temperature ☐ scents ☐privacy ☐ time of day ☐days of the week ☐visitors ☐small spaces/ overcrowding ☐other Click here to enter text._____	☐bathing ☐medication ☐past experiences ☐ toileting ☐changes in routine ☐resistance to care ☐other Click here to enter text._____
What works to prevent or reduce the behaviour(s) e.g., When I am agitated, it helps if I…	☐Go for a walk ☐Listen to music ☐Watch TV ☐Draw ☐Read (Bible/Book) ☐Have space and time alone ☐Talk 1:1 with_____Click here to enter text. (who?) ☐Participate in activities ☐Consult a family member or friend			

POTENTIAL DE-ESCALATION TECHNIQUES Identify potential de-escalation strategies using above information such as respect personal space, actively listen, offer choices, give eye contact, use humor
Click here to enter text._

Appendix B: Laurentian University Research Ethics Board Ethics (LUREB) Approval Certificate, October 2020

APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS

Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL / New / Modifications to project X / Time extension

Name of Principal Investigator and school/department	Judith Horrigan, Nursing, Oghenefego Akpomi-Eferakeya, (graduate researcher) Renee Berquist, St. Lawrence College, Jessica Dugas, Sault College, Leata Rigg, Northern College
Title of Project	Assessing the Reliability and Validity of Public Services Health and Safety Association Acute Care Violence Assessment Tool (VAT)
REB file number	6020811
Date of original approval of project	October 13th, 2020
Date of approval of project modifications or extension *(if applicable)*	October 30th, 2020
Final/Interim report due on: *(You may request an extension)*	October 13th, 2021
Conditions placed on project	

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g., you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate LU REB form. In all cases, please ensure that your research complies with Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations and best wishes in conducting your research.

Rosanna Langer, PHD, Chair, *Laurentian University Research Ethics Board*

Appendix C: Laurentian University Research Ethics Board Ethics (LUREB) Approval Certificate, September 2021

APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS

Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL / New / Modifications to project / Time extension X	
Name of Principal Investigator and school/department	Judith Horrigan, Nursing, Oghenefego Akpomi- Eferakeya, (graduate researcher) Renee Berquist, St.Lawrence College, Jessica Dugas, Sault College, LeataRigg, Northern College, co-Investigators,
Title of Project	Assessing the Reliability and Validity of Public Services Health and Safety Association Acute CareViolence Assessment Tool (VAT)
REB file number	6020811
Date of original approval of project	October 13th, 2020
Date of approval of project modifications or extension *(if applicable)*	October 30th, 2020 December 14th, 2020 September 28th, 2021
Final/Interim report due on: *(You may request an extension)*	October 13th, 2022
Conditions placed on project	If any further focus groups are to be held during this phase, they must be conducted remotely as no COVID mitigation plan has been submitted.

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB.If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback offinal results to participants), you must request an extension using the appropriate LU REB form. In all cases, please ensure that your research complies with Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence withthe REB office.

Congratulations and best wishes in conducting your research.

Rosanna Langer, PHD, Chair, *Laurentian University Research Ethics Boar*

Appendix D: Recruitment Script to Use to Recruit Participants for Phase 2 Focus Groups

Study Title: Assessing the Reliability and Validity of the Public Services Health and Safety Association Acute Care Violence Assessment Tool (VAT)
(Can be done in person or on the Telephone)
Hello [name of potential participant], my name is (insert name) and I am a research assistant working with a research team to Assess the Reliability and Validity of the Violence Assessment Tool here at the Sault Area Hospital. The reason I am talking with you is that you have experience using the Violence Assessment Tool (VAT) to assess patients for potential violent behaviours.
You are being invited to participate in a focus group with nurse colleagues to identify any missing factors, components, or behaviours in the VAT that may need to be included modified or changed to assess risk factors that may predict violence. The focus group session is expected to take approximately one to two hours and will be held using Zoom Technology to maintain physical social distancing requirements, at a location that is convenient for participants.
[IF NO] Thank you for your time. Good-bye. [IF YES] Continue
I would like to assure you that:
· This study has been reviewed and received ethics approval from the
· Joint Group Health Centre/Sault Area Hospital and Laurentian University, in Sudbury, ON, Research Ethics Boards
· Your participation in the study is completely voluntary.
· Your employment will not be affected in any way if you choose to participate or not to participate in the study.
· Your name will not be used in this study and the research team will be the only people who will have access to your responses.
· The research team will maintain confidentiality. No individual information or responses collected will be shared with other participants, your co-workers, supervisors, or administrators.
· All identifying information will be removed for the data. You have the choice to answer only those questions they are comfortable answering.
· Only aggregate data will be reported in studies and publications.
Would you be interested in finding out more information?
[IF NO] Thank you for your time. Good-bye.
[IF YES] Thank you; we appreciate your interest in our research!
I have a brief one-page information sheet that of frequently asked questions that describes the study in more detail that I can go over with you.
Frequently asked questions for Phase 2 Focus Groups
When will the study start?
The focus group will take place in the late fall 2020.
What is my commitment?
The focus group is expected to take one to two hours.
Is there compensation for taking part in the study?
You will not be paid for participation in this study. It is voluntary. A $20.00 Tim Hortons gift card will be given to participants in the focus groups in appreciation for their involvement.
What are the benefits of the study?
You may or may not benefit directly from participating in this study. As a participant you will provide valuable information on the reliability and predictive validity of the VAT instrument to identify patients who may pose a risk of violence towards nurses and other health care workers.

Knowledge from this study will be informing the PSHSA on ways that the VAT instrument may need to be revised. All stakeholders could benefit from reducing the number of injuries from violent incidences towards health care workers based on patient assessments using the VAT instrument.

What are the risks?

There are no physical or medical risks to you from participating in this study, but it is possible that a question we ask may be stressful for you or make you uncomfortable. You may choose to decline to answer questions or decline to participate further in the focus group interview at any time if you experience any discomfort. In the event that you experience any difficulties such as emotional distress or discomfort, you may wish to contact the Employee and Family Assistance Program (EFAP) at the hospital toll free at 1-844-880-9142.

Focus groups will be conducted using Zoom, a virtual videoconferencing technology and participants can choose the location where they would like to participate.

A potential social risk is that focus groups cannot provide complete anonymity since all group members are able to see and interact with each other. There may be a risk of reprisal from supervisors, peers, or co-workers if the confidentiality and privacy of participants' responses in the focus groups becomes compromised. Although all focus group participants will be asked to keep the identities of which persons participate in the group along with any discussions confidential, anonymity and confidentiality cannot be guaranteed.

If you would like to participate can a member of the research team contact you to provide you with an information package and a consent form to sign?

NO – thank you for your time

YES – Name: _____ Phone # _____

Contact information: (email) _____

Thank you for your time!

Appendix E: Participant Recruitment Poster Phase 2

LaurentianUniversity
UniversitéLaurentienne

Attention Nurses

You are being invited to participate in a research study that is titled:
Assessing the Reliability and Validity of the Public Services Health and Safety Association Acute Care Violence Assessment Tool (VAT)

Your participation is needed for a Focus Group session that will evaluate the Violence Assessment Tool (VAT) to determine if there are missing factors, components, or behaviours in the VAT tool that need to be included, modified or changed to assess risk factors that may predict violence

Why participate in this study?

In Ontario, 56% of lost-time injuries were related to violence towards nurses working in acute care hospital settings

Aim of Study

The aim of this study is to assess the reliability and validity of the VAT instrument.

Process

The focus group is expected to take one to two hours of your time and will use Zoom technology to maintain social distancing requirements.

Nurses who have indicated willingness to participate and have given permission to be contacted by the research team will be given an information package with a consent form to sign.

Benefits of Participating

Your participation will provide valuable information on how the VAT instrument can predict the risk of violence for Front line health care workers in Northeastern Ontario

Who is Conducting this Study?

Judith Horrigan, RN, MSc.N, Ph.D.
Laurentian University, School of Nursing,
Renée Berquist, RN, PhD., St. Lawrence College,
Jessica Dugas, RN, MN, Sault College,
Leata Rigg, RN, MN., Northern College, &
Oghenefego Akpomi-Eferakeya, Graduate Student MSc. Program

Want More Information or have Questions?

Please contact:

Judith Horrigan, by telephone 705-675-1151 ext. 3718 or via email jhorrigan@laurentian.ca

This Study is Funded by:

The Centre for Research in Occupational Safety and Health (CROSH) &
The Public Services Health and Safety Association (PSHSA)

Appendix F: Phase 2 Focus Group Information Package and Informed Consent to Participate in a Research Study

Title of Study:	Assessing the Reliability and Validity of the Public Services Health and Safety Association (PSHSA) Acute Care Violence Assessment Tool (VAT)
Principal Investigator	Judith Horrigan, RN, MScN, PhD.
Co-Investigators	Jessica Dugas, RN, MN, Renée Berquist, RN, MScN, PhD. Leata Rigg, RN, MN. & Oghenefego Akpomi-Eferakeya, MBBS, MSc. (Graduate Student)
Funding Agency/Sponsors:	1. Centre for Research in Occupational Safety and Health (CROSH). c/o Laurentian University, Ramsey Lake Road, Sudbury, ON, P3E 2C6 2. Public Services Health and Safety Association (PSHSA). c/o 1800 18, 4950 Yonge St, North York, ON, M2N 6K1. 3. Laurentian University Research Fund, Laurentian University, Ramsey Lake Road, Sudbury, ON, P3E 2C6

Emergency Contact: In the event that you experience any difficulties such as emotional distress or discomfort, you may wish to contact the *Employee and Family Assistance Program (EFAP) at the hospital toll free at 1-844-880-9142.*

Questions or Concerns: If you have any questions or concerns about this study, you can contact: *Dr. Brian Mitchell the Joint Group Health Centre/Sault Area Hospital Research Ethics Board Chair* via telephone at 705-759-5560. You can also contact the *Research Ethics Officer, at the Laurentian University Research Office*, telephone: 705-675-1151 ext. 3213, or 2436 or call toll free at 1-800-461-4030 or via email: ethics@laurentian.ca.

You are being invited to take part in a research study.

This is a consent form. It provides a summary of the information the research team will discuss with you. If you decide that you would like to take part in this research study, please sign this form to confirm your decision. If you sign this form, you will receive a signed copy of this form for your records. Please know that you will not giving up or waiving any legal rights by signing this consent form and can withdraw your participation in the study at any time.

What you should know about this study:

- This form explains what will happen if you join this research study.
- Please read it carefully. Take as much time as you need.
- Please ask the research team questions about anything that is not clear.
- You can ask questions about the study any time.
- If you choose not to be in the study, it will not affect your employment.
- If you say 'Yes' now, you can still change your mind later.
- You can quit the study at any time.
- You will not have any ramifications to your employment if you decide not to participate in or quit the study later.

Why is this study being done?

Workplace violence has become an area of increasing concern with nurses being at a higher risk of violence in the workplace than other categories of health care providers and other workers (Registered Nurses Association of Ontario, 2009). In Ontario, 56% of lost-time injuries were related to violence towards Registered Nurses working in acute care hospital settings (Ontario Government, 2019). The RNAO (2009) suggested that workplace violence has significant impacts on nurses' physical and psychological health and on the retention of nurses in the workplace.

The Ministry of Labour, Training & Skills Development (MLTSD) and the Ministry of Health and Ministry of Long-Term Care (MOHLTC) have made reducing workplace violence in health settings a priority and have partnered with the Public Services Health and Safety Association (PSHSA) to develop tools to address workplace violence through the Violence, Aggression and Responsive Behaviour (VARB) Project (MOL & MOHLC, 2017). The PSHSA has developed the Acute Care Violence Assessment Tool (VAT) to assist in assessing the risk of violence by patients. This topic is relevant to nurses working in Northern Ontario. Findings from Horrigan's (2018) PhD. Study indicated that the majority of RNs (72.5%) reported experiencing physical violence and psychological violence (57%) by a patient. Since violence from patients presents the highest risk, the MLTSD and MOHLTC have recommended this tool to be used in all hospitals across Ontario as a means to identify and prevent violent events before an injury occurs. CROSH in partnership with PSHSA is conducting a pilot research study to determine the reliability and validity of the VAT instrument. The assessment of risk could prevent incidences of violence towards nurses and all Health Care Workers (HCWs) that would improve the occupational health and safety conditions in the workplace.

Why do I have the option of joining the study?

The purpose of this study is:

1. To determine the reliability and validity of the VAT instrument used to assess the risk of violence in acute care settings, and
2. To identify any existing gaps of information needed to be included in the tool.

There are two phases to this study:

Phase 1 involves collecting VAT assessments from patient's charts located in the Health Records department after they have been discharged. Information from the VAT assessment will be linked to any reported incidences of violence recorded on the patient's chart, employee incident reports, and or reported to the Occupational Health and Safety department.

Phase 2 involves virtual focus groups to identify any missing factors, components, or behaviours in the tool that need to be included modified or changed to assess risk factors that may predict violence.

Because the Sault Area Hospital nurses have been using the VAT assessment, you are now being asked to consent to participate in one focus group with nurse colleagues to identify any missing factors, components, or behaviours in the tool that need to be included modified or changed to assess risk factors that may predict violence. Nurses in the focus group will be fellow staff nurses. No one who has a position of authority over you will participate in your focus group.

If I agree to join this study, what would I need to do?

You will be participating in one virtual focus group that will involve approximately 6-8 nurses from one of the three care units (a medical unit, a mental health unit, and the Emergency

Department). The group will be conducted utilizing Zoom technology to respect physical distancing requirements. The Zoom platform that will be used is through Laurentian University, and not through the United States webpage. Laurentian Universities connection is secure and will be used to record the session.

The virtual focus group would take approximately one to two hours in length and held at a location that is convenient for the participants. Virtual focus groups will be shown a video using an actor to demonstrate potential risks of violence towards other persons. During the video nurses will use the VAT instrument to score the patient's risk of violence. Nurses will be asked to complete sections A and B of the VAT. Section A assesses risk indicators and behaviours. Section B involves calculating the overall risk rating and actions that may be taken associated with the score. After the video nurses will be asked to share their observations and identify any missing factors, components, or behaviours in the VAT instrument that may need to be included, modified or changed to assess risk factors that may predict violence.

What are the potential benefits if I join this study?

As a participant you will provide valuable information on the reliability and predictive validity of the VAT instrument to identify patients who may pose a risk of violence towards nurses and other health care workers. Knowledge from this study will be informing the PSHSA on ways that the VAT instrument may need to be revised. All stakeholders could benefit from reducing the number of injuries from violent incidences towards health care workers based on patient assessments using the VAT instrument. However, you may not get any benefit from being in this research study.

What are the potential harms or risks if I join this study?

There are no physical or medical risks to you from participating in this study, but it is possible that a question we ask may be stressful for you or make you uncomfortable. You may choose to decline to answer questions or decline to participate further in the focus group interview at any time if you experience any discomfort. You do not need to answer questions that make you uncomfortable or that you do not want to answer. The focus group will be recorded during the focus group session. In the event that you experience any difficulties such as emotional distress or discomfort, you may wish to contact your hospital EFAP toll free at 1-844-880-9142.

You are being asked to volunteer your time that is not paid by the hospital. Nurse participants will be given a $20.00 Tim Horton card for any inconvenience they experience. Focus groups will be conducted using Zoom, a virtual videoconferencing technology and participants can choose the location where they would like to participate.

A potential social risk is that focus groups cannot provide complete anonymity since all group members are able to see and interact with each other. There may be a risk of reprisal from supervisors, peers, or co-workers if the confidentiality and privacy of participants' responses in the focus groups becomes compromised. Although all focus group participants will be asked to keep the identities of which persons participate in the group along with any discussions confidential, anonymity and confidentiality cannot be guaranteed.

How would you keep my information confidential?

As previously mentioned, focus groups cannot guarantee anonymity and confidentiality. All participants will be asked not to identify participants and keep all discussion confidential. All information that is collected, used or disclosed for this study will be handled in a confidential manner. Anything that you say or do in the study will not be attributed to you personally. No identifying names will be used or linked to the group. Anything that we find out about you that could identify you will not be published or told to anyone else, unless we get your permission.

Reports based on the gathered data will contain no information that might link an individual with a particular quote, unless expressed permission has been granted.
No person or administrative personnel who have authority over your employment will have any access to your focus group data. No identifying information will be collected or shared to or with employers. The information obtained will be kept in a locked filing cabinet in a secure location of Dr. Judith Horrigan and be only available to the Principal Investigator's research team. All data stored on computers will be password protected. Any links of participants to data will be stored in a separate location to maintain confidentiality. The information (raw data) will be kept and destroyed in five years according to the Joint Group Health Centre/Sault Area Hospital research ethics board policies and procedures for data storage and destruction.
These are some reasons that we may need to share the information you give us with others:

- If it's required by law.
- If we think you or someone else could be harmed.

Do I have to join this study? What other options are there?
Your participation in this study is voluntary. You may decide not to be in this study, or to be in the study now, and then change your mind later. Your decision will not affect your current or future employment at the Sault Area Hospital. The research team will tell you about new information that may affect your health, welfare, or willingness to stay in this study.
Other groups that may look at the study records include:
The Joint Group Health Centre/Sault Area Hospital Research Ethics Board oversees the ethical conduct of this study at this hospital.
Would it cost me money to be in the study?
It will not cost you money to participate in this study.
Would I be paid if I join this study?
You will not be paid for participation in this study. Participation in the focus groups is voluntary and to be held outside of the time they are scheduled to work. A $20.00 Tim Horton's card will be provided to the participants as appreciation for your time.
Who do I contact if I have problems, questions, or want more information?
For any comment or questions about your rights as a participant in a study, you may contact *Dr. Brian Mitchell the Joint Group Health Centre/Sault Area Hospital Research Ethics Board Chair via telephone at 705-759-5560*. The Research Ethics Board is a group of people who oversee the ethical conduct of research studies. These people are not part of the study team. Everything that you discuss will be kept confidential.
You can also contact the *Research Ethics Officer, at the Laurentian University Research Office, telephone: 705-675-1151 ext. 3213, or 2436 or call toll free at 1-800-461-4030* or via email ethics@laurentian.ca.
For more information about the study you can also contact the Principal Investigator, Judith Horrigan RN, MSc.N, PhD, for more information via email at jhorrigan@laurentian.ca

Phase 2: Focus Group Consent to Participate in a Research Study

Title of Study:	Assessing the Reliability and Validity of the Public Services Health and Safety Association (PSHSA) Acute Care Violence Assessment Tool (VAT)
Principal Investigator	Judith Horrigan, RN, MScN, PhD.
Co-Investigators	Renée Berquist, RN, MScN, PhD. Jessica Dugas, RN, MN, Leata Rigg, RN, MN. & Oghenefego Akpomi-Eferakeya, MBBS, MSc. (Graduate Student)
Funding Agency/Sponsors:	1. Centre for Research in Occupational Safety and Health (CROSH). c/o Laurentian University, Ramsey Lake Road, Sudbury, ON, P3E 2C6 2. Public Services Health and Safety Association (PSHSA). c/o 1800 18, 4950 Yonge St, North York, ON, M2N 6K1. 3. Laurentian University Research Fund, Laurentian University, Ramsey Lake Road, Sudbury, ON, P3E 2C6

Emergency Contact: In the event that you experience any difficulties such as emotional distress or discomfort, you may wish to contact the *Employee and Family Assistance Program (EFAP) at the hospital toll free at 1-844-880-9142*. If you have any questions or concerns about this study, you can contact the *Joint Group Health Centre/Sault Area Hospital REB Chair Dr. Brian Mitchell via telephone at 705-759-5560.* You can also contact the *Research Ethics Officer, at the Laurentian University Research Office, telephone: 705-675-1151 ext. 3213, or 2436 or call toll free at 1-800-461-4030* or via email: ethics@laurentian.ca.

Declaration of Consent

By signing this form, I confirm that:

- This research study has been fully explained to me and all of my questions answered to my satisfaction;
- I have read each page of this form and I understand the requirements of participating in this research study;
- I understand I have legal rights as a research participant and that by signing this form I do not give up or waive these legal rights;
- I voluntarily agree to take part in this study.

_____ _____ _____

Signature of Participant PRINTED NAME Date

Person obtaining consent: By signing this form, I confirm that:

- This study and its purpose has been explained to the participant named above
- All questions asked by the participant have been answered
- I will give a copy of this signed and dated document to the participant

_____ _____ _____

Signature of Person Conducting PRINTED NAME Date
the Consent Discussion

Appendix G: Focus Group Interview Questionnaire for VAT Study

1. Can you tell us a little about yourselves?

Introduce Case Study Video for VAT Assessment

We have 4 videos of actors who will demonstrate a variety of behaviors.
We would like each of you to assess each of the patients individually using the VAT instrument. Please complete the sections A and B during the video. After each video we will pause to ensure you are done your assessment, before showing the next video.

Show Videos

Following the viewing of all videos: Is everyone done their assessments? Now we would like to go around and check in with each of you to see what your findings are. We will discuss each scenario individually.

1. Can each of you share the observations of your assessments? What behaviors were noted?

2. Lets take a look at the similarities.

3. Now let's look at the differences.

4. What are your thoughts on these similarities and differences?
   a. Are there factors that influenced your scoring?
   b. Have you had past experiences that may have influenced your scoring?
   c. How do you think your nursing background may have influenced your assessments?
   d. Can you tell us more about that?

5. Can you tell us a bit about your experience with this form?
   a. Prior to this study were you familiar with it?
   b. Can you tell us more about that?
6. What are your thoughts on the use of this tool to assess the risk of violence in patients?
   a. Is the form user friendly?
   b. In your opinion has it been helpful in identifying patients at risk of violence?
      i. Can you tell us more about that?
   c. Have you experienced any challenges or barriers in using the VAT tool?
      i. Can you tell us more about that?
7. Would you recommend any changes/revisions to the tool?
   a. Have you identified any missing behaviors or components that could be included in this tool?
   b. Are there any other changes you would recommend?

Interview Focus Group Questions:

5. Have any of you experienced physical or psychological violence in the workplace?
    a. Can you tell us more about that?
    b) How often has this occurred?
6. According to the Occupational Health & Safety Act of the Government of Ontario. Violence has been categorized into four types.

Type I or the External Perpetrator: where the violent person has no relationship to the worker or workplace
Type II or the Client/Customer: where the violent person is a client at the workplace who becomes violent towards a worker or another client,
Type III or Employment Related: where the violent person is a worker or has/had some type of job-related involvement with the workplace,
Type IV or Domestic Violence: where the violent person has a personal relationship with an employee or client

    a. What is the most common type of violence you've witnessed/experienced?
    b. How would you categorize the violence you have witnessed/experienced? (type I, II, or III)
7. Do you have any suggestions we can bring to hospital administration to help address violence in the workplace?

8. Are there any other comments or information that you
would you like to add? Either about the tool itself or management of violence in general.
9. Can you tell us more about that

Other prompts:

- Can you please explain more about that?
- Can you give me more details?

Thank you again for your time

Appendix H: Focus Group Demographic Interview Questionnaire for VAT Study

Date of Interview (day/month/year): _____ Place of Interview: Zoom

Hello, we would first like to say thank you again for participating in this interview. We are (names of researcher and facilitators) and will be conducting this session. We would like you to share your experiences with the use of the Violence Assessment Tool. There are no right or wrong answers to the questions we will ask you. Feel free to ask us to repeat the question or ask for clarification if you do not understand the question. You may also choose not to answer a question. If you need a pause or a break, we can stop the interview at any time.

Each of you were given the information package and consent form prior to this focus group meeting. Do you have any questions before we start?

We have a short questionnaire that we are asking you to complete. Please take a few minutes to fill in the demographic questionnaire.

Demographic Questionnaire

1. Please circle your qualification RN RPN Other _____

2. Please check off your age range
- 20-30 ☐
- 30-40 ☐
- 40-50 ☐
- 50-60 ☐
- 60+ ☐

3. Please check off your job Status
- Full Time ☐
- Part Time ☐
- Casual ☐
- Other _____

4. Years of Working Experience
- <1 year ☐
- 1-5 years ☐
- 5-10 years ☐
- 10-15 years ☐
- 15-20 years ☐
- 20-25 years ☐
- 25-30 years ☐
- >30 years ☐

5. Years Working at Sault Area Hospital
- <1 year ☐
- 1-5 years ☐
- 5-10 years ☐
- 10-15 years ☐
- 15-20 years ☐
- 20-25 years ☐
- 25-30 years ☐
- >30 years ☐

6a. What patient care unit do you work on? Medical Unit 3B ☐

Mental Health Unit ☐

Emergency Department ☐

6b. How many months/years have you worked in this care unit? _____ (months) ____ (years)

7. Sex:

Female ☐ Male ☐ No Response/Rather not say ☐

8. Highest Level of Education

Diploma ☐

Nursing Degree ☐

Masters Degree in Nursing ☐

Masters Degree Other ☐

PhD Degree in Nursing ☐

PhD Degree Other ☐

8a. Experiences of Physical Violence:
Have you ever experienced any physical violence in the workplace?
*Physical Violence is defined as: "the use of physical force against another person or group, that results in physical, sexual or psychological harm. It includes among others, beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching".

☐Yes ☐No

8b. If Yes: Did you experience physical violence from:

☐a Patient ☐a Patient's family ☐a Co-worker ☐Other:

9a. Experiences of Psychological Violence:
Have you ever experienced any psychological violence in the workplace?
*Psychological Violence is defined as the: "intentional use of power, including threat of physical force, against another person or group, that can result in harm to physical, mental, spiritual, moral or social development. It includes verbal abuse, bullying/mobbing, harassment and threats"

☐Yes ☐No

9b. If Yes: Did you experience psychological violence from:

☐a Patient ☐a Patient's family ☐a Co-worker ☐Other:

*Definitions taken from: pp. 3-4. International Labour Office, International Council of Nurses, World Health Organization, & Public Services International. Joint Program on workplace violence in the Health Sector. (2002). Framework guidelines for addressing workplace violence in the health sector. Geneva, Switzerland: Authors, pp. 3-4 [47]

Appendix I: Transcription Conventions

1. Each speech contribution is transcribed as a separate paragraph. To increase readability, after the paragraph, a blank line is added.
2. Paragraphs for interviewer(s) or moderator(s) are introduced by "I:" or "M:", those for the interviewee(s) by unique abbreviations, e.g., "R:". Numbers are added to the abbreviations ("M1:", "M2:", "R1:", "R2:", etc.) to distinguish between several people in a recording. As an alternative to abbreviations, names or pseudonyms can be used. Labels for speakers are written in bold for better recognition.
3. Speech is transcribed verbatim, i.e., not phonetically or in summary form. Dialects are not transcribed but translated as accurately as possible into the standard form, e.g., standard English.
4. Language and punctuation are standardized slightly where necessary, i.e. to approximate written language. For example, from "He's gonna write a book" to "He is going to write a book." The word order, definite and indefinite articles, etc. are retained even if they contain errors.
5. Clear, longer pauses are indicated by ellipsis points in brackets (...). Depending on the length of the pause in seconds, one, two, or three points are used; for longer pauses, a number (in digits) corresponding to the duration in seconds.
6. Intentionally stressed words are underlined.
7. Very loud speech is indicated by writing in capital letters.
8. Affirmative or agreeing utterances made by interviewers (mhm, aha, etc.) are not transcribed so long as they do not interrupt the flow of speech of the interviewee.
9. Short interjections made by the other person, such as "Yes" or "No," are included in brackets in the speech without starting a new paragraph.
10. External interruptions or interferences are noted in double brackets stating the cause, e.g., (cell phone rings).
11. Vocal utterances made by both the interviewee and the interviewer are noted in simple brackets, e.g., (laughs), (groans), or similar.
12. For videos: nonverbal actions are placed in simple brackets, such as (opens the window), (turns away), or similar.
13. Incomprehensible words and sections are identified by (unclear).
14. All information that would allow an interviewee to be identified is to be rendered anonymous**.**

(Kuckartz & Radiker, 2019, p. 42).